Population Review

Volume 43, Number 2, 2004

Type: Report pp. 101-119

Men’s Understanding of Women’s Health Issues in Kanpur City, India: A Preliminary Research Report

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Introduction

This report presents preliminary findings gleaned from a research project on men’s understanding of women’s health issues in a rural village outside of Kanpur, one of the largest cities in India. The growing importance of socio-psychological models of health in the area of health care decision-making, coupled with recent thinking that it is imperative to involve men in women’s health care development projects, were the main motivations for the study. Several studies have identified the significance of cultural beliefs associated with health and illness (Herzlich, 1973; MacElroy and Jezewski, 2001; Siegrist, 2001). It is now clear that in a patrifocal society one cannot do much to empower women without involving men (Necchi, 2001), and programme efforts will have limited impact unless men are reached (Pachauri, 1999). Health depends on several factors such as social representations, family support, awareness, choices, and health seeking behavior. All of these factors in turn depend on social structure and social roles. Thus it is important to examine how and what men think about women’s health issues. This paper attempts to provide preliminary answers to several questions: What are men’s beliefs regarding the importance of women’s health? What are the elements of men’s thinking that most importantly impact women’s health? What general factors affect women’s health and well-being? Does urban contact and concomitant changes have a positive or a negative impact on health? What health care options are available to people? This report attempts to answer these questions and identifies some research gaps to be addressed in the future.

Objectives of the Study

The main objectives of the present study are to:

- examine men’s views regarding the importance of women’s health in a rural

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setting;

- examine men's representations of women's health and illness and their implications for the health and well-being of women;
- explore the subjective understanding of diseases of women, particularly those associated with reproductive health;
- examine to what degree and extent husbands and wives communicate about women's health problems and health seeking options available to them;
- examine men's views on the prevalence of domestic violence and ways of preventing it;
- explore family size norms, family-planning preferences and family planning practices;
- explore knowledge about HIV/AIDS.

Methodology

This study is based on a survey of all currently married males aged twenty to fifty-five living in Itara, a small village located just outside of the city of Kanpur. In order to achieve the above stated objectives of the study, a questionnaire was prepared covering the following items: socio-demographic characteristics of the respondents, subjective indicators of health, extent and causes of domestic violence, ideal family size, family planning practices, and health choices. The questionnaire was pre-tested and modified in the same village. The survey team, consisting of two investigators, spent more than a month collecting data from the village. Prior to the investigation, one of the investigators had worked for a long period of time in Itara (working in the area of health care) and had developed a good rapport with the people. The authors of this study held two focus group discussions in the presence of the investigators when the fieldwork was over.

Background of the Village

Itara is divided into two hamlets located at the periphery of the city of Kanpur. It is about fifteen kilometers from the outskirts of Kanpur and about eight kilometers from Manthana, a small town, situated along the famous G.T. Road. Good roads connect Itara to the outside world but there is no public transport to the village. As per the records of Gram Sabha (the village governing body), the population of the village is 2,700. The list of registered voters contains 830 names. The voters list, however, may not be a good source of data on population. The reason is that many families have left the village and are not likely to return back, but the voters list (a list of voters prepared by the election office for the purpose of voting in elections for legislative assembly and parliament) and village records continue to include them. The actual number of families in the village is around 155. Nearly 50 percent of the whole population of the village consists of *Yadavas* (a caste of people who were traditionally involved with raising herds). The rest of the population is mixed and is spread across the *Brahmin*, *Thakur*, *Dhobi*, *Lohar*, *Nai, Muslim* and *Teli* castes. The village *sarpanch* (i.e., the elected head of the village governing body) belongs to the *Thakur* caste. The village is quite peaceful. Caste

rivalries which are common to many villages in the state are not observed in Itara.

The main occupation of the villagers is farming. For most, the landholding size is small. The majority of respondents have less than five *bighas* (two acres) of land. Around 25 percent have up to twenty *bighas* (eight acres). A few families have more than twenty *bighas.* Among them the inherited land has not yet been divided among married brothers. Some of the brothers are not living in the village, but their claim to the land still exists and they exchange cash and farm produce with the brother living in the village. Most of the land is irrigated via canal and pumping sets. Thanks to improvements in infrastructure, irrigation facilities, and techniques of production, land productivity has risen significantly in the last few decades, but the farmers are not better off. The cost of farm inputs (seed, irrigation, labour, chemical fertilizers, pesticides, etc.) has risen considerably and most farmers are at the subsistence level. Consequently agriculture is not a profitable activity for small and marginal farmers. They are doing this simply because "there are no employment opportunities elsewhere." To supplement their income, most people engage in dairy farming. Ninety percent of the farmers maintain cattle. The people of Itara sell milk and other dairy products in Kanpur. Some sell milk at the village collection centre which is supported by a local NGO. Most people are illiterate. Two schools have been opened recently in the village. These schools provide education up to Intermediate (twelfth standard) level. As most of the houses in the village are of *pucca* (brick and cement) construction, the people of the village may look quite well off (from Indian standards) to an outsider. But in reality, the economic conditions of the people are quite precarious, and for most of the villagers life is extremely difficult. Nearly one third of the families are officially classified as living below the poverty line (called BPL in local parlance). Village roads are broken. They are made of bricks and are poorly maintained. As in the other parts of rural Uttar Pradesh, cow dung clogs the roadside drains and dirt and mud are everywhere.

