

**Process of Couple Communication  
in Reproductive Health  
among Rural Married Couples in India**

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## Summary

Communication is often recognized as a cornerstone of modern society. Helping couples communicate about reproductive health is viewed as vital for involvement of both the partners in decision making, treatment seeking and promoting health. It is hence crucial to understand 'communication' among married partners before designing any couple-targeted strategies. Communication is a process which involves more than sending and receiving messages. For comprehensive understanding of communication, it is important to consider various components of communication such as the relationship between partners, the context, the mode or channel, consequence in terms of behaviour and the content. The present study focuses on couple communication in reproductive health among married couples in rural Pune, India, emphasizing on learning the entire 'process' of communication.

**Chapter 1** introduces the study subject in the context of communication and its theories, couple communication studied in various subjects of health, couple communication in relation to reproductive health in India and elsewhere, the reproductive health programme in India and trends in male involvement. It further states the gaps in the existing research and mentions the study aim and objectives.

In India, the family is the most important institution that has survived through the ages. India, like most other less industrialized, traditional, eastern societies is a collectivist society and collectivism is reflected in greater readiness to cooperate with family members and extended kin on decisions affecting most aspects of life, including career choice, mate selection, and marriage. Families adhere to a patriarchal ideology and endorse traditional gender role preferences. Traditionally, emotional ties between spouses are considered a potential threat to the solidarity of the patrilineal group and hence there is a tendency to limit communication between spouses. Traditions and values guide couples' reproductive health behavior in such a way that most of the related issues are assigned to the women's domain. In other words, the family and kinship network, traditions, cultural norms and gender-power relations influence young couples' reproductive health communication and behavior. On the other hand, like elsewhere, the reproductive health programme in India, certainly intends to enhance male involvement in reproductive health.

Most of the existing literature around couple communication in India as well as in other developing countries has focused on components of reproductive health, mostly contraceptive



behaviour, sexuality or high-risk sexual behaviour. Also, there are numerous studies about determinants of couple communication in terms of gender-power relations, or family network. However, there is hardly any literature focusing on couple communication in rural married couples, with a comprehensive understanding of the details of the process of communication. Further, in the seemingly traditional society as that of India, where couples do not marry by choice and are influenced by kinship and family network; reproductive health is mainly considered as an exclusive 'women's domain' and there are efforts to improve male involvement in reproductive health; non-existence of such a study further widens the gap in body of literature.

Present study aims **To learn about process of reproductive health related communication among young married rural couples**-Scope of reproductive health in this study is restricted to the most common events in the span of reproductive life, which are- fertility, planning parenthood, childbirth, sexual relations. The study does not include other issues such as abortion, infertility, Sexually Transmitted Infections or HIV. There are four specific objectives-

1. To explore communication and behavior of rural married couples in relation to fertility during reproductive life span
2. To learn communication of married couples about their sexual relationship in relation to gender stereotypes
3. To understand communication and behavior of rural married couples around childbirth against the backdrop of traditions
4. To analyze the narrations of the husband and wife about the wife's reproductive health problems

**Chapter 2** describes the study setting, population, tools of data collection, sampling details and limitations of the study. The study was conducted in a rural set up on the outskirts of Pune city, in Western Maharashtra, India. It was a community based qualitative and exploratory research conducted between 2006 and 2008. The study area is one of the fastest developing tehsils of Pune District, surrounded by Western Ghats and the Pune-Mumbai Express Way cuts through the Tehsil. Reproductive health services are delivered to the community mainly through public sector having grass root health workers to improve the outreach. In spite of the development that has taken place in this Tehsil, due to urbanization especially around the Expressway; the area still represents a rural set up of Western Maharashtra dominated by a kinship-oriented, Maratha caste, agrarian community. Most of the families are either joint or

extended. It is a patriarchal society, where families are mostly headed by men. However, issues related to reproductive health are mostly women's domain.

The study involved a preparatory phase during which Key Informants from formal and informal sectors were interviewed in-depth to learn about traditions and norms related to couple communication and behavior. The main phase of the study involved in-depth interviews of 35 married couples selected with the help of the Village Health Functionaries. The sample selection for the couples was based on an inclusion criterion of having undergone sterilization, not more than a year at the time of the interview, with a purpose to cover different events on the reproductive life span. The study tool for interviewing the married couples was a Visually Assisted Interview guide, which consisted of hand-drawn illustrations of day-to-day life scenarios. Husband and wife were interviewed simultaneously and separately (with assistance from a male researcher) to avoid sharing of information. Mostly the interviews were completed in one session, though more visits were paid to approach and plan the interview. Data was thematically analyzed around themes such as- methodological issues, traditions regarding childbearing, male involvement in reproductive health, gender stereotypes related to sexuality and the concept of planning parenthood. Also process of communication was analyzed in terms of place, type and form, duration, content and barriers for communication and about differential narrations by husband and wife.

There are in all five research papers developed in this study based on the dataset of 35 married couples focusing on methodological aspects of the study and different issues of couple communication. These research papers are included here as different chapters from Chapter 3 to Chapter7.

**Chapter 3** is based on the methodological approach of the study and deals with the process of construction of the Visually Assisted Interview Guide and its validation at field level. It covers the literature around qualitative and quantitative tools of data collection used in various reproductive health researches and emphasizes the need to have interactive and friendly tool for eliciting sensitive and personal information from married couples. The paper then describes the multilayered process of construction of the tool and stresses that visuals in the tool should ensure value addition to the generally used in-depth interview guide. The next section in the paper includes validation of the tool in the field and highlights the advantages and limitations of the tool. As the researcher used hand-drawn illustrations for interviewing married couples in this study, it was thought important to write about the entire process of construction and validation of

this tool, especially in the context of studying 'behind close doors' subjects among married couples from a rural set up.

**Chapter 4** attempts to explore couple communication and behavior of rural married couples about fertility and planning parenthood. This paper drives us through various stages on the reproductive life span, where couples discuss fertility and plan their family. Couples seem to start discussing about planning family only after the birth of the first child, due to obvious pressure for proving fertility and the negative values attached to infertility. Opting induced abortion is also considered as an option for planning family, though elder women have mostly opposed these decisions. There are important players who initiate couple communication in this subject such local health provider; as well as those who influence the decisions about fertility, such as the elder women in the family, especially the mother-in-law. Men in the study have generally preferred to have a small family and have discussed this with their wives, however, due to family pressure their intentions did not always get translated into behavior. The paper emphasizes on men being interested in discussion and decision making in fertility but family network, elder women in the family acting as gatekeepers for fertility related decisions. This paper recommends strategies to involve the family in order to create favorable environment for young couples to decide and implement their own fertility desires.

**Chapter 5** focuses on married couples' communication and behavior about their sexual relations and attempts to analyze the same against the gender based stereotypes of sexuality. Responses of men and women about initiation and decision-making in sex and sexual abstinence for various reasons are studied. The paper reveals that women do take part in the discussion and decision-making in sex and express their sexual desires though they are not the active partners in sex. Women have narrated about mutually decided sexual encounters as well as non-consensual sex, on which men have different opinion. However, non-consensual sex is differentiated from 'forced sex' and the paper confirms the need to learn these nuisances of sexual experiences before labeling them as 'forced' or non-consensual sex'. It is an important finding that sexual abstinence initiated by women for religious reasons, is mostly respected by men. The paper thus suggests a beginning of process of change in sexual communication and behavior, where women were stereotypically expected to be passive partners in sex and not allowed to express themselves. Women's ability to express and negotiate sex is commonly

considered as an indicator of autonomy having implications on her reproductive health and hence the study findings should be appreciated as positive steps in this direction.

**Chapter 6** explores the change and continuity of couples' communication and behavior in childbearing against the backdrop of traditions. The paper focuses on traditional practices in this subject based the data from Key informants and attempts to plot the current practices of married couples against the backdrop of these traditions. The paper points towards differential pattern ranging from adherence to and departure from the traditions in various issues of childbearing. Traditionally, couples are rarely encouraged to discuss childbearing issues and mostly family members are the decision-makers. Women in the study, contrary to the traditional notions went for medical confirmation of pregnancy and sought antenatal care. Couples showed departure from traditional practices and communicated about certain issues of childbearing such as antenatal care; whereas there was limited couple communication in other issues as place of delivery and issues around birth of the child. Traditions and influence of family network seemed to play differential roles in affecting couple communication and behavior around various issues of childbearing. However, generally, men's non-farm or non-traditional occupation was more associated with couples' departure from traditional practices of communication and behavior. The paper concludes that couples struggle between following traditions and adapting change in relation to various issue of childbearing. It recommends that reproductive health programme should design strategies, depending on the differential role family and traditions play in different areas of childbearing and appreciate and encourage the existing involvement of men.

**Chapter 7** analyzes differential narrations of husband and wife about wife' reproductive health problems. Communication between husband and wife is an important determinant in reproductive health of the couple as it reduces risk of unintended pregnancies, acquiring sexually transmitted infections and does influences health seeking behavior in case of reproductive health problems. Hence, it is crucial to learn about reproductive health problems in women from the perspective of husband and wife, especially in a society, where open communication between married partners around reproductive health is limited. The results show that almost half of the women experienced reproductive health problems such as complications during pregnancy or delivery, side effects or infections due to contraceptive usage or symptoms suggestive of Reproductive Tract Infections (RTI). Husbands and wives narrated discrepantly about wives' problem during pregnancy and men hardly talked about the delivery

complications that their wives had. Further, there was discrepancy in the narration about side effects due to use of contraceptive methods and almost none of them mentioned about any symptoms suggestive of RTIs, experienced by their wives. The paper attempts to analyze the reasons of discrepancy by using the communication model by Friedemann and suggests two pathways of malfunctioning communication-first between the woman and her husband and the second between the husband and the researcher, both as a result of either individual or collective norms. The paper suggests that synthesis of differential narrations is essential for arriving at strategies to improve couple communication or partner notification.

**Chapter 8** discusses overall findings of this research across the five different papers. The research findings are then discussed in the Indian context, generally confirming the changing trend that young couples are being more supportive and concerned about each other's health desires and goals. However, one should not forget that this is only the beginning of change and young couples have a long way to go in order to achieve the same. It needs to be appreciated that the pace of this process of change will differ in different parts of the country depending upon socio-demographic, political situations and health programmes in various populations. Hence, projections based on one such research may not be applicable for the entire rural population of India. The importance of community based studies should not be underestimated though, to learn the specifics in different contexts. The study findings are also compared with similar other settings in the world, where gender-power relations, family network, culture and societal norms play an influential role for young couples.

This exploratory qualitative study represents a rural, kinship-oriented, agrarian society of Western Maharashtra, where family and traditions play a crucial role in couples' married life, from arranging marriage to decision-making in all the life events. Though the couples in the study communicate about reproductive health issues, they are not always able to translate communication into behavior change, in their compulsion to respect family, traditions and culture. The study projects that for young married couples from rural society, it may be challenging to follow traditions and yet adapt to change. It, therefore, becomes important to understand the entire process of social change, particularly in the area of reproductive health. Couple communication may have a cascading effect on larger health and social issues like family health, sexual and domestic violence and healthy marital relationship and thus should be understood in any given society. However, unless the existing couple communication is studied as a 'process', efforts to improve the same may not be constructive enough.

The study suggests some further research such as learning effects of existing health programmes on couple communication, determinants of couple communication and translation of communication into behavior change.

Within its limited scope, the study definitely has some implications for the local health programme. The present study findings can provide some leads in designing concrete initiatives and strategies for young married couples- for example, preparing counseling material around sexual abstinence method for various reasons. The study recommends that existing involvement of men in reproductive health, for example men accompanying wives during antenatal care, should not only be welcome by the programme and but further utilized as opportunities to build their skills in communication and motivate them to be more supportive towards their wife to have a share in decision-making. Lastly, the study emphasizes on the fact that couples though empowered to communicate with each other about reproductive health, are not necessarily able to implement the same. Hence, it recommends that tailoring locally suitable strategies focusing on the young couples, without ignoring their family, may work better to achieve their 'targets'.

The study tool for interviewing married couples- the Visually Assisted Interview Guide- is enclosed as an Annex at the end of this thesis.

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## Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
BAMS	Bachelor of Ayurvedic Medicine and Surgery
BHMS	Bachelor of Homeopathic Medicine and Surgery
Cu-T	Copper T
HIV	Human Immunodeficiency Virus
ICDS	Integrated Child Development Scheme
ICPD	International Conference on Population and Development
IEC	Institutional Ethics Committee
IUD	Intra Uterine Device
MBBS	Bachelor of Medicine, Bachelor of Surgery (Latin-Medicinae Baccalaureus, Baccalaureus Chirurgiae)
MDGs	Millennium Development Goals
MPW	Multi Purpose Worker
NFHS	National Family Health Survey
NGO	Non-Governmental Organization
PHC	Primary Health Centre
RH	Rural Hospital
RTI	Reproductive Tract Infection
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
VAIG	Visually Assisted Interview Guide
VHF	Village Health Functionary
US	United States
WHO	World Health Organization



# Chapter 1

## **Introduction**



## **Chapter 1- Introduction**

Reproductive health addresses the reproductive processes, functions and system at all stages of life- reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so (WHO, 2009). It is more than a decade- since the International Conference on Population and Development (ICPD, 1994) - that there has been a clear emphasis on empowering couples to decide about their own reproductive health related issues. Communication being the essential foundation for decision-making, couples should be able to communicate with each other about their sexual needs, be informed about their reproductive health and make independent choices about family planning. More importantly, they should be motivated and supported to implement their own desires and intentions to achieve reproductive health goals. Helping couples communicate about reproductive health is viewed as vital for involvement of both the partners in decision making, treatment seeking and promoting health. It is hence crucial to understand 'communication' among married partners before designing or implementing any couple-targeted strategies or programmes. The present study focuses on couple communication in reproductive health among married couples in rural Pune, India.

### **1.1. Communication**

Communication between two persons, i.e. interpersonal communication is defined as interaction taking place between two persons and there are different forms, styles and types of communication- for example verbal, non-verbal communication, communication having different types of message such as factual or inference based etc (Keller, 1996). Communication is often recognized as a cornerstone of modern society. Communication is a process which involves more than sending and receiving messages. Scholars from various disciplines such as psychology, psychotherapy, sociology, linguistics and communication theories have stated models and theories explaining the components of communication as a process. The comment from one of the leading sociologists and a communication theorist, Lasswell Harold (1948) about communication is well known- 'Who (says) What (to) Whom (in) What channel (with) What effect. One of the most influential linguists of the 20<sup>th</sup> century Roman Jakobson (1960) with his pioneering work in structural analysis of language, distinguished six communication functions, each associated with a dimension of the communication process-context, message, channel,

code, sender and receiver. An expert in the field of analytical psychotherapy, Paul Watzlawick in his communication theory (1967) - the famous Five Axioms, states that communication is a cyclic process, based on the relationship of the partners and involves verbal as well as non-verbal modalities. Psychologist and communication expert- Friedemann Schulz von Thun (1981) in his communication square or Four Ears Model elaborates upon four layers of communication, which are-matter, relationship, self-revealing and appeal. He further describes about the differential understanding of messages between sender and receiver which can cause malfunction in the interpersonal communication. It thus, becomes important in any communication study, to learn the entire 'process' of communication, considering various components or layers of communication such as the relationship between partners, the context, the mode or channel, consequence in terms of behaviour and of course the content or matter that is communicated.

## **1.2. Literature review about couple communication**

Couple communication is the backbone of marital relations and has been widely studied in different settings around the world in the context of a variety of disciplines. The importance of couple communication has been studied in relation to promoting gender equality in the control over sexuality between marital partners in Nigeria (Nigeria- Wusu and Isiugo-Abanihe, 2007). In a study in Nepal, it was stated that improved couple communication may achieve women's empowerment and their health goals (Mullany, Hindin and Becker, 2005). In the field of psychology, couple communication has been studied in relation to improving the psychosocial health of women in Australia (Ferroni and Taffe, 1997). In another study conducted among couples in the United States, the researchers studied couple interaction between spouses coping with health failure and the importance of textual analysis of actual communication (Rohrbough et al, 2008). In a biomedical randomized controlled study, the importance of couple partnering was stated as essential in adherence of health practices such as for Lipid Enhancing Strategies (Voils et al, 2009). In health research, Morgan (2009) stated about quality of marital interactions being a strong predictor of health outcome and hence recommended inclusion of communication pattern in clinical practices. In an anthropological study, Hooper and Ong (2005) pointed towards the importance of understanding the interplay between patient and wife as a care provider by listening to the wife's narration of her husband's pain.

Over the last decade a sizable body of literature has added a great deal to our understanding of couple communication in relation to reproductive health (see Beckman, 1983 and Becker 1996, for review of earlier research) Couples who communicate with each other about reproductive health, reduce the risk of acquiring Sexually Transmitted Diseases (STDs) and unintended pregnancies (Keller, 1996). Douthwaite et al (1998) conducted a qualitative study among men and women (not couples) in Pakistan about couple communication related to withdrawal use. It was found that despite a relatively high level of communication leading to withdrawal use, sexual pleasure was not discussed openly between the spouses and the researcher suggested attempts to encourage positive couple dynamics. Razzaque (1999) in a survey of married couples from Bangladesh found that wife and husband agreement was an important factor in translating preference for children into behavior and hence suggested the need to motivate both the partners to agree about ceasing childbearing. Wolff, Bland and Ssekamatte (2000) used survey and focus group data in two districts of Uganda to study the role of couple negotiation on the unmet need of contraception and the decision to stop childbearing. They found out that opposition from partner significantly affected the unmet need as well as method choice among women. De-Silva (2000) in his research in Sri Lanka studied about husband-wife communication influencing their contraceptive behavior and showed the positive association between the two. Kimuna (2001) studied fertility and family-planning decision-making through National Demographic Health Survey on a sample of 1257 matched couples in Kenya. This study showed that discussion of fertility and family-planning between the spouses was one of the important factors to influence ever-use of family planning. Ayaga (2002) in the longitudinal quantitative study among couples in Navrongo, presented the importance of couple communication on family planning behavior of couples. In a study among men from Turkey about withdrawal Ortayli et al (2005) have opined that withdrawal may contribute to communication on both contraception and sexuality in couples. In Vietnam, Ghuman (2005) studied 800 men and women from rural and urban communes. The researcher pointed towards women reporting lower levels of marital sex suggesting that expression of sexuality is seen as more legitimate and natural for men than for women. Nahar (2005) studied the effect of spousal communication on increased use of contraceptives among rural women of Bangladesh.

In India, as well, various qualitative and quantitative studies are carried out in and around couple communication and reproductive health. George (1998) in her study from Mumbai based on in-depth interview of 65 married women and 23 of their husbands, looked at sexual negotiation (as the process of communication between two people) and studied the differential perspectives of men and women on sexual pleasure, sexual coercion and sexuality. Balaiah et al (2001) in the quantitative study conducted in rural Thane, Maharashtra found that family planning, spacing and contraceptive methods were not frequently discussed between spouses, indicating that husbands took their own decisions in planning families. Santhya and Dasverma (2002) studied spousal communication on reproductive illness among rural women in South India and its influence on preventive and curative behaviors and stated various reasons for non-communication between spouses. Padmadas, Hutter and Willenkens (2004) based on the National Family Health Survey Data for Andhra Pradesh showed that a lack of interspousal communication about family planning is associated with a shorter reproductive span associated with low level of use of modern contraceptives to space births. Ravindran and Balasubraminan (2004) in their qualitative research conducted among 66 women and 44 of their husbands in rural Tamil Nadu, studied the decision-making process of abortion in the context of women's sexual rights and found that non-consensual sex, sexual violence and women's inability to refuse their husbands' sexual demands appeared to underlie the need for abortion. Bloom, Singh and Suchindran (2005) have studied couple communication as a protective factor against the risk of HIV in Northern India. In a recent study conducted in the close vicinity of this present research, in rural and urban Pune, by Alexander et al (2006), one of the findings was that partner communication and negotiation about sex were rare. However this study was conducted among unmarried young men and women.

The review of literature regarding couple communication in health issues, and especially about reproductive health stresses the importance of it for various health outcomes. The majority of these studies have focused on particular aspect of health or reproductive health and attempted to prove relationship between couple communication and the desired health outcome. Though most of these researchers have recommended the need to improve couple communication and learn the communication pattern, very little is known about couple communication as a process, in a comprehensive way.

### **1.3. Reproductive health of young married couples in socio-cultural context**

In India, the family is the most important institution that has survived through the ages. India, like most other less industrialized, traditional, eastern societies is a collectivist society that emphasizes family integrity, family loyalty, and family unity. More specifically, collectivism is reflected in greater readiness to cooperate with family members and extended kin on decisions affecting most aspects of life, including career choice, mate selection, and marriage (Hui and Triandis 1986). In India, families adhere to a patriarchal ideology, follow the patrilineal rule of descent, are patrilocal, and endorse traditional gender role preferences. The man-woman relationship, most of the times, is based on the formal marriage system and the husband's family has tremendous hold on the couple's life, their behavior, their relationship with each other and, their health decisions. Hence it is important to understand the concept of "couples" in the Indian context. In India, majority of marriages are arranged mainly by elders of the household and kinship and husband and wife are not known to each other before marriage. Goyal (2001) has mentioned about the ambivalence and inhibition in the mind of even educated people about having 'dialogue' with partners. Contrary to the occidental cultures where relationships culminate into sexual relations, in a typical rural society of India, the entire relationship between husband and wife "begins" with sex, consequent to marriage. Married couples are worried, especially in the beginning of their relationship, about rejection in sexual life and hence may avoid discussing with each other, topics such as sex, childbearing or reproductive health in general. Also they are rarely encouraged to have open discussion around these issues. In fact, emotional ties between spouses are considered a potential threat to the solidarity of the patrilineal group and hence there is a tendency to limit communication between spouses (World Bank, 1996). Cultural notions and family structure have important implications for women such as on their autonomy to decide about their reproductive careers. For example- the traditional notion was that childbearing is not an event worthy of medical attention (Kanitkar and Sinha, 1989) and the concept of special care during the antenatal period was not known traditionally in India (Jeejebhoy and Roy, 1995). Jeejebhoy and Bott (2006) have commented about power imbalances and women's inability to negotiate sexual matters possibly increasing young women's risk of nonconsensual sexual experiences. Powerlessness of young married women in negotiating fertility with husbands and extended families is documented also among Bangladeshi couples (Gipson and Hindin, 2007). Elder family members especially the mothers-in-law are known to play the role of gatekeepers in most of the decision-making related to fertility in

India, but also in rural population in Mali (Madhavan, Adams and Simon, 2003). In many Sub-Saharan African cultures, spousal discussion of sexual matters is discouraged, and other persons—commonly, in-laws—act as conduits through which partners can exchange ideas on these topics (Ezeh, 1993; Blanc, 1996 and Castle et al, 1999). Chowdhury (2003) studied about sociology of first birth in rural Bangladesh and pointed towards objection from in-laws and financial concerns as barriers to seeking health care. In other words, family and kinship network, traditions and social and cultural norms influence young couples' reproductive health communication and behavior.

Traditions and values guide couples' reproductive health behavior in such a way that most of the related issues are assigned to the women's domain. Similar to rural societies in China (Hardee, Xie and Gu, 2003), women in most of the parts of India, do not carry on the family line, they leave home after marriage and carry the burden of taking care of children and home in addition to taking almost sole responsibility for family planning. Gender-based inequities influence reproductive and sexual health of couples, especially young women. While men are expected to, by and large, remain within the confines of a monogamous marriage, there is social indifference to their indulging in extra-marital sex, whereas female sexuality is defined as something threatening to society and requiring male control (Ramasubban, 1995). Ravindran and Subramanian (2004) in her study from rural Tamil Nadu, India, have studied married women's sexual rights and ability or inability to refuse sex. Gender norms often dictate that women and girls should be ignorant and passive about sex, which greatly constrains their ability to negotiate safer sex or access appropriate services (Garg and Sharma, 2006). As Apte (2000) mentioned in a study of rural men on the outskirts of Pune, men were found to play almost no role in antenatal and postnatal care which was considered exclusively a women's domain. Men seldom perform the role of active and supportive partners of women. However, women mostly follow the decisions taken by men as was also studied among Latina women in the United States by Pulerwitz et al (2000). Similar to India, gender power relations and stereotypes seemed to have influenced reproductive health in terms of contraceptive behavior in rural Nepal (Chapagain, 2005). Gender based power inequities generally incorporate the belief that men should control women's sexuality and their child-bearing capacity (Blanc, 20001). In India (Raju and Leonard, 2000), as well in some other countries such as Ghana (Bawah et al, 1999) and Egypt (El-Zanaty et al. 1999) and Tanzania (Maman et al. 2001), men control financial resources and women's mobility which, in turn, affects women's access to and use of reproductive health services.



Verma and Mahendra (2004) express that gender stereotypes in sexuality, about submissive females and powerful males, possibly restricts access to health information, hinder communication and encourage risky behavior among women and men in different but equally dangerous way. Blanc (2001) reviewed gender power relations with sexual health and stated that verbal communication between partners about reproductive health is low in many developing countries and that gender-based power inequities contribute to a lack of communication.

Thus, relationship between traditions, family network and gender-power relations affecting couples' reproductive health is clearly stated by researchers in India and elsewhere.

#### **1.4. Facts and figures for India and Rural Maharashtra**

In India, the National Family Health Survey data (NFHS-III, 2005-06) shows a positive trend in various reproductive health indicators such as Total Fertility Rate (TFR) being 2.7, 53% of the rural population using contraceptives, 72% of rural women seeking antenatal care and 31% of rural women having institutional deliveries. Compared to previous survey data, these indicators show positive trends. Data for rural Maharashtra scores better in terms of lowered fertility rate (TFR-2.3), increased contraceptive use (67.1) and institutional births (50.5), as compared to the national figures. District Pune (study site) presented TFR as 2.3 in the Census data of 2001 (Guilmoto and Rajan, 2002). Studies in India and elsewhere have stated about the link between improved couple communication affecting fertility decisions and contraceptive use of couples (Kimuna and Adamcheck, 2001; Sabu et al, 2004; Wolff, Bland and Ssekamatte (2000). Hence, the positive trend in indicators presented for rural Maharashtra and Pune, will help to contextualize the study results.

#### **1.5. Male involvement in reproductive health**

Given the background of the traditional gender-based power relations and the influence of the family institution on reproductive health of young married couples in India as well as many of the developing countries, recent efforts to involve men in reproductive health in these settings cannot be overlooked. Involvement of men in reproductive health though specially stressed upon since the ICPD, 1994; has been studied since more three decades. Ringheim (1993) examined two decades of social science research on male contraceptive. Edward (1994) wrote about role of men in contraceptive decision-

making mainly with US perspective. In recent years, studies from various setting in the world have documented changing role of men in reproductive health. In Turkey, (Turan et al, 2001) ideas about fatherhood seem to be undergoing change and now young men want to be helpful towards the wife during pregnancy and delivery. India's reproductive health programme has considered 'male involvement' as important, in their national policy (Khan and Panda, 2004), ever since 1994. There are studies and interventions by government as well NGOs to enhance participation of men in maternity care for example- study in New Delhi (Varkey, 2001) and rural Maharashtra in Ahmednagar (Barua 2006). There is an inclusion of 'Men's section' in the National Family Health Survey-III report. In the report for Maharashtra, (NFHS-III, 2005-06- Maharashtra Report), this section based on men '*age 15-49 whose youngest living child was age 0-35 months*', highlights that 58% of rural men were present at any ante natal visit of their wives. To about 46% of men from rural area health providers had ever told about what to do if the mother had any pregnancy complication. However, this percentage was as low as 24% and 27% in case of telling men specifically about convulsion and vaginal bleeding as signs of pregnancy complications; respectively. This report indicates that the reproductive health programme certainly intends to welcome more men in maternal care.

Of course, male involvement has been criticized against the issues of risk of increasing male dominance and effects on women's empowerment, increasing the gender gap (Helzner, 1996 and Singh, 2002). But, increased couple communication and joint decision-making may achieve women's empowerment as well as their health goals (Mullany, Hindin and Becker, 2005).

To summarize, it is evident from literature review around couples studies in reproductive health and communication that it is essential to have an understanding about how young married couples in rural set ups discuss their reproductive health. Most of the existing literature around couple communication in India as well as in other developing countries has focused on components of reproductive health such as contraceptive behaviour, sexuality or high-risk sexual behaviour. Also, there are numerous studies about determinants of couple communication in terms of gender-power relations, or family network. However, there is hardly any literature focusing on couple communication in rural married couples, with a comprehensive understanding of the details of the process of communication. Further, in the seemingly traditional society as that of India, where couples do not marry by choice and are influenced by kinship and family network;

reproductive health is mainly considered as an exclusive 'women's domain' and there are efforts to improve male involvement in reproductive health; non-existence of such a study further widens the gap in body of literature.

### **1.6. Aim and specific objectives of the study**

#### **Aim- To learn about process of reproductive health related communication among young married rural couples**

Scope of reproductive health in this study is restricted to the most common events in the span of reproductive life, which are- fertility, planning parenthood, childbirth, sexual relations. The study does not include other issues such as abortion, infertility, Sexually Transmitted Infections or HIV. It was a purposive decision to achieve the most homogeneous sample in a community based qualitative study. Couple communication in case of infertile couples, or decision-making regarding induced abortion are essentially different areas where couples may communicate differently than in the normal course of events. The word 'process' includes, learning about place, content or matter, time and context of communication. It also covers the consequence of communication in terms of reproductive health behavior, problems faced and supportive factors. Thus, the process of couple communication will be studied across four major areas of reproductive health, stated as four specific objectives as follows-

#### **Specific objectives-**

- 1- To explore communication and behavior of rural married couples in relation to fertility during reproductive life span
- 2- To learn communication of married couples about their sexual relationship in relation to gender stereotypes
- 3- To understand communication and behavior of rural married couples around childbirth against the backdrop of traditions
- 4- To analyze the narrations of the husband and wife about the wife's reproductive health problems

This study is expected to widen the knowledge about couple communication in terms of its channel, mode, type, context and content. It will further throw light upon the relationship between couple communication and couple behavior. It should enhance the understanding about the influence of family, kinship, culture, traditions and gender based stereotypes on the couple communication. It may also serve as a platform for studying

various subjects such as impact of male participation on reproductive health, strategies to improve partner notification, gender power relations influencing reproductive health and significance of traditions in given society. The study will have implications for the local health programmes by suggesting strategies to improve couple communication and reproductive health behavior. Couple communication is one of the crucial facets on the entire marital relationship of the couple and hence understanding about their communication especially in sensitive issues as that of reproductive health, may give insights on approaches towards establishing marital harmony among couples in general.

## Chapter 2

# Methodology



## 2. Methodology

### 2.1 Study site and population

Maharashtra is India's second largest state in terms of its population (more than 96 million). More than 50% of the population is rural and the state has a Hindu majority (72%). Pune is one of 35 districts of Maharashtra state and has fourteen Tehsils. The district population is around 7.2 million (Census of India, 2001).