The health infrastructure in rural areas in the whole state of Uttar Pradesh is very poor. Consequently, people depend on private practitioners who are basically quacks and have no degree in allopathic medicine. Most of them are untrained. There are no trained practitioners of Indian system of medicine either (Yunani, Ayurvedic or Homeopathic) in the area. An Auxiliary Nurse and Midwife (ANM) named Chandramukhi works in the village, but she lives in Manthana. Unfortunately, she lost her eyesight and cannot walk properly without assistance. Her son performs all the duties (immunization, maintaining registers, etc.) assigned to her by the state government. Cultural norms of the area permit such informal arrangements for formal roles. There is one traditional healer in the village. He is known for treating illnesses with locally available herbs. In addition, he is often called upon to insert *birba* (a folk remedy derived from the root of a local plant) in the vagina for treatment of reproductive problems and for abortion. Nobody other than the healer has any knowledge about what herbal preparations he uses. According to the village sarpanch "there are no health or family welfare activities in the village."

The Respondents

As mentioned above, there are about 155 families in the village. The survey team could identify only 149 male respondents in the age group 20 - 55 years. All of them were interviewed. Other men were not available in the village when the survey took place. The

average age of the respondents is 35.5 years. The average age of wife of the respondents is 32.2 years. Average annual family income of the respondents is Rs. 31, 940 (nearly 750 US dollars). The main sources of income are agriculture and animal husbandry (particularly the sale of buffalo milk). The sex ratio among children is 883 females per 1,000 males. Focus group discussions (FGD) showed that female infanticide is not in existence anymore and the practice of foeticide on the basis of a sex-determination test during pregnancy is not there. People have neither the facilities nor the money for a sex-determination test during pregnancy. Thus "neglect of female babies" most likely explains the low sex ratio. As shown by Keyfitz (1968), a stopping rule in favor of male children could also be a significant reason behind the low proportion of female children in the population.

Itara is a male dominated village. Women are subservient to men and have lesser decision making power in the family than do men. Sex roles are clearly distinguished and the sexual division of labor is apparent to any observer. Males work in the fields and sell milk. Some of them work as laborers in the adjoining city. Women remain at home and do all of the household jobs and take care of dependent children. Only five women were found working outside of the house. One was a *Nain* (a lady belonging to the caste of barbers), who gives massages to women for up to two weeks after childbirth and applies colors to body parts. A second one was a washerwoman. A third was an *anganwadi* worker--a village level functionary appointed by the state government to take care of educational, nutritional and health needs of the younger children of the village. She is also responsible for various other works assigned to her from time to time. And the fourth and fifth women working outside of the home were two landless laborers. Unlike other *Yadava* dominated villages where women participate in raising animals, grazing and milking, most women of Itara do not work outside their homes. A sociologist may explain this by evoking the *Thakur* model of *sanskritization (a social process in India by which lower castes emulate the culture of the people of the warrior castes and whereby they can claim a higher position on the caste hierarchy)*. It is believed to be unlike a *Thakur* to permit women to move freely outside the house. One cannot see a *Brahmin* or a *Thakur* woman outside, though one can sometimes see a few *Yadava* women working outside home. In a study of Uttar Pradesh and Karnataka, Rahman and Rao (2004) noted a "negative wealth effect" on the status of women in which a rise in wealth in rural society suppresses the traditional work and social power of women. The situation in Itara is no exception to this rule.

Various types of changes are occurring in rural society. Some of them have a positive effect on status of women, while others have a negative effect. Nucleation of family seems to have a net positive effect. In nuclear families, married women do not live under the power of the mother-in-law. As such, family nucleation liberates women. A nuclear family is associated with interdependence of sex roles and greater equality. Other cultural changes such as *sanskritization*, however, may have an adverse effect. Higher status in the caste hierarchy is associated with restrictions on women's movements. When their freedom is restricted by new status-values, women cannot move around freely or mix with other men and women of the village. In this situation, they have very little interaction with the outside world and are dependent on husbands for virtually everything. Consequently, the gains from family nucleation are neutralized by new status considerations in which caste pride plays an important role. For example: During an

informal conversation, the village *sarpanch* said that a few days before he had broken his TV set because after seeing the TV serials his wife had started saying that she had equal rights in all matters.

Major Findings

The major findings of the study, based on interviews with 149 male respondents, are given below. They are organized into separate sections: importance of women's health and social representations of health and illness; prevalence of diseases with special reference to reproductive health; husband and wife communication; health care options and health seeking behavior; domestic violence; family size and family planning; and sexuality.

Importance of women's health and social representations of health and illness

Data on perceptions of male respondents regarding the importance of women's health show that women's health is quite important for husbands. The reasons given for this are primarily functional. For example, informants believe that maintaining the house and raising children are the two most important roles for women and that a healthy woman can perform these roles more effectively than an ill woman (Table 1). 91.9 percent of the respondents said that the health of a woman is important for the performance of household chores. 55 percent of the respondents said that healthy women are in a better position to take care of children. "If they are healthy they can more effectively perform their traditional roles of taking care of the house and children." Moreover, respondents asserted that a healthy woman maintains peace and harmony in the family, provides greater sexual satisfaction to her husband, contributes to family income by taking care of cows and buffaloes, and attends to visitors.

How do men know whether women are healthy or not? There are always some subjective indicators of health and illness that are commonly used by the respondents. Therefore the following question was asked: "What indicates that a woman is healthy or ill?" Table 2 presents data on representations of health and illness. For the majority of respondents (64.4 percent) a smiling face is the best indication that a woman is in good health. Being active and alert or doing all household chores efficiently is another indicator. In order of number of responses, answers to the question as to what indicates that a woman is ill are as follows: looks lazy/tired; cannot serve the family members; gets to cot (meaning that she always wants to lie down); and becomes irritable. Other responses (less than five in number) are as follows: beats children; complains about small matters; is seen taking home remedies; and tells someone in the family. In most cases, women would not immediately tell anyone in the family about their health problems. They ignore the initial symptoms and tolerate till the problem becomes quite severe. In addition, husbands may not assess the severity of wives' problems simply from "reading their face." Husbands, spend very little time with wives. Only when a problem becomes severe do women tell their husbands about it. Oftentimes this leads to delays in detection of the problem, and delays in meeting the doctor.

Major diseases of women

Frequencies of reported diseases prevalent among women in Itara are shown in Table 3. The main diseases affecting women are headache, abdominal pain, fever, white discharge, backache, cholera, filaria, and eye pain, reported by 46.3 percent, 42.3 percent, 34.2 percent, 32.9 percent, 22.8 percent, 18.8 percent, 8.1 percent and 6.0 percent respondents respectively. (Percentages add to more than 100 due to multiple responses.) All of these problems, with the exception of white discharge, are common problems that are not confined to women. Among them, backache may sometimes be caused by gynecological problems. However, only limited conclusions can be drawn on the basis of the reported illness. To assess the real patterns of diseases prevalent among women one needs reliable clinical and/or hospital data. Illiterate informants cannot identify the real cause of illness. They cannot even diagnose properly what kind of health problem they or their wives have. When people are asked to state what could be the reasons behind the above-mentioned diseases, a large number of respondents failed to give any reason. Others attributed them to poor diet, lack of cleanliness, change of weather, worries, overwork, and inability to stick to a fixed time for meals.

The question on the nature and cause of illness was followed by a question about knowledge of reproductive health problems. The results of the analysis show a mixed picture (data not tabulated in this paper). More than half of the male respondents seem to know about personal and reproductive health problems of women, but as many as 39.60 percent of the respondents do not know about such problems among women. In all, 46.31 percent of the respondents mentioned *prasoot rog* (white discharge) as a reproductive health problem. Irregular menses was reported by 17.4 percent respondents, excessive bleeding by 10.1 percent, inflammation of the uterus by 4.7 percent, boils on the vagina by 4.0 percent of the respondents, and all other reproductive health problems by less than 3 percent of the respondents. In order of number of responses, these other problems include irregular menses, excessive bleeding, inflammation of the uterus, delay in childbirth, *kinahi fansna* (placenta) or "child not coming out," uterus prolapse, early pregnancy, breast tumor, non-medical or unprotected termination of pregnancy, sterility, and AIDS.

About possible causes of women's health problems, the majority of respondents said that they do not understand the causes. 10.7 percent said that diseases are caused by lack of nutritious food; 9.4 percent said that they are due to lack of personal hygiene; and another 9.4 percent said that they are due to overwork (They aver that due to lack of assistance women continue to work hard even during pregnancy time and that is one of the major causes of health problems among women). A small percentage of respondents attributed women's health problems to being sexually active up until the time of delivery, weakness, taking hot and spicy food, excessive sex or sex during menstruation, early childbirth, or a large number of children (data not tabulated in this paper). It comes naturally to rural people to attribute the unique problems of women's to sex and reproduction, but very few of them realize that many of the reproductive problems arise from infections.

During focus group discussions (FGD) it was said that the problem of white discharge is very common among women. The consensus was that "80 percent" of the women have been suffering from this problem. However, in the survey only 30.2 percent of the respondents expressed that their wives had a reproductive health problem. In response to

the question on whether their wives had a health problem (permitting up to three responses), 69.8 percent of the respondents said that their wives had no health problem. In order of number of responses, the other 31.2 percent reported the following health problems: headache (10), weakness (7), abdominal pain (7), breathing trouble with swelling on body (5), irritation in eyes (5), backache (4), white discharge (3), cold (2), piles (1), irregular menstruation (1), sleeplessness (1), pain in joints (1), mental problem (1), breast pain (1), asthma/breathing trouble (1), and inflammation of uterus (1). Probing further, the respondents were asked whether their wives had any reproductive health problem. In response, 20.1 percent of the respondents said that their wives had a reproductive problem such as watery/white discharge, irregular menses, bleeding for more number of days than normal, boils on vagina, inflammation of uterus, uterus prolapse, infertility, and gastric problem. Out of 149 respondents, as many as 9.4 percent respondents mentioned watery/white discharge alone. 4.0 percent mentioned about irregular menses and 3.4 percent about bleeding. Other problems were mentioned by less than 3.3 percent (5) of the respondents.