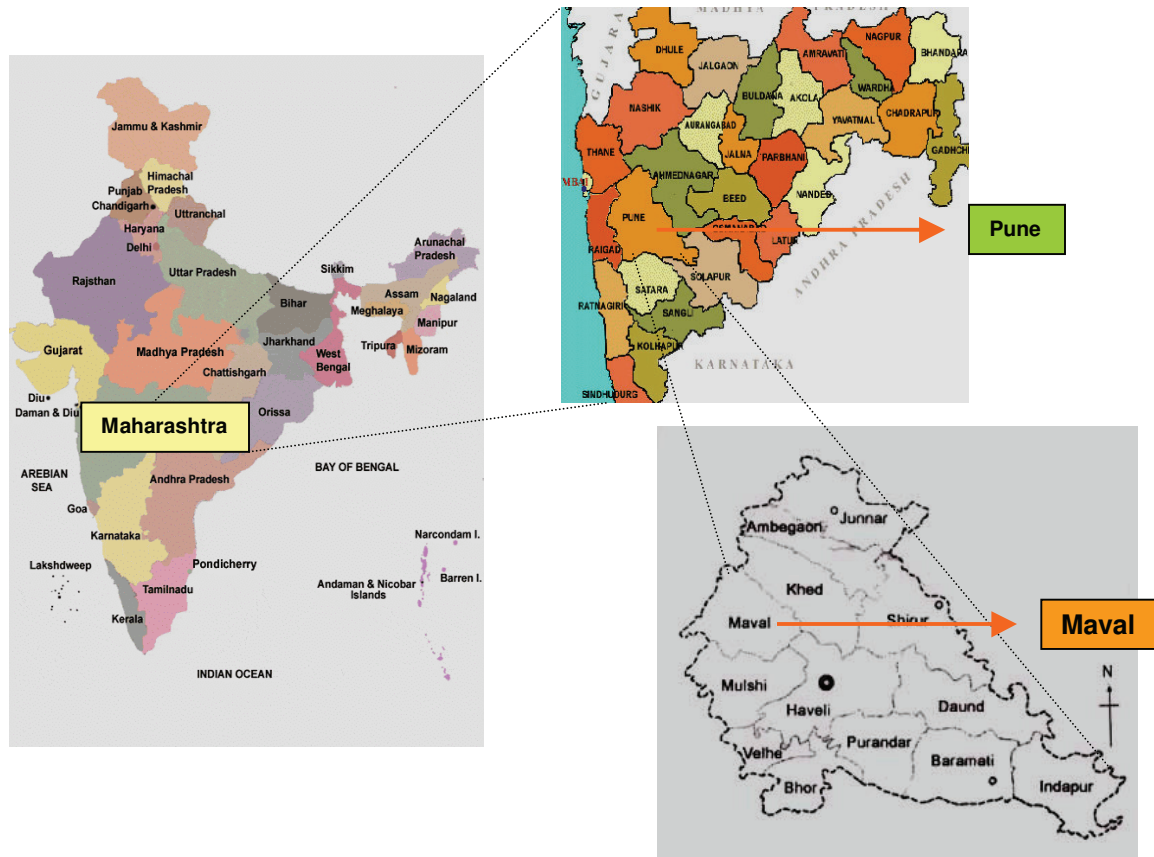


Figure 2.1 Maps of India, Maharashtra and Pune

The current study was conducted in the rural outskirts of Pune, in Maval which is one of the tehsils (sub-divisions) of Pune district. Maval has a population of around 300 thousand spread among 184 villages. The Tehsil is surrounded by the Western Ghats and the Mumbai-Pune Highway cuts through the Tehsil. It is one of the fastest developing tehsils of Pune district, with many upcoming industries, educational institutes, plant nurseries and floriculture. Most of the villages have geographical access by road, though during the rainy season, the conditions of the roads deteriorate and commuting becomes a problem for some of the remote villages. There are two main towns in the Tehsil, where most of the private medical practitioners, private multi-specialty hospitals, markets and shops are clustered.

Reproductive health services are delivered to the community through a strong public health system via 6 Primary Health Centres and their sub-centres (one each catering to a population of 5000) and 2 Rural Hospitals (RH). Auxiliary Nurse Midwives (ANM) and Multi Purpose Workers (MPW) are the grass root level health providers of this health system. The ANMs and *Anganwadi* staff<sup>1</sup> are mainly responsible for providing Ante Natal Care (ANC), promoting the use of contraception and acceptance of terminal method of family planning<sup>2</sup>.



In spite of the development that has taken place in this Tehsil due to urbanization, especially around the Expressway; the area still represents a rural set up of Western Maharashtra dominated by a kinship-oriented, Maratha caste<sup>3</sup>, agrarian community. Most of the families are either joint or extended. It is a patriarchal society, where families

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<sup>1</sup> In India, the government runs pre-schools called '*Anganwadi*' in all the villages through Integrated Child Development Scheme (ICDS) under the Department of Health and Social Welfare. These pre-school teachers along with responsibility of teaching in the school are also responsible for assisting the PHC staff to provide anti natal and post natal services. The Tehsil has more than 200 such pre-schools having an equal or more number of pre-school staff

<sup>2</sup> Terminal method of family planning mainly refers to female sterilization, which is the most preferred method in rural Indian society.

<sup>3</sup> Caste- It is a group of individuals socially stratified on the basis of occupation, endogamy, social culture and political power. 'Maratha' is the predominant caste in rural set ups of Western Maharashtra.



are mostly headed by men, who play a significant role in decision-making in the family. However, issues related to reproductive health are exclusively under women's domain.



## **2.2. Sample selection and recruitment of respondents**

The study was a community-based, qualitative exploration among young married couples from rural set up which aimed at understanding the process of couple communication in reproductive health. It was conducted in the area of three (out of six) Primary Health Centres (PHC), selected randomly.

The study involved a preparatory phase where key informants from the community (n=10) were interviewed to understand traditions, norms and practices about couple communication and behavior in reproductive health. They included the Traditional Birth Attendant, a female medical practitioner in the study area, an old woman in the community, a leader of the local Self Help Group, a male medical practitioner at the private hospital in the study area, a mother of a local administrator and an *Anganwadi* teacher. This was a purposive sample from the community. This phase helped in designing the tool for interviewing selected couples in the study. Also some of the key informants were later interviewed to contextualize the data collected from the couples.

The main phase involved in-depth interviews of married couples.

#### Sampling of married couples-

To cover the entire spectrum of reproductive health-related issues- pregnancy, delivery, family planning, sexual relations and reproductive health problems; the present study focused on married couples that have at least one child and have used a terminal method of contraception (female sterilization<sup>4</sup>). To minimize the recall bias of the respondents, it was decided to select couples that have undergone sterilization, not beyond a period of one year at the time of the study. Village Health Functionaries (VHF)<sup>5</sup> from the selected area, assisted the researcher in recruitment of couples, based on the records of female sterilization maintained by them. Couples fulfilling the sample selection criteria regarding time of female sterilization were randomly selected from the list available with them. The VHFs then contacted these couples; briefly oriented them about the study and sought verbal consent from them to participate in the study. The couples who gave consent to participate, were then approached by the researcher for conducting the interview. In all, forty-one couples were identified for interviews during the study period.

Purposive sample typically relies on the concept of 'saturation'. In this study, couples fulfilling the inclusion criterion were purposively selected, in order to cover data on various events on the reproductive life span. We attempted to analyze data at frequent intervals and checked the degree of data saturation and also the pattern of variability. As (Guest, Bunce and Johnson, 2006) mentioned, though the idea of saturation is helpful at the conceptual level, it provides little practical guidance for estimating sample sizes, prior to data collection, necessary for conducting qualitative research. We covered almost 10% sample of the study universe (which means the total number of couples from the three PHC areas, who have undergone family planning operation not more than one year before the date of interview, during the study period). In all, thirty-five married couples were interviewed in-depth in the study.

The response rate of respondents was more than 80%. Out of forty-one couples short-listed, there were six couples who did not participate in the study. In case of four couples, the husband and wife could not manage to spare time together for being

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<sup>4</sup> Female sterilization is the commonly accepted terminal method of contraception and village health functionaries maintain the record of each woman who undergoes sterilization, irrespective of the place of sterilization, i.e. public or private hospital.

<sup>5</sup> Village health functionaries- Auxiliary Nurse Midwife (ANM) and *Anganwadi* worker

interviewed. In case of two couples, there was denial from one of the partners for giving the interview and we could not find any convincing reason for the same.



Figure 2.4. – A woman on her way to the river for washing clothes

### **2.3. Study tools-**

For interviewing the key informants, an interview guide was prepared. With the given background of the study sample, various options were thought of to elicit the desired information from husbands and wives. In the initial phase of preparing the study tools, various other tools such as a simple interview guide, a '3X3 matrix' were prepared and tested at field level. The researcher experienced challenges in administering these tools such as, women felt shy about discussing their sexual relationship; there were difficulties in generating willingness among men to talk about their personal life or keeping them engaged throughout the interview etc. Moreover, to elicit information from husband and wife over sensitive issues such as that of their sexual relationship, in one session, was equally challenging. The study subject being sensitive and the nature of the study being exploratory and qualitative, importance of having an in-depth interview guide was never underestimated. However, the researcher felt a need to have a more interactive tool and thus thought about having visual assistance to an interview guide.

Visuals methods coupled with participant narratives provide strategies to empower participants to define the problem of interest, encourage participants to reveal what might be uncomfortable or unknown, and identify and develop resources (Hurwoth et al 2005). Researchers have used various forms of visuals such as photographs or movie clips (Petchesky 1987; Prosser, 1998; Radley and Taylor, 2003). In this study as well, photographs or movie clips were considered as an option. However, for rural community,

it was thought not be a user friendly and easy to comprehend tool. There was a concern that respondents would get more involved in the personalities shown in the photographs or cinema clips, rather than thinking about the subjects depicted. Also the apprehension was that the respondent might not relate with the personalities who are considered to be 'heroes of reel life' and not real life. Cartoons, a creative way of depicting a subject, were another option. However, considering the seriousness of the topic and perceptions of local people towards 'cartoon' as a visual form, the researcher thought it would be an inappropriate idea. There was a need to have a simple, respondent-friendly and adequately flexible tool. The researcher felt that the most appropriate and effective tool would be combining the use of words and drawings - in the form of sketches- close to respondents' lifestyle depicting their day-to-day life scenes. Hand drawn pictures, sketches or images by the respondent are widely used in reproductive health but mainly as a research method (Jaswal, 1997; Apte, 2000). The anthropological research of Victora and Knauth (2001), examined graphic and verbal images of the reproductive system of men and women living in Brazil. Guillemin (2004) asked women attending menopausal clinics to draw how they understood menopause following an individual interview and she mentions that drawings offer a rich and insightful research method to explore how people make sense of their world.

Hence the researcher decided to prepare an interview guide which is supported by visuals for interviewing the couples. This tool is labeled as Visually Assisted Interview Guide (VAIG). The tool involved picture cards having hand-drawn illustration of day-to-day life scenarios (some examples are shown in Figure 2.5) and an in-depth interview guide around each scenario. The researcher's husband, who is an artist and has experience of working in the subject of reproductive health as well as rural community, helped in constructing the visuals. Each subject of reproductive health under study, such as pregnancy and sexual relationship had a set of hand-drawn pictures depicting the subject. Also there were some pictures helping to elicit data around general communication of the couple and their lifestyle.



Figure 2.5 -Examples of picture cards used as a part of VAIG

The operational definition of reproductive health guided the broad areas of enquiry in the tool. It also included sections on personal data of the couples, socio-demographic details, information about family, general communication including time, duration, content of communication, determinants etc.

The tool was simultaneously administered to husband and wife (in absence of each other, separately) by male and female researchers respectively.

*The study tool VAIG is enclosed at the end as an annex.*

#### **2.4. Pilot testing of tools for interviewing married couples**

For interviewing the married couples, an interview guide without any visuals was initially prepared and pilot tested with men and women. Also it was discussed at field level with key informants to get their inputs. Some additional issues were suggested during these discussions which were later incorporated in the interview guide such as 'privacy available for the couple'. Also inputs from interviews with experts from the study subject- a counselor working at infertility and male sexual and reproductive health clinic, and an experienced researcher in reproductive health in India, helped in revision of the interview guide and conception of the visuals. Based on these initial discussions, subjects of visuals were identified and thus a Visually Assisted Interview Guide was prepared. This tool was once again pilot tested at field level with men as well as women (with eight respondents). Appropriate changes were made in the textual part of the guide i.e. the questions or probes as well as in the pictures. For example- earlier there was no picture card around sexual abstinence, but during the pilot testing, it was experienced that adding a separate card on this subject was necessary to elicit the details on this subject.

Pilot testing of this tool helped in understanding the appropriateness, comfort level, comprehension of questions as well as pictures, by male and female respondents. An analysis based on the eight in-depth interviews during pilot testing ensured that no further revisions of the tool were necessary.

(Chapter 3 of this thesis is based on construction and validation of this tool.)

## **2.5. Data collection-**

Data were collected between 2006 and 2008. As the researcher was not affiliated or associated with any research institute in Pune, India for conducting this research, most of the research work was handled by her individually. She had previously worked in the study area and had rapport with the health and development functionaries. During the initial phase of the study, her male assistant and she made several visits to the study sites and had informal discussions with village health functionaries and villagers about the study. This phase lasted for about six months, during which they also interviewed some of the key informants. Though interviewing key informants continued, the data from this phase helped not only in designing the VAIG for interviewing the couples in the initial stage of the study, but also for contextualization of data from couples around existing practices of couple communication, at a later stage.

The next phase was interviewing couples, which lasted for about one and a half years. This phase included preparation of the tools for interviewing couples, pilot-testing the tools in the field and revisions of the tools before starting to collect data from the study sample. The male assistant conducted interviews of the men (husbands) in the study. This helped in taking care of gender issues at field level about a woman interviewing a man regarding his reproductive and sexual life issues. Also husband and wife had to be interviewed simultaneously so that there was no sharing of information between them and hence it was required to have the assistance of another interviewer. All the interviews were conducted in the local language i.e. *Marathi*. Each interview was generally completed in one session, due to difficulties in arranging a schedule for re-interview. On an average during one field visit, one couple was interviewed. The interviews were either recorded (if consent was given by respondent) or field notes were taken during the interview.



## **2.6. Sharing field experiences- rapport establishment and interviews of couples**

We hired a vehicle and left for the field generally in the evening i.e. at about five o'clock. The villages were at a distance of 25-70 km from the main city and it took us from 40 minutes to one and a half hours to reach the field village, depending on the traffic on the Expressway, the conditions of the approach road to the village and the rains. In the rainy seasons, heavy rains, disruption of electricity, poor condition of the approach road and respondents having workload on the farm, further interrupted the field work. Villagers, especially men were free to discuss things usually in the evenings, after work hours. It was very difficult to find husband and wife both available for interview at the same time due to their busy schedule. We contacted the VHF and, received a list of probable samples from their work area. They contacted the sampled couples and fixed up an appointment for us. Most of the times, the VHF himself or herself guided us to the house of the respondent, introduced us to them and then left. My assistant and I introduced ourselves in details to the couple, and if necessary to the whole family. We then sought an informed verbal consent from the couple for the interview. Sometimes we even had to discuss the same, with other family members. Generally there was an informal discussion about their on-going activities. We then separated the couple for conducting interviews.

It was always a challenge to take the woman out from the family, and find privacy to discuss her personal issues. Sometimes, there were supportive women in the family, who volunteered to substitute her for cooking, looking after her children and other household chores for that evening. All these women had their youngest child not older than two years (on an average) because of our selection criteria of interviewing women who had their sterilization not more than a year before the time of interview. But sometimes, there were difficulties in arranging her interview and many times, I conducted the interview in the kitchen, while the woman was cooking. Most of the interviews were conducted sitting on the floor along with the respondent. It helped in creating an informal environment for the interview and also made it easy to spread the picture cards in front of the respondent and discuss various issues. This made the respondent comfortable while giving responses. This approach helped in finding private time with her for the necessary duration as it did not hamper her work and thus other family members did not mind either. Each interview lasted for approximately an hour and twenty minutes. Even if the interviews were previously planned, we always had to wait for the couple to get ready for the interview for reasons such as the man was busy with work, he was not available at home, the woman was busy cooking, the children did not let the mother speak, or some other family members were present, denying us have the privacy required for conducting the interview. Some times, we had to revisit the couple to find the appropriate time and place for the interview. In each visit, we planned the interview for the next visit.

## 2.7. Data management and analysis-

Field notes taken in *Marathi* were expanded and the entire interview was transcribed and translated in English. The interviews were coded and managed in the software Atlas ti. Broad areas of inquiry in the interview tool formed the broad codes, which were then sub-coded. Couple communication was then thematically analyzed around themes such as- methodological issues, Indian traditions regarding childbirth, male involvement in reproductive health, gender stereotypes related to sexuality and the concept of planning parenthood. Also process of communication was analyzed in terms of place, type and form, duration, content and barriers for communication. The study mainly involved learning about actual practices in relation to couple communication and there were very few questions around knowledge, perceptions, opinions or intentions, where husbands and wives would have differed in their responses. Also considering the qualitative nature of the study, the size of the sample and the objective of the study which was to learn the process of couple communication, it was not appropriate to match their responses for all the questions to understand agreement or disagreement. Hence, it was attempted to analyze and match male-female responses for limited subjects.

### 2.8- Timeline of the research project (October 2005- March 2009)

Months 1-3:	Initial visits in the field- informal discussions with community members, observations, discussion with staff from PHC, interviews of key informants, literature review
Month 4-6:	Interviews of key informants, identification of PHC staff for supporting the study, literature review
Month 7-8:	Preparation of study tool to interview couples, identification of couples, literature review
Month 9-10:	Pilot testing and revision of tools, identification of couples, literature review
Month 11-13:	Construction of final study tool VAIG, identification of couples, first level consent seeking by PHC staff, literature review
Month 14-24:	Data collection (including analysis during data collection), data management, literature review
Month 25-36:	Data management, data analysis, paper writing, literature review
Month 37-42:	Data analysis, paper writing, thesis writing, literature review



## **2.9. Ethical considerations**

Since the study is on couple communication on the sensitive and personal subject of reproductive health issues, informed verbal consent from the respondents was obtained at two levels: firstly by the VHF before recruiting them in the study and then by the researcher before starting the interview. Also verbal consent was sought for recording the interview. More than half of the sample gave consent to record their interviews. They were assured freedom to participate or withdraw from the study at any point (even after giving first level consent to the VHF) without giving any explanation to the researcher or to the VHF. The time and place for conducting the interview was decided by the couples and the researcher occasionally had to make multiple visits to respect their decision. The researcher ensured that the respondents were interviewed in complete privacy and no information was revealed to any of the family members, friends or even the spouse. Of course, using the information collected through this study only for academic purpose, and not discussing it with or disclosing it to anyone else for any other purpose, would ensure the important aspect about protection from harm to the respondent.

There was no possibility of seeking ethical clearance from any Institutional Ethics Committee (IEC) at local level. The University of Pune did not have an IEC at the time of my project work. Recently they have formed an IEC; however, it is still not functional. I conducted the research at individual level and was not associated with any organization for my research. Hence, the research does not have any ethical clearances/ agreements sought from a formal research ethics body.

## **2.10 Advantages of study tool- VAIG-**

VAIG helped the researcher in conceptualizing the entire process of husband and wife communication in reproductive health within local cultural context.

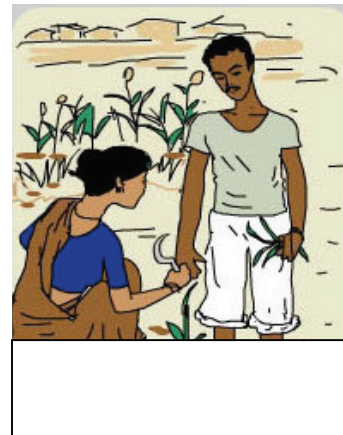
The respondents were able to visualize their day-to-day life at home, on the farm or outside the house and could think about when, what, how and where they talked to each other about reproductive health issues- for example 'talking about personal issues only at night', 'not talking about sexual relations when outside the house', etc.



The tool also helped in reducing 'recall bias' and missing out minute details around communication. For example, to the visual and question around husband's role in post-natal period of his wife (as shown in Figure 2.6), one husband replied,

*'I went to meet her on the 12<sup>th</sup> day of her delivery. Met her and came back on the same day. There were many people around, so how could I talk or discuss anything with her! I could not go there often due to my job. She was there for one and a half months. That is the custom. So decisions were taken at 'higher level' in the family. I did not say anything in that matter.'*

Essential flexibility was offered to respondent because role of visuals was to navigate the respondent's thoughts in a particular direction and not to restrict him to think only about what is depicted in the visual. Appropriate questions and probes were crucial to achieve this necessary flexibility. For example, there is a picture of husband and wife working on their farm and talking to each other (as shown in the figure 2.7). Some of the respondents answered, *'We do not have a farm', or 'I don't work on the farm'*. It was important to lead them towards various other possible situations where they could have privacy. If visuals are used to elicit information in isolation without having the necessary questions/ probes, it can limit the scope of eliciting information.



These visuals involved concrete leads and helped me in desensitization of respondents for sensitive subjects such as sexual expectations and sexual negotiations. The respondents gave details regarding the process of communication about their sexual relationship, without any reservations. To quote a young woman living in an extended family-

*'Is there anything wrong in having it (sex) 'the other way round', means woman on the top? I like it that way and he also does not have any problem (Feeling guilty). We don't do it that way, everyday but once in 3-4 months. I am sometimes worried, is it that if one does it this way, they will have AIDS? I cannot talk about this to anyone. My husband anyway laughs at me because I always keep worrying about something or the other.'*

It was felt that bridging the gap between the respondent and the researcher and building trust in the respondent's mind was very crucial. Without using visuals this process could

not have been so effective. Deacon and Boule (2007) had a similar finding about using case vignettes as an appropriate mechanism to elicit of patterns of stigma.

Specific situations such as 'Husband has gone to meet his wife after her delivery' helped the wives in the study to remember their entire experience and answer in depth about the communication process. The wives spontaneously narrated about communication with other family members especially with their mother and the mother-in-law. Though it was known that these family members have an important role in the decision-making at family level, we have avoided including them in the picture. We worried that their inclusion in the picture could give a wrong message that they are or should be involved in the decision-making. However, the respondents could think beyond the subjects and objects portrayed in the visuals and their narration did not limit necessarily to the communication between spouses.



The advantages of visuals were also experienced for interviewing couples on highly sensitive subjects such as their sexual relationship. These situations illustrated, for example (as shown in the figure 2.8), 'Husband wanting to have sex and wife not willing for the same' could be 'read' by the respondents and they could comprehend the situation without many explanations from the interviewer.

These visuals had 'leads' but there was no harm done to the respondent's right of denying the situation depicted in this visual. There were responses such as 'Yes, it happens when I go close to her, she is tired or does not have the mood, but then I 'prepare' her for it because I cannot sleep without having it'; and also there were responses such as 'No, this never happens. We have it only when she wants it.' In other words, even these leading visuals could help to elicit realistic responses without having to ask any subjective or judgmental questions.

Lastly, the study has overcome potential obstacles in approaching couples for reproductive health studies. Stan (1996) in the review of couple studies in reproductive health mentioned about potential obstacles due to complexities arising in data collection—lower response rate than for individuals and potential contamination of responses unless interviews are conducted separately and simultaneously. Present study findings are based on the narrations of husbands and wives and the response rate from both of them

was more than 80%. Also there is a possibility that because most of the interviews were conducted in one session, the researchers received most spontaneous responses from husbands and wives, as they had no opportunity to discuss or decide or plan the responses.

### **2.11. Limitations of the methodology**

There is always a self-selection bias from participants which is beyond the control of a researcher. For example, people who have strong opinions or knowledge are more willing to participate in a survey. Similarly in this case, one cannot overrule the possibility that, couples who are comfortable in talking about reproductive health or about communication had more participation in the study. The study subject was sensitive and intimate for the respondents and supposedly to be discussed only 'behind close doors'. Hence, in spite of the efforts to establish rapport with the respondent, we do not deny the possibility that the respondents did not disclose all the details about their reproductive health related communication with their partner, especially on sensitive issues such as sex-related communication.

Although more than one visit was paid to one couple (for planning and conducting the interview), the actual interview was (in most cases) conducted in one session, as it was not feasible to arrange the time and place to meet the couple repeatedly. 'In-depth' interviews are expected to run over more than one session. Though the researcher used visuals to elicit maximum information in a relatively short period, the 'depth' of the data needs to be appreciated against the feasibility.

The study sample with due consideration given towards degree of saturation and proportion with the study universe, truly represents the rural community under study in terms of their background characters such as age, education, occupation, type of family and caste. However, the study being qualitative in nature with small sample size, all the findings cannot be generalized or extrapolated to the larger population of rural communities all over India but surely suggests concepts and strategies that can be generalizable.

## Chapter 3

# **Understanding couple communication in reproductive health by using Visually Assisted Interview Guide (VAIG)**



**Understanding couple communication in reproductive health by using Visually Assisted Interview Guide (VAIG)**

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### **3.1. Abstract**

Learning process of couple communication, in terms of place, time, duration, content, style, form and barriers, is crucial before developing strategies to improve communication among rural couples in India. Considering the sensitivity of the subject, cultural setting, family dynamics and difficulties in reaching couples, visuals with an interview guide, proves effective. Current paper explains construction and validation of Visually Assisted Interview Guide (VAIG). Context limits the choice of visual forms and hence hand-drawn pictures from day-to-day life scenarios were used in the tool. Tool construction primarily considered adding value to the interview guide and to offer ease/comfort to the respondents and researchers for eliciting personal information. Results show that hand-drawn pictures subtract the respondent and replace him with the individual illustrated and thus give realistic, impersonal responses around sensitive issues. VAIG is useful in understanding the process of couple communication in reproductive health in a rural context.

**Key words-** reproductive health, couple communication, hand-drawn visuals, rural

### **3.2. Introduction**

The importance of couple communication to enhance sharing thoughts and feelings between husband and wife, to improve mutual decision-making and thus to help in achieving better reproductive health outcome, is known. Keller (1996) has reported that sexual partners who communicate about reproductive health issues reduce their risk of acquiring a sexually transmitted disease (STD) or of unintended pregnancy but few couples feel comfortable talking openly about sex. Couples who talk to each other about family planning and reproductive health can reach better, healthier decisions (Population Reports, 1998). Bloom, Singh and Suchindran (2005) have studied couple communication as a protective factor against the risk of HIV in Northern India. Learning more about the process of couple communication, in terms of the place, the content, the style, the barriers, the form etc. is crucial before developing strategies to improve couple communication, especially among rural couples. However, such learning poses challenges related to the sensitivity of the subject, the cultural setting, the gender dynamics in the family and practical difficulties of reaching both husband and wife in a rural set up for eliciting in-depth information.



Couple communication in relation to reproductive health has been widely studied using various quantitative and qualitative tools of data collection. Kimuna (2001) studied fertility and family-planning decision-making through National Demographic Health Survey on a sample of 1257 matched couples. Traditionally, family planning surveys relied on responses only from women but in this survey Kimuna matched the data from both men and women sampled in the survey. However, survey as a tool of data collection answers 'what', 'how' and 'why' about a research issue in a limited way. Hence for learning more about sensitive issues in reproductive health, researchers have preferred using qualitative tools of data collection. Ortayli et al (2005) conducted in-depth interviews among 62 male factory workers in Turkey to understand men's perspective on withdrawal. In India, Ravindran (2004) interviewed 66 women and 44 of their husbands to elicit information about women's preferences to have induced abortions rather than use contraception in the context of gender relations between couples. Santhya (2002) studied spousal communication on reproductive illness among rural women and its influence on preventive and curative behaviors by using quantitative as well as qualitative methods. George (2000) in her study around first sexual experiences of newly married adolescent women in Mumbai used narratives of women from two data sets gathered from focus group discussions and in-depth interviews.

Although tools such as interview guides and narrative techniques are useful in eliciting qualitative and in-depth information from the respondents, they may have their own limitations in offering the respondent the comfort and ease (at which they can respond regarding) required to respond freely on many aspects of marital life including reproductive health issues because these are intimately personal issues.

To learn about sensitive subjects such as reproductive health, visual methods are viewed as established methods having a qualitative perspective and approach of data generation. Keller (2008, 428) pointed out that measures that are not culturally relevant or sensitive to the experiences, and traditions or beliefs of local people may result in obtaining unreliable or non-interpretable data and used visual methods to measure physical activity and dietary intake among Hispanic women. Visuals are used in various forms as photographs, movie clips or hand drawn pictures in different settings. As is described by Donaldson (2001), data in the form of photographs can be used to improve understanding in several areas including reproductive health. In visual anthropology, photos are used to achieve a multi-dimensional approach in studying culture and specific

subjects such as rituals or home-life (Collier and Collier 1986). Frith and Harcourt (2002) used the photo-elicitation method to capture women's experiences of chemotherapy treatment. To collect data around perceptions of quality of prenatal care among immigrant Latina women, Bender, Harbour, Thorp and Morris (2001) designed a qualitative interview tool with photographs representing components of quality. Several other studies explain use of movie clips or photographs to have a detailed documentation of the research activities (Petchesky 1987; Prosser, 1998; Radley and Taylor, 2003).

In health research, especially in African countries, pictures in the form of vignettes have been widely used in health research, more related to HIV/AIDS (Deacon and Boulle, 2007). Also there have been studies around visual imageries and how people construct these imageries (Rose, 2001). Haaland (2000, 9) has extensively used pictorial forms with the community and mentions use of pictorial forms for various purposes e.g. by community health workers for record keeping of distribution of a commodity such as drugs, and for describing and quantifying problems by community members. In addition to using visuals either to impart a message or educate or to document various processes, visuals can be creatively used to elicit information on a range of subjects from a group of participants or from an individual.

Based on reviewing various research methods used in understanding sensitive reproductive health related issues, I decided to use an innovative approach in eliciting information from couples in the study. The aim of this current study was to understand the process of couple communication in reproductive health in terms of its style, place, duration, period, frequency and content. For the study, reproductive health was operationally defined as all the issues related to pregnancy, delivery, family planning, reproductive health problems and sexual relationship. I used hand-drawn pictures as an integral part of an interview guide and labeled this tool as Visually Assisted Interview Guide (VAIG).

### **3.3. Context / background**

Pune is one of the fastest growing cities of Maharashtra, a state in western India. The study site, Maval Tehsil<sup>6</sup> is located on the Northwest of Pune city and Pune-Mumbai Express way cuts through the Tehsil. It is surrounded by the Sahyadri mountain ranges and is a region of heavy rainfall growing paddy as the main crop. Around three hundred thousand people reside in this Tehsil. Though it is one of the fastest developing tehsils of Pune district with many upcoming industries, educational institutes, plant nurseries and floriculture, it still represents a typical rural site dominated by the kinship-oriented Maratha caste<sup>7</sup>, a largely agrarian community. Most of the families are either joint or extended. There are two main towns, where most of the private medical practitioners, private multi-specialty hospitals, markets and shops are clustered.

All the couples were Hindu and most of them (27/35) live in either a joint or an extended family. Out of 35 couples, 26 men and 33 women had studied up to 10<sup>th</sup> standard or less than that. Families were mostly agriculturists wherein, 20 men had agriculture as their main occupation and 6 men had agriculture as their secondary occupation, as they were involved in service on contract basis at the time of interview, but had agriculture as the main source of income for their families. All the women were housewives. As the youngest child of all the women was less than three years old, most of these women were not able to work in the farm or acquire additional jobs and hence only 9 of the 35 women had some secondary occupation such as farming, petty business or service. Majority of the couples had completed their family with either two (25/35) or three children (9/35). One couple had six children, five daughters before having their son. This profile of the couples is extremely congruent with a typical rural Maharashtrian community.

It was decided to conduct the study in the rural set up because the aim was to learn about couple communication in a setting where there is more influence of traditions, more kinship oriented families, comparatively less exposure to media and less access to health services. I was exposed to the study area through previous research projects and

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<sup>6</sup> Tehsil-It is an administrative unit of a District consisting of a group of villages. As an entity of local government, it exercises certain fiscal and administrative power over the villages and municipalities within its jurisdiction.

<sup>7</sup> Caste- It is a group of individuals socially stratified on the basis of occupation, endogamy, social culture and political power.

hence had rapport with local health functionaries<sup>8</sup> who helped in recruiting the study respondents. Some of the cases were recruited through snowball technique (one respondent interviewed suggested the name of the other respondent who was either her friend or her relative).

In a patriarchal society like Indian society, the life of an individual mostly revolves around his family and marriage. Sex is 'sanctioned' only within marriage (Kanbargi and Kanbargi, 1996), which is formally arranged by elderly members of the kinship and most of the times, the concerned individuals have no freedom in partner selection. Contrary to the occidental cultures where relationships culminate into sexual relations, in India the entire relationship between husband and wife 'begins' with sex (Sawant, 1996-81). Married couples are worried, especially in the beginning of their relationship, about rejection in sexual life and hence may avoid discussing with each other, topics such as family planning, sexual problems, gynecological morbidities and reproductive health in general. This is the crucial period of their married life, where open communication about such issues will actually help them in understanding each other's attitudes and behavior in relation to reproductive health and will give more strength to their relationship. With this background, married couples were included as respondents in the study.