It may be noted that in the socio-economic milieu of Itara the survey data are likely to underestimate the extent of health problems among women as women's reproductive problems are defined as normal or "inevitable lot in life" rather than as a treatable condition. A culture of silence prevails in the village (Dixon-Mueller, 2001) and women's problems remain unnoticed or neglected. At the same time, focus group discussions might overestimate the extent of the health problems. It may be surmised that in focus group discussion those who have known such problems or whose wives are suffering from such problems tend to dominate the discussion. Those who have not known health problems, tend to keep silent despite interventions from the researchers.

Husband-wife communication

Do husbands talk to their wives about reproductive problems? What options are available to them in case their wives have health problems? Analysis shows that most men have been talking to their wives regarding reproductive problems. Only a small minority of respondents (27.5 percent) do not discuss reproductive problems with their wives. They perceive no need for such discussions. The majority of respondents (72.5 percent) discuss such problems with their wives (data not tabulated in this paper). When such problems come up for discussion, they talk about what can be done about the problem, what options are available to them, what they should do about the problem, where they can get treatment, and how they can arrange the money needed for treatment.

The following section deals with two issues. First, what do the residents do when their wives fall ill? And second, the various options that the residents of Itara have with regard to diagnosis and treatment of illness.

Health seeking behavior and options

The first and foremost sociological question regarding the health seeking behavior among rural people is: What do they want to do in case of an illness? The common assumption about traditional societies is that people place greater faith in home remedies and indigenous herbal preparations than in modern medicines. The present study does not corroborate this. The data show that when men come to know about their wives' illness they look for various alternatives. 51.7 percent of them approach the ANM or medical

doctor, 26.8 percent opt for home remedies or herbal preparations, 14.1 percent attempt to change dietary practices, 12.7 percent discuss the problem with the elderly people in the village, 6.7 percent approach the local *dai* (traditional birth attendant), 6.0 percent purchase some medicine from a medical shop without consulting a doctor (this option is exercised mostly in cases of common seasonal diseases), and a few abstain from sex or take action to improve personal hygiene. It seems that if the appropriate facilities are available, people chose scientific medicine over magic, traditional healing or indigenous knowledge. It is worth noting that non-scientific healing practices and associated practitioners are on the decline.

From the FGDs it is clearly established that in Itara the health needs of women are placed much below those of men, children, and even animals. Men and children, especially male children, are first to draw attention if they have a health problem. It is not an exaggeration to say that the people of Itara show greater concern about their animals than they do about their women. If a buffalo falls sick, even for one day, it will be taken to a veterinary doctor for treatment. But, all too often, if a wife falls sick no attention is paid to her. To quote a respondent: "As long as a woman can feed the animals she is seen as healthy. When she cannot do so or cannot cook meals she is seen as sick." Men feel that health problems among women are natural. Unless they become too weak or are in critical condition, no action may be required. Most of the time when they are finally taken to a doctor they are already in a serious condition.

The problem caused by neglect of women is compounded by the fact that trained medical doctors are not within the reach (i.e., within the vicinity of the village) of most people. Lack of time (in a subsistence economy it is difficult for people to abstain from work even for a day or two) and money also discourages people to do anything about women's health. It is surprising that urban contact has hardly changed the level of sensitivity to women's health issues. Culturally, the men of Itara are hardly distinguishable from those of remote villages. The new prosperity arising from better prices for milk (thanks to the activities of a local NGO) has made them more assertive. As stated earlier, the new prosperity has reduced the *perceived economic contribution* of women. As a consequence, it has lowered the overall power of women within the family.

As to what husbands can do when their wives fall ill, 87.9 percent of the respondents say that they can help their wives by "taking them to a doctor." 20.1 percent say that they can help their wives by saving money or borrowing money for "bad days". A few of them assert that they should refrain from sex or get her an herbal medicine (data not tabulated in this paper). It is not surprising that 79.8 percent of all the respondents cannot identify a person in the village or the nearby area who treats women for general health problems. 10.1 percent of the respondents provide the names of doctors who do not have any formal training in modern medicine. Some of them have a degree in *Ayurveda* (there are many institutions which give such degrees but the credibility of such degrees is very low) but they are practicing allopathic medicine. Some are quacks without any formal training. In the absence of proper facilities, village people approach them for treatment even when they knew that the consulting practitioner does not have any formal training and may prescribe a wrong treatment. A few respondents list the names of traditional *vaidyas* (i.e., *Ayurvedic* practitioners), primary health centre doctors, traditional *dais*, or ANMs.

It must be stressed that recognition of health problems and knowledge of a doctor may barely create a situation in which a man may think of going to a doctor. To actually

consult a doctor one requires money. Since the people of Itara earn just enough to survive, illness of a family member often produces a serious financial crisis. In this context, a husband may be aware that his wife has a health problem, and may even be inclined to take action to treat her problem, but various factors compel him not to act. There are several reasons for not acting:

- The degree of severity is perceived to be low (in large part because people do not want to accept the condition of helplessness).
- There is no doctor in the neighborhood.
- In the opinion of elderly family members irregular menses, etc. are common problems of women that need no attention, and they can be cured with home remedies and dietary control.
- It is not possible to go to Kanpur frequently because of time and monetary constraints.
- People cannot afford the doctor's fees or bear the high cost of medicines.
- Herbal treatment is thought to be sufficient.
- No need is felt, and the husband thinks that "it is natural for a woman to have some or other type of problem always."

Shortage of money and lack of reach of health facilities are two major factors that prevent people from utilizing state health services. For medical treatment people have to go to Chaubepur, Mandhana, IIT or Kanpur city. To quote a respondent: "They could go to a doctor only when they have money. If they do not have money, they cannot do anything." Another respondent said: "At the primary health centre too the story is the same. First of all, that is also far away. Then you have to buy medicines from the open market. Doctors do not give you anything. They simply prescribe medicines to be bought from the medical shops. Also the doctors placed at the hospital (state run primary health centres) are not competent and concerned." These observations apply both to men and women. Yet, since women have a lower place in family, though they may have greater health requirements, they tend to suffer more.

Domestic violence

Among other things, indicators of female reproductive health include freedom from sexual relations and harmful or unwanted sexual practices (including violence and coercion within sexual relationships), an absence of reproductive tract infections, and the capacity to determine the number and spacing of births (Dixon-Mueller, 2001). Not much is known about violence within sexual relationships in India. National Family Health Survey (NFHS-2) data has shown that in India southern states have a greater degree of domestic violence than the northern states, even though the latter are socially less developed than the former (IIPS, 2000). To explain the seeming contradiction between indicators of social development and domestic violence in India, one has to look critically at the methodology of the survey and the quality of data on domestic violence produced by NFHS-2. It is also possible that, due to higher levels of literacy and legal awareness in the southern states, reporting of domestic violence in the survey is better there than in the northern states. Moreover, in the northern states there may be greater acceptance of

domestic violence and, therefore, much of it is hidden in the survey. It may also be hypothesized that early gains in development and education among women may be associated with greater violence against women because with better opportunities and better education both males and females become more assertive at both the social and familial level. This seems to be the case in Itara today. As time passes, however, the forces of family nucleation, education, legal consciousness and greater interdependence of spouses may reduce the level of violence against women in the family.

46.3 percent of the respondents (69) accept that there have been occasions when out of aggression they or other members of the family beat their wives. In most cases the husband himself beats the wife. Among 19.4 percent of the cases (29) detailing the number of beatings during the last month, 14.1 percent husbands (21) beat their wives once during the last month, 4.0 percent (6) twice, and 1.3 percent (2) three times or more.

The study also included a few questions on the causes of domestic violence and ways of preventing it. The question on causes of domestic violence was asked in two ways. First, by referring to the causes of violence in their own house. And second, by referring to the general village situation. In both cases similar answers were given. Yet, more people responded to the second question than to the first one. The data show there are several factors that lead to domestic violence or wife beating. Wife beating practice is well accepted and is both a manifestation and legitimation of male dominance. Out of 149 male respondents, 48.3 percent said that the main cause of domestic violence is the failure of wife to agree with the husband on familial and other issues (Table 4). Other major responses regarding causes of domestic violence are liquor consumption among men (31.5 percent), suspicion regarding wife's character (30.9 percent), and the sale of grains without the husband's knowledge (28.9 percent). The question regarding what a woman can do to save her from domestic violence was asked only generally, and respondents were free to give up to three responses. The following responses were forthcoming: a wife should not argue with her husband (47.0 percent); a woman should finish her work on time (34.2 percent); a woman should respect the elderly members of the family (20.1 percent); and a wife should follow her husband (18.8 percent).

Several studies within and outside of India suggest that there is a connection between a woman's refusal to have sex with her husband and domestic violence. When the question was asked whether refusal to have sex with husband leads to domestic violence, 80.5 percent of males responded (120) positively, thus corroborating the connection.