Further, considering the operational definition of reproductive health for the study, it was decided to include couples having at least one child (as infertility was not included in the operational definition of reproductive health related issues) and those who have undergone family planning operation. In this way, we could cover a range of events from conception, pregnancy, delivery, family planning up to completion of family. To minimize the recall bias of the respondent, it was decided to select couples that have undergone the family planning operation not more than one year before the time of involving them in the study.

Within this context of the study setting and the study population, the broader study aimed at exploring the details of the process of couple communication in reproductive health in rural India using a qualitative approach. The current paper focuses on the

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<sup>8</sup> PHC staff- Auxiliary Nurse Midwife and Multi Purpose Worker. Anganwadi workers- In India, the government runs pre-schools in all the villages under Integrated Child Development Scheme. Anganwadi workers are teachers in these pre-school who are also responsible for assisting the PHC staff to provide anti natal and post natal services

process of construction and validation of the study tool- VAIG I, with the help of another male researcher who administered this tool to 35 married couples.

### **Other tools of data collection**

With the given background of the study sample, I thought about various options to elicit the desired information from husbands and wives. In the initial phase of preparing the study tools, various other tools such as a simple interview guide, a '3X3 matrix' were prepared and tested at field level. I experienced challenges in administering these tools e.g. women felt shy to discuss their sexual relationship; men were reluctant or disinterested in talking about their personal lives etc. Moreover, to elicit information from husband and wife on sensitive issues such as their sexual relationship, in a single session, was challenging for me. For qualitative, exploratory and sensitive research, the importance of having an in-depth interview guide was never underestimated. However, I felt a need to have visual assistance to an interview guide. Visuals methods coupled with participant narratives provide strategies to empower participants to define the problem of interest, encourage participants to reveal what might be uncomfortable or unknown, and identify and develop resources (Hurwoth et al 2005).

Researchers have used various forms of visuals such as photographs or movie clips (Petchesky 1987; Prosser, 1998; Radley and Taylor, 2003). However, use of any of these tools, for example, electronic medium with rural community, was not considered user-friendly or easy to comprehend. The option of using real life photographs or clips from local cinema involved concern about the respondents getting more involved in the personalities shown rather than thinking about the subjects depicted and thus not being able to relate with the personalities who are considered to be 'heroes of reel life' and not real life. Considering the seriousness of the topic and perceptions of local people towards 'cartoon' as a form of visual, I thought it would be an inappropriate idea. There was a need to have a simple, respondent-friendly and adequately flexible tool. I felt that the most appropriate and effective tool would be combining use of words and drawings - in the form of sketches- close to respondents' life style depicting their day-to-day life scenes. Hand drawn pictures, sketches or images by respondent are widely used in reproductive health (Jaswal, 1997; Apte 2000; Victora and Knauth, 2001; Guillemin, 2004).

It would be worth understanding the process of construction as well as validation of this tool -VAIG at field level.

### **3.4 Process of construction on VAIG-**

Process of construction of VAIG included construction of interview guide and visuals. The interview guide was already constructed and pilot-tested at field level. However, having visual assistance to this interview guide and making necessary adaptations in the guide according to the visuals, involved various steps.

#### **Step 1: Choosing the form of visual**

I decided to use visuals in the form of hand drawn sketches, which would reflect the respondent's day-to-day life, as closely as possible. I had previously used such drawings as a resource for imparting health education in various other research projects and have always received a fruitful response from the rural community.

#### **Step 2: Selecting an artist**

To quote Schwartz (1989- cited by Harrison 2002, 859) - 'viewing and producing of photographic imagery is a patterned social activity' and the author emphasizes on having an understanding of everyday contexts and practices (Harrison 2002, 859). Hence the process of construction of such a tool requires an altogether different set of skills and expertise. In this study, the artist had experience of more than a decade of working with rural setting for community based reproductive health related issues. He had worked extensively on developing visual health education material for the rural community and hence had thorough knowledge about local setting, local people, local life-style etc. For example, typical structure of the house in a village, clothing style of young people while working on the farm, etc. Selecting an artist having such detailed knowledge about the study setting was the first crucial step.



#### **Step 3: Same visuals for husband and wife**

We decided to use the same visuals for husbands and wives in order to have comparative data on various subjects. They had to be easy to understand and interpret by men as well as women. However, considering the gender based stereotypes in Indian

society, it was expected that men and women would respond to these visuals differently, based on their own frame of reference, their own cultural background and their gender.

#### **Step 4: Taking hints from local community and experts**

During the preparatory stage of the study, local field experts hinted and suggested that 'privacy' for the couple was one of the major key determinants for couple communication and in the rural set up, 'privacy' had various dimensions. From field experiences, it was observed that the number of rooms, structure of the house, family size, privacy within the house, privacy on the farm, privacy outside the house, mobility of the couple, number of children, age of children, role of the mother-in-law, decision making in the household, etc. were related in 'offering privacy' to the young couple. If privacy is to be explored as a 'determinant' to study couple communication, all these dimensions of privacy should be studied. It was decided to have a series of pictures to depict most of these dimensions of privacy while eliciting information from the couple. There were three different pictures- couple at home, couple on the farm and couple traveling together.



#### **Step 5: Sequencing of visuals from 'simple' to 'complex'**

The next step was to decide upon whether to have sketches of individuals or scenario. A lot of discussion went into this decision, and finally we decided to follow the logic of going from 'simple' to 'complex'. The initial sections of VAIG included simple sketches of a typical rural man and woman (as shown in Fig. 3) to elicit information about the personality of husband and wife. In the remaining sections, the sketches depicted situations/scenarios. For example- privacy, arguments/fights between husband and wife, etc. We have used thought-provoking and day-to-day life scenarios. The idea was to have self-explanatory as well as easy to understand visuals to which the respondents would be able to relate easily.



#### **Step 6: Themes of sketches**

The study objective was to understand details of the process of couple communication in reproductive health. Obviously, this objective was a guiding point for all the visuals.



However, it was crucial to look at how these words - 'process' 'communication' and 'reproductive health' - were operationally defined for the study purpose.

- a. 'Process' involved when, where, what, how, etc. about communication
- b. 'Communication' itself had various dimensions such as direct/indirect, passive, verbal/non-verbal, and various forms such as agreement, instruction, argument, decision, etc.
- c. 'Reproductive health' included five issues - pregnancy, delivery, family planning, sexual relations and reproductive health related problems.

Thus sketches had to be thematically drawn considering operational definitions of all the above terms. I had series of discussions with the artist on these themes.

### Step 7: Capturing cultural norms, practices and program related issues through visuals

However, the next step was to decide 'Under these themes, which key issues should be depicted?' 'Pregnancy, which traditionally, is exclusively the woman's domain was one of



the considerations while for constructing the visuals. Based on literature review and policy around reproductive health outcomes related to pregnancy (Razzaque, 1999; Turan, Nalbant, Bulut & Sahip, 2001); it is expected that there should be husband-wife communication around availing anti-natal care services, general care and support at home including her diet, rest, workload, etc. Also, there would be communication around practices related to fulfilling her cravings, celebrating

her pregnancy, sending her to her natal home for 'better care', sexual relations during pregnancy, etc. It was important to understand whether couples talk to each other around events, practices and cultural norms during pregnancy, which will influence health of the mother and the child. Hence these sub-themes were depicted in the visuals to learn more about communication around pregnancy. One of the visuals on this subject (as shown in Fig. 4) depicted a pregnant woman-her diet, medicines, immunization, etc.

To capture norms and practices during the intra and postnatal periods and consequent communication between husband and wife, we prepared a visual as shown in Fig. 5 A man and his wife with their newborn baby (*that is how new-*





born babies are generally wrapped in a cloth in the rural setting). As per the tradition, most women are sent to their natal homes for delivery and they are expected to stay there for a period of at least five weeks after childbirth. This period is supposed to be a period of ritual pollution<sup>9</sup>. The husband may make brief visits to his in-laws' house to meet his wife and baby. The purpose of this visual was to understand the husband's interactions with his wife during her post-natal period.

### Step 8: Depicting sensitive subjects in a subtle way

Preparing sketches around sensitive subjects as sexual relations was a challenge in itself and required a series of trials before finalizing the visual. For example- I gave a



brief to the artist about showing 'abstinence' in the picture. The Fig. 6 shows how we portrayed 'abstinence'. The artist sketched abstinence in many other ways-some of them were too bold to be used for the rural community whereas some sketches were too abstract for comprehension. It was crucial to respect the sensitivity of

the subject as well as convey a clear message so that the respondents would be led to think about this situation. Depicting sensitive subjects in a subtle way was a time-consuming process. Moreover, I anticipated that such a visual may not be self-explanatory for all the respondents and hence the questions around this visual had to take care of guiding the respondent to the desired subject through a series of questions such as-

What do you see in this picture? Why are husband and wife sitting like this? (Probe) May be they have decided not to have sex for some reasons? Does that happen in your case? Can you tell me more about it? When does it happen? Why does it happen? How do you decide about it? Etc.

### Step 9: 'Leading' scenario

Some of the visuals depicted a 'leading' scenario. There was a clear purpose behind having such leading sketches. It is known that 'leads' can be positively used to elicit the desired information in qualitative research. These leads were based on the data from community experts and my previous experience. For example- one of the places, where

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<sup>9</sup> Post-natal period of five weeks is considered to be of 'ritual pollution'. Woman is supposed to remain in seclusion for this period of time due to the polluting effects of childbirth.

husband and wife can have privacy was 'the kitchen'; another was 'when they both travel together on a two-wheeler'. These ideas were drawn from common experiences of villagers and thus portrayed a leading situation for the respondents. The visual (Fig. 7) around 'husband and wife at leisure' may lead a respondent to think about 'is such privacy available for them', 'what happens when both of them have privacy', 'whether they spend that time in the kitchen, etc'. before they can respond about what they talk in privacy. Hence, it was crucial to design the questions to help the respondent not only to react to what was depicted in the visual and but also relate it to his or her personal experience. The questions around this visual were-



What do you see in this picture? Does such a situation happen in your life? Do you have relaxed time for both of you? What do you do at such time? If not in the kitchen, are you both together at any time of the day or night? Then what do you talk about at such times? Etc.

### **Step 10: Ensuring connectivity and value addition between visuals and words**

As the name of the tool suggests, the visuals were expected to assist the in-depth interview guide and hence these sketches and the questions/ points were expected to be connected to, and have a value addition to, each other. Hence, developing visuals and questions around each of these visuals was a simultaneous process and involved pre-testing in the field at each stage. The key point was to ensure that the respondents were able to have association/relation between the scenario sketched and the questions asked, before the tool was ready for administration.

### **Step 11: Introducing each theme in the VAIG**

The VAIG had different sections such as- personal and family information, personality of husband and wife, general communication, pregnancy, delivery, family planning, sexual relations, reproductive health related problems and reproductive health communication with others. Each of these sub-sections except the first one, included a set of visuals. The information regarding the background of the respondents was collected with the help of structured questions, incorporated in the first section of the interview guide. A clear and brief introduction to each sub-section was an integral part of VAIG. This aimed

to navigate the respondents to the desired subject and reduce further explanations around each separate visual.

### **Ethical considerations**

Since the study is about a sensitive and personal subject such as communication between husband and wife on their reproductive health issues, informed oral consent was sought from all the respondents. They were assured freedom to participate or withdraw from the study at any point without giving any explanation to us. We ensured that the respondents were interviewed in complete privacy and no information was revealed to any family member, friend or even the spouse. Of course, using the information collected through this study only for academic purpose and not discussing it with and disclosing it to anyone else for any other purpose would ensure the third important aspect- protection from harm to the respondent.

### **3.5 Validation of VAIG at field level**

An effort was made to validate the tool at field level during the process of construction and after the process of construction. The main purpose of validation was to judge whether the respondents were comfortable in understanding and responding to the visuals. However, analysis of data collected using these visuals is beyond the scope of this paper.

VAIG is an interview guide assisted by visuals and hence discussion around each visual started with a question- 'What do you see in this picture? What do you think they are talking about? Does that happen in your case? Do you experience this in your life? ...and so on.' In other words the visuals gave a chance to start the discussion about the desired issue, firstly with the persons depicted in the visual and then about personal experiences of the respondent. The purpose was to elicit impersonal but realistic responses to various subjects including sensitive ones such as sexual relationship.

*A quote- 'If we are traveling on the vehicle, till we reach our house, our mouth is never closed. We keep talking some or the other thing, but not much about ...about sexual life and all. I mean [feeling shy] yes, we do talk all these but we talk it even at home, because we have a big house.'* – A farmer living in a joint family

### **Interpretation of visuals at field level-**

VAIG involved interpretation of images shown in the visuals by the respondents and hence it was about 'making sense of meanings assigned' (Harrison 2002, 864) by the respondents.

Overall responses from the couples were that they found the visuals 'easy' and that they could help them visualize the scenario, take them 'through' the situation and help them to remember what actually happened during that period in their own life. A 22-year-old housewife, living in an extended family, expressed, '*You have shown what happens in my life and it is so easy to understand what questions you are asking me*'. In this case, it required very little probing. However, in some cases, questions/ probes asked around each visual, played a role in the interpretation of visuals by the respondents. Another experience was that the respondents felt comfortable when they saw something that happens in their life, shown in the pictures. It was to assure them that these things were common, especially for issues such as couples having poor communication, difficulties in communication on sexual issues or both of them fighting over some issues. The respondent's first reaction was, '*Yes, it does happen with us,*' It is possible that visuals could make certain issues/probes impersonal and less threatening for the respondent and yet provide realistic responses.

Barthes (1981) investigates the effects of photographs on the spectator and derives two concepts: *studium*, relating to cultural, linguistic and political interpretation of a photograph and *punctum*, establishing a direct relationship with the object or person within the photograph. In the present research, some visuals were simple and respondents could establish a direct relationship easily. For example, a visual depicting contraceptive devices. On the other hand, some visuals required to be interpreted by the respondents within the existing cultural context. For example, *Figure 6* depicting abstinence.

Another example was that of a man who said after seeing the visual of husband and wife shouting/fighting with each other, '*We do fight but not so loudly as shown, or not so seriously*'. Visuals acting as icebreakers for certain sensitive issues as that of sexual negotiation, violence, etc. helped to probe these issues in depth without being offensive.

It was observed that none of the variables such as the respondent's educational background, and type of family had any relation with the ease at which the respondent

could interpret these visuals. Men and women with less education or from a joint or extended family could interpret the visuals as comfortably as the ones with higher education or from a nuclear type of family. It was the subject depicted or the simplicity with which the subject was depicted, which determined the level of interpretation by the respondent. For example, all types of respondents could comfortably interpret simple visuals such as the one depicting pregnancy related care, whereas most of them needed leads to interpret the visuals related to privacy and sexual relations.

### **Responses across five different main themes of RH**

In general depicting an abstract concept as that of communication in a visual form was a challenge. However, the thorough introduction about the study subject helped the respondent to understand and interpret couple communication in relation to each of the five different reproductive health themes. Visuals around pregnancy, delivery, and to some extent family planning, were obviously less threatening and easy to comprehend by men as well as women. Comparatively, visuals on sensitive subjects as sexual relations, abstinence, and reproductive health related problems and communication on these matters, definitely needed more directions and probes. However, the visuals definitely helped the respondent as well as us as researchers to be comfortable about the subject and have detailed discussion around it.

### **Issues related to administration of the tool**

The introduction before showing any visuals was crucial. It was necessary to explain to the respondents, 'The visuals are some examples, to help them think about these issues. Sometimes they may see themselves in the picture and sometimes they may not'.

At times, due to non-availability of adequate light, space (as some of the interviews were conducted in late evenings, in a small hut, in the field etc.) we faced difficulties in showing the visuals. They either had to wait to have some alternative source of light available or had to change the venue of the interview. But it was always worth taking efforts to show them the visuals and probe further about the issue.

Some times, there was interference of children during the interview and they were curious about the pictures. I would show them simple pictures used in the initial sub-sections of VAIG. I had to take precaution of not making all the visuals available to them.

All the respondents expressed comfort and ease with the visuals. To most of the respondents, we could make only one visit to complete the interview. In one session, making a couple comfortable to talk about a sensitive subject, to retain their interest in the subject and keep them engaged for almost an hour was definitely a challenge. Without having visuals it would have been difficult to face this challenge.

Some of the visuals were self explanatory, such as the visual around 'Anti-natal care for a pregnant woman' and thus required minimum probing on the part of the interviewer. This was thought to be an added advantage to elicit qualitative information, especially from a male respondent by a male interviewer over issues that are known to be 'women's topics'. The person, who assisted me in interviewing the husbands in the study, experienced a great ease in establishing rapport with them with the help of these visuals.

To quote his experience, '*....without these sketches...it would not have been so easy to talk to a man about his sexual relations and communications, sitting in his bed room. These visuals really acted as ice-breakers and I was more comfortable to ask questions after showing the visuals.*'

### **Advantages of VAIG-**

Perspectives and understandings shared using visual methods point the way for the investigators to reconceptualize existing measures (data) within a meaningful context (Keller 2008, 430). VAIG helped me in conceptualizing the entire process of husband and wife communication in reproductive health within local cultural context.

The respondents were able to visualize their day-to-day life at home, on the farm or outside the house and could think about when, what, how and where they talked to each other about reproductive health issues. Also these pictures helped to elicit the information on process of communication in terms of time, frequency and duration and the associated norms followed by them, without much questions or probing- for example 'talking about personal issues only at night', 'not talking about sexual relations when outside the house', etc.

A housewife living in a joint family reacted to the pictures around privacy, '*This is our room. So in the night, we do get time to talk. But nothing in the daytime. How can we? People will say, "Look at this woman. They are married for four*

*years now and still.....she..". So in the daytime we talk about other things at home. During night, after children are fast asleep, we get privacy; we talk about all personal things at night. We have to wait. That way there is no problem of privacy.'*

The respondents were able to narrate their experience and the entire process of communication in their family around various reproductive health issues depicted in the visual. This in turn, helped in reducing 'recall bias' and missing out minute details around that issue. For example, to the visual and question around husband's role in post-natal period of his wife, one husband replied,

*'I went to meet her on the 12<sup>th</sup> day of her delivery. Met her and came back on the same day. There were many people around, so how could I talk or discuss anything with her! I could not go there often due to my job. She was there for one and a half months. That is the custom. So decisions were taken at 'higher level' in the family. I did not say anything in that matter.'*

Essential flexibility was offered to the respondent because the role of visuals was to navigate the respondent's thoughts in a particular direction and not to restrict his thinking to only what is depicted in the visual. Appropriate questions and probes were crucial to achieve this necessary flexibility. For example, there is a picture of husband and wife working on their farm and talking to each other. Some of the respondents answered, 'We do not have a farm', or 'I don't work on the farm'. It was important to lead them towards various other possible situations where they could have privacy. If visuals are used to elicit information in isolation, without having the necessary questions/ probes, it can limit the scope of eliciting information.

These visuals involved concrete leads and helped me in desensitization of respondents in sensitive subjects as sexual expectations and sexual negotiations. The respondents gave details around the process of communication around their sexual relationship, without any reservations. To quote a young woman living in an extended family-

*'Is there anything wrong in having it [sex] 'the other way round', means woman on the top? I like it that way and he also does not have any problem [Feeling guilty]. We don't do it that way, everyday but once in 3-4 months. I am sometimes worried, is it that if one does it this way, they will have AIDS? I cannot talk about*

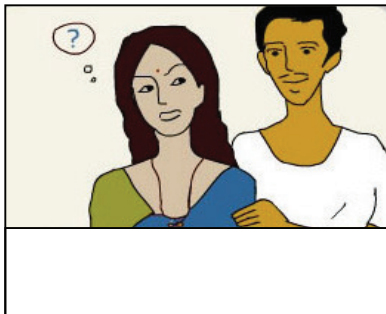


*this to anyone. My husband anyway laughs at me because I always keep worrying about some or the other thing.'*

I felt, that bridging the gap between the respondent and myself, and building trust in the respondent's mind was very crucial. Without using visuals, this process could not have been so effective. Deacon and Boulle (2007) had a similar finding about using case vignettes as an appropriate mechanism to elicit of patterns of stigma.

Specific situations such as 'Husband has gone to meet his wife after her delivery' helped the wives in the study to remember their own experience and answer in depth about the communication process. The wives spontaneously narrated about communication with other family members especially with their mother and the mother-in-law. Though it was known that these family members have an important role in the decision-making at family level, we have avoided including them in the picture. We worried that their inclusion in the picture could give a wrong message that they are or should be involved in the decision-making. However, the respondents could think beyond the subjects and objects portrayed in the visuals and their narration was not limited necessarily to the communication between spouses.

The advantages of visuals were experienced also for interviewing couples over the most sensitive subjects such as their sexual relationship.



These situations illustrated, for example, '*Husband wanting to have sex and wife not willing for the same*' could be 'read' by the respondents and they could comprehend the situation without many explanations from the interviewer. These visuals had 'leads' but there was no harm done to the respondent's right of

denying the situation depicted in this visual. There were responses such as '*Yes, it happens when I go close to her, she is tired or does not have the mood, but then I 'prepare' her for it because I cannot sleep without having it*'; and also there were responses such as '*No, this never happens. We have it only when she wants it.*' In other words, even these leading visuals could help to elicit realistic responses without having to ask any subjective or judgmental questions.



### **3.6 Conclusion**

Traditional methods of data collection -both quantitative and qualitative- have their own strengths and weaknesses. However, both have certain limitations in eliciting detailed information from respondents, in a less time-consuming and more comfortable way for the respondent as well as the researcher. Men generally do not like to talk about sensitive subjects such as marital relations in front of others and hence Ortayli et al (2005) preferred conducting in-depth interviews with them rather than conducting a focus group discussion. For studying traditional concepts and customs on pregnancy, birth and post-partum in Rural Korea, Sich (1981) designed an ethnographic study involving multiple tools such as use of existing information about the family from various sources, behavioral observations and interviews which required him/her to visit each household between 2-8 times. Considering the scope of my study, I preferred a method that would be innovative in terms of establishing rapport with the respondents- both men and women, within the limited time that was available, making them comfortable to discuss sensitive subjects such as couple communication in reproductive health - and provide reliable and interpretable data.

The potential of visuals as a method of data collection is widely mentioned in many disciplines since more than a decade, such as Anthropology (Collier and Collier, 1986), Pediatrics (Hanna and Jacob, 1993), Child Development (Fury, Carlson and Sroufe, 1997), Sociology (Hughes, 1998), Reproductive Health (Donaldson, 2001) and Tourism (Garrod, 2008). Visuals not only elicit and produce life experiences and perceptions; but also provide tangible and very rich data that 'speaks to the truth' in research (Keller, 2008).

It is important to choose a suitable form of visual considering the available resources, the community under study, the subjects to be studied and the capacity of the investigator to use this tool. As the study shows, there were many reasons behind choosing visuals in the form of hand-drawn illustrations as against photos or movie-clips, in a rural, less educated community. Guillemin (2004, 274) has reviewed that use of drawings as therapeutic tools and in social science research has largely been limited to children and she further suggests that the use of drawings as research methodology offers a potentially valuable resource for social researchers. Drawings in the form of vignettes are extensively used in health research (Hughes, 1998; Deacon H and Boule

A, 2007). But current study has shown that drawings used for assisting an in-depth interview for eliciting information from an individual around sensitive subject is equally useful.

However, the process of construction of drawings and the interview guide needs to be considered and studied. As compared to photo-elicitation, where photographs are assembled by the investigator or produced by the participants and used to stimulate interview dialogue (Keller, 2008); construction of VAIG using hand-drawn illustrations is a multifaceted and multi-stepped process. Starting from selection of the form of visual, artist, themes and sub-themes, it expects a detailed thinking from the methodologist around the study subject- objectives, research questions and expected outcome of the study, the social and cultural context within which the study is to be conducted and programme and policy related information about the study subject. Of paramount importance is to ensure that the visuals add a value to the conventional qualitative data collection tool.

Validation of VAIG at field level pointed that male as well as female respondents, irrespective of their educational and family background, could interpret the visuals and narrate their experiences around couple communication. For example, a young woman said, VAIG helped me in conceptualizing the entire process of husband and wife communication in reproductive health within local cultural context. The respondents were offered essential flexibility while responding to sensitive subjects like sexual communication. They were able to associate themselves with the drawings and could share life experiences with minimal reservations. The respondents were helped to 'visualize' events around situations depicted in the drawings and detail out the entire process of communication around that event.

To conclude use of VAIG has shown that hand-drawn pictures can subtract the respondent and replace him with the individual illustrated and thus give impersonal yet realistic responses. Visuals sometimes replace a series of questions and are explicit enough, whereas sometimes they play a supportive role to the questions in the interview guide. Ultimately, the data do depend on the respondent's reactivity towards visual methodology but our experience of using a visually assisted interview guide with the rural couples was definitely encouraging in terms of establishing rapport, eliciting the necessary information and making the respondents feel comfortable, even about sensitive topics like their sexual relationship. In this study, there has been one refusal

from a husband and a wife (not the same couple). Of course, the credit is due to many factors but certainly one of very important factors would be the 'visuals'.

### **Acknowledgement**

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## Chapter 4

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# **Couples talk: Explorations around communication and behavior regarding fertility among Indian rural married couples**





**Couples talk: Explorations around communication and behavior regarding fertility among Indian rural married couples**

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#### **4.1 Abstract**

**Introduction:** Couple communication facilitates 'planning' parenthood. Little is known about communication and fertility behavior during reproductive span and hence this paper focuses on understanding these issues among rural married couples.

**Methods:** Qualitative exploratory research was conducted in Maharashtra. Thirty-five couples were interviewed in-depth using a Visually Assisted Interview Guide.

**Results:** Couples talked about fertility but none of them talked about 'planning', before first child and wanted to have it at the earliest. Though one fourth of the husbands desired one child, the wife or the mother influenced them to alter this intention. None of the couples desired more than two children. One fourth had a third child due to family pressure and the rest took an informed and shared decision regarding sterilization after two children. Eight couples talked of abortion as family planning method, but could not do so without consulting husband's mother. Desire for more children was found to be elderly women's preference in the family. Couples discussed using contraceptive method but the husbands mainly decided its use.

**Conclusion:** Couples' mutually sharing their fertility intentions and taking informed decisions with men's preference for small family size indicates the process of social change, which should be considered from programmatic perspective.

*Key words: couple communication, behavior, fertility, rural*

#### **4.2. Introduction**

Since the International Conference on Population and Development (ICPD, 1994), there has been a clear emphasis on empowering couples to decide about their own reproductive health related issues, including fertility. However, studies (Ayaga 2002, Sharma 2002) have shown that couples can be empowered to take such decisions, in a more planned and responsive way only if they are encouraged to interact and communicate these issues with each other. Total Fertility Rate (TFR) and Contraceptive Prevalence have been short-listed as indicators for monitoring reproductive health in the Millennium Development Goals (MDG-2000). Numerous strategies and efforts are put towards involving men in having a shared decision about fertility.

There have been numerous studies of couples around fertility and parenthood and various other issues such as preference for sterilization, (Rutenberg and Landry, 1993);

gender equality, fatalism and couple communication on spousal agreement about pregnancy wantedness (Digest, IFPP, 2004) and men's attitude and behavior and couples' fertility (Bankole, 1998). However, it is well known that socio-cultural context and gender-based norms influence husband-wife interactions and their fertility decision making (Gipson and Hindin, 2007). In India, various studies are conducted around couples' fertility behavior. Zavier and Padmadas (2000), based on the NFHS-1 data, mentioned about characteristics of couples from Kerala, who used a spacing method before sterilization. Another study by Padmadas, Hutter and Willekens (2004) based on NFHS-2 data showed that a lack of interspousal communication about family planning is associated with a shorter reproductive span explaining the low level of use of modern contraceptives to space births. A survey in Uttar Pradesh (Stephenson, Koenig & Ahmed, 2006) pointed towards the association of domestic violence and contraceptive adoption focusing on gender-role attitudes and community norms around domestic violence. Summarizing, studies have mainly highlighted determinants of fertility behavior such as male involvement, gender equality, and domestic violence, desire to have sterilization; however, very little is known about how married couples in a rural set up of India, discuss and decide about fertility at various points on the life span of reproduction. Current paper focuses on understanding of married couples' communication and behavior related to fertility in rural Maharashtra.

### **4.3. Methodology**

Maharashtra is India's second largest state in terms of its population (more than 96 millions). More than 50% of the population lives in rural areas and the state has a Hindu majority (72%). Pune is one of six divisions of Maharashtra state having a population of more than 19 millions. The current study was conducted in one of the tehsils of Pune district, Maval with a population of around 300 thousand, spread among 184 villages. The Tehsil is surrounded by Western Ghats and the Mumbai-Pune Express Way cuts through the Tehsil. It is one of the fastest developing Tehsils of Pune district, with many upcoming industries, educational institutes, plant nurseries and floriculture. Most of the villages have geographical access by road. There are two main towns in the Tehsil, where most of the private medical practitioners, private multi-specialty hospitals, markets and shops are clustered. As is common for the rest of the state, the study site demonstrates a strong presence of public health system through Primary Health Centres (PHC) and Rural Hospital (RH). Auxiliary Nurse Midwife (ANM) and Multi Purpose

Worker (MPW) and Integrated Child Development Scheme (ICDS) workers are the grass root level health providers for provision of Ante Natal and Post Natal Services.

In spite of the development that has taken place in this Tehsil due to urbanization, the area still represents a rural site dominated by kinship oriented Maratha caste agrarian community of Western Maharashtra. Most of the families are either joint or extended. It is a patriarchal society, where families are mostly headed by men, who play a significant role in decision-making in the family. Married couples are worried, especially in the beginning of their relationship, about rejection in sexual life and hence may avoid discussing with each other, topics such as fertility, sexual problems, gynecological morbidities and reproductive health in general.

The broader study aimed at understanding the process of couple communication in reproductive health. It was a community-based study and involved in-depth interviews of 35 married couples. Data was collected between 2006 and 2008. Current paper is drawn from this broader study with a focus on couple communication and behavior regarding fertility.

#### Sample selection

Fertility decision-making involves decisions about when to have the first child, spacing between two children, number of children, sex composition of children, using spacing methods of contraception, using terminal method of contraception. To cover this entire spectrum of fertility related issues, the current study has focused on 35 married couples that have at least one child and have used a terminal method of contraception (female sterilization). To minimize the recall bias of the respondent, it was decided to select couples that have undergone sterilization not beyond one year at the time of involving them in the study. The researcher was exposed to the study area through previous research projects and hence had rapport with local health and development functionaries<sup>10</sup> who helped in recruiting the study respondents. The sample represents the rural community of the study area, in terms of caste, occupation, educational background of men and women and type of family.

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<sup>10</sup> Staff at the Primary Health Centre- The Auxiliary Nurse Midwife and the Multipurpose Worker and workers at the *Anganwadi* run by Integrated Child Development Scheme, together maintain the record of sterilization of couples in their work area. Based on these records, they helped the researcher to recruit the necessary sample.

## Study tools

The broader study involved a preparatory phase where key informants from the community were interviewed in-depth in order to learn about norms and patterns of couples communication and behavior regarding reproductive health. This phase helped in designing the tool for interviewing selected couples in the study. Married couples were interviewed with the help of a Visually Assisted Interview Guide (VAIG). The tool was simultaneously administered to husband and wife (in absence of each other, separately) by male and female researchers respectively. The tool involved picture cards having hand-drawn illustration of day-to-day life scenario and an in-depth interview guide around the scenario. It covered various aspects of reproductive health, fertility being one of those. The tool also included questions on personal data of the couples, socio-demographic details, information about family and a series of questions around general process of inter spouse communication including time, duration, content of communication, determinants etc.