According to the qualitative data obtained during the study, the following situations can lead to wife beating: wife is too assertive and makes independent decisions; husband comes home in a state of intoxication and beats his wife; and husband puts pressure on his wife for sex against her wish. Unemployment, leading to rising tensions within the family, increasing use of liquor, and suspicion of infidelity are also implicated as factors leading to domestic violence. At the same time it must be said that the situation is changing. Younger generation males are more caring and concerned about spouses than was the case earlier. Nucleation of family leading to greater interdependence of husband and wife may be posited to be the main factor behind this. Parental concern may be another. In the past, for the parents of a daughter, arranging for her marriage was like giving her in *kanyadan* (charity). Now parents are much more concerned about the fate of the married daughters. "These days girls' parents ensure that they give their daughter to such a family in marriage in which there is a separate room for the new couple and there

is no interference of in-laws," said a milkman.

Family size and family planning

Reproductive health issues are intricately linked with family size and family planning practices. Therefore, a few questions were asked on these matters. As is the case elsewhere in rural UP, the ideal number of children in Itara is two--one son and one daughter. Some people want two sons and one daughter. But, by and large, no one wants a large family. Only two respondents said that if they had more children they would have more *hanak* (power) in the village and kin circle. Further probing on this matter revealed that, while the association between numbers of children and power might be true in Itara, these two respondents did not want to have a large family. They were repeating an old position that is no longer relevant with regard to decisions on family size. The mean of the ideal family size (IFS) is low at 2.75. Yet, the average number of living children is 3.36, and nearly half of the respondents (48.32 percent) have five or more living children. 23.49 percent of the respondents have six or more living children. (Data not tabulated in this paper).

The knowledge of family planning methods is universal. Everybody knows about tubectomy, vasectomy, condoms and pills. Half of the respondents know about copper-T. 38.9 percent of the respondents (58) know about natural methods, but only 12.1 percent (18) know about "injections (injectables)" (Data not tabulated in this paper). There is a caveat here. Respondents' understanding of family planning methods, particularly natural methods, is far from exact. For example, they think that the menstruation time and the next 4-5 days after it constitute the period in which the chance of conception is highest. In addition, they believe that 7-8 days after the menses has stopped there is no risk of conception. This shows that urban contact and improved mass communication have not changed the level of understanding of family-planning methods among the rural people of UP. The myths that were observed in this region in 1970's (Sharma, 1987) are still prevailing. A similar observation was made by the Reproductive and Child Health (RCH) Project which showed that general knowledge of contraceptive methods is almost universal in India but knowledge of specific methods offered via family planning units is quite poor (IIPS, 2001).

In general, there is a favorable attitude towards family planning. Among 149 male respondents interviewed in the study, 73.8 percent (110) showed a favorable attitude towards use of family planning methods (Table 5). When respondents are asked to indicate their most preferred method of family planning, 42.2 percent of them said that they preferred condoms and tubectomy. Separately, condoms are preferred by 24.8 percent of the respondents, and tubectomy by 17.4 percent. No one preferred vasectomy. Pills, Copper-T and natural methods are preferred by nearly 10 percent each. The general notion is that after the vasectomy operation one becomes too weak to work. Since most of them have to do hard physical labor in the fields, or in marketing milk and milk products (carrying milk to city on bicycles), they are afraid of going for a vasectomy operation. To them, tubectomy too may cause problems, but since women engage in less arduous tasks, and they are not so important for the survival of family, they can afford to take the risk.

Table 6 shows that the actual number of users of family planning is less than the number of respondents who approve the use of any family planning method. Out of 73.8 percent respondents (110) who have favorable attitudes towards family planning

methods, only 61.7 percent respondents (92) use a family planning method. Of all of the male respondents included in the study, 23.5 percent (35) are using condoms, and 3.3 percent (5) are using natural methods. Thus only 26.8 percent (40) are using male methods. 34.9 percent respondents (52) say that their wives are using a female method such as tubectomy (16.8 percent), pills (9.4 percent), Copper-T (6.7 percent) or injection (2.0 percent). This discrepancy between male methods and female methods can be explained in terms of the gender roles and lower status of women. There are some who are not using any family planning methods. But they have already completed their family size. When they were asked why they were not using any family planning method, they gave the following reasons: "menses stopped;" "wife was not keeping well;" "wife was pregnant;" "did not want to interfere in God's will;" and "they use *sanyam* (restraint)."

It has to be highlighted that although everyone knows about vasectomy there was not a single case of this method in the village. As stated above, the main factor behind this is the fear that surgical methods of family planning (whether vasectomy or tubectomy) make one weak. There is a general feeling that males, being the bread earner of the family and requiring hard physical labor in agriculture or milk selling business, should not go for a vasectomy. "Even women do not permit men to go for operation," said some respondents. To them, "women work at home and they can afford to go for operation." There is also a common belief that the male operation could make a man sexually weak. Then his wife might satisfy her sexual urge via an extramarital relationship and bring dishonor to the family in the process.

Sexuality

13.4 percent (20) respondents are sexually inactive. All others, 86.6 percent, are sexually active. Among them 55.0 percent engage in sex only once a week, 18.1 percent twice a week, 10.8 percent thrice a week, and 2.7 four or more times (Table 7). In the milieu of poverty in Itara, sex is a major source of relaxation and recreation, and as long as their health permits, couples continue to have sex. At the same time, the traditional belief is that sexual restraint expands the life span and sexual indulgence results in a shorter life. "For healthy and long life one must preserve his semen." Interestingly, there is no similar belief for women.

In the backdrop of a traditional society, it is surprising that as many as 38.9 percent of the respondents (58) accepted having sex with someone other than their wife. However, in all such cases this was an unplanned, casual encounter with a woman in the village before their marriage. Married people seem to be restrained. No married man has an extramarital relationship. This explains why most of the respondents who ever had any sexual relationship with someone other than his wife had it below the age of 20 years. Since the premarital relationships were all unplanned, nobody used condoms during the sexual act (data not tabulated in this paper). It seems that in rural UP a great deal of value is placed on sexual purity, both before and after marriage. Yet traditional sexual norms before marriage (at least as applied to males), seem to be fairly relaxed. Often the knowledge about the possibility of sexual affairs of unmarried sons or daughters suggests to parents that the children are now of marriageable age, and that they should look for a suitable "match" for them. Affairs with married women are rare. This situation calls for the promotion of sex education among adolescents using both formal and informal approaches.

The village of Itara is very close to Kanpur. Yet only 67.8 percent of the respondents (101) had heard about HIV/AIDS. 32.2 percent of the respondents (48) had never heard about it. Only 47.6 percent of the respondents (71) could mention at least one possible cause of HIV, right or wrong. The perceived causes, in order of number of responses, are sexual relationship with commercial sex workers (26.8 percent), intercourse with a menstruating woman (12.1 percent), and used needles and blood transfusions (8.7 percent). Most of the respondents believe that one can save himself from developing HIV by "keeping away from commercial sex workers".

Conclusion

The data collected from Itara shows that social structure and culture affect women's health through their influence on the subjective importance of health, constructions of health and illness, health seeking behavior, and norms regarding family building and sexuality. Itara has the advantage of being close to an industrial city. In addition, there is an active NGO working in the area for economic development. As a result of improved agricultural productivity and more remunerative prices for milk, the economic condition of the villagers has improved to some extent, though not beyond the subsistence level. However, this has not helped in raising the status of women. There seems to be a negative wealth effect on the status of women which may be linked to the adoption of the *Thakur* model of s*anskritization* by all castes, including the *Yadavas*. Consequently, even among those castes which gave greater freedom to women earlier, women are confined to homemaking and animal care. Since women are dissociated from agriculture and trading and play only household roles, considered to be marginal to the household economy, their health has a lower place in the value system of the village (even below that of animals). In this context the health of men and animals supersedes that of women. This is the case even though women suffer from several common and reproductive health problems. The common problems of women include headache, abdominal pain, fever, and white discharge. In most cases women share their health problems with their husbands, but due to lack of importance given to women's work, poor health infrastructure, and difficulties in availing the services of a trained doctor, men tend to develop a casual attitude towards women's health.

In the patrifocal society of Itara women suffer on many fronts. Domestic violence is common. Men and women are conscious of the economic disadvantages of a large family. However, in majority of cases the responsibility of using family planning methods lies with the women. In other words, the patriarchal social structure of Itara compels women to use pills or Copper-T, or to go for tubectomy. Adoption of pills and Copper-T require support from family planning workers (such as ANM) and these methods are used early in marriage. Once the desired family size is achieved, tubectomy is supposed to be the proper (terminal) method of family planning. There is not a single case of vasectomy in the whole village. This is because women, who play a supportive and perceivably non-economic role, are encouraged to go for more risky options. People have a very poor understanding of the causes of diseases, physiology of reproduction, and HIV/AIDS. Even those who show any knowledge about these things show at best "fuzzy knowledge."

There are, however, some positive trends. The impact of the mass media and family

nucleation leading to a greater interdependence between spouses have improved the evaluation of women's roles. There is an increasing concern among parents about the well-being of married daughters. Knowledge related to the health and well-being of women is spreading thanks to the media and rural health infrastructure. In the future, economic gains associated with development, if continued, can be expected to counter the negative wealth effect of the past and help women. Still there is a need to promote information, education and communication among the people. And the public health system in the rural areas must be strengthened. If affordable health care services can be made available in the vicinity of the village, men will encourage their wives to take advantage of them. In the future, men's attitudes towards women's health will depend more on economic prosperity and the spread of health infrastructure. Unfortunately, the present situation does not point to a future marked by positive economic development, widespread prosperity and the strengthening of health infrastructure. The current scenario in Itara is marked by the twin problems of rising aspirations and rising unemployment. This scenario is not conducive to women's development in the near future, especially when the village is passing through the demographic revolution and has a high growth rate of population.