## Ethical considerations

Since the study is about a sensitive and personal subject such as communication between husband and wife about their reproductive health issues, informed verbal consent was sought from all the respondents. They were assured freedom to participate or withdraw from the study at any given point if they were willing to do so without giving any explanation to the researcher. The researcher ensured that the respondents were interviewed in complete privacy and no information was revealed to any of the family member, friends or even the spouse. Of course, using the information collected through this study only for academic purpose and not discussing it with and disclosing it to anyone else for any other purpose would ensure the third important aspect about protection from harm to the respondent.

## **4.4. Results**

The results are presented around profile of the couples and progression of fertility related communication and behavior on the life span of reproduction.

### **Profile of the couples**

Following the sample selection criterion, all the couples were married and had undergone sterilization (female sterilization) not more than a year ago at the time of the interview. All the couples were Hindu and most of them lived in either a joint (7/35) or an

extended family (20/35). Families were mostly agrarian (26/35) and some (6/35) had business of dairy or plat nursery. Few men were also working in the nearby industries on a contract basis. Out of 35 men, 26 had studied up to 10<sup>th</sup> standard or less than that. All the women were housewives and some of them were additionally involved in agriculture. Majority of the couples had completed their family with two children (26/35)<sup>11</sup>. Men were in the age group of 25-46 and women were in the age group of 20-36. This profile of the couples is extremely congruent with a typical rural Maharashtrian community, as stated in the NFHS-III.

### **1. Before the birth of the first child-**

In the traditional Indian society, a woman is expected to be a 'mother' after marriage, at the earliest and thus has to 'prove' her fertility. With this notion, most of the couples in the study wanted to have their first child as early as possible. They rarely discussed about 'waiting' before having their first child, or 'planning' about having the first baby. At this stage, most of the communication between the couples evolved around waiting for the wife to conceive.

*A 32-year-old woman living in an extended agrarian family said, "In our house, we normally follow the pollution period and I sit aside during my periods. During those days, we keep a vessel upside down in one corner of the house. Every time, I would keep that vessel, my husband would ask, "Oh, you again had it?"*

An important family member who was involved in communication at this stage was the mother-in-law of the woman. Most of the women (26/35) mentioned about missing periods first to the mother-in-law along with her husband. The mother-in-law instructed the husband to take his wife to a doctor to confirm pregnancy; except in case of nuclear family where the communication took place only between the husband and the wife.

We enquired about communication between husband and wife over the disclosure of pregnancy. Most of the husbands were 'happy' to hear about wife's pregnancy. When asked the wives, most of them mentioned that their husbands were naturally happy about it however, it was something expected by them.

*As a 26-year-old housewife living in a joint family said, "He felt good because anyways we never wanted to wait before having our first baby."*

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<sup>11</sup> National Family Health Survey III- Total Fertility Rate for Rural Maharashtra is 2.31.

To summarize, none of the spouses in the study, talked to each other around 'planning', before having their first child and all of them wanted to have their first child as early as possible after getting married. Mother-in-law in the family was a crucial individual in guiding the couple to go for pregnancy confirmation.

## **2. After the first child**

It was evident that mostly husband and wife started talking about spacing or planning about children, only after they had their first child, irrespective of whether it was a boy or a girl. In case of half of the couples, communication about spacing was initiated by a health provider-either the doctor where the wife had her first delivery, or the village nurse, who came home for advice on contraception. Further, between the husband and the wife, the wife initiated communication with her husband by conveying the message of health provider to him.

As one of the wives, a 24-year-old farm laborer living in an extended family mentioned, *"The nurse who comes home for immunization had told me. So I wanted to insert a Cu-T [IUD]. Husband said, "Why to go for all these things? We should reduce our 'relations' [sex]. That is it. Why Cu-T and all. Woman's health declines due to that (tambine zizte baai)." So I did not use it, but we followed 'that' [sexual abstinence]."*

The remaining couples spontaneously discussed contraception after their first childbirth.

A 27-year-old housewife living in a joint family said, *"We both said, "Let Karan [their first son] be big enough." Also he would frequently have fever. So we said, "Let his health improve". Both of us decided that till he becomes big we would not have a second one. I decided to use Cu-T with the advice from the doctor who came to our village. Husband said, "Okay, do that."*

A husband- 30-year-old farmer living in an extended family- said, *"After our first child, she got her periods after 10-11 months. See first time, after marriage she conceived after two and a half years. So we did not think it necessary to wait before having the second child though she did talk to me about using a Cu-t. [Pause] We did not use anything and she got pregnant again in that same month [of having her periods]."*

Communication between husband and wife about using a spacing method was initiated either by a health provider or the couple themselves, but the decision about whether to use a contraceptive method or not was dominated by husbands.

However, there were eleven couples in the study, who discussed about going for sterilization at this stage, i.e. after having one child, irrespective of the sex of the first child. It is important to note that out of these eleven couples, in case of nine couples, it was the husband who was keen to have only one child but either his wife or his parents insisted for having another one. These couples had communication regarding family size and sterilization but for one or the other reason, decided to have more children.

A 26-year-old illiterate housewife living in a nuclear family said, *"I had high blood pressure and convulsions during my first delivery and had to have a caesarian. My husband decided that I should have operation [sterilization] after having one daughter, but I insisted for having a second one. We had our second daughter."*

A 30-year-old driver studied up to 10<sup>th</sup> standard living in an extended family, told his wife after having their first son, *"I think you should have operation [sterilization]. I am not sure about my job. We should give good education to one child,"* but his mother convinced the couple to have the second child and they had one more son.

In other words, though one fourth of the husbands (9/35) talked to their wives about limiting their family to one child, the wife or the mother influenced them to alter their decision and they had more than one child.

### **3. During second pregnancy- Abortion as a method of planning family**

The second point of communication about spacing was when the wife already conceived second time. There were five couples who talked about abortion in second pregnancy as a means to adhere to their desire of spacing or limiting family. Three couples had discussion about going for abortion for spacing.

A 23-year-old housewife studied up to 9<sup>th</sup> standard living in an extended family mentioned, *"My husband took me to a private doctor and asked me to take an injection. I did so. We talked to each other about this and did not tell my mother-in-law because my husband said that she would not let us do this [abort the child]. It did not 'drop'. Later my mother-in-law came to know about it and*



*got angry with my husband and me.*" This woman had her second child when the first one was less than two years old.

The remaining two couples talked about going for abortion to limit the family.

A 27-year-old housewife living in an extended family narrated, *"That time, my husband even said about going for curetting. But then every one at home said, "It is like a murder (hatya), isn't it when it is five months!" So nobody at home was willing for that and so he also did not say much and I continued."*

Though these five couples talked to each other about having an abortion as a method of family planning, they could not decide about it without talking with other family member, especially the mother-in-law. Ultimately, the mother-in-law did not let the couple have abortion and thus none of the couples actually had one.

#### **4. After the birth of the second child**

All the 35 couples had communication after the birth of their second child regarding whether the wife should go for sterilization or have a third child. In all, 26 couples talked to each other about going for sterilization at different points of time and for different reasons and then opted for sterilization. Following are some quotes to explain this further-

A 25-year-old housewife who studied up to 7<sup>th</sup> standard, living in a joint family said, *"My husband was standing outside the room when I had my second delivery. I asked him to help me. I was shouting. He did not realize that I had delivered. Then he came in. He saw all that. Then he told me, "You have had enough of pain. No more children now." I had operation a year after that."*

A 24-year-old factory worker studied up to 9<sup>th</sup> standard living in an extended family said, *"We had already done the mistake during second time [they had an unsuccessful attempt of aborting the child and the wife continued her second pregnancy]. So even before the second child was born, my mother had told us, "Have this one and then go for operation". After my wife's delivery, my mother started talking about it at home. My wife had her operation after 4-5 months of her delivery. My mother decided everything about that."*

A 25-year-old housewife who studied up to 7<sup>th</sup> standard, living in a joint family said, *"Though we decided to have only two children, I had my operation when our second child-daughter was two and a half years old. We both had decided that. We did not have relations almost for one and a half years."*

In other words, 26 couples shared with each other, their views, reasons and intentions regarding having sterilization. They discussed about the same at various points, either

during second pregnancy, during second delivery or later and took an informed and shared decision regarding limiting their family size.

The remaining 9 out of 35 couples talked about having a third child and hence discussed about spacing after the birth of their second child.

*A 26-year-old farmer studied up to 5<sup>th</sup> standard living in a joint family said, "After having a son and a daughter, I wanted to have operation, so did my husband. But other family members did not want it. He listened to them. They asked us to have one more and we did so. What to do...but after the third one, I insisted for it. That time my mother-in-law also agreed for it."*

*A 31-year-old Anganwadi worker living in an extended family said, "After two daughters, my mother-in-law wanted me to have at least one son. That time, my husband and I had a fight. Other family members scolded me for not listening to them. Finally I told my husband, "I will go for the third. If it is a boy, no problem; but even if not, I will still go for operation." Then everyone agreed. I had a son."*

In case of these nine couples, the wives wanted to limit the family and they communicated their intention to the husband as well as the mother-in-law but were convinced by them for having one more child.

All the 35 couples had communication regarding limiting their family size after two children. However, in case of eleven couples in spite of having communication about this issue between the spouses, elder family members overruled the decision-making and convinced the couple to have their third child.

### **5. During third pregnancy- Abortion as a method of planning family**

Out of the nine couples that had more than two children, three couples talked about going for abortion during third pregnancy.

*A 26-year-old housewife studied up to 10<sup>th</sup> standard (wife of the former political leader in the village) said, "My mother-in-law wanted me to have a son. When I conceived the third time, after having two daughters, I wanted to go for abortion after checking the sex of the baby. Husband did not want it. We argued over it for quite a long time. Finally it was my fifth month, when we went to the doctor. The doctor was not ready for aborting it and I had third daughter. Then I went for operation."*

A 23-year-old illiterate housewife living in an extended family said, “My husband and me talked about it when I had already conceived. My brother-in-law told me, “You can take those pills [oral pills for abortion]” but my husband said, “No, why to kill the baby? We will have it, whatever it may be!” I wanted to go for operation after having two daughters; even my husband was willing for that. But my mother-in-law did not allow us. My husband generally does not disobey her. So I had a third child, a son.”

A 28-year-old housewife studied up to 9<sup>th</sup> standard living in a joint family said, “After having two daughters, when I conceived for the third time, I told my husband, “Now we have had two daughters, so we should check what is the sex of the baby. Even if it is an infanticide, we have to think about our future, so we should go for check-up.” I decided everything on my own and he agreed for it.” She had two abortions because it was a female fetus<sup>12</sup>.

Thus, during the third pregnancy, three out of the nine couples talked about abortion after checking the sex of the child and the remaining six couples, did not had any communication regarding sterilization or limiting their family size or going for abortion during this pregnancy.

#### **4.5. Discussion**

Talking about fertility, involved number and sex composition of children and spacing between two children. Husband and wife communicated about fertility at various stages during reproductive life span. Couples did not really discuss about fertility before having their first child. As Chaudhury (1983) mentioned, all of them wanted to have their first child as early as possible and shared this intention with each other. They discussed with each other mainly about expectations and concerns around wife’s conception and proving fertility to the family and society. In this sense, this first point was considered to be crucial on the life span of reproduction, since in Indian context, status of the couples, especially the married woman, is associated with her ability to prove fertility at the earliest. Obviously, couples were not expected to discuss about spacing before proving

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<sup>12</sup> In India, as per the Pre-natal Diagnostic Techniques Act, 1994, section 6, determination of sex is prohibited and Medical Termination of Pregnancy (MTP Act 1971) does not permit female infanticide. However, due to strong son preference, small family norm, practices like tradition of giving dowry (gifts by father of bride in cash or property to the groom), laws that govern property inheritance and the cultural perception about the familial name through the male line, female infanticide still exists, though it is illegal.

their motherhood and fatherhood to the society. This may justify husbands in the study reacting casually over disclosure of wife's conception.

It was evident that mostly husband and wife started talking about spacing or planning about children, only after they had their first child, irrespective of whether it was a boy or a girl. A health provider, either the doctor where the wife had her delivery, or the village nurse who came home for advice on contraception, was crucial in initiating communication between husband and wife. However, some couples spontaneously discussed using a contraceptive method and the husbands were not much in favor of it. It is known that women often are not the sole decision-makers about the use of contraception (Network, 1998). Varkey et al (APHA 2002) have mentioned that while services concentrate on women with female only methods, studies show that decision making still remains in the hands of male partners or family elders. This study points out that men should be equally informed and counseled about use of contraception, if its acceptance has to increase.

Husbands were not necessarily the ones who preferred to have more children. Couple communication after first childbirth points towards the fact that one fourth of the husbands who participated in the study were satisfied with having one child, irrespective of the sex of the child<sup>13</sup> and talked about it with their wives. However, they were convinced by the wives or mothers and decided to have more than one child. It shows that despite the secondary status of the women in the society, fertility being women's domain, they rule the decision-making (which was supported by key informants' interviews conducted in the preparatory phase of the broad study). Similar was the finding in a study carried out among rural Mali women (Madhavan, Adams & Simon, 2003) where older women as gatekeepers were found to encourage high fertility.

Communication about abortion as a method of family planning, during second or third pregnancy showed that husband's mother had a crucial role as a decision maker. Ravindran and Balasubramanian (2004) in their study among rural women in Tamil Nadu, India found that decision of abortion for spacing was mainly taken by the woman who sought support for the same from her mother-in-law. In present study as well, though husband and wife discussed with each other regarding abortion, none of them had it because of not being supported for the same by husband's mother. High fertility is found to be a preference of women, especially the elder women in the family and the study emphasizes on importance of involving elder family women in the family planning

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<sup>13</sup> National Family Health Survey-III- Total **wanted** fertility rate for rural Maharashtra is 1.79.

initiatives. Similar was the recommendation by Madhavan, Adams and Simon (2003) who suggested that reproductive health programmes should consider woman's larger social networks including the social gatekeepers such as the mother-in-law.

Reproductive health program considers 'percentage of women with two children wanting not more children' as one of the key indicators of measuring success (NFHS-III). Further, men's and women's desire to limit childbearing is also considered as the indicators. More than 20% of men and women in the age group of 15-49 from rural Maharashtra desire to limit childbearing after one child (NFHS-III). Similar to this finding, present study shows that men do intend to have less children (even one child of any sex) and do communicate the same to their wives, however they are not able to translate this into reality due to family pressure. However, men influence decision in terms of adoption of temporary method of contraception having their own rationale behind the same and discuss these issues with their wife. Hence, couple communication about adoption of contraception, fertility intentions and decision-making process in the family, should also be given due consideration by programme.

#### **4.6. Conclusion**

Fertility communication among couples and shared decision-making indicates the beginning of the process of social change. This finding need to be appreciated in the context of the exploratory nature of the study and the study sample, which represents a rural kinship oriented agrarian society of Maharashtra, where elderly women continue to dominate fertility related decisions. Hence, it is important to promote couple communication about fertility, but equally important is to create an enabling environment for them to take informed decisions in a mutually shared manner. As ICPD defines- '*Reproductive health implies that people .....have the capability to reproduce and the freedom to decide if, when and how often to do so.*'

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## Chapter 5

# **Crumbling stereotypes- married rural Indian couples talking about their sexual relationship**





**Crumbling stereotypes- married rural Indian couples talking about their sexual relationship**

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## **5.1. Abstract**

**Introduction-** In societies, where explicitly discussing sex is considered a taboo, couples fail to express about sex to their partners and women take a passive role. In the context of importance of communication in sexual relationship and prevailing gender norms in the society of India, this paper aims to understand rural married couples' responses about their sexual communication and behavior.

**Methods-** It was a qualitative exploration conducted in rural community of Maharashtra near Pune. Couples (n=35) were interviewed in-depth with the help of a Visually Assisted Interview Guide with hand-drawn pictures.

**Results-** Couples' responses about taking initiative and decision-making in sex, initiation and reasons for sexual abstinence were studied. One fourth of the women expressed their desires to have sex to their husbands and more than two third of the men and women narrated having mutually consented sex. Non-consensual sex was differentiated from 'forced sex' and men and women had different perspectives of narrating these types of sexual experience. Men and women had different reasons to initiate sexual abstinence.

**Conclusion-** Despite all the values and stereotypes, women's sexual desire becoming vocal, heard and to an extent, respected by partners is positive. Sexual communication surely has cascading effect on issues such as domestic violence and gender power relations. Health programmes should build upon the changing trend and promote young married couples to discuss sex, not only in the context of reducing 'risk' but also as a 'healthy' foundation for marital relationship.

**Key words-** couples, rural, India, sex, stereotypes, sexuality, gender, communication

## **5.2. Introduction**

Worldwide, since many years, importance of communication about sexual relationship between spouses has been studied in relation to various factors such as sexual satisfaction (Cupach and Comstock, 1990) and emotional well being of women (Ferroni and Taffe, 1997). However, women's capacity to discuss reproductive health matters is found to be associated with equality of women with men (Becker and Robinson, 1998; King Robert G., 1979) and frequent spousal communication is likely to promote gender equality in control over sexuality between married partners. (Onipede and Uche, 2007). Traditionally, men have a stronger cultural prerogative than women in initiating and negotiating sexual relationship (Mason, 1994; Balmer et al 1995) and also they are more

likely to report having sex with their spouses (Ghuman, 2005). In India, where 'explicitly discussing sex is considered a taboo', couples fail to express their sexual desires, expectations and problems freely to their partners. Because emotional ties between spouses are considered a potential threat to the solidarity of the patrilineal group, there is a tendency to limit communication between spouses (World Bank, 1996-46). Because of family pressure, peer pressure, cultural values and norms; couples most often do not understand the importance of communication throughout their life and especially at the beginning of their married life. Moreover, gender norms have always dictated women to take a passive role in sex and not express about sexual desires openly. In the context of importance of communication in sexual relationship and prevailing gender norms in the society of India, this paper aims to understand rural married women's responses about their sexual communication and behavior with husband. The paper focuses on two issues -initiation and decision making in sex and sexual abstinence-'when to have sex or when not to have sex.'

In India, sex is sanctioned within marriage which is a formal alliance arranged by family members. Relationship between husband and wife "begins" with sex consequent to marriage. Both spouses are worried about rejection in sexual life and its consequences and hence may avoid discussing sex. Goyal (2001) has mentioned about ambivalence and inhibition in the mind of even educated people and further expresses the need for 'dialogue' for enabling environment in this regard. Concepts of masculinity and femininity are constructed since childhood and greatly influence marital relationships. Gender norms often dictate that women and girls should be ignorant and passive about sex, which greatly constrains their ability to negotiate safer sex or access appropriate services (Garg & Sharma, 2006). While men are expected to, by and large, remain within the confines of a monogamous marriage, there is social indifference to their indulging in extra-marital sex, whereas female sexuality is defined as something threatening to society and requiring male control (Ramasubban 1995-217,18 & 35). Traditional rural society is hierarchical and dominated by men and its patrilineal and patrilocal structures have important implications for women such as on their autonomy to decide about their reproductive careers. Men generally believe that sex within marriage is their right. Women are supposed to play a passive role and not assert about their rights related to sexual behavior and sexual health or even discuss sex openly. Ravindran and Balasubramanian (2004) in Tamil Nadu, India, have studied about rural married women's sexual rights and ability or inability to refuse sex. A study conducted in

rural Thane district of Maharashtra (Balaiah, Ghule et al, 2001) points out towards poor communication between husband and wife around family planning and men taking their own decisions in this regard. This study though not directly involving sexual behavior issues indicates towards need to learn about women's experiences in reproductive health area. Evidence extrapolated primarily from qualitative studies suggests that patriarchal norms, power imbalances and women's inability to negotiate sexual matters may increase young women's risk of nonconsensual sexual experiences (Jeejebhoy and Bott, 2006). Another study of married women's sexual relations in Indian context, conducted in Gujarat and West Bengal (Santhya et al 2007) focuses upon coerced sex within marriage. Gender stereotypes in sexuality, about submissive females and powerful males, may restrict access to health information, hinder communication and encourage risky behavior among women and men in different but equally dangerous way (Verma and Mahendra 2004- 74). The issues related to sexual negotiations within marriage were studied in urban settings of Mumbai by George (1998), who found that women felt that it was not appropriate for them to express their sexual needs.

Despite the heterogeneity in terms of cultural practices and traditions, gender stereotypes seem to overrule the sexual behavior and communication of young married men and women, across India. Very few studies are based on qualitative explorations among rural married couples around the issues of sexual communication and behavior. The review of studies across India and in other developing countries thus generates the need to explore what and how rural married couples respond about their sexual life experiences- in terms of initiation, negotiation and decision-making.

### **5.3. Methodology**

#### **Study site**

Maharashtra is India's second largest state in terms of its population (more than 96 millions). More than 50% of the population is rural and the state has a Hindu majority (72%). Pune is one of six divisions of Maharashtra state having a population of more than 19 millions. Present study was conducted in Maval- one of the tehsils of Pune district covering a population of around 300 thousand, spread among 184 villages. The Tehsil is surrounded by Western Ghats and the Mumbai-Pune Express Way cuts through the Tehsil. It is one of the fastest developing Tehsils of Pune district, with many upcoming industries, educational institutes, plant nurseries and floriculture. Most of the

villages have geographical access by road. There are two main towns in the Tehsil, where most of the private medical practitioners, private multi-specialty hospitals, markets and shops are clustered.

In spite of the development that has taken place in this Tehsil due to urbanization; the area still represents a typical rural site dominated by kinship oriented Maratha caste<sup>14</sup> agrarian community. Most of the families are either joint or extended. It is a typical patriarchal society, where families are mostly headed by men, who play a significant role in decision-making in the family. Contrary to the occidental cultures where relationships culminate into sexual relations, in a typical rural society in India, the relationship between husband and wife “begins” with sex.

#### Study tools

Present paper is drawn from a broader study that aimed at understanding the process of couple communication in reproductive health. It was a community-based study and involved a preparatory phase where key informants from the community (n=10) were interviewed in-depth in order to learn about patterns of couples communication and behavior regarding reproductive health. This phase helped in designing the tool for interviewing selected couples in the study. In all, 35 married couples were interviewed in-depth. Because couple communication and sexual relationship are issues “behind close doors”, researcher used an innovative tool labeled as Visually Assisted Interview Guide (VAIG). The tool involved picture cards having hand-drawn illustration of day-to-day life scenario and an in-depth interview guide around the scenario. It covered various aspects of reproductive health, sexual relationship being one of those. The tool also included personal data of the couples, socio-demographic details, information about family and a series of questions around general process of inter spouse communication including time, duration, content of communication, determinants etc. The tool was simultaneously administered to husband and wife (in absence of each other, separately) by male and female researchers respectively.

#### Sample selection and recruitment of couples

To cover the entire spectrum of reproductive health related issues- pregnancy, delivery, family planning, sexual relations and reproductive health problems; present study

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<sup>14</sup> Caste- It is a group of individuals socially stratified on the basis of occupation, endogamy, social culture and political power.

focused on married couples that have at least one child and have used a terminal method of contraception (female sterilization<sup>15</sup>). To minimize the recall bias of the respondent, it was decided to select couples that have undergone sterilization, not beyond a period of one year at the time of involving them in the study. The study was conducted in the area of three (out of six) Primary Health Centres (PHC) selected randomly. The PHC staff requested Village Health Functionaries (VHF)<sup>16</sup> to assist the researcher in recruitment of couples, based on the records of female sterilization maintained by them. Couples following the sample selection criteria regarding the time of female sterilization were short listed and then contacted by the VHF. Couples, who verbally gave consent to the VHF participate in the study, were then approached by the researcher for conducting interview. In all forty-one couples were identified for interviews, but four of them were not available (husband and wife to be available at the same time for interview) for interview. There were two respondents (one male and one female, not husband and wife), who refused to participate in the interview at this stage without giving any convincing reason for the same.

#### Ethical considerations

Since the study is about a sensitive and personal subject of communication between husband and wife about their reproductive health issues, informed verbal consent from the respondent was obtained at two levels, firstly by the VHF before recruiting them in the study and then by the researcher before starting the interview. They were assured freedom to participate or withdraw from the study at any given point. The time and place for conducting the interview was decided by the couples and the researcher occasionally had to make multiple visits to respect their decision. The researcher ensured that the respondents were interviewed in complete privacy and no information was revealed to any of the family member, friends or even the spouse. Of course, using the information collected through this study only for academic purpose and not discussing it with and disclosing it to anyone else for any other purpose would ensure the protection from harm to the respondent.

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<sup>15</sup> Female sterilization is the commonly accepted terminal method of contraception and village health functionaries maintain the record of each woman who undergoes sterilization, irrespective of the place of sterilization, i.e. whether she had it in a public hospital or a private provider.

<sup>16</sup> Village health functionaries- Auxiliary Nurse Midwife (ANM) and *Anganwadi* worker- Government run preschools present in every village.

## 5.4. Results

**5.4.1. Socio demographic profile of the couples-** of the married couples is shown in table 5.1.

**Table 5.1: Socio demographic characteristics of married couples**

Socio-demographic characteristics of couples (n=35)	Frequency
<b>Type of family<sup>17</sup></b>	
Joint	7
Extended	20
Nuclear	8
<b>Education husband</b>	
Illiterate	0
Primary (1-4)	1
Secondary (5-10)	25
Higher Secondary (11-12)	7
Graduation/ Post graduation	2
<b>Education of wife</b>	
Illiterate	5
Primary (1-4)	1
Secondary (5-10)	27
Higher Secondary (11-12)	1
Graduation/ Post graduation	1
<b>Main occupation of husband</b>	
Farming	20
Service	10
Other	5
<b>Secondary occupation of husband</b>	
Farming	6
Service	9
Petty business	3
Business	3
<b>Main occupation of wife</b>	
Housewife	35
<b>Secondary occupation of wife</b>	
Farming	5
Other	4
<b>Number of live children</b>	
Two	25
Three	9
Six	1

All the couples were Hindu and most of them lived in either a joint or an extended family (27/35). Out of 35 couples, 26 men and 33 women had studied up to 10<sup>th</sup> standard or less than that. Families were mostly agriculturists wherein, 20 men had agriculture as their main occupation and 6 men had agriculture as their secondary occupation. These six men were involved in service on contract basis at the time of interview, but had agriculture as the main source of income for their families. All the women were housewives. As their youngest child was less than three years old, most of these women were not able to work in the farm or acquire additional job and hence only 9 of the 35

<sup>17</sup> Nuclear family- Husband-wife and their unmarried children

Joint family- Husband-wife, husband's parents and children

Extended family- Husband-wife, husband's parents and children, unmarried or married sibling/s and / or other relatives

women had some secondary occupation as farming, petty business or service. Majority of the couples had completed their family with either two (25/35) or three children (9/35). One couple had six children, five daughters before having their son. This profile of the couples is extremely congruent with a rural Western Maharashtrian community.

There are some additional characters of these couples important from the point of view of learning about their sexual communication and behavior. Women were asked about the nature of their husband and about themselves. There were 21 out of 35 women whom perceived that they were more talkative than their husbands, whereas almost half of the women (17/35) felt that they had 'free' communication with their husband about sexual relations. Sex being a very intimate and sensitive issue, even talking about it assumes 'privacy for the partners' as a pre requisite. Hence women were further asked a series of questions to learn about privacy available for the couple. There were six women who perceived lack of privacy as a problem for communication with spouse, for reasons such as presence and dominance of mother-in-law, long work hours of the husband, or lack of private space. However, their husbands did not perceive any problem related to having privacy.

#### **5.4.2. Communication about sex**

Married couples' responses regarding their sexual communication and behavior are presented here around two issues- A. Initiative and decision making in sexual relationship and B. sexual abstinence i.e. about '*when to have or not have sex and why*'. The most common place and time of the day to have sex or even discuss about it, was 'inside the house' (not on the farm) and 'only during night'. Hence, couples' responses need to be considered in this context of the most common practice of sexual behavior and communication.

##### **5.4.2.1. Initiation and decision making in sexual relationship**



In a traditional rural Indian society, husband-wife relationship is a patterned behavior and woman, especially in her married sexual relationship, is expected to take a passive role and agree to her husband's desires and instructions. Stereotypes around masculinity and femininity prevalent in the society, even today, demand this passive role from



the married woman. In this context, the study focused on understanding responses from men and women about initiation and decision-making in sexual relationship. For eliciting this information, as shown in Figure 5. 1.- a picture card portrayed a scenario- "*Husband is willing to have 'sex' whereas wife does not want it...then*"- With a series of probe questions around this picture, women were led to respond regarding their personal experience in such situation. This was definitely a leading scenario, however, women responded about not necessarily only in congruence with what was depicted, but explained the process of initiation of sex, negotiation between two of them and decision-making.

#### Initiating sex

In the case of almost 3/4<sup>th</sup> of the couples, it was always the husband who initiated sex either because he preferred it that way or because the woman did not like to take initiative.

*"I never take the lead, never. I don't like it. I don't wish to have sex. It is both, I don't have the wish and also I don't know how to say it. Generally I myself never have the wish to start it. I don't like to have it. But when he wants....I like it"*- An illiterate woman from a joint family, whose husband is a farmer

*"Generally I take the lead. She [wife] sleeps on the floor with the children and my mother. I sleep on the bed. When I want it, I whisper and call her on the bed... late night when the children and the mother are fast asleep. So she comes on the bed...we do the 'practical' and get rid of it. Then she goes back and sleeps with the children."* A 30-year-old farmer and a seasonal worker in sugar factory studied up to 9<sup>th</sup> standard living with his wife, mother and children in a one-room house.

In rest of the couples, wives occasionally took initiative in sex; however the husbands decided about agreeing to or refusing it.

*"I say 'it' to him sometimes. But if he is not tired, he agrees and if he is tired, he tells me, "I am feeling very tired today. Let us sleep." So we talk to each other about it."*- A housewife from a joint family studied up to 9<sup>th</sup> standard, whose husband is a farmer and has a business of fodder.

When probed for reasons for not taking initiative, men mentioned about 'shyness' or in general 'less desire on her part to have sex' as the reasons for not taking initiative in sex. Women in addition to these reasons responded about fear about denial for sex from husband and feeling of 'awkwardness' about 'woman asking for sex from husband'. However, no clear explanation or reason was found from the couples about what motivates women for at least initiating sex though occasionally. None of the women, who occasionally took initiative in sex, perceived any problem in having privacy for sexuality related communication.

Decision about whether to have sex or not-

The detailed narration of couples showed that there were three different dimensions of decision-making in sex, consensual sex, forced sex and non-consensual sex. Non-consensual sex was differentiated from forced sex.

There were almost 1/3<sup>rd</sup> couples, where wives who mentioned about having sex only upon mutual agreement and never having a forced sex.

*"If I am tired and want to sleep, he never forces me. I don't need to say anything. He reads my face and say, "Okay, go to sleep now." Since beginning, he had understood me about these things. Yes, sometimes he teases me, "You don't have much "interest"; but does not get angry about it. He never fights with me over that. In fact he is like...when I am tired and I go to serve him food, he looks at me and says, "You go and sleep, I will take the food myself."- A housewife studied up to 9<sup>th</sup> standard, from an extended family, whose husband works in a private company.*

Importantly there was not much discrepancy in the responses from husbands of these women around having mutually agreed sex.

In case of a small number of couples, women responded about being "forced" by husbands for having sex, however their husbands had a different perception about their sexuality related communication and experience.

*"Once I had bleeding for almost fifteen days. He knew it but he does not follow any such thing [whispered] even if I am having bleeding and if he wants it, he **wants** it, he does not listen. I tried saying "No", but he got angry. He gets very angry, does not talk. Then I take a step back, or he fights over that, in the middle*

*of the night. So instead of all that...let it go.”- A housewife studied up to 5<sup>th</sup> standard, from a joint family, whose husband is a farmer. This woman perceived lack of privacy as a problem.*

*In case of all these women, their husbands presented with an ‘atypical’ character related to sexuality or masculinity, such as problem of premature ejaculation, excessive masturbation, night blindness or being alcoholic. Narration from one husband, whose wife responded about frequently being forced for sex.*

*“I talk to her, I use different methods. Even if I have the mood, I avoid “pressurizing” her for having relations. May be I put my hands around her, leg on leg and all...then only if I get some response...then the further actions, otherwise I leave it. I “control” it. But both of us need “this” because there is no other addiction. Because I cannot do without it, till my body is not relaxed, I cannot sleep. Because she also thinks in that way. Even if she does not have that mood, she knows about my body stress and so her “involvement” is also there. She has that understanding.”- A 32-year-old graduate and former political leader of the village living in an extended family.*

Importantly, in the third category of little more than half of the couples, women talked about generally having mutually shared decision making about sex but occasionally having non-consensual sex for various reasons. They submitted to the demand of sex from husband either because of the perceived fear about consequences from husband; or out of sense of duty of being a ‘wife’, or not expressing ‘strong’ refusal for the same.

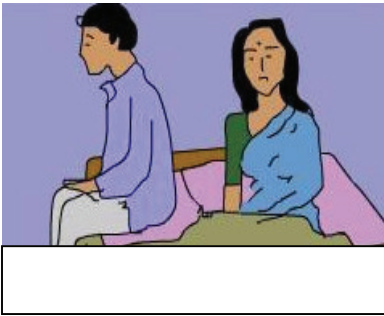
*An illiterate woman from an extended family felt shy and laughed. She said, “Yes, it happens, that I don’t want. I say, “No” but even then he does it. He demands it. If I refuse him then he goes to sleep, if I **really** [emphasizing on the word] refuse. Then he does not get angry. But generally it depends on his mood, nothing of mine (mazhe kaahi naste)”*

*The husbands in these case, mostly narrated having sex upon mutual agreement from their wives.*

*“I talk to her sweetly, then she also feels it, then she also talks to me sweetly. Only if I talk sweetly to her, it will happen, otherwise my work will get spoilt (aaple kaam phaphalnaar). So I ask her and she does not say no. Sometimes she is tired, then I don’t force her. Of course, I become restless then (tevdhyapurte*

walwal karnaar) but if she insists for not doing it, then I don't force her. Only once we had fight over it, but then I talked sweetly to her and we could resolve it the same night." - A 31-year-old farmer studied up to 9<sup>th</sup> standard.

#### 5.4.2.2. Sexual abstinence- *When to have or not have sex?*



One of the key issues while discussing about husband-wife communication in sexual relationship, is around following abstinence or in simpler words, communication around 'when to have or not have sex'. It is important to understand not only about when the couples follow abstinence but also for what all reasons/ situations they decide not to have sex. In other words, couples have

their own perceptions about 'when' and 'when not' to have sex for various reasons.

In the present study, as shown in *Figure 5.2*- a picture card showing 'Husband and wife are sitting on the bed, not facing each other'; was used to portray sexual abstinence in a symbolic subtle way. Women were asked to describe, '*What they see in the picture? Why the couples are sitting like this?*' If necessary, the respondents were given a hint about abstinence<sup>18</sup>. They were asked to narrate their personal experience in this regard. Women mentioned about following abstinence for various reasons.

All women talked about following abstinence during pregnancy and post-partum. Abstinence during pregnancy was either a result of advice from a medical provider or after discussion and mutual agreement between husband and wife. It was observed that the initiation of period of abstinence and its duration depended on the risk involved in pregnancy or risk perceived by the couple.

*"We stopped it after three months in the pregnancy. I had some stomachache and then I told him about that. He said, "Okay, then we will not have it, why to take a risk? This is our first baby." and so we stopped it. During second pregnancy, there was no problem so we continued it up to 7-8 months"-* a housewife, studied up to 9<sup>th</sup> standard, from an extended family.

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<sup>18</sup> There is no single word in local Marathi language for abstinence, so the term was explained to the respondents.

As women mostly had their first and sometimes even the consequent deliveries at their mother's place, post-natal abstinence<sup>19</sup> was strictly followed by all the couples. When the wife returned to her husband's place, generally she was asked to sleep 'next to her mother-in-law' for a period of few months in order to maintain 'good health' of the baby and the mother. Though this was a forced abstinence instigated by elder women and husbands not always being happy about this decision, women mentioned that husbands respected the decision with some exceptions as this-

*"Our bedroom was leaking, it was monsoon. My mother-in-law wanted me to sleep next to her for few more days. My son was two months old. [Feeling shy] but, my husband got the roofing work done immediately and asked me to sleep in the bedroom."- A 22-year-old farmer, studied up to 9<sup>th</sup> standard from an extended family.*

Husbands did not express any problems in following abstinence during this period. One of them said-

*"She [wife] was at her parents after delivery. My mother said that let her be there for some more days, till she feels comfortable. It did not matter much to me, whether she was there or not, because I have the habit of masturbation, so...nothing about other woman or anything. So there was no issue, no 'tension'. After she back, I used condom for some time. Till then I would just 'hit it' and be 'free' [have masturbation]. I have openly talked about it with her."- A 31-year-old farmer and factory worker studied up to 10<sup>th</sup> standard and living in a joint family.*

Women also initiated the decision about following abstinence for religious reasons- such as *religious fast*<sup>20</sup>, ritual, worship, religious ceremony in the family or depending on the

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<sup>19</sup> Post-natal period of one month and a week is considered to be of 'ritual pollution'. Women generally go to their natal homes for having deliveries. Husbands make sporadic visits to inquire about the health of the baby and the mother but rarely have privacy to discuss about their personal issues

<sup>20</sup> Religious fast- Families usually worship their family deity. Different family deities are worshiped on different days in the week. Family members, especially women, observe fast on these days.

phases of moon<sup>21</sup>. Husbands of these women mostly respected their desire and abstained on these days.

*“Generally I never say “No” for having sex to my husband. He fasts on every Saturday and Monday. I asked him whether we should follow abstinence on those days and he said, “Ok, it is manageable.” Otherwise I never say, “No” to him.”* – a 25-year-old woman who looks after poultry business of family, studied up to 7<sup>th</sup> standard, from an extended family. Husband works as an electrician.

*“I always tell my husband about full moon and no moon night, but he does not believe in all these. I told my husband that it is the matter of faith. He asks for it, but then I say, “No” and he never forces me for relations, never.”*- a 28-year-old housewife studied up to 9<sup>th</sup> standard, living in an extended family, husband is a farmer.

Some women also mentioned about being ‘tired’ (5) or were unwell (2) as the reasons to refuse sex. However, whether they actually followed abstinence for these reasons depended on woman’s wish against her physical condition and husband being of ‘understanding’ nature.

*“Sometimes I say ‘no’ to him, not because I don’t want it, but because I am too tired. But then ‘it’ [sex] happens”*- a 22-year-old farmer studied up to 9<sup>th</sup> standard living in an extended family.

*“Sometimes I go to sleep and then he says, “You anyways like to sleep.” It happens that I get tired and then go to sleep. But then, he understands because she [her five months’ old daughter] gets up 2-3 times during night so I get tired. So he does not force me.”*- A 24-year-old housewife studied up to 10<sup>th</sup> standard living in a joint family

All the six women who perceived lack of privacy as a problem to have sex, mentioned about “reduced frequency and/or desire for sex”.

A 23-year-old housewife studied up to 7<sup>th</sup> standard, from a joint family, staying in a one-room household, said, *“We have it when mother-in-law goes out. But*

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<sup>21</sup> People sometimes follow sexual abstinence on full moon or no-moon days due to fear of ill-effects of lunar cycle.

*rarely once or twice in a month, if he is willing then he calls me on the bed. I should check whether she is fast asleep and then we quietly have it.”*

Their husbands did not have similar perception about sex, but generally responded that they did not ‘discuss’ much about sex. As one of them said-

*“I anyways don’t like ‘sexy’ talks. I am not much interested in talking, what is there to talk about. Just do ‘it’ and that is it.”* A 28-year-old farmer and contract worker in a company living in a joint family who had studied up to 10<sup>th</sup> standard.

There were four couples in the study, where the women discussed about using a contraceptive method for having spacing between two children, but the husbands preferred to follow abstinence. They perceived that there was more risk associated with using an artificial contraceptive method rather than avoiding having sex. Following abstinence as a natural method of contraception was a sole decision of the husbands.

*“The doctor said that she could even have a cu-t. But both of us did not think about that. I said, “Why to have problem, better would be if we don’t keep relations too often. That is how we followed it. Yes, one has to have that control on his mind. Both of us never had any fight, irritation over this issue”-* a 26-year-old man working in the plant nursery living in an extended family who had two children with a gap of two years.

Abstinence for one or the other reasons was a common experience mentioned by all the respondents. Women decided about when not to have sex, especially for religious reasons and pregnancy or post-natal period. However, abstinence as a natural way of contraception was a sole decision of husband. There were situational reasons such as lack of privacy, death of family member, fights in the family or presence of guests, which forced the couples to abstain from sex.

## **5.5. Discussion and conclusions**

The study findings represent couples living on the rural outskirts of Pune city. The study site shows certain signs of urbanization and modernization yet retains its rural features in terms of mostly being agrarian and kinship oriented. Change in behavior and communication is a slow process. Especially in societies where women are expected to be a passive partner in sex, this process will be further slowed down. There is hesitance to change not only from men but also from women as can be interpreted from this study. Similar was a finding from Goyal’s (2002) study from Rajasthan, India, who found that



women agreed to the belief that within married unions, sex is a male prerogative and women should not express desire for sex. In Vietnam, Ghuman (2005), studied 800 men and women from rural and urban communes and pointed towards women reporting lower levels of marital sex suggesting that expression of sexuality is seen as more legitimate and natural for men than for women. Khan (2001) based on research in Bangladesh, has mentioned that women's sexual roles are meant to be private and controlled, rather than public and expressive. Contrary to these studies, it is important to note that despite all the values and stereotypes attached to women taking a lead or active role in sex or even being expressive about sex in Indian society, almost one fourth of women from present study expressed their desires to have sex to their husbands and more than two third of the couples- men as well as women narrated their experience of having mutually consented sex.

The study finding regarding women's narration about consensual or non-consensual sex needs further discussion in Indian context as well on the canvas of studies conducted in other developing countries. There are many studies which have discussed about women's experience of non-consensual sex in India and elsewhere (Khan, 2001; Goyal, 2002; Ravindran and Balasubramanian, 2004 and Santhya et al, 2007). Ravindran and Balasubramanian (2004) found in their qualitative study among rural women from Tamil Nadu found that almost sixty percent of the women experienced non-consensual sex and the present study shows a similar pattern in this regard. However, in the present study non-consensual sex is differentiated from 'forced sex' because, these terms may have different nuances in individual life, as the present study shows. Though women have talked about having sex without their wish, they have not communicated their unwillingness to their partners for various reasons. As Goyal (2002) stated that, women's belief that their sexuality should be controlled by men, may result in not communicating the unwillingness to male partners by them. Santhya et al (2007) based on a survey research conducted in two states of India- Gujarat and West Bengal, have elaborated upon range of behaviors included in 'non consensual sex'. Also, Jeejebhoy and Bott (2006) in their review collated about non-consensual sexual experience of young people from developing countries, have mentioned about young people submitting under pressure to partner's demands for sex as an expression of commitment. Khan (2001) has mentioned in a similar study conducted among 54 women from rural and urban Bangladesh that forced sex was identified as a regular phenomenon within married life. Rather, some women mentioned about 'enjoying forced sex'. Though, women in the



present study have not expressed 'enjoyment' in having forced sex, their narration points towards the subtle difference in 'forced sex' and 'non-consensual sex'. Additionally, husbands of these women who experienced 'forced sex', have presented different and atypical characters regarding their masculinity and have discrepancy in their narration of sexual experience with their wives. Hence, the present study confirms to the need of carefully categorizing or labeling sex as 'non-consensual' or 'forced sex' and having detailed analysis of sexuality and sexual experiences of men as well as women.

Couples have reported of following sexual abstinence, initiated by husband or wife or forced abstinence for various reasons. Women have initiated sexual abstinence on religious grounds which suggest their adherence to the traditional practices, however, husbands respecting this initiation from wives hints towards the change. For reasons, other than religious, such as postnatal or during pregnancy, elder women in the family have continued to hold the decisions, whereas for rest of the reasons of abstinence, men are the decision makers. Not many published studies were found in the rural married population in India, around sexual abstinence and further investigation is necessary to understand range of reasons for following abstinence and decision-making by men or women. Couple's dependence on abstinence initiated by husband, should be studied in the light of its preference over contraception for spacing as is also mentioned by Ravindran (2004) in study from Rural Tamilnadu; as well as probability of high risk sexual behavior during post natal abstinence period as pointed out by Ali and Cleland (2001) in their study in Cote d'Ivoire.

Privacy being the pre-requisite for having sex and sexual communication, women seem to perceive lack of privacy as an obvious obstacle for husband-wife communication as was also found by Goyal (2002) among married couples in Rajasthan, India. However, men do not necessarily talk about privacy. Possibly, this could be explained against the differential perspectives of men and women towards sex as were also seen by George (1998) in the couples from Mumbai. Other factors such as type of family, husband's or wife's education and their occupation do not show direct association with husband-wife communication about sexual relations. In other words, there needs to be more investigation to learn about motivating or enabling factors to improve sexuality related communication among rural couples.

Certainly, present research shows that women from rural society have started discussing and deciding about their sexual life in terms of occasional initiation in sex and having sex upon mutual agreement with their husband. Also men are being supportive towards their wives in this regard. Rural married couples challenging the stereotypes of power relations favoring men, and attempting to openly express about their sexuality, is promising and is a positive sign of approaching towards reproductive health. As Khan (2002) points out, attempts should be built on this process of change towards having open communication between husband and wife, so as to make their sexual life enjoyable and to address their reproductive health needs. Definitely one should carefully avoid over-generalization from the present study conducted with a relatively small sample of rural part of India and focusing on reproductive health in general with sexual relations as one of its areas of enquiry. A large scale research is needed to capture the depth and richness of men's and women's sexual life experiences in the context of social change in developing rural societies. Additionally, women's ability to express and negotiate sex is commonly considered as an indicator of autonomy having implications on her reproductive health; hence, further research can focus on relationship between sexual communication and other reproductive health outcomes such as, gynecological morbidity, unwanted pregnancies and high-risk sexual behavior as well as with other indicators of women's status. Considering the cascading effect sexual communication has on health and marital relationship of couple, health programmes should definitely create opportunities for promoting young married couples to discuss sex. These can be through organizing community based interactive programmes for newly married couples or one-to-one counseling session. However, considering the stereotypes attached to sexuality and discussing sex, it is important to design strategies in a subtle way, respecting the local culture.

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## Chapter 6

# **Continuity and change in behavior and couple communication about childbearing against the backdrop of traditions in rural India**



**Continuity and change in behavior and couple communication about childbearing on the backdrop of traditions in rural India**

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## **6.1 Abstract**

**Introduction-** Traditionally rural married Indian couples are rarely encouraged to have open discussion about childbearing. However, programmatic efforts, exposure, impact of media and access to resources contribute to change in men's involvement in this subject and motivate couples to have joint-decision making. Present paper focuses on understanding continuity and change in behavior and communication between spouses around childbearing against the backdrop of traditions, in rural India.

**Methodology-** Key informants (n=10) from formal and informal sectors were interviewed using in-depth interview guide, for learning traditional practices. Married couples (n=35) narrated about present practices related to childbearing and were interviewed using a Visually Assisted Interview Guide consisting of hand-drawn sketches depicting life-scenarios.

**Results-** Women contrary to the traditional notions went for medical confirmation of pregnancy and sought antenatal care. Couples showed departure from traditional practices and communicated about certain subjects of childbearing such as antenatal care; whereas there was limited communication in other subjects as place of delivery and issues around birth of the child. Traditions and influence of family network seemed to play differential roles in affecting couple communication and behavior around various issues of childbearing. However, generally, men's non-farm or non-traditional occupation was more associated with couples' departure from traditional practices of communication and behavior.

**Conclusion-** Couples shuffle between following traditions and adapting change in relation to various issue of childbearing. Reproductive health programme should design strategies depending on the differential role family and traditions play in different areas of childbearing and appreciate and encourage the existing involvement of men.

**Key words-** couples, rural, India, childbearing, traditions, communication, behavior

## **6.2 Introduction**

In India, traditions and values guide couples' reproductive health behavior in such a way that most of the related issues are assigned to women's domain. Couples are rarely encouraged to have open discussion around childbearing and men seldom perform the role of active and supportive partners of women during childbearing. On the other side, reproductive health programme aims at involving men to a greater extent. Also factors such as exposure to outside world on account of mobility, impact of media and access to



resources largely contribute to process of change. In milieu of these contrasting ideas, current paper focuses on understanding continuity and change of behavior and communication between spouses about childbearing against the backdrop of traditions, in rural India. With demarcated areas of continuity and change; the paper helps to learn differential pattern of couple communication and men involvement in childbearing.

### **6.3 Background**

For more than two decades researchers from developing countries have studied role of traditions, cultures and family network affecting childbearing and involvement of men in this subject. Sich (1985) has mentioned about stereotypical assumption of Western clientele that a pregnant woman is entitled to much attention by her husband, family and other public and further states that this assumption is not true in rural Korea except for the early period of first pregnancy. Chowdhury (2003) studied about sociology of first birth in rural Bangladesh, and found that food intake and workload does not change with pregnancy; and objection from in-laws and financial concerns are barriers to seeking health care. Waszak, Thapa and Davey (2003) in their study conducted in Nepal, about influence of gender norms on reproductive health, mentioned about traditional beliefs regarding motherhood in terms of woman's diet and work, affecting their health. In South Africa, traditionally, men did not accompany their partners for antenatal or postnatal care services and are not expected to attend the birth of their child (Kuene et al, 2004). In Kenya, cultural barriers and peer pressures acted as barriers to men's participation in reproductive health care (Muja et al, 2000). In other words, traditions, family network and cultural practices seem to influence couples' behavior regarding childbearing.

In India, as elsewhere, children are extremely important as propagators of family name and hence women are valued as wives and more as a mother. Conceiving with a child is synonymous with proving status in the family. Within the general context of beliefs related to health and illness, those concerning pregnancy and childbirth are of particular relevance to women's health (World Bank Report, 1996). Traditional notion was that childbearing is not an event worthy of medical attention (Kanitkar and Sinha, 1989). The concept of special care during the antenatal period was traditionally not known in India (Jeejebhoy and Roy, 1995). Contrary to the occidental cultures where relationships culminate into sexual relations, in a typical rural society of India, the entire relationship between husband and wife "begins" with sex consequent to marriage. Married couples are worried, especially in the beginning of their relationship, about rejection in sexual life

and hence may avoid discussing with each other, topics such as sex, childbearing or reproductive health in general. However, the elder family members especially the mother-in-law plays a crucial role in decision making related to these important events of a young woman's life. Men are generally kept away from actively discussing these issues with their wives or taking any decisions about help seeking. Men were found to play almost no role in antenatal and postnatal care which was considered exclusively a women's domain (Apte, 2000).

However, though cultural biases and traditions exist against allowing men to be involved in discussion and decision-making in childbearing, this is changing with the increasing efforts of male involvement. Men seem to be more interested reproductive health than before, as was stated by Kuene et al (2004) about Zulu men in South Africa. There are many efforts to include men in antenatal care programmes - Kenya (Muja et al, 2000), Turkey-by Diemer (1997) and Turan et al (2001) and India being no exception in this regard (Varkey, 2001 and Barua 2006). Increasing male involvement assumes improved couple communication and change in behavior. India, since 1994 has considered about involving men in their national policy (Khan and Panda, 2004). Reproductive health programme intends to welcome men in maternity care and suggests more interactions between the health provider and the men during antenatal and delivery visits, as is shown in the National Family Health Survey-III report (NFHS-III 2005-06, Maharashtra Report).

In this context, the paper aims to learn about continuity and change of rural married couples' behavior and communication during childbearing against the backdrop of traditions.

#### **6.4 Methodology**

Maharashtra is India's second largest state in terms of its population (more than 96 millions). More than 50% of the population is rural and the state has a Hindu majority (72%). Pune is one of six divisions of Maharashtra state having a population of more than 19 millions. Current study was conducted one of the Tehsils of Pune district-Maval Tehsil- covering a population of around 300 thousand spread among 184 villages. The Tehsil is surrounded by Western Ghats and the Mumbai-Pune Express Way cuts through the Tehsil. It is one of the fastest developing Tehsils of Pune district, with many upcoming industries, educational institutes, plant nurseries and floriculture. Most of the

villages have geographical access by road. There are two main towns in the Tehsil, where most of the private medical practitioners, private multi-specialty hospitals, markets and shops are clustered.

Reproductive health services are delivered to community through public health system with 6 Primary Health Centres and its sub-centres (one each catering to a population of 5000), 2 Rural Hospital (RH). Auxiliary Nurse Midwife (ANM) and Multi Purpose Worker (MPW) are the grass root level health providers of this health system. The ANMs and *Anganwadi* staff<sup>22</sup> are mainly responsible for providing Ante Natal Care (ANC), promoting use of contraception and acceptance of terminal method of contraception<sup>23</sup>.

In spite of the development that has taken place in this Tehsil due to urbanization; the area still represents a rural site dominated by kinship oriented Maratha caste agrarian community. Most of the families are either joint or extended. It is a patriarchal society, where families are mostly headed by men, who play a significant role in decision-making in the family. However, issues related to childbearing are exclusively under women's domain.

The broader study was a qualitative exploration among young married couples from rural set up which aimed at understanding the process of couple communication in reproductive health. It was a community-based study and involved in-depth interviews of 35 married couples. It involved a preparatory phase where key informants from the community (n=10) were interviewed to understand practices about couples communication and behavior in reproductive health. This phase helped in designing the tool for interviewing selected couples in the study. To cover the entire spectrum of the reproductive health, married couples that have at least one child and have used a terminal method of contraception (female sterilization) were selected. To minimize the recall bias of the respondent, it was decided to select couples that have undergone sterilization not beyond a period of one year at the time of involving them in the study.

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<sup>22</sup> In India, the government runs pre-schools in all the villages through Integrated Child Development Scheme (ICDS) under the Department of Health and Social Welfare. These pre-school teachers along with responsibility of teaching in the school are also responsible for assisting the PHC staff to provide anti natal and post natal services. The Tehsil has more than 200 such pre-schools having an equal or more number of pre-school staff

<sup>23</sup> Terminal method of contraception mainly refers to female sterilization, which is the most preferred method in India.

Local staff from health and development sectors (ANMs and *Anganwadi* workers) helped in recruitment of the couples (n=35) in the study. Current paper is drawn from this broader study with a focus around inter-spouse communication regarding childbearing in the context of existing traditions.

Married couples were interviewed with the help of a Visually Assisted Interview Guide (VAIG). The tool was simultaneously administered to husband and wife (in absence of each other, separately) by male and female researchers respectively. The tool involved picture cards having hand-drawn illustration of day-to-day life scenario and an in-depth interview guide around the scenario. It covered various aspects of reproductive health, childbearing being one of those. The tool also included personal data of the couples, socio-demographic details, information about family and a series of questions around general process of inter spouse communication including time, duration, content of communication, determinants etc.

## 6.5. Results

### 6.5.1. Background of the study couples

Table 6.1: Socio demographic and childbearing related characteristics of couples

<b>A. Socio-demographic characteristics of couples (n=35)</b>	<b>Frequency</b>
<b>Type of family</b>	
Joint	7
Extended	20
Nuclear	8
<b>Education husband</b>	
Illiterate	0
Primary (1-4)	1
Secondary (5-10)	25
Higher Secondary (11-12)	7
Graduation/ Post graduation	2
<b>Education of wife</b>	
Illiterate	5
Primary (1-4)	1
Secondary (5-10)	27
Higher Secondary (11-12)	1
Graduation/ Post graduation	1
<b>Main occupation of husband</b>	
Farming	20
Service	10
Other	5
<b>Main occupation of wife</b>	
Housewife	35
<b>Total no. of live children</b>	
Two	25
Three	9
Six	1
<b>B. Characteristics related to childbearing</b>	
<b>Total no. of home deliveries</b>	
Total no. of women who had one or more home deliveries	16
Total no. of home deliveries* (*No. of total deliveries= 85)	25
<b>In which month the woman went to natal home during her first pregnancy?</b>	
Before seventh month	2
During seventh month	8
During ninth month	17
After delivery	5
Didn't go	2
No data	1
<b>Duration of Post-delivery stay at mother's place after first delivery</b>	
One month or less	5
One month and one week- ( <i>Savva mahina</i> - Traditionally this period is considered to be a period of ritual pollution)	10
Two months or more	15

All the couples were Hindu and most of them lived in either a joint or an extended family (27/35). Families were mostly agriculturists (26/35) wherein, 20 men had agriculture as their main occupation and 10 men were recently involved in service on contract basis but had agriculture as the main source of income for their families. There were five men who either were involved in some business or worked as a laborer. Out of 35 couples, 26 men and 33 women had studied up to 10<sup>th</sup> standard or less than that. All the women

were housewives. As the youngest child of all the women was less than three years old, most of these women were not able to work in the farm or acquire additional job and hence only 9 of the 35 women had some secondary occupation- either farming (5/9) or petty business or service (4/9). Majority of the couples had completed their family with either two (25/35) or three children (9/35). One couple had six children, five daughters before having their son. This profile of the couples is extremely congruent with a typical rural community in Western Maharashtra.

Characteristics of couples related to childbearing, showed that half of the women had one or two deliveries at home<sup>24</sup>. The total number of home deliveries was 25 (out of total number of 85 deliveries including live and still births). There were two women who had a still birth each and one of them had the delivery at home. Out of 35, 10 women went to their natal home for first delivery before 9<sup>th</sup> month and 17 went during 9<sup>th</sup> month of pregnancy. Twenty-five out of these 27 women stayed at natal home for a period of minimum of a months and a week. There is an obviously reduced contact between husband and wife during intra and post natal period due to this traditional practice.

### **6.5.2. Traditions and present practices of communication and behavior**

Existing literature in India and elsewhere points towards influence of traditions on childbirth related practices of women. Results of this paper focus on two major areas- a. Traditions related to communication and behavior regarding childbirth - based on data elicited from key informants and b. Present practices of couple communication and behavior regarding childbirth- data elicited from young couples in the study based on their own experience.

#### **6.5.2.1. Traditions related to communication and behavior**

Key informants in the study narrated about traditions related to childbirth based on their knowledge about the community and also based on their own personal experience (in some cases).

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<sup>24</sup> NFHS-III data for rural Maharashtra- Percent distribution of women giving birth in the last five years- 50.8% home deliveries-Own home-29.7%, Woman's mother's home-20.6%, 50.5% Deliveries at health facility

### Key informants' interviews-

In the present study in all ten key informants were interviewed. The selection of key informants was purposive based on the researcher's previous experience and rapport in the field area and recommendations received during initial informal visits in the field area. The objectives of conducting key informants' interview for this research were- to learn about changing patterns of couple communication existing at present, to understand traditional practices regarding couple communication and behavior, to know about marital relationship of young couples in general in rural areas and to get directions for approaching the couples and constructing the appropriate tool for interviewing them. To cover the wide spectrum of information that was necessary from interviews of key informants, individuals from various areas and sectors such public health staff, private medical practitioners, Traditional Birth Attendants (TBA), old and young women and other influential personalities in the field area, were interviewed.

Following table presents the detailed profile of the key informants-

**Table 6.2 Profile of the key informants**

Sr No	Age	Sex	Occupation	Education
1	35	Female	Private female Homeopath working in the nearby area	B.H.M.S.
2	40	Male	Director of the only private tertiary hospital (multi-specialty hospital) in the field area. He is the second generation practitioner in the study area. His father was a famous practitioner in the Tehsil.	B.A.M.S
3	38	Female	Wife of the director of this hospital and in-charge for managing all gynecology related cases (not a gynecologist)	B.H.M.S.
4	46	Female	Anganwadi sevika in the field village	9 <sup>th</sup> std
5	55	Female	TBA working in the field for 22 years	Literate
6	31	Female	Housewife, conducts stitching classes for young girls in the village	12 std
7	24	Female	Housewife	M.A. English
8	36	Female	Housewife, active member of women's saving group	7 <sup>th</sup> std
9	38	Male	Medical doctor at the PHC	M.B.B.S.
10	59	Female	Mother of the political leader in the village	6 <sup>th</sup> std

Most of the key informants were females, as they were expected to know more about the study subject. To understand the childbirth related traditions in the study population, traditions are grouped under three categories- the ones related to conception, to pregnancy and lastly to delivery.

### **Conception**

A woman is expected to conceive as early as possible after marriage. She experiences ill-treatment from community if she does not conceive within a year of her marriage. Women follow pollution period during menstruation and sit aside during that period. Also in families, the woman a pot upside down in one corner of the house, during her menstruation period. Hence, if a married woman missed her periods, the family, especially the mother-in-law comes to know about it. Most of the communication related to 'women's subject' happens between the young woman and her mother-in-law. Once a woman misses her periods and there is communication about the same with her mother-in-law, she asks her to wait for some more time. There is no communication about missing periods, immediately with the husband. The mother-in-law discloses this to him once she is sure about it. As a 59-year-old lady studied up to 5<sup>th</sup> standard said, "*The husband says 'Okay' and goes back to plough...that is it.*" Traditionally, there is no concept about medical confirmation of pregnancy.

### **Pregnancy**

During pregnancy, the woman does not need any special attention. She lives her routine life, in terms of diet, work, and taking rest as well as her sexual relations with husband; except that her family members offer help to her for heavy physical work. Rarely, she is asked for her cravings. Husband fulfilling his wife's cravings or helping her in household chores, is rarely seen. There is no communication between them about her diet, workload or taking rest.

As 59-year-old woman studied up to 6<sup>th</sup> standard and mother of a local political leader narrated her own experience of pregnancy-

*"Only once it happened that I was serving lunch to my husband, in the farm and I asked for a piece of bread (bhakri) from his share. He gave it to me, but in the evening, after going home, he told his mother, "I am very hungry. She ate some of my bread..that is how I did not eat much." Then my mother-in-law was so angry with me saying, "I should not eat like a man." That is how men used to be, not caring about wife."*



There is no planning for delivery in terms of decision about place of delivery or arranging logistics, during early months of pregnancy. Elderly women in the family, the mother-in-law takes all the decision, sometimes in consultation with the woman's parents. Registration for Ante Natal Care check-up is not found to be necessary as childbearing is not something worthy of medical attention. The woman is expected to work throughout her pregnancy as taking rest may hamper normal delivery. In general there is minimal communication between husband and wife during pregnancy, as it is mainly women's domain, so elderly women in the family, especially the mother-in-law dominates the decisions. As the senior TBA from the community said, "*The mother-in-law used to follow the daughter-in-law the whole day, asking her to complete the work. So what and how can the young woman talk to her husband or with anyone?*"

### **Delivery**

Though there is a tradition of sending the woman to her natal home for first delivery, she is sent there in the 9<sup>th</sup> month, so that she keeps working till the last month. There is a fear that if the woman is sent to her natal before 9<sup>th</sup> month, she will take rest and not work enough, thus will have problem in having normal delivery. Deliveries are conducted at home by untrained TBA known as *Suin*, or elderly women in the family. Sometimes, the woman delivers without anybody to supervise or assist. As one the Key informants narrated the experience of her second delivery-

*"I was collecting firewood and started having pain in my stomach. My mother-in-law was around me. Then I worked in the farm, with continuous pain for the whole day. Finally, in the evening, my mother-in-law asked to me stop working and go home. I went home and was about to cook but then I delivered. By the time she came home, I had already delivered. I don't remember where my husband was, somewhere in the village. Then I took rest for twelve days and started working from then on. That is it. That was the practice."* – A 46-year-old Anganwadi worker studied up to 9<sup>th</sup> standard.

If any complication arises, the mother-in-law or other elderly women in the family, decide about where to take woman. There is no communication between husband and wife over this subject. Duration of woman's stay at her natal home is decided by her mother-in-law and varies from 5 days to one month and a week. Traditionally, various worships are performed on the 5<sup>th</sup> or 12<sup>th</sup> day of childbirth in the interest of the well-being of the baby.