Problems for future research

This study, being only exploratory, has illuminated certain trends at the village level. It has not been able to probe deeper into the interactions of gender, caste and class. There are a number of questions that need to be answered through a detailed study. Some of them may be identified as follows. First and foremost, what is the nature of the relationship between the structure of power at the family level, social development and gender roles? How do the constructions of health and illness interact with economic and technological development? What is the mechanism through which constructions of health and illness affect sexuality, husband-wife communication, and health seeking behavior? What are the cultural determinants of violence against women and how are they responding to various processes of change? In order to explore these issues, one has to interview both the husband and wife, and assess to what degree and extent their responses are congruent. Future research must also include a clinical examination of a sample of women so that the validity of data on reported illness can be checked. A comparative study of clusters of villages in different stages of contact with larger, urban centers can help in understanding the processes of change and how concepts of health and illness change in response to urban contact. Such a study will also shed light on how concepts of health and illness change in response to changes in the mode of production. To achieve this, data is required from well-designed quantitative surveys as well as from focus group discussions, personal narratives and qualitative life histories. Finally, because the mass media is changing the way people think about sexuality and sexual norms in general, there is a need to obtain an in-depth understanding of this phenomenon and assess its impact on perceptions and practices associated with reproductive health in rural areas.

Acknowledgements

The authors wish to thank Mr. Manoj Singh and Mr. Naresh Mishra, both with WIZMIN Management Consultants, Kanpur, for collecting primary and secondary data and helping with the group discussions. The authors are also grateful to Dr. J. Roberts for comments on earlier drafts of the paper which have led to significant changes in the style of presentation as well as in substantive issues.

TABLES:

TABLE 1: IMPORTANCE OF WOMEN'S HEALTH

Importance	*Number of Responses*	*Percentage*
Smooth conduct of household chores	137	91.9
Good care of children	82	55.0
Birth of healthy children	41	27.5
One does not have to waste money on treatment	37	24.8
Peace in the family	30	20.1
Sexual satisfaction to husband	25	16.8
Peace of mind for husband	22	14.8
More income	17	11.4
Her own peace of mind	13	8.7
Maintenance of cattle	5	3.3
Better care of guests	4	2.7
Other reasons related to family activities and childbirth	4	2.7

Total number of respondents (N): 149

TABLE 2: REPRESENTATIONS OF HEALTH AND ILLNESS

Indicators of health			*Indicators of illness*		
Indicator	Number of responses	Percent	Indicator	Number of responses	Percent
Smiling face	96	64.4	Looks lazy/tired	111	74.5
Active/alert	68	45.6	Family members not served in time	70	47.0
Efficient	58	38.9	Stays in bed/sleeps	58	38.9
Happy	26	17.4	Irritable	23	15.4
Tireless	19	12.8	Mentally disturbed	16	10.7
Peaceful	7	4.7	Does not eat or bathe in time	11	7.4
Good speech	5	3.3	Slow movements	10	6.7
Maintains time	5	3.3	Looks depressed	10	6.7
Others (free from illness, management of stocks, looks pretty	7	4.7	Others (e.g. house disorganized)	5	3.3

Total number of respondents (N): 149

TABLE 3: DISEASES OF WOMEN

Diseases	*Number of responses*	*Percent*
Headache	69	46.3
Stomach/abdominal pain	63	42.3
Fever	51	34.2
Prasoot rog (white discharge)	49	32.9
Backache	34	22.8
Cholera	28	18.8
Filaria	12	8.1
Eye pain	9	6.0
Tuberculosis	4	2.7
Others (stone, piles, arthritis, breathing troubles)	12	8.1

Total number of respondents (N): 149

TABLE 4: CAUSES OF DOMESTIC VIOLENCE AND WAYS OF PREVENTION

Causes of Domestic Violence	*Number of responses*	*Percent*	*Ways of preventing domestic violence*	*Number of responses*	*Percent*
Wife does not listen to husband	72	48.3	Wife should not argue with husband	70	47.0
Husband is addicted to liquor and returns home intoxicated	47	31.5	Wife should finish all household chores in time	51	34.2
Suspicion of extramarital relationships	46	30.9	Wife should respect elderly members of the family	30	20.1
Selling grains without husbands' permission	43	28.9	Wife should follow her husband	28	18.8
Picks up quarrel/rigid attitude	34	22.8			
Wife insults family member other than husband	26	17.4			

Total number of respondents (N): 149

TABLE 5: FAMILY PLANNING PREFERENCES

Method	*Number of respondents*	*Percent*
Method preferred	110	73.8
Condoms	37	24.8
Tubectomy	26	17.4
Pills	14	9.4
Copper-T	16	10.7
Natural methods	15	10.1
Injection	2	1.4
Vasectomy	0	0.0
Do not accept any method	39	26.2
Total	**149**	**100.0**

TABLE 6: USE OF FAMILY PLANNING METHODS

Method	*Number of resspondents*	*Percent*
Users	92	61.7
Condoms	35	23.5
Tubectomy	25	16.8
Pills	14	9.4
Copper-T	10	6.7
Natural methods	5	3.3
Injection	3	2.0
Vasectomy	0	0.0
Non-users	57	38.2
Total	**149**	**100.0**

TABLE 7: COITUS FREQUENCY

Frequency per week	*Number*	*Percent*
Once	82	55.0
Twice	27	18.1
Thrice	16	10.8
Four times or more	4	2.7
Sexually inactive	20	13.4
Total	**149**	**100.0**

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