The period of one month and one week, locally referred as 'savva mahina' is considered to be of ritual pollution, during which mobility of the woman is restricted. A woman going to natal home for her delivery, further reduces the existing opportunities for couple communication during this period. Men in the family hardly play any role during or after delivery of the woman. It is mainly the mother-in-law, if the woman had her delivery at husband's home or her mother in case if she had her delivery at natal home, who discusses and decides about it. The young husband, who follows the path of his father, has never seen men being involved in these matters and hence keeps himself away from the same. "He is considered to be like a hollow man with no substance (*dham dhokla an aatun polka*)" as said by an informal key informant from the community- a 46-year-old *Anganwadi* worker studied up to 9<sup>th</sup> standard.

In other words, there were various traditions and customs around childbirth and traditionally, couples were hardly encouraged to discuss about the same. The family, especially the mother-in-law ruled most of the decisions in this subject and medical care was scarcely sought, except in case of some complications. Following quote aptly connotes the traditional couple communication practices-

*"We all know that 'love is blind' but husbands never understood that 'one can give it a voice'. They never made an attempt to talk 'few sweet words to their wives.', 'enquire about her health', or 'sit next to her to have a casual chat'.* a 59-year-old woman studied up to 6<sup>th</sup> standard and mother of a local political leader

#### **6.5.2.2. Present practices of communication and behavior regarding childbearing**

In-depth interviews of couples (n=35) have provided data on present practices of communication and behavior regarding seven issues of childbearing starting from disclosure of pregnancy to communication during post-natal period. Narrations from women as well as their husbands are considered for presenting this data.

Almost one-third of the women, talked about missing period first to their mother-in-law, following the tradition and there was no immediate communication or action taken about confirmation of pregnancy. In case of little less than half of the women, the mother-in-law immediately asked her son to take his wife to doctor for confirmation of pregnancy. The husband did not have much to say about it, but expressed happiness. Only when the mother-in-law asked him to take his wife for pregnancy confirmation, he did so. However in case of 1/4<sup>th</sup> couples, the wives directly spoke to husband about it. Later, it was

disclosed to the mother-in-law. Husbands voluntarily initiated taking wives doctor for pregnancy confirmation.

*“I started vomiting and feeling giddy. Obviously, I told my husband. There was no chance to talk to my mother-in-law. We had such a big family that time. I could not talk to her. So I just told him. Even he did not tell anybody. He immediately took me to doctor. The doctor checked my urine and told me that I am pregnant (divas gelet). I told my husband. Obviously he was happy.”* A 24-year-old farmer living in an extended family talking about her experience of first pregnancy

All the women went for medical confirmation of pregnancy and sought antenatal care thereafter. Women sought routine antenatal care from government clinic in the village and went to private provider in the nearby town for having an ultra sound examination for confirming about health of the baby<sup>25</sup>. This was a new trend either advised by the provider or suggested by family member, especially during the first pregnancy just to confirm that “everything was normal”. For seeking routine antenatal care in the village, women went alone, as generally husband and wife do not travel together within the village. But, when the antenatal clinic was far off, and for all the ultra sound examinations (which are generally conducted in the poly-clinics or private hospitals located in the nearby towns), men accompanied their wives. The data showed that almost half of the couples discussed about fixing up an appointment with the health provider for ANC, reminding wife about ANC visit date and about taking the tablets and even forcing her to complete all the prescribed doses and injections during ANC, taking wife for ANC visit, and talking to health provider about her health.

*“I always had to remind her about going to doctor. I used to call the doctor and take appointment and keep reminding her about that. I always went with her to doctor at Dehu road [a nearby town]”*- A 30-year-old farmer studied up to 9<sup>th</sup> standard living in an extended family. His wife sought ante natal care from a private doctor from the nearby town.

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<sup>25</sup> The National Family Health Survey III for Rural Maharashtra reports 33.7 % of pregnancies with an ultrasound test and the percentage being highest for first pregnancy.

*“Whenever it is something serious, like going for sonography<sup>26</sup> or admitting her for delivery, I am always there. I give personal attention and go with her and talk to the doctor. For ‘doses’ [routine immunization during ANC] in the village, she can go alone. I don’t have to look into that.”*- A 32-year-old graduate managing his plant nursery and the former political leader in the village

Narrations from wives of these men supported about their husbands being actively involved in seeking antenatal care.

Care at home during pregnancy involved diet, workload, taking rest and keeping a vehicle ready for commuting in case if emergency arises. Almost 1/4<sup>th</sup> of the men had no or minimal discussion with their wives on these issues and showed no change in behavior in terms of taking care of wife, as per the narrations of the women. Data from the men mostly matched the responses of wives, with some exception such as-

A woman mentioned that-

*“Mouth of my bag [uterus] was small and the doctor asked me to take rest, sleeping on left side, every afternoon. My husband did not say anything there. After coming home he told me, “Not possible. Work at home and in the field, how can mother manage these things? Take rest only whenever possible.” I did not take rest and continued working till eight months.”* This woman 22-year-old housewife living in an extended family did not have any problem during her delivery.

Her husband when asked about his wife’s pregnancy said,

*“Sometimes her legs would hurt, or she would have some other pain, then I would give her tablet and water. Or in the evenings, she would ask for milk and then I used to give it to her. I have done all that. But she did not have any other problem.”*- A 30-year-old farmer studied up to 9<sup>th</sup> standard

A little less than half of the men either communicated with wives around care during pregnancy but were not actually involved in providing care; or offered care in one or the other aspect but did not have discussion about it. They offered help in terms of making logistic arrangement or looked after wives’ medication and started ‘adoring them more’. However, there were some couples who had discussion about care during pregnancy

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<sup>26</sup> Sonography is the word commonly used by the community for referring to an ultrasound.

and also the husbands were actually involved in provision of care during wife's pregnancy.

*"He used to get fruits for me from Pune. I asked him to get whatever I felt like eating. Also he told me, "You can sit at one place and do cooking. I will help you for other things." He helped me to fetch water and for washing clothes. There was nobody else at home. My mother-in-law had to manage the work on the farm and monitor the work of other laborers."- A 28-year-old housewife studied up to 7<sup>th</sup> standard living with husband, two children and widowed mother-in-law.*

There were some differences in the narrations of women and their husbands around details of communication and provision of care. For example, the husband of this woman only mentioned about helping wife for fetching water and lifting heavy things at home. But, the supportive role of husband during pregnancy was consistently reported by men as well as women.

It was observed that husband was involved more in communication as well as actual care of wife during her pregnancy, in case of either nuclear family and also in joint family where manpower to manage the household chores and work on the farm was a difficulty. In case of extended family, as narrated by men and confirmed by their wives, the questions of men being directly involved in care did not arise due to help offered by other young women in the family.

Sending the woman to her natal home for delivery was discussed in the context of amount of workload and availability of manpower in her conjugal family as well as in her natal family. There was also discussion about place of delivery-home or a health facility and type of health facility-public or private. In case of few couples there was hardly any discussion between husband and wife over this issue and husband's mother was an important decision maker. A little less than half of couples though discussed over this issue, followed the instructions of the mother of the husband.

*"I went to 'Maher' [mother's home] in the 9<sup>th</sup> month. My in-laws said that they would not send me there in the seventh month. My mother, I and even my husband felt that I should go there in 7<sup>th</sup> month because there was not much work here. But my in-laws, especially mother-in-law said, "If you go there earlier, you will take rest and not work. That is not good." So I went there in the 9<sup>th</sup> month."- A 26-year-old farmer living in an extended family.*

Husbands of these women mostly talked mother or parents, being the important decision-maker in this regard, as one of them said-

*"We both, husband and wife first talked about it, then we told my father and mother, when I should send her. I said, "In seventh month", but they said, "In eighth month". We had this opinion and parents had different opinion. Finally, she was sent there in the 8<sup>th</sup> month." A 32-year-old factory worker and farmer, studied up to 9<sup>th</sup> standard living in an extended family.*

However, almost one-third of the couples shared their opinions about sending wife to natal home and took an informed decision.

*"We will go to hospital [he had registered her name with a private hospital in the nearby town] from here. At your father's place who will do the running around in case of emergency? Here, I am available. We have a vehicle, so it is better if you are here."- A 33-year-old farmer studied up to 7<sup>th</sup> standard living in an extended family.*

*His wife narrated, "Husband had decided upon that. What he said about problem in commuting from my mother's home was true. So he decided everything. Of course, my mother wanted me to go there earlier, but I did not go."- A 24-year-old housewife studied up to 10<sup>th</sup> standard living with her husband, two children and mother-in-law.*

The duration of wife's stay at natal home after her delivery was considered to be an important issue because it has implications on woman's workload, diet and rest after delivery; as well as the opportunities available for couples to have discussion during this period. Almost for half of the women, their mother-in-law made this decision and there was no communication with the woman's husband about this.

*"I stayed at my mother for 'Savva mahina' [one month and one week]. My mother-in-law said, "If the baby is okay, you stay there for a month and then come back. But if the baby starts crying a lot, if you cannot manage, then may be you should stay back for more time." A 27-year-old housewife living with her husband, two sons and widowed mother-in-law.*

There were some couples who discussed about this issue but preferred to follow the tradition. As one of the husbands said-

*“All these things were decided by my mother. My wife was there [at her natal home] for savva month because she had ‘normal’ delivery, so there was no point in her waiting there for more time. There are some rituals. I decided about that. I told them for whatever time they want, she can be there. My mother had told them about savva month. So she came back after savva month”- A 32-year-old graduate managing his plant nursery and the former political leader in the village*

There were few couples who discussed about this and took their own decisions.

*“My husband said, “It will be better if I stay there at least for three months. Once I come here, I will have to work hard...bring firewood and all. There will be no time to take rest. So he insisted that every time after my delivery, I stay at my mother’s place for at least three months.”- A 28-year-old illiterate laborer living with her husband and three children.*

It was mostly parents of the wife or husband who decided about whether the woman should deliver at home or in a hospital and about choosing the hospital for her delivery. Men had little say in this matter, especially because the deliveries took place at wife’s natal home.

*“My mother decided everything. She and my wife talked about it. Women talked about it. I was not involved. They all decided on their own, my mother, father and her family members. She had both her deliveries at home. Her grandmother is a TBA (Suin).”- A 25-year-old man studied up to 9<sup>th</sup> standard, worker in a private company on contract basis living in an extended family.*

However, in case of half of the couples, the men were part of this discussion and decision.

*“We all decided about that. I also decided it. I told her [wife] to deliver in a hospital and she had her delivery in hospital. I was there with her.”- A 30-year-old contract worker studied up to 10<sup>th</sup> standard.*

*Wives of these men also mentioned about decision being taken at family level, depending on the discussions between the two families.*

There were few couples who discussed about this subject and also took an informed decision, themselves.

*“Her father’s financial condition was not that good. Also there are no commuting facilities available at their village. So I told her that she should stay here for delivery. I used to take her to hospital for her delivery, I decided about the*



*hospital. She [wife] also said, 'Okay' for that."- A 33-year-old farmer who has studied up to 7<sup>th</sup> standard living in an extended family.*

Responses from wives of these men showed that it was either the wife or the husband who suggested for a particular place of delivery and the other partner agreed to it.

There were varying responses for the question- *'When did husband go to meet his wife after her delivery?'*- ranging from *'husband took the wife for delivery and was present in the hospital'*, *' husband came to meet me only after the 5<sup>th</sup> day worship of Goddess of Fortune'* to *'He never came to see me, I came here when the baby was three months' old'*. There were different factors affecting this pattern- such as influence of family and tradition, distance of woman's natal home, relationship of the husband with the woman's natal family and husband's work schedule. Hence, though there were some women who experienced complications during delivery such as convulsions and high blood pressure, or tear of vagina, these women being at the natal home; their husbands did not necessarily discuss about complications or treatment with them. As one woman narrated-

*"I was always scared of hospital. He knew it. I was at mother's place and had started getting pains, but I never told her. Then I delivered at home. But there was a tear and I had to be taken to hospital. There were no stitches. It got cured. I did not inform him. I told him only on the next day. He was very angry. He always wanted me to deliver in hospital. He came to see me on the 6<sup>th</sup> day after the worship on the 5<sup>th</sup> day. So during my second delivery, he insisted that I should deliver in hospital and should not wait at home. I did that."- A 24-year-old woman working as a housewife and as a farmer studied up to 5<sup>th</sup> standard and living in an extended family. She was at her mother's house for having both her deliveries.*

In her family, they followed the custom about husband not coming to visit his wife, till the 5<sup>th</sup> day worship of the Goddess of Fortune and hence he visited her only on the 6<sup>th</sup> day of her delivery. During his interview, he did not talk about any problems that his wife had during her delivery.

All women had some interaction with their husband during post natal period. The amount of interaction changed depending upon the place of delivery (husband's or natal home), frequency of husband's visit to her natal home and the privacy available for them to have communication. Little more than half of the men attempted to visit wife occasionally or at least talk to her over telephone (in case of a very small number of couples). The



remaining couples had frequent interactions with their wives. However, both men and women mentioned that their interaction during this period, whether telephonic or in person, had limitations in terms of having detailed discussion due to constant presence of other family members, especially elderly women, around the young woman. Subjects discussed during these interactions involved woman's health, immunization of the child, use of contraception and duration of woman's stay in her natal home. However, not necessarily all the couples talked about all these issues. In case of wife having her delivery at her natal home, husband felt 'awkward' to discuss anything at wife's natal home in presence of her family members.

*"He [husband] used to come there once in eight days. He did not talk much because of the big family. He used to phone me on my brother's mobile phone, every day so we used to talk every thing on the phone but not much when he would come there. There are parents, one sister and one brother. The brother is elder to me, so how can I talk anything in front of my brother. In the house, it used to be difficult."- A 24-year-old housewife studied up to 10<sup>th</sup> standard, husband has studied up to 12<sup>th</sup> standard and is a landowner. They live with two children and his widowed mother.*

*"I used to frequently call her up. Also I used visit her once in 2-3 days. I used to talk to her about my work and matters at home. I used to tell her, "Love the baby. Take care of him. Take him to hospital for doses [immunization]." - A 38-year-old worker in sugar factory, studied up to 9<sup>th</sup> standard living in an extended family.*

The present practices of couples regarding communication and behavior about childbearing showed that in certain areas such as seeking antenatal care, care at home during pregnancy and decision about sending the woman to her natal home, men were more involved in the discussion and decision making with their wives and other family members. Although, there were some couples who relatively showed more communication during post-natal period, it was still only a 'brief' discussion.

## **6.6. Discussion**

### **6.6.1. Changing trend regarding seeking formal care**

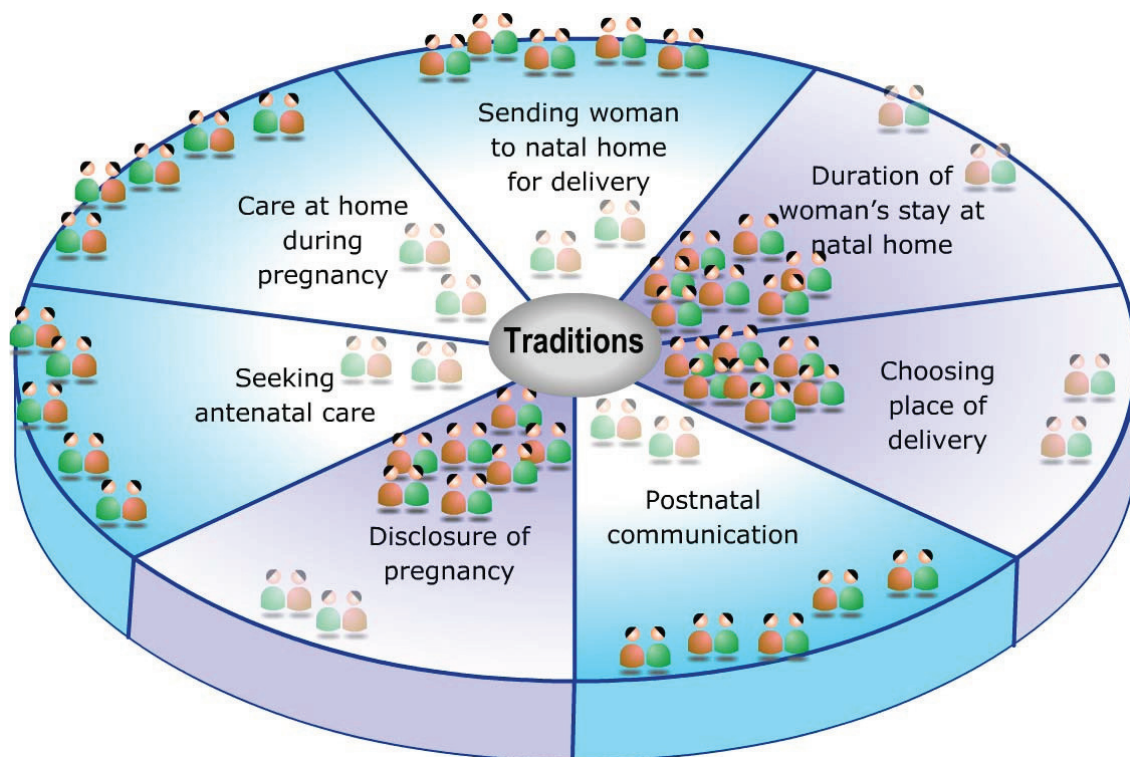
Traditionally, as Kanitkar and Sinha (1989) and Jeejebhoy and Rao (1995) mentioned and the key informants in this study narrated, there was no practice or preference for

seeking medical help during pregnancy or childbearing. However, the study reports that women sought antenatal care and little less than of half of them had home deliveries. National Family Health Survey-III data for rural Maharashtra (NFHS-3, 2008) in which percent distribution of women giving birth in the last five years shows that there are still 11.2 women who do not seek any antenatal care and there are 50.8% home deliveries. These indicators show improvement as compared to the previous survey data. Hence, present study confirms the rising positive trend in these indicators. Changing behavior in terms of seeking access to health care, suggests towards increased chances of communication between spouses on these issues.

### 6.6.2. Couples' communication and behavior against the backdrop of traditions

Following diagrammatic representation captures the pattern of couples' communication and behavior against the backdrop of traditions.

**Figure 6.1: Diagrammatic representation of traditions and present practices of communication and behavior regarding childbearing**



The centre of the circle is the nucleus of traditions regarding childbearing which were narrated by the key informants. There are seven different segments of the circle, representing seven major issues of childbearing. The diagram represents the trend reported in the study and the number of couples plotted does not match with the exact number of respondents. There are some couples who largely follow traditions (plotted close to the nucleus), whereas some couples show marked departure from the traditions (plotted close the circumference). There are four issues of childbearing namely-seeking antenatal care, care at home during pregnancy, sending wife to natal home for delivery and postnatal communication, where couples show maximum departure from traditions. In the remaining three subjects namely- disclosure of pregnancy, duration of woman's stay at her natal home and choosing place of delivery, couples seemed to follow traditions and have limited communication.

#### **6.6.2.1. Departure from traditions**

Almost one-third of the couples departed from traditions in more than four subjects of childbearing (out of the seven presented in the diagram). Traditionally, as mentioned by the key informants men had followed their fathers, in terms of not discussing or involving in issues of pregnancy and delivery that are women's domain. These couples showed departure from traditions in terms of seeking medical care and husbands generally being more involved in discussion and decision-making during antenatal care, delivery and post-partum. In Turkey, (Turan et al, 2001) men similarly described about their own father being physically and emotionally distant but ideas about fatherhood seem to be undergoing change and now young men want to be helpful towards wife. Researchers have attempted to analyze factors affecting couple communication and behavior with increased male involvement related to childbearing. In Indonesia, education of couples, showed influence on their power to use prenatal and delivery care (Beegle, Frankenberg and Thomas, 2001); whereas Barua (2006) in her study in Rural Maharashtra found that men involved in non-farm occupations were more supportive towards their wives. Mullick et al (2003) mentioned about Zulu men in Africa, that men may be more interested in their partners' well-being during antenatal and postnatal period, than is usually the case because of their shared role in producing a healthy child. The present study confirms the findings of Barua (2006) from rural Maharashtra that men with non-farm or non-traditional occupation and increased work related mobility; seem to be more communicative with their wives around childbearing. Probably, increased access to resources and economic opportunities has effects on men's communication and

behavior regarding reproductive health, but it needs to be further studied. As well, effects of programmatic efforts to interact with men around antenatal and postnatal care, may have resulted in changing communication and behavior of couples around these subjects of childbearing. However, the extent of involvement of men is not the optimum and there is still scope to improve the same. Though further validation is necessary, men accompanying wives during antenatal care and their interest in having communication with wife during postpartum should be viewed as possible opportunities for strengthening couple communication in reproductive health.

#### **6.6.2.2. Continuing traditions**

On the other hand, the present study points towards specific areas of childbearing where, couples still follow the traditional practice of restricted communication; and family network and traditional norms seem to influence them relatively more. As Zondi et al (2003) have stated that though men themselves, as well as their partners, would prefer more active role during pregnancy, delivery and infant care, the societal and health system norms often mitigate against this. In some subjects of childbearing such as disclosure of pregnancy, duration of woman's stay at natal home and decision about choosing place of delivery, couples in the present study had limited communication. There can be some possible explanations behind this differential pattern, which are supported by various studies. Disclosure of pregnancy is probably the first time when there is discussion about any reproductive health related issues because couple hardly talk about planning their family, or discuss sex when newly married. This should explain adherence of women to traditional practice of discussing about conception initially with the women in the family. Secondly, women in the study population practiced the norm of going to natal home for childbirth. This norm reduces opportunities of couple communication during this period, though some of them had sporadic communication over telephone. The subjects such as duration of her stay at natal home, choosing the place of delivery and dealing with complications around delivery, if any, continued to be discussed and decided among elder family members and husbands had no substantial role in this regard. This is yet another similar finding from Barua's (2006) study in rural Maharashtra. The researcher pointed towards reasons of men's absence from routine care- such as wife going to natal home for delivery and existing perception that this issue is women's domain. As was seen in Zulu community in South Africa (Mullick et al, 2003), even in India, traditionally men are not encouraged to be involved during the childbirth and hence, some of the men in the present study seemed to follow the traditions of not

visiting wife immediately after delivery. Role of family and traditions is more active and influential for young couples during this period. As Chowdhury (2003) found in her study in Bangladesh that most women were expected to deliver at their marital home and mother-in-law made this decision. In present study, however, it is not always the mother-in-law but even the woman's parents are involved in the process of this decision-making. To summarize, in spite of men's desire and efforts to be involved in communication and behavior related to childbearing, traditions and family network play an active role in certain areas of childbearing. Hence, research and interventions attempting to achieve reproductive health outcomes such as increased institutional deliveries, Emergency Obstetric Care, improved postnatal care as well as postnatal counseling for contraception, should give due consideration towards continuing traditional influence.

Issue of male involvement has been discussed with several concerns from researchers and activists all over the world. There has been perceived risk in bringing men into domains where women have traditionally been in charge, as reviewed by Helzner (1996) about gender implications of male involvement in reproductive health programme. Based on studies among adolescents in South Asia, Singh (2003) mentioned about involving men to become a double-edged sword substituting women's empowerment. On the other hand, Mullany, Hindin and Becker (2005) in their research in Nepal, showed that increased couple communication and joint decision-making may achieve women's empowerment as well as their health goals. Thus, the changing tradition of men getting more involved in discussion and participation in childbearing, invites broader understanding of its linkage with women's status, reproductive health outcome and implications for programme in rural set up. However, without male involvement, couples cannot achieve their goals of having mutually shared and respected decisions around childbearing.

### **6.7. Conclusion**

Present research should be viewed as an attempt to learn married couples' struggle between following traditions and adapting change in relation to childbearing, especially in a patriarchal society, where reproductive health is still women's domain. These findings based on a qualitative piece of exploration in one of the rural parts of India cannot be potentially generalized to entire society in the developing world, or even to the rural parts of India. However, there are two clear implications for the health programme in the local set up- firstly, opportunities to build upon existing couple communication and

behavior such as men's interest and practices of accompanying wives during antenatal visits and secondly, to create platforms for improving couple communication during delivery and postnatal period, with due consideration to the influence of culture, traditions and family network. Certainly, in absence of favorable and supportive environments in the family, couple communication may not get translated into behavior change. Hence, understanding the complexity of changing behavior and communication of couples against the backdrop of continuing traditions in any given society should be a pre-requisite before designing reproductive programme strategies targeting couples.

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## Chapter 7

# **Differential narrations of husband and wife about wife's reproductive health problems- a study in rural married couples in India**



**Differential narrations of husband and wife about wife's reproductive health problems- a study in rural married couples in India**

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This article has been prepared as a working paper

## **7.1 Abstract**

Communication between husband and wife is an important determinant in reproductive health of the couple as it reduces risk of unintended pregnancies, acquiring Sexually Transmitted Infections and does influence health seeking behavior in case of reproductive health problems. Hence, it is crucial to learn about reproductive health problems in women from perspective of husband and wife, especially in a society, where open communication between married partners around reproductive health is limited.

**Methods-** Married couples (n=35) from a rural set up in Pune, India were interviewed in-depth with the help of a visually assisted interview guide having hand-drawn pictures. The interviews of husband and wife were conducted simultaneously and separately.

**Results-** Almost half of the women experienced reproductive health problems such as complications during pregnancy or delivery, side effects or infections due to contraceptive usage or symptoms suggestive of Reproductive Tract Infections (RTI). Husbands and wives narrated discrepantly about wives' problem during pregnancy and men hardly talked about the delivery complications that their wives had. There was also discrepancy in the narration about side effects due to use of contraceptive methods and almost none of the men mentioned about any symptoms suggestive of Reproductive Tract Infections, experienced by their wives.

**Conclusion-** Discrepancy in the narrations of husband and wife about wife's reproductive problem may be a result of malfunctioning communication between spouses or even between the spouse and the researcher, because of various individual and collective norms. Synthesis of differential narrations is essential for arriving at strategies to improve couple communication or partner notification.

**Key words-** couple, rural, India, communication, reproductive health, differential, narration

## **7.2. Introduction**

In relation to sexual and reproductive health, studies have revealed the importance of couple communication in different dimensions. Couple communication is crucial for implementing partner notification programmes, as patient referral is the recommended starting point for partner notification programs (WHO, 1989) and is considered the most feasible for developing countries (Mathews, Coetzee et al., 2002). Couple communication helps in reducing risk of acquiring Sexually Transmitted Diseases (STDs) and unintended pregnancies (Keller, 1996) and in influencing curative behavior

in case of reproductive illnesses (Santhya and Dasvarma, 2002). It is crucial to learn about reproductive health problems in women from perspective of husband and wife, especially in a society, where open communication between married partners around reproductive health is limited. The present paper focuses on understanding couple communication about wife's reproductive health problems analyzing narrations of husbands' and wives' on this subject.

### **7.3. Background**

Blanc (2001) reviewed gender power relations with sexual health and stated that verbal communication between partners about reproductive health is low in many developing countries and that gender-based power inequities contribute to a lack of communication. Globally, women's social and economic status in relation to their male sexual partners have conferred an increased vulnerability to Sexually Transmitted Infections (STIs) and HIV (Heise & Elias, 1995), and gender is increasingly recognized as an important determinant in reproductive health and health-seeking behavior (Currie & Wiesenberg, 2003; WHO, 2002). Gender stereotypes in sexuality possibly restrict access to health information, hinder communication and encourage risky behavior among women and men in different but equally dangerous way among Indian couples (Verma and Mahendra, 2004).

Male involvement in discussion and decision-making about reproductive health problems of women is extremely crucial for various reasons. As Corinne, Shefner and Sood (2004) studied in Indonesia, husbands' participation in pregnancy was thought to reduce non-medical and indirect causes of maternal deaths, such as the delay in recognizing pregnancy-related complications and the delay in reaching a healthcare facility promptly. In India (Raju and Leonard, 2000), as well in some other countries such as Ghana (Bawah et al, 1999), Egypt (El-Zanaty et al. 1999) and Tanzania (Maman et al. 2001), men control financial resources and women's mobility which, in turn, affects women's access to and use of reproductive health services. Also, it is important to have men's involvement in this subject, because they may also be seen as the principal vectors of their partner's sexual health regarding STIs (Kuene et al, 2004). Not uncommonly, women who perceive themselves to be in a monogamous relationship are at risk of infection because of their partners' sexual behaviours (Dallabetta, Lag and Lamptey, 1997).

It is further important to learn couple communication about reproductive health problems in India, where couples are rarely encouraged to have open discussion around issues such as sexual and reproductive health problems and there is a tendency to limit communication between spouses (World Bank, 1996-46). There is limited spousal communication in issues such as RTIs as was found among rural South Indian women by Santhya and Dasverma (2002).

Since more than two decades, researchers have looked at differential narrations from husband and wife either in terms of their perspectives, agreement or reporting on various reproductive health issues, such as fertility in rural India by Vlassoff and Vlassoff (1978), contraceptive use among Swiss couples (Hopflinger and Kuhne, 1983) and Turkish couples (Kulczycki, 2008), sexual experience among urban couples in Mumbai, India (George, 1998) and fertility or childbearing preferences among Bangladeshi couples (Razzaque, 1999; Gipson and Hindin, 2007).

Responses from husband and wife about wife's reproductive health problems reflect the extent of couple communication. Studies in India, have reported contrasting findings in this regard. Women seem not to inform their husbands about their gynaecological symptoms (Bang and Bang 1994, Ramasubban and Rishyasringa 2000) and are often, as noted by Ramasubban (1995) 'too afraid and confused to bring this [symptoms] to the notice of the family . . . both because they are not supposed to have such problems in the first place and also because they are socially deemed to be polluters, the originators of sexual problems'. By contrast, Patel (1994) and Oomman (2000) both reported that women discussed their symptoms with their husbands.

In this context, present paper explores the responses of husband and wife about wife's reproductive health problem with an attempt to analyze the differential pattern.

#### **7.4. Study site**

The study was conducted in the rural outskirts of Pune city in the state of Maharashtra. More than 50% of the population of the state is rural and the state has a Hindu majority (72%). The study location Maval Tehsil covers a population of around 300 thousand, spread among 184 villages. The tehsil is surrounded by Western Ghats and the Mumbai-Pune Express Way cuts through the Tehsil. It is one of the fastest developing tehsils of Pune district, with many upcoming industries, educational institutes, plant nurseries and

floriculture. Most of the villages have geographical access by road. There are two main towns in the Tehsil, where most of the private medical practitioners, private multi-specialty hospitals, markets and shops are clustered. In spite of the development that has taken place in this tehsil due to urbanization; the area still represents rural site dominated by kinship oriented Maratha caste<sup>27</sup> agrarian community. Most of the families are either joint or extended. It is a patriarchal society, where families are mostly headed by men, who play a significant role in decision-making in the family.

### **7.5. Methods**

Present paper is drawn from a broader study that aimed at understanding the process of couple communication in reproductive health. It was a community-based study and involved a preparatory phase where key informants from the community (n=10) were interviewed in-depth in order to learn about patterns of couples communication and behavior regarding reproductive health and the traditions related to this subject. This phase helped in designing the tool for interviewing selected couples in the study. In the next phase, 35 married couples were interviewed in-depth. Researcher used a tool labeled as Visually Assisted Interview Guide (VAIG). The tool involved picture cards having hand-drawn illustration of day-to-day life scenario and an in-depth interview guide around the scenario. It covered various aspects of reproductive health, reproductive health problems being one of those. The tool also included personal data of the couples, socio-demographic details, information about family and a series of questions around general process of inter spouse communication including time, duration, content of communication, determinants etc. The tool was simultaneously administered to husband and wife (in absence of each other, separately) by male and female researchers respectively. Present paper draws findings from the interviews of these 35 married couples.

There were sets of questions to know about reproductive health problems among women. Even men were asked to narrate the experience of their wives. As the interviews of men and women were conducted simultaneously and separately, there was no chance that the male interviewer interviewing a husband would know about his wife's health problem. Hence, all the responses from men and women are spontaneous

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<sup>27</sup>Caste- It is a group of individuals socially stratified on the basis of occupation, endogamy, social culture and political power

responses and not probed for cross-checking information received from the other partner.

#### Sample selection and recruitment of couples

To cover the entire spectrum of reproductive health related issues- pregnancy, delivery, family planning, sexual relations and reproductive health problems; present study focused on married couples that have at least one child and have used a terminal method of contraception (female sterilization<sup>28</sup>). To minimize the recall bias of the respondent, it was decided to select couples that have undergone sterilization, not beyond a period of one year at the time of involving them in the study. The study was conducted in villages under the jurisdiction of three (out of six) Primary Health Centers (PHC) selected randomly. The PHC staff requested Village Health Functionaries (VHF)<sup>29</sup> to assist the researcher in recruitment of couples, based on the records of female sterilization maintained by them. Couples following the inclusion criteria regarding the time of female sterilization were short listed and then contacted by the VHF. Couples, who verbally gave consent to the VHF to participate in the study, were then approached by the researcher for conducting interview. In all forty-one couples were identified for interviews, but four of them were not available (husband and wife to be available at the same time for interview) for interview. There were two respondents-one male and one female (not the same couple), who refused to participate in the interview without giving any convincing reason for the same.

#### Ethical considerations

Since the study was about a sensitive and personal subject of couple communication in reproductive health issues, informed verbal consent from the respondent was obtained at two levels, firstly by the VHF before recruiting them in the study and then by the researcher before starting the interview. They were assured freedom to participate or withdraw from the study at any given point. The time and place for conducting the interview was decided by the couples and the researcher occasionally had to make multiple visits to respect their decision. The researcher ensured that the respondents were interviewed in complete privacy and no information was revealed to any of the family member, friends or even the spouse. Of course, using the information collected

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<sup>28</sup>Female sterilization is the commonly accepted terminal method of contraception and village health functionaries maintain the record of each woman who undergoes sterilization, irrespective of the place of sterilization, i.e. whether she had it in a public hospital or a private provider.

<sup>29</sup> Village health functionaries- Auxiliary Nurse Midwife (ANM) and *Anganwadi* worker- Government run preschools present in every village.



through this study only for academic purpose and not discussing it with and disclosing it to anyone else for any other purpose would ensure the last important aspect about protection from harm to the respondent.

## **7.6. Results**

### **7.6.1. Socio demographic profile of the couples**

All the couples were Hindu and most of them (27/35) lived in either a joint or an extended family. Out of 35 couples, 26 men and 33 women had studied up to 10<sup>th</sup> standard or less than that. Families were mostly agriculturists wherein, 20 and 6 men had agriculture as their main and secondary occupation respectively. These six men were involved in service on contract basis at the time of interview, but had agriculture as the main source of income for their families. All the women were housewives. As the youngest child of all the women was less than three years old, most of these women were not able to work in the farm or acquire additional job and hence only 9 of the 35 women had some secondary occupation as farming, petty business or service. Majority of the couples had completed their family with either two (25/35) or three children (9/35). One couple had six children, five daughters before having their son. This profile of the couples is extremely congruent with a rural Maharashtrian community.

### **7.6.2 Narrations about reproductive health problems experienced by women**

Almost half of the women in the study had ever experienced reproductive health related problems. These were complications during pregnancy or delivery, side effects or infections due to contraceptive usage or symptoms suggestive of Reproductive Tract Infections (RTI). Men were asked set of questions to respond on these issues. However, most of the times, they just mentioned about wife not having any problem or complication. As the interviews of husband and wife were conducted simultaneously and separately, the male interviewer while interviewing the husband of the woman did not know about his wife's health status. Hence, probing men was based on the commonly reported reproductive health problems among women.

Little less than 1/4<sup>th</sup> of the women had symptoms such as bleeding or pain in the stomach during pregnancy and were advised to have bed-rest. All these women sought formal care from private practitioner and their husbands accompanied them for seeking care. Most of them mentioned about discussing about the symptoms with their husbands. However, in some cases, husbands' narrations did not confirm the same.

Moreover, decision about whether the young woman should follow doctor's advice about bed-rest, always depended on the consent from the mother-in-law, availability of manpower to manage household chores and possibility of sending the woman to her natal home for taking rest.

*"Mouth of my bag [uterus] was small and the doctor asked me to take rest, sleeping on left side, every afternoon. My husband did not say anything there. After coming home he told me, "Not possible. Work at home and in the field, how can mother manage these things? Take rest only whenever possible." I did not take rest and continued working till the eighth months." This woman, 22-year-old housewife living in an extended family, did not have any problem during her delivery.*

Her husband when asked about wife's pregnancy said,

*"Sometimes her legs would hurt, or she would have some other pain, then I would give her tablet and water. Or in the evenings, she would ask for milk and then I used to give it to her. I have done all that. But she did not have any other problem."- A 30-year-old farmer studied up to 9<sup>th</sup> standard.*

There were very few women who narrated the experience of miscarriage during pregnancy. These wives when probed mentioned that they talked about this event with their husbands and were advised to seek medical care, without having much discussion about the same. However, husbands of none of these women mentioned about any health problem that their wives had during pregnancy.

*"I had bleedings, big clots and all. That time, my mother-in-law and I had some fights, so I did not tell her anything. It dropped down [miscarriage] and then I went for 'curetting'...whether I talked to husband....Yes...but he would not know anything. Why I had stomach ache, why I would have clots and all? How would a man understand! It was just one and a half months. So he did not really know much. I just told him. Then I went to hospital. My mother was with me. He also came."- A 27-year-old housewife studied up to 11<sup>th</sup> standard, recently living in a nuclear family with husband and two children.*

Her husband mentioned,

*"During her pregnancy, she went for check-up to the General Hospital with my mother. I was not home, most of the times. Later, my parents decided to send her to her mother's place because she having weakness. She could not lift heavy things, I would go for work, then how would she manage? My parents....means*

*generally we give them respect when they are in present there, otherwise they don't say anything about such issues. So I sent her there, during the sixth month [of her pregnancy]."- A 30-year-old man working in a private company as contract laborer studied up to 7<sup>th</sup> standard.*

There were a few women who had problem during delivery such as prolonged labour, tear of vagina, convulsions due to high blood pressure and breach. None of their husbands spontaneously talked about any such problem experienced by their wives, though their wives talked about discussing these issues with their husbands at a later stage. In all these cases, except one the wives were at their natal home for having delivery.

*"I was always scared of hospital. He knew it. I was at mother's place and had started getting pains, but I never told her. Then I delivered at home. But there was a tear and I had to be taken to hospital. There were no stitches.. it got cured. I did not inform him. I told him only on the next day. He was very angry. He always wanted me to deliver in hospital. He came to see me on the 6<sup>th</sup> day after the worship on the 5<sup>th</sup> day. So during my second delivery, he insisted that I should deliver in hospital and should not wait at home. I did that."- A 24-year-old woman working as a housewife and as a farmer studied up to 5<sup>th</sup> standard and living in an extended family. She was at her mother's house for having both her deliveries.*

In some families, the couples followed the custom about husband not coming to visit his wife, till the 5<sup>th</sup> day worship of the Goddess of Fortune. Her husband did not talk about any problems that his wife had during her delivery.

Her husband when asked to narrate about the delivery details of his wife said-

*"She delivered at home, actually she was on her way to the hospital, but she delivered there in a tempo. So they brought her back home. Her grandmother was with her. I came know within 1-2 hours and mother was there. I went there immediately in the evening."*

When asked about what discussion he had with his wife, he said,

*"I asked her about, "When did your stomach start paining? At what time?" It started since previous night. Which vehicle was arranged, who all were there? Where was the delivery conducted? She said on the way she delivered."*

*Everything was normal..she and the baby, it was a baby girl.”- A 32-year-old farmer studied up to 9<sup>th</sup> standard and additionally working in a private company.*

There were little less than ¼<sup>th</sup> of the women who experienced side effects or problems such as having abdominal pain or vaginal discharge after using an Intra Uterine Device (IUD) or condom (by husband). In one case the woman narrated having conception due to misplaced IUD. There was discrepancy in the responses from men about their wives' experience of contraceptive devices.

A man narrated about his wife having problem with use of an IUD-

*“I used condom..may be for a month. But then I stopped it..just. Then she went and got a Cu-T [IUD] inserted. She had it almost for two years. But then it had gone ‘inside’ and ‘damaged’ her so she went and removed it. Then she conceived within few months.”- A 32-year-old graduated man looking after his farm and plant nursery, also a former political leader of the village.*

However, his wife narrated about her husband having problem of premature ejaculation.

*“Earlier he tried using condom. I was okay with that. There was no problem for me. But he had problem with that. He had “heat” in his body. So while putting it on, “it” [penis] would become “small”. So he stopped using it and there was no problem with “heat”. Then I put Cu-T and there was no problem. I had it almost for two years and then removed it. I did not have any problem with it.” A 26-year-old housewife studied up to 10<sup>th</sup> standard from an extended family.*

Lastly little less than ¼<sup>th</sup> of the women narrated about symptoms suggestive of Reproductive Tract Infections- such as irregular menses, vaginal discharge, burning micturation and vaginal prolapse. But these data are only based on the narratives from the women and there is no clinical verification available for the same. Except one woman, who had vaginal prolapse, the others mentioned about talking about this with their husbands. However, in most of these couples, there was discrepancy in the responses from women and their husbands. In some cases the husbands did not mention at all about wives' health problems, whereas some husbands responded differently about description of symptoms and / or treatment seeking of their wives. Following is the narration from the woman who had vaginal prolapse-

*“During my first delivery, I had stitches. But they were wrongly put. That place was left out open and the stitches were put in a wrong place. Since then I am having this, it comes out [pointed towards vagina-prolapse]. It is not much,*

*only when I sit on two legs..while working or washing clothes, it sometimes comes out. Sometimes I have discharge but not too often. There is no other problem. He does not know this. I feel awkward to tell him. I don't know how to tell him! Not that he will say anything but, I have not told him yet. I have only talked with other women around. They say I may need to remove my bag [uterus-hysterectomy]. I don't know. I will tell him sometimes. He has not yet understood...it is not much. So.....”-* A 24-year-old housewife studied up to 7<sup>th</sup> standard living in a nuclear family with her husband and two sons.

Her husband's narration about his wife's delivery-

*“She went to her natal home in the 6<sup>th</sup> month [of her pregnancy]. She had her delivery at home. I went to see her on the third day. What to do! People at home, went there turn by turn, so I went on the third day. First my father went, then my brother and then me. Somebody had to be home to look after the farm and the house. I went there, asked whether everything was fine. People at home, means her parents and all said that there was no problem, so I left from there. [Interviewer-Did you talk to her?] No, her house was small. And there were other elder people at home, so even if I wanted to talk to her, it would not be possible. Later, my father decided to bring her back after a month and a week and he went to bring her back.”*

During the discussion about sexual relationship he said,

*“We have it only when she has the ‘mood’. If she says, ‘No’, I don't force her.”-* A 30-year-old man working in a private company studied up to 7<sup>th</sup> standard.

## **7.7. Discussion**

The data clearly points out towards discrepancy in the narrations of men as well as women about experience of reproductive or sexual health problems. Blanc (1996) reviewed couple studied related to reproductive health and stated that concordance between partners on subjective matters is in the range of 60 to 70 percent. There are various possible reasons that could explain the discrepancy. Of course, one cannot overrule the possibility of recall bias on part of one of the partners or unfelt need to disclose about partner's health problem by the respondents. But more importantly, it is essential to look at these discrepancies in the context of the knowledge, cultural norms about communication and behavior and gender based stereotypes. The present study population represents a patriarchal male dominated society, where couples are rarely

encouraged to have open discussion about their reproductive or sexual health matters. Researchers have pointed towards gender stereotypes in sexuality affecting reproductive and sexual health in various ways in India and elsewhere (Verma and Mahendra, 2004; Currie & Wiesenbergs, 2003; WHO, 2002). As Becker (1996) mentioned possible reasons for incorrect responses between husband and wife on issues such as spontaneous abortions may be that husband was not informed about all such events. Hence, the discrepancy in the narrations may be an outcome of lack of communication between married partners because in this study the researchers had no opportunity to verify from the husbands about whether their wives had communicated about their health problems to them. Lack of communication about such issues can be due to individual and collective perceptions about the symptoms of possible RTIs, cultural norms about acceptable behaviors of men and women, and gender- and non-gender-based inequalities as was studied among rural couples from Tamil Nadu (Santhya and Dasverma, 2002).

However, there is a possibility that there was malfunctioning in the communication between the respondent and the researcher, resulting in the discrepancy in the data from husband and wife. In the present study, we try to synthesize possible reasons behind differential narrations with the help of the following diagram.

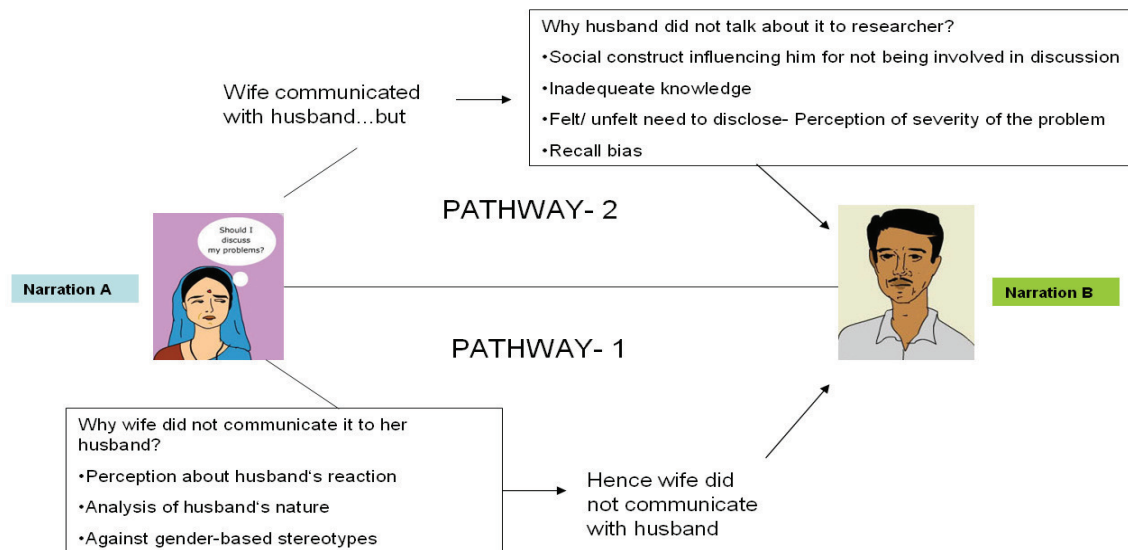


Figure 7.1- Possible reasons for differential narrations from husband and wife about wife's reproductive health problems

The diagram 7.1 attempts to present two different pathways which could result in having differential narrations from husband and wife about an event, in this case reproductive health problem experienced by wife.

The Pathway-1 is that wife does not communicate about her problem to husband and hence obviously, husband does not narrate anything about it. There can be various reasons grounded in her individual characters such as perceived fear about husband's reaction, or biased analysis about husband's nature, inadequate knowledge about the problem and its seriousness; and about the need to communicate it to her husband; or it could be driven by social norms or gender-based stereotypes for example, as one of the women in the study said- "*How would a man understand anything about bleeding and clots!*" Based on the qualitative data from rural women in South India, Santhya and Dasverma (2002) similarly construed that lack of communication between husband and wife may be consequence of individual or collective perceptions about the causes of symptoms of RTIs, cultural norms about acceptable behaviors of men and women, and gender and non-gender based inequalities. Hence, this pathway, may be an outcome of the prevailing 'culture of silence' or differential gender norms for men and women as stated by Ramasubban (1995), operating unfavorably for women.

The Pathway-2 is based on the response of the wife that she has discussed her reproductive health problem with her husband. Studies have reported that women do discuss about their symptoms with their husbands (Patel, 1994 and Oomman, 2000). However, the husband communicated or narrated about it to the researcher differently. In this case as well, there can be some individual related factors such as inadequate knowledge about the health problem or differential perceived severity of the problem and hence the unfelt need to communicate the same to the researcher. Differential response from husband may be out of recall bias on his part; or the social construct that influences men, generally for not getting involved in reproductive health related discussions, because in India male involvement in reproductive health is still a nascent phenomenon (Apte, 2000; Khan and Panda, 2004).

This diagram needs to be further discussed in the context of 'communication' as a process, between the spouses or between one of the spouses and the researcher. This diagram can be compared with the 'Communication Square' by psychologist and communication expert, Schulz (1981). He describes four components of communication-



matter, relationship, self-revealing and appeal. Hence in this case, in either of the pathways, there could be differential understanding about the matter, context, appeal made by the sender to the receiver while receiving the message or the underlying relationship between the sender and receiver (wife to husband, or husband to researcher). Schulz further describes that such differential understanding between sender and receiver can malfunction the interpersonal communication.

Applying this model to some of differential narrations in the present study, probably explains '*Why a woman was apprehensive about discussing her vaginal prolapse with her husband?*' Santhya and Dasverma (2002) found that rural South Indian women had various perceptions about their husbands' reactions on disclosure of symptoms, as was this woman. As Friedemann says, communication of these women with their husbands may have been affected by their understanding of self-revealing and the consequence of appeal they make through the communication.

In another case, the young man was not supposed to meet his wife for five days after her delivery. This man stated that his wife had no problem during her delivery; whereas she narrated experience of tear of vagina. This difference in his narration can be out of recall bias, or lack of knowledge about the symptom or its seriousness<sup>30</sup> or as a consequence of the traditional practice of men being absent during birth of the child as wife goes to natal home for delivery, as was also found by Barua (2006) in rural Maharashtra.

A similar approach is explained by Klisch et al (2007) who conducted a study in Bolivia which is geographically and culturally the most diverse countries in Latin America. The researchers synthesized the experience of partner notification among Bolivian women having Syphilis. Based on Zimmerman (1995) framework, the researchers stated that there are various components such as intrapersonal, interactional and behavioral which may affect the notification. Similar to the present study, Klisch et al (2007) stated that interactional component of this framework, focused on two reasons affecting notification,

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<sup>30</sup>The men's report for Maharashtra, based on the National Family Health Survey-III in 2005-06, states that , to about 46% of men from rural area health providers had ever told about '*what to do if the mother had any pregnancy complication*'. However, this percentage was as low as 24% and 27% in case of telling men specifically about convulsion and vaginal bleeding as signs of pregnancy complications, respectively.



first being the woman's analysis about her partner and second being the social constructs.

### **7.8. Conclusion**

Husband-wife communication about wife's reproductive health problems is a key strategy to fostering shared decision-making and responsibilities on reproductive health matters (Santhya and Dasverma, 2002). Differential narrations of husband and wife about wife's reproductive health problems can be on various grounds of individual and collective or societal norms. Analysis and synthesis of such differential narrations should be the foremost step before arriving at strategies to improve couple communication or partner notification. The diagrammatic representation of two pathways in the present study is just an attempt in this direction and large scale population based research may help in converting it into a model for describing malfunctioning communication. However, it prompts us while analyzing differential narrations in couples' study to ensure that malfunctioning of communication between the respondent and the researcher is not misinterpreted as lack of spousal communication.

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## Chapter 8

# **Discussion and conclusions**



## **8.1 Methodological issues**

Visuals, certainly add value to the traditional or conventional tools of data collection, if constructed, administered and validated appropriately in the field. This study pointed out that construction of Visually Assisted Interview Guide using hand-drawn illustrations was a multifaceted and multi-stepped process. Starting from selection of form of visual, artist, themes and sub-themes, it expected a detailed thinking from the methodologist around the study subject- objectives, research questions and expected outcome of the study, the social and cultural context within which the study is to be conducted and programme and policy related information about the study subject. There were of course, some issues during administration of the tool in the field, such as importance of appropriate introduction and ensuring appropriate place of interview, before showing the visuals to the respondent, and making essential probing around the visuals based on the responses and reactions of the respondent. Hence, an experienced researcher and interviewer becomes the prerequisite before applying such methodology in any given setting for any research. Validation of VAIG at field level pointed out that, male as well as female respondents, irrespective of their educational and family background, could interpret the visuals and narrated their experiences around couple communication. It helped in conceptualizing the entire process of couple communication in reproductive health within a local cultural context. The respondents were offered essential flexibility while responding to sensitive subjects like sex. The visuals subtracted the respondent and replaced him/her with the individual illustrated and thus provided impersonal yet realistic responses with minimal reservations. Ultimately, respondent's reactivity towards visual methodology was important, but the researcher's experience of using a visually assisted interview guide with the rural couples was definitely encouraging in terms of establishing rapport, eliciting the necessary information and making the respondents feel comfortable.

In this study husbands and wives were interviewed using the same tool. In a society, which is otherwise patrilocal and male-dominated, there is a great deal of gender segregation in terms of thoughts and actions. Traditionally, reproductive health issues are almost exclusively a woman's domain. Hence it was crucial to elicit responses in this subject from men as well as women. Also, there are not many published qualitative studies related to understanding process of couple communication in reproductive health. Of course, there are studies focusing on couples and reproductive health related

issues such as fertility in rural India by Vlassoff and Vlassoff, as early as in 1978 and contraception in Switzerland by Hopflinger and Kuhne in 1983 and studies focusing on differential reporting, narrations, perceptions or experiences of husband and wife in various reproductive health issues (George, 1998; Douthwaite, 1998; Razzaque, 1999). Hence, one of the purposes of interviewing husband and wife was also, to learn about such differentials in the narrations. Also, getting data from both the genders on the study subject was important as the views (and experiences) of both spouses matter and contribute to a fuller understanding of how couples decide on their contraceptive practice (Kulczycki, 2008) or reproductive health in general. Additionally, this approach had implications during fieldwork and data collection; because men and women felt equally important as respondents for giving an interview about their reproductive health communication and experiences.

## **8.2 Overview of findings**

Communication of couples, in reproductive health related subjects is discussed in four chapters written as research papers- fertility and planning parenthood, sexual relations, childbearing and reproductive health problems. Following is an overview of findings across the four research papers-

**Chapter 3** focuses on couple communication about fertility and planning parenthood at various stages of reproductive life span.

Couples do not really discuss about fertility before having their first child and want to have their first child as early as possible which is linked to the fact that status of the couples, especially the married woman, is associated with her ability to prove fertility at the earliest. Obviously, couples are not expected to discuss spacing before proving their motherhood and fatherhood to the society and start talking about it only after they have their first child, irrespective of whether it is a boy or a girl.

Secondly, husbands are not necessarily the ones who prefer to have more children and at times, are convinced by wife or mother to have more children<sup>31</sup>. Also, the mother-in-law seems to play a crucial role in a couple's life, deciding about induced abortion as a

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<sup>31</sup> National Family Health Survey-III- Total wanted fertility rate for rural Maharashtra is 1.79



method of family planning. It shows that despite the secondary status of women in the society, fertility being a women's domain, women rule the decision-making<sup>32</sup> which was supported by key informants' interviews conducted in the preparatory phase of the study and also reported in other settings such as rural Tamil Nadu, India (Ravindran and Balasubramanian, 2004) and rural Mali (Madhavan, Adams & Simon, 2003). High fertility is found to be a preference of women, especially the elder women in the family and though couples communicate about their intentions of having small family they are not able to translate it into reality without consent from them. The study thus emphasizes the importance of involving elder family women in the family planning initiatives which primarily promote small family norm.

**Chapter 4** highlights couple communication and behavior about sexual relationships in relation to existing gender stereotypes.

The study shows that married women hesitate to take initiative in sex, though few of them have occasionally attempted this and are supported by their husband. There are various reasons behind this, such as stereotypes around male and female sexual behavior and the belief that within married unions, sex is a male prerogative and women should not express desire for sex (Goyal, 2002). Women are expected to be a passive partner in sex (Isiugo-Abanihe, 2000; Khan, 2001; Ghuman, 2005; Garg and Sharma, 2006) and this study shows that they are not the sole decision maker in this regard. However, it is important to note that despite all the values and stereotypes attached to women taking a lead or active role in sex or even being expressive about sex, almost one-fourth of the women in the present study express their desires to have sex to their husbands, and more than two-third of the couples experience mutually consented sex.

Secondly, women talk about having sex against their wish as different from having forced sex. Having sex against their wish arises out of non-communication about unwillingness on women's part which results out of their perception that sexuality should be controlled by men as was also found by Goyal (2002) or out of submission under pressure to demand for sex from husbands as discussed by Jejeebhoy and Bott (2006).

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<sup>32</sup> Generally in the kinship oriented family, women's status follows a trajectory of having no status to high status, with various milestones indicating rise in the status. The first milestone is when she proves her fertility. Her status is further elevated when she gives birth to a male child. Lastly, when her son gets married and she becomes the 'mother-in-law', she almost acquires the status as that of the father-in-law or the head of the household

Whereas, there are few women in the study, who narrate experience about forced sex in spite of communicating to their husbands about unwillingness for the same. In this case, their husbands have presented different and atypical characters regarding their masculinity and have discrepancy in their narration of sexual experience with their wives. The study thus confirms the need for carefully categorizing or labeling sex as 'non-consensual' or 'forced sex' and having detailed analysis of sexuality and sexual experiences of men as well as women.

The third important finding in this paper details out various reasons initiated and communicated by men or women about following sexual abstinence. Women have suggested sexual abstinence on religious grounds, which indicates their adherence to the traditional practices. However, it is important that men have shown respect towards this desire and suggestion from their wives hinting towards the change. On the other hand, men have initiated abstinence for reasons such as family planning and have preferred the same over modern contraceptive method (Ravindran and Balasubramanian, 2004). Abstinence for other reasons such as during pregnancy or postpartum is mainly decided by elder women in the family. Not many published studies are found on sexual abstinence in the rural married population in India and further investigation is necessary to understand various reasons for following abstinence, the decision-making and its consequences such as probability of high-risk sexual behavior during postnatal abstinence period as is pointed out by Ali and Cleland (2001)

In conclusion, women mostly do not act as lead or active partner in sex within marriage; but they take occasional lead in initiating sex and most of the times, have sex upon mutual agreement with their husbands. This is a process of sharing power in sexual relations that has begun recently. In other words, rural married women challenging the tradition of power relations favoring men, and attempting to express their sexuality, is a promising and positive sign of approaching positive reproductive health. Attempts should be made to build on this process of change, towards having open communication between husband and wife, so as to make their sexual life enjoyable and to address their reproductive health needs.

**Chapter 5** is about learning couple communication and behavior regarding childbearing against the backdrop of traditions.

The first important finding against the backdrop of tradition of 'not seeking any medical help during pregnancy or childbirth' is that all women in the study sought antenatal care and almost half of them had institutional deliveries. This changed behavior suggests increased possibilities of communication between spouses on these issues.

Secondly, couples present differential patterns in terms of following traditions or departing from the same, in different areas of childbearing. In issues such as seeking antenatal care, taking care of wife during pregnancy, decision about sending wife to her natal home for having delivery and post-natal communication with wife, couples tend to depart more from the traditional practice of restricted communication. Similar to other studies (Turan et al, 2001; Mullick et al, 2003; Barua, 2006), men were supportive and interested in their wives' well being during antenatal and postnatal period and actively discussed about care with them, though the extent of their involvement is not the optimum and there is still scope to improve the same. The study hints towards the fact that, men engaged in non-farm (which is the traditional occupation) show relatively more departure from traditions and are more communicative with their wives around these subjects. Probably, there are other reasons such as increased access to resources, economic opportunities, or programmatic efforts that contribute to increased couple communication and change in their behavior regarding reproductive health, but needs to be studied further. However, this changing pattern, for example, men accompanying wives during antenatal care, should be viewed as a possible opportunity for strengthening couple communication in reproductive health.

On the other hand, the third important finding is that in other specific areas of childbearing, couples still follow the traditional practice of restricted communication; and family network and traditional norms influence the same. These issues are disclosure of pregnancy, duration of woman's stay at natal home and decision about choosing place of delivery. Traditional norm of discussing reproductive health only among women and restrictions on newly married couples for having open communication, seemed to affect woman's communication about disclosure of pregnancy. Women have mostly discussed it with the mother-in-law and husbands are less involved in this matter. Other areas, where couples have followed traditions are, when the woman visits her natal home for having delivery. This traditional norm reduces opportunities of couple communication during this period, though some of them had sporadic communication over telephone. The issues such as duration of her stay at natal home, choosing the place of her delivery

and dealing with complications around delivery, if any, continue to be discussed and decided among elder family members and husband has no substantial role in this regard. Reasons of men's absence from routine care can thus be 'wife going to natal home for delivery' and existing perception that this issue is in women's domain (Barua, 2006). Also, men though interested, are not encouraged to be involved during childbirth, as was also seen in Zulu community in South Africa (Mullick et al, 2003). Role of mother-in-law (Chowdhury, 2003) and the woman's parents; and the traditions is more influential for young couples during this period.

In conclusion, the paper highlights that married couples struggle between following traditions and adapting change in relation to childbearing, especially in a patriarchal society, where reproductive health is still a women's domain. In spite of men's desire and efforts to be involved in communication and behavior related to childbearing, traditions and family network play an active role in some areas of childbearing. Hence, research and interventions attempting to achieve reproductive health outcomes such as increased institutional deliveries, Emergency Obstetric Care, improved postnatal care as well as postnatal counseling for contraception, should give due consideration towards the continuing influence of family network and traditions on young couples.

**Chapter 6** is a working paper which focuses on the differential responses of husband and wife about wife's reproductive health problems.

The data clearly reveals a discrepancy in the narrations of men and women about reproductive or sexual health problems in women. There are various reasons that can explain the discrepancy and the paper attempts to analyze the same on two different pathways. First one relates to the possibility of lack of communication between the woman having reproductive health problem and her husband. This can be a result of individual and collective perceptions about the symptoms of possible RTIs, cultural norms about acceptable behaviors for men and women, and gender- and non-gender-based inequalities (Santhya and Dasverma, 2002).

Some women in the study have communicated their reproductive health problems to their husbands and the second pathway describes reasons behind discrepancy in the narration of husband and wife, despite the issue being communicated between them. There can be reasons such as inadequate knowledge about the health problem,

differential perceived severity of the problem and hence the unmet need to communicate the same to the researcher or just a recall bias. However, it can also be the social construct that influences men, generally for not getting involved in reproductive health related discussions, because in India male involvement in reproductive health is still a nascent phenomenon (Apte, 2000; Khan and Panda, 2004).

These findings are then compared with Schulz (1981) Four Square Model of Communication, which describes that such differential understanding between sender and receiver can malfunction the interpersonal communication.

In conclusion, differential narrations of husband and wife about wife's reproductive health problems can be on various grounds of individual and collective or societal norms. Analysis and synthesis of such differential narrations should be the foremost step before arriving at strategies to improve couple communication or partner notification and this paper with two pathways of communication and comparison with Schulz's (1981) model, prompts us to ensure that malfunctioning of communication between the respondent and the researcher is not misinterpreted as lack of couple communication.

### **8.3. Study findings in the national and international context**

The present study was conducted in a rural set up of Pune District and the study sample represents a patriarchal, kinship-oriented, agrarian community of Western Maharashtra. Even today almost 72% of the Indian population is rural (Census of India, 2001) and most of the rural communities in India are patriarchal, kinship-oriented, and agrarian, in spite of the religion and caste differences across various regions and states. Compared to earlier generations, young people in India are healthier, more urbanized and better educated than ever before (Santhya and Jejeebhoy, 2007) and the study shows that young couples are engaging themselves more and more in the shared decision-making about their reproductive life. Involvement of men in discussion and decision-making about reproductive health, as the study shows, (also Varkey, 2002; Barua, 2006), should be appreciated in the existing patriarchal system all over India, which is known to have important implications for the reproductive health behavior of the males (Koenig and Foo, 1985) and consequently of the couples. For a long time, studies in India have mentioned the subordinate role of women, control of men, constraints and inability to negotiate their reproductive and sex life and access reproductive health services (Raju

and Leonard, 2000; Apte, 2000; Ravindran and Subramanian, 2004; Garg & Sharma, 2006). Present study challenges these commonly studied findings, favoring one particular gender and it confirms that young couples are changing in terms of being more supportive and concerned about each other's health desires and goals. However, it should only lead to interpret that it is the beginning of a process of change and there is still a long way ahead to go, because family network, gender-based stereotypes, traditions and culture, continue to influence young couples, though to varied extent.

Further, the pace of this process of change will differ in various rural communities of India having diversities in terms of health services, health programmes, presence of NGOs and women's empowerment movements. Consequently, young couples' health behavior and communication is expected to have variations across various settings. Hence, projections based on one such research may not be applicable for the entire rural population of India. But one can expect positive change in couples' reproductive health behavior and communication in most of the young population (Santhya and Jejeebhoy, 2007), though with different pace.

Researchers, especially in reproductive health, have always stated the importance of understanding socio-economic and cultural antecedents in different settings (Jejeebhoy, 1995) and context (Cleland, 2006) for successful implementation of programmes and evolving policies. Hence, in a diverse population as that of India, there is always a need for community-based in-depth studies such as this, to capture local realities to design feasible and sustainable reproductive health strategies.

The changing trend about couples communicating about reproductive health and taking joint decisions about the same, is seen also in other settings in the world, such as Japan (Ogawa and Hodge, 1999), Sri Lanka (De-Silva, 2000) and Turkey (Kulczcki, 2008). With the positive trends in the study in terms of male involvement and couple communication, the control of the family network on the young couples should not be underestimated. Though to lesser extent, than was documented in 1996 (World Bank), there is still a tendency to limit communication between spouses, which is asserted through the type of residence and family network or in-laws. In many other kinship and family-oriented societies, spousal discussion is discouraged. In-laws, mostly act as conduits through which partners can exchange ideas (Ezeh, 1993; Blanc, 1996 and Castle et al, 1999), act as gatekeepers in fertility decisions (Madhavan, Adams & Simon,

2003) and object young women for seeking health care during pregnancy (Chowdhury, 2003). Women in the present study have attempted to express and communicate their sexuality to their husbands. Such communication is likely to promote gender equality in control over sexuality between married partners (Wusu and Isiugo-Abanihe, 2007) and hence these findings should be valued against existing gender power relations.

#### **8.4. Conclusion**

This exploratory qualitative study represents a rural, kinship-oriented, agrarian society of Western Maharashtra, where family and traditions play a crucial role in couples' married life, from arranging marriage to decision-making in all the life events. Though the couples in the study communicate about reproductive health issues and men attempt to get involved in it, they are not always able to translate communication into behavior change, in their compulsion to respect family, traditions and culture. The study projects that for young rural married couples it may be challenging to follow traditions and yet adapt to change. It therefore becomes important to understand the entire process of social change, particularly in the area of reproductive health. Couple communication may have a cascading effect on larger health and social issues like family health, sexual and domestic violence and healthy marital relationship and thus should be understood in any given society, in its totality. It is definitely important to promote couple communication about reproductive health, but equally important is to create an enabling environment for them to do so and take informed decisions in a mutually shared manner. As ICPD defines- '*Reproductive health implies that people .....have the capability to reproduce and the freedom to decide if, when and how often to do so.*' However, unless the existing couple communication is studied as a 'process', efforts to improve the same may not be constructive enough.

#### **8.5. Further areas for research**

The study aimed to understand the process of couple communication in reproductive health in its totality and has created platform for further research in this area on the following issues-

A study designed to understand the perspective of the health care providers about couple communication and behavior, will be useful to suggest improvement at



programme level- for example, experiences of grass-root health worker regarding couple communication around contraceptive use, experiences of health providers about partner notification in case of reproductive health illness and interactions with men during antenatal or post natal visits.

Present study has limitations in drawing conclusive statements about determinants of couple communication, though it hints towards factors such as husband's occupation, and influence of family. Hence, large-scale and multi-centric studies are invited to derive models to measure couple communication in reproductive health and arrive at determinants that will help to improve the same.

Couple communication does not always get translated into behavior change, as present study has shown. But, further research can help in testing this hypothesis with justifications, for identifying the barriers in this translation.

### **8.6. Implications for the public health and reproductive health in local setting**

There is absence of documentation that describes the initiatives to build egalitarian relationships among young couples or measures that would clearly have implications for sexual and reproductive health in India (Santhya and Jejeebhoy, 2007). However, at Maharashtra state level, there is a planned activity mentioned about conducting rallies (*melava*) for mothers-in-law, daughters-in-law, sisters-in-law and the newly married couple to improve the homely environment so that the beneficiaries can utilize the Reproductive and Child Health services (State PIP, 2008-09). The present study findings can provide some leads in designing concrete initiatives and strategies for young married couples- for example, preparing counseling material around sexual abstinence method for various reasons, providing knowledge about reproductive health problems and illustrating importance of sharing sexual desires, needs and expectations.

The study recommends that existing involvement of men in reproductive health, for example men accompanying wives during antenatal care, should not only be welcomed by the programme and but further utilized as opportunities to build their skills in communication and motivate them to be more supportive towards their wife to have a share in decision-making.



Also the study reconfirms that a couple-targeted approach to achieve the desired reproductive health outcome, may not always work, considering the impact of family network on young married couples in issues such as fertility. Hence, it recommends that tailoring locally suitable strategies focusing on the young couples, without ignoring their family, may work better to achieve their 'targets'. For example- having interactive sessions with the mother-in-law at an individual level and conducting community-level campaigns for motivating mothers-in-law to be supportive towards the young couples.



## Chapter 9

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## Chapter 10

# Curriculum Vitae





**Shilpa Santosh Karvande- (Maiden name- Shilpa Raghunath Walawalkar)**

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**Date of Birth:** 02. 11. 1971  
**Marital status:** Married  
**Nationality:** Indian  
**Languages known:** English, Hindi, Marathi (Mother tongue)

**Education qualifications:**

<b>Year</b>	<b>Duration</b>	<b>Name of the diploma /degree</b>	<b>University</b>
2000	4 months	Health Care & Management in Tropical Countries	Swiss Tropical Institute, Basel
1999	1 year	Family Health and Counselling Correspondence course	Marie Stopes, London
1994	2 years	Masters in Science with Anthropology (Including Medical Anthropology)	University of Pune, India
1992	3 years	Bachelor of Science with Zoology (Including Botany and Chemistry)	University of Pune, India

**Work experience:**

Year 2001- till date Working as a course facilitator for the Health District Management course in Swiss Topical Institute, Basel, Switzerland (The course is held every year in the month of June). The course is about designing health related project proposal in resource poor settings. It is an interactive module for participants from all over the world.

Year 2006- till date Working with Maharashtra Association of Anthropological Sciences (MAAS) Pune as a Research Associate for DFID Funded TARGETS Consortium in collaboration with London School of Hygiene and Tropical Medicine. Currently working on various projects on communicable diseases in different parts of India.

Year 2003- 2005 Free Lance Consultant for various projects on reproductive health –HIV, RTI/STDs- in terms of designing proposals, research methodology, qualitative data collection and analysis, curriculum planning for training of community volunteers, designing data collection tools for reproductive health related communication etc.

Year 2000-2002 Project co-investigator for a study on Reproductive Health Education for married couples in rural India, coordinated by ICRW and funded by Rockefeller Foundation. Responsibilities in this study involved training rural volunteers for reproductive health education, counselling the couples for various reproductive health problems and preparing the training

- Year 1998-2000 curriculum for the rural reproductive health educators, capacity building of local resources and support for project report  
Research Officer for a study on Domestic violence and reproductive health in rural India- a study by Ford Foundation. This study involved qualitative research – interviews of 100 women and 60 men in villages around Pune city, Maharashtra, India. Key tasks handled during this project were training of field investigators for qualitative data collection tools, sensitisation of field investigators for reproductive and sexual health related issues, inputs for data analysis and report writing
- Year 1995-98 Research Officer for a behavioural study on Induced abortion in Rural India- a study by Ford Foundation. This study was carried out in three districts and involved interviewing women who had abortion, the providers of abortion from formal as well as informal set up and the husbands and other family members.
- Year 1994-95 Research Assistant for a project on Women and Leprosy: Gender Based study funded by WHO. This study was carried out in four districts in urban, rural and tribal area. It gave insights on women being doubly jeopardized, on the grounds of gender and illness. Various problems faced by women, who were staying at home, who were deserted and were staying at leprosy homes, or leprosy colony were studied in details.

**Conferences:**

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1. Ganatra, B., Hirve S., Walawalkar S., Garda L., Rao V.N. (1998) Induced abortions in a rural community in Western Maharashtra: Prevalence and patterns, KEM Hospital Research Centre, Pune (Unpublished).
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# Chapter 11

## **Annex**



### **11. Annex- Visually Assisted Interview Guide (for women)**

(Similar guide was prepared for men with necessary changes. The original guide was prepared in local language Marathi. It has questions/ probes constructed in informal way, for easy administration in the field. The guide attached here as an annex, includes English translation of the questions for the understanding of the readers.)

# Process of Couple Communication in Reproductive Health among Married Couples in Indian Society

Ph.D.

**Shilpa Santosh Karvande**

University of Basel and Swiss Tropical Institute  
Basel, Switzerland

October 2005

# Couple communication in reproductive health

## Visually Assisted Interview Guide

### Interview schedule for female respondents

*(Instruction- Probe with the given set of questions only when applicable and necessary)*

#### Introduction:

सुखी वैवाहिक जीवन, वैवाहिक जीवनातील नातेसंबंध, संभाषण, आरोग्यासंबंधी आपण बोलणार आहोत. विवाहित जोडप्यांचे आयुष्य जास्तीत जास्त सुखी होण्यासाठी काय गोष्टी आवश्यक आहेत त्या दृष्टिकोनातून हा अभ्यास आहे. पती पत्नीच्या आयुष्यातील वेगवेगळे महत्वाचे विषय आपण बोलणार आहोत- जसे गरोदरपण, मूल होणे, आरोग्य, वैवाहिक संबंध आणि महत्वाचा विषय म्हणजे लैंगिक विषय. आपण अगदी मोकळेपणाने बोलावे अशी इच्छा आहे. वेगवेगळी चित्रे आपल्याकडे आहेत त्यांचा आपण चर्चा करताना उपयोग करून घेणार आहोत. आपण पती पत्नीचे एकमेकांशी होणारे संभाषण, बोलणे, वेगवेगळ्या विषयांवर चर्चा करणे कसे असते हे बघणार आहोत.

### 1. Demographic details

1.1 Age	
1.2 Education	
1.3 Occupation	
1.4 Religion	
1.5 Caste	
1.6 Place of residence- (village proper/ hamlet)	

### 2. Family details

Native place:

#### About her current family

##### 2.1 Type of family: nuclear, joint

## 2.2 Details of family members:

Sr no.	Relation with the respondent	Education	Occupation
1			
2			
3			
4			
5			
6			
7			
8			

### Derived information from the above table:

2.3 Total No. of family members (including children): \_\_\_\_\_

2.4 No. of married couples residing in the same household: \_\_\_\_\_

### 3. Marriage details

3.1 Age at marriage \_\_\_\_\_

3.2 Type of marriage- love marriage/ arranged marriage \_\_\_\_\_

3.2 If arranged marriage- by whom and how?

3.4 Role of the respondent and her partner

### 4. Household information

Head of the household: \_\_\_\_\_

Decision making power /status of the respondent and her partner

5. No. of rooms

### 6. Reproductive/ Obstetric history of the respondent

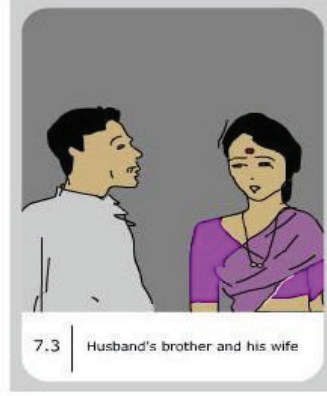
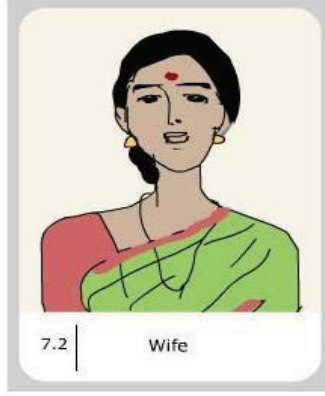
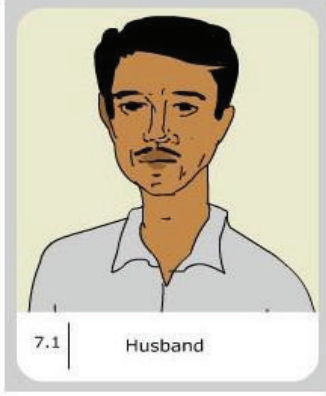
6.1 No. of pregnancies- \_\_\_\_\_ 6.2 No. of children live \_\_\_\_\_

6.3 No. of abortions \_\_\_\_\_ 6.4 No. of miscarriages \_\_\_\_\_

6.5 No. of still births \_\_\_\_\_



## 7. General communication



7.1 How is your spouse- by nature, way of talking, behavior, hobbies, likes and dislikes, any addictions?

कसे आहते तुमचे मालक ? (बोलणे, वागणे, आवडी निवडी, सवयी, व्यसन ?)

7.2 How are you- by nature, way of talking, behavior, hobbies, likes and dislikes?

तुम्ही कशा आहात ? (बोलणे, वागणे, आवडी निवडी, सवयी)

7.3 If husband's brother is married-

Do you all stay together? If yes, the way both of them-husband's brother and wife talk to each other, or behave with each other, does it affect you? If yes, how?

दीर-जाऊ (असल्यास)

एकत्र राहता का ? त्यांच्या एकमेकांशी बोलण्याच्या पद्धतीचा, एकमेकांशी वागण्याचा तुमच्यावर कधी काही परिणाम होतोका ?

## 8. Pregnancy, delivery, planned parenthood

गरोदरपण, बाळंतपण, पाळणा लांबवणे हे विषय आपण आता बोलणार आहोत. असे असते की बायकांचा विषय- पण तरी देखील या विषयात घरात काही ना काही चर्चा होत असते. आहार, औषधपाणी याबद्दल प्रत्येकाची वेगवेगळी मते असतात. नवरा बायकोची किंवा सासू-सुनेचे काही तरी बोलणे होते. तुमच्या घरात सुद्धा त्यावेळी काही तरी बोलणे झालेच असेल- दवाखान्यात जाण्याबद्दल, डोस घेण्याबद्दल किंवा डिलीव्हरी कोठे करायची त्याबद्दल. तर आपण गरोदरपण या विषयापासून सुरुवात करू



### 8.1 Care during pregnancy- immunization, diet and medicines

Pregnant woman is shown in the picture and also about her care during pregnancy. In such subjects, when you were pregnant what would you discuss with your husband? With whom would you talk about what you should eat, what not and which medicines you should take etc.? What would your husband talk to you?

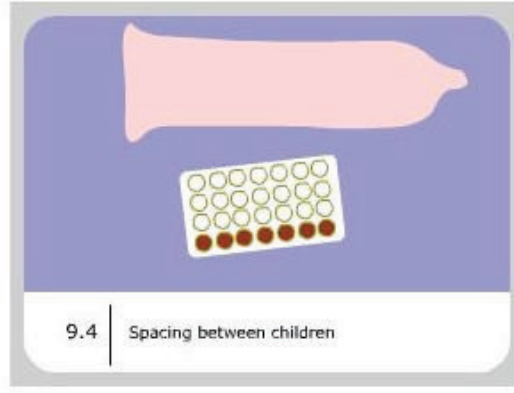
गरोदरपणातील काळजी-लस, आहार, औषधे

चित्रात गरोदर बाई आणि तिची काळजी दाखवली आहे-खाणेपिणे, औषधपाणी, दवाखान्यात जाणे. या विषयात तुम्ही गरोदर असताना मालकांशी कायकाय बोलणे व्हायचे? काय खायचे, काय नाही, कोणकोणती औषधे घ्यायची हे कोणकोणाशी बोललात? मालक तुमच्याशी कायकाय बोलायचे?

### 8.2 A woman who has delivered a baby is staying at her mother's place (normal practice in India) Husband has come to meet her and asks her, "When will you come back?" When you had your baby (first, second...) for how many days did you at your mother's place? Who decided on that? What did your husband say in relation to this? (If she has not gone to her mother's place- why not? What was husband's opinion?)

बाळ झालेली बाई आईकडे-नवरा भेटायला- तिकडे कधी येणार परत?

तुम्ही बाळ झाल्यानंतर पहिल्या वेळेस, दुसऱ्या वेळेस किती दिवस माहेरी होतात? ते कोणी ठरवले? मालक काय म्हणाले या सगळ्या बाबतीत? माहेरी गेला नाहीत तर का? मालक काय म्हणाले?



8.3 Where to have delivery? At mother's place or here? Should you register yourself for ANC in a hospital? All these issues- with whom did you speak? Who decided what is to be done? What did your husband say?

डिलीव्हरी कुठे करायची? आईकडे का इथेच? दवाखान्यात नाव नोंदवायचे का? हे तुम्ही कोणकोणाशी बोलतात? कोणी आणि कसे ठरवले? मालकांचे म्हणणे काय होते?

8.4 Spacing between children

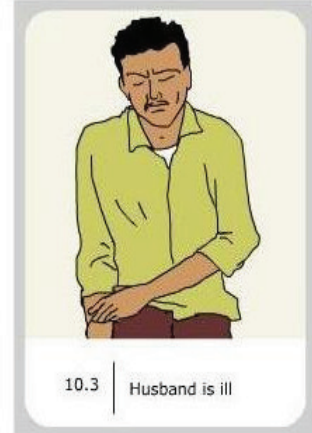
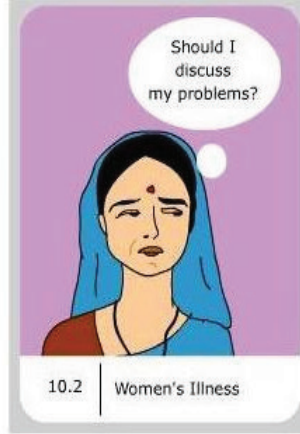
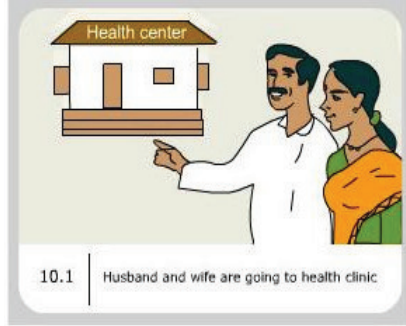
Since marriage, till now, have you spoken about spacing? Who spoke (you, husband or some other family member on behalf of you etc.)? Who speaks more in such subjects? (Ask for after marriage, after first child, after second child etc.) What was your opinion? What was your husband's opinion? Finally who took the decision?

पाळणा लांबवणे

लग्न झाल्यापासून आतापर्यंत पाळणा लांबवणे या विषयावर बोललात का? कोण बोलले? या विषयात कोण जास्त बोलता? लग्नानंतर लगेच, पहिल्या बाळानंतर किंवा त्यानंतर? तुमचे काय म्हणणे होते? मालकांचे काय म्हणणे होते? शेवटी कोणाचे म्हणणे चालले?

## 9. Reproductive health problems and treatment seeking

माणूस म्हणले की तब्येत कधीतरी कमी जास्त होते, काही ना काही त्रास होतो. पुरुषांचे म्हणून काही आजार, त्रास असतात आणि काही आजार हे बायकांचे असतात. काही वेळेस या गोष्टी मोकळेपणाने बोलल्या जात नाहीत, लाज वाटते. यावर उपचार केले जात नाही, कधी दुर्लक्ष होते. या आजारांचा कधी कधी दैनंदिन जीवनावर, पती पत्नी संबंधांवर सुद्धा परिणाम होतो. तर आता आपण या विषयावर म्हणजे प्रजनन आरोग्य आणि तब्येतीचा त्रास यावर बोलू या. पती पत्नीच्या संबंधांमध्ये दोघांचे आरोग्य चांगले असणे याला फार महत्त्व आहे आणि या महत्त्वाच्या विषयावर पती पत्नी एकमेकांशी किती बोलतात हे समजून घेणे गरजेचे आहे.



### 9.1 Husband and wife are going to health centre

When did both you go to any health center together? Does he accompany you on his own or you have to tell him to come along? What does he generally say about it? If he has some problem and wants to go to hospital, does he tell you?

नवरा बायको दोघे दवाखान्यात चाललेत

तुम्ही दोघे नवरा बायको असे दवाखान्यात एकत्र केव्हा केव्हा गेलात? ते स्वतःहून येतात का तुम्हाला त्यांना सांगावे लागते? त्यांचे त्याबद्दल काय म्हणणे असते? त्यांना काही त्रास होत असेल आणि दवाखान्यात जायचें असेल तर तुम्हाला सांगतात का?

### 9.2 Women's illness

Women may have different illnesses or problems- may be abdominal pain, problems related to menstruation, burning while urinating, white or other vaginal discharge, pain while having sex etc. Sometimes, a woman doesn't even talk about it to her husband. Have you experienced any such problem? What problem?

(If she had/has suffered from any of the above health problem, please ask following questions appropriately depending on the answer to each question)  
When? With whom did you talk about it and how did you communicate? Did you talk to your husband? When? What did you tell him? What did he say on that? What treatment did you have? Did you go to any health provider? Who accompanied you? How was that decided? What advice did the health provider give you? What did your husband say on that? If your husband had accompanied you to the health provider, with whom did the doctor communicate? If husband did not accompany you, after coming home did you talk to your husband about it? When? What? What did he say?

बायकांचे आजार-

बऱ्याचदा बायकांना वेगवेगळे त्रास असतात- या चित्रात दाखवल्याप्रमाणे गोटात दुखतेय/ पाळीचा त्रास होतोय/ लघवीला जळजळ होतेय/ अंगावरून पांढरे जातेय/ संबंधाच्या वेळी दुखतेय वगैरे आणि काही वेळेस असे होते की हे त्रास होतात हे बाई नवऱ्याशी बोलत नाही. तुमच्या बाबतीत यातले काय घडते ? कधी आणि कोणकोणता त्रास झाला होता ? कोणाशी बोललात ? कसे सांगितले ? मालकांशी बोललात का ? केव्हा ? काय सांगितले त्यांना ? त्यावर ते काय म्हणाले ? काय उपचार केलेत ? दवाखान्यात गेलात का ? बरोबर कोण आले होते का ? ते कसे ठरले ? डॉक्टरने काय सल्ला दिला ? त्यावर नंतर मालकांचे काय म्हणणे होते ? मालक जर दवाखान्या बरोबर गेले असतील तर डॉक्टरबरोबर कोण बोलले ? जर मालक बरोबर गेले नसतील तर घरी आल्यावर त्यांना तुम्ही काय सांगितले ? त्यांनी काही विचारले का ?

### 9.3 Husband's illness

Sometimes men have problems such as problem related to urination, or sexual relations etc. at such times, with whom do they normally communicate? Did or does you husband suffer from any problem?

If yes, what happened? How did you come to know? What exactly did he communicate to you? What treatment did you have? Did you accompany him for treatment seeking? What did the health provider tell him? How did you come to know about it? Did he take that treatment completely? During that period did both of you talk to each other about this problem or treatment or provider?

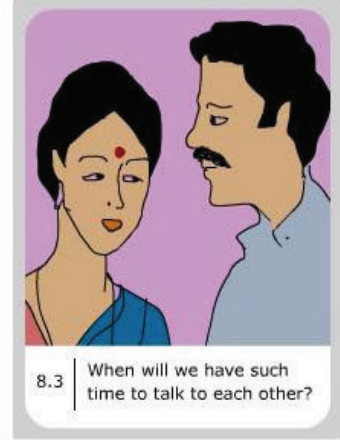
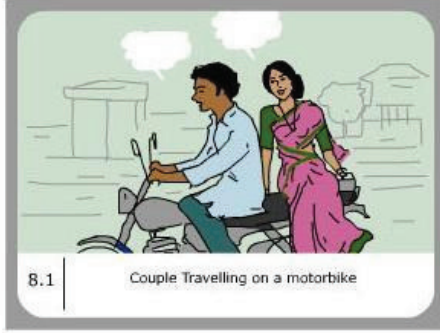
नवऱ्याला आजार-

काही पुरुषांना सुद्धा काही त्रास होत असतात जसे लघवीच्या वेळी त्रास होतोय किंवा संबंध करताना अडचणी येतात वगैरे आणि अशा वेळी पुरुष कोणाशी बोलतात ? तुमच्या मालकांच्या बाबतीत असा अनुभव कधी आला होता ? काय झाले होते ? तुम्हाला कसे कळाले ? त्यांनी त्याबद्दल तुम्हाला काय सांगितले ? उपचार काय काय केले ? तुम्ही बरोबर गेला होतात का ? डॉक्टरांनी त्यांना काय सांगितले ? ते तुम्हाला कसे कळाले ? पुढे उपचार शेवटपर्यंत घेतले का ? त्याकाळात एकमेकांशी त्याबद्दल काही बोललात का ?



## 10. Communication- place, type and time of communication

नवरा बायकोत जे बोलणे होते ते वेगवेगळ्या विषयांवर होते- वेगळ्या ठिकाणी होते, काही विषयांना एकांत हवा असतो, काही विषय सगळ्यांसमोर बोलले जातात. काही वेळेस प्रेमाने संभाषण होते, काही वेळेस वादविवाद होतात. काही गोष्टी दिवसा बोलल्या जातात काही गोष्टी बोलण्यासाठी रात्रीची वाट बघावी लागते. कधी घरात चर्चा होते तर कधी बाहेर फिरताना, काम करताना विषय निघतात. या सगळ्या गोष्टींबद्दल आपण बोलू या.



### 10.1 Couple traveling on a motorbike-

When do both of you travel together- like this on a motorbike or otherwise? At such times, only both of you are together. Taking this opportunity, do you talk to each other about subjects which you normally do not discuss- some sensitive subjects? If yes, what are these topics?

मोटारसायकलवर बसून चाललेले जोडपे

तुम्ही दोघे बाहेर केव्हा आणि कुठे जाता ? या वेळी तुम्ही दोघेच असता. या संधीचा फायदा घेऊन एकमेकांशी असे विषय बोलता की जे एरवी बोलायला मिळत नाहीत-समजा नाजूक विषय ? कोणते विषय ?

### 10.2 Couple working in field

Do you ever work together like this in field? If yes, what subjects do you discuss at such times? Any discussion about sensitive subjects?

शेतात एकत्र काम करणारे जोडपे

अशी एकत्र काम करायची वेळ येते का ? अशा वेळी एकमेकांशी कोणकोणते विषय बोलता ?

### 10.3 Privacy- place for discussing sensitive subjects

Sometimes it happens that husband and wife want to talk to each other about something but they do not get privacy for the same, does it happen in your case? Which are such subjects? Then what do you do?

नाजूक विषय एकमेकांशी कधी बोलणार, एकांत ?

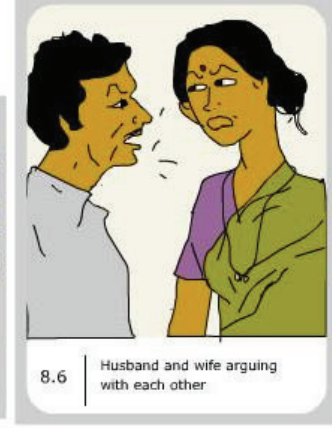
काही वेळेस असे होते की बरेच विषय नवरा बायकोला एकमेकांशी बोलायचे असतात पण एकांत नसतो ? असे तुमच्या बाबतीत घडते का ? असे कोणते विषय असतात ? मग अशावेळी काय करता ?



8.4 Husband and wife are chatting



8.5 Communication before and after having children



8.6 Husband and wife arguing with each other

10.4 Husband and wife are chatting with each other in the kitchen. What may they be talking? If a couple is chatting like this and may be there are other people in the house in some other rooms, will that affect their chatting? How? Do you experience this? What do you do at such times?

स्वयंपाकघरात एकमेकांशी बोलत बसलेले जोडपे-रात्रीची वेळ-काय बोलत असतील हे दोघे एकमेकांशी ? असेजेव्हा एखादे जोडपे बोलत असते आणि समजा घरातील बाकीची माणसे दुसऱ्या खोलीत आहेत, त्यांच्या बोलण्यावर त्याचा काही परिणाम होईल का ? काय परिणाम होईल ? तुम्हाला असा अनुभव येतो का ? काय करता अशा वेळी ?

10.5 Communication before having children and after having children

They say that after having a child husband and wife relationship changes. Did you ever feel that there has been some change in your relations with your husband? Probes- Means the topic of communication between both of you, now and then, are they different? How? Or the time available for communication, now and then? Do you feel any such difference? What difference? And why? Has your husband said anything about it to you?

बाळ होण्यापूर्वी होणारा संवाद आणि आताचा संवाद यात फरक ?

असे म्हणतात की बाळ झाल्यानंतर नवरा बायकोचे नाते बदलते. तुम्हाला असे कधी जाणवले का की तुमच्या दोघांमध्ये काही फरक झाला ? म्हणजे आता बोलण्याचे विषय वेगळे आहेत-तेव्हा वेगळे होते ? किंवा बोलण्यासाठी मिळणारा वेळ आता आणि तेव्हा ? असा काही फरक तुम्हाला जाणवतो का ? काय फरक झालाय आणि का ? मालक तुमच्याशी त्याबद्दल काही बोलले का ?

10.6 Husband and wife arguing with each other

Is it that husband and wife would obviously or generally arguments over some or the other issues? On what subjects do both of you have arguments?

एकमेकांशी वाद विवाद घालणारे नवरा बायको

नवरा बायको म्हणले की कधी तरी वाद विवाद होणार- असे असते का ? तुमच्या दोघांमध्ये कोणत्या विषयांवर वाद होतात ?

## 11. Sexual communication

आतापर्यंत आपण पती पत्नी मध्ये संभाषण कसे होते, गरोदरपण, बाळंतपण, पाळणा लांबवणे, आरोग्य अशा विषयांमध्ये पती पत्नी कसे बोलतात, काय बोलतात, कुठे बोलतात आणि काय अडचणी येतात हे बघितले. आता आपण अजून नाजूक आणि पती पत्नीच्या नात्यामधील महत्त्वाच्या विषयावर बोलू या. पती पत्नीमधील संबंध- माझी इच्छा आहे की या विषयावर मोकळेपणाने बोलू या. मी देखील माझ्या आयुष्यात या सगळ्या गोष्टी अनुभवल्या आहेत, अडचणी असतील तर सोडवायचा प्रयत्न केला आहे, त्यामुळे त्यात लाजण्यासारखे काही नाही. आपण ही चर्चा करतोय ही आपल्या दोघातच राहणार आहे त्यामुळे बिनधास्त होऊन तुम्ही बोला. आपला उद्देश परत एकदा लक्षात घ्या- पती पत्नीचे वैवाहिक आयुष्य सुखी करण्यासाठी त्यांच्यात होणारा संवाद कसा आहे हे आपल्याला बघायचे आहे.



### 11.1 Expectations from each other with regards to sexual relations

How should he behave? He should not do certain things or he should do certain things- with regards to sexual relations.. do you feel that? What is it? Do you talk to him about what you feel? What did you say? What did he say on that? He also may be having some likes and dislikes? Does he talk to you about those? What does he say? What do you say on that?

संबंधाच्या बाबतीत असलेल्या एकमेकांच्या अपेक्षा, आवडी निवडी

ह्यांनी असे वागावे? अमूक एक गोष्ट करू नये किंवा करावी असे वाटते का- संबंधाच्या बाबतीत? त्यांच्याशी तसे बोललात का? काय बोलतात? ते त्यावर काय म्हणाले? त्यांच्या पण काही आवडी निवडी असतील? ते तुमच्याशी बोलतात का? काय म्हणतात? त्यावर तुम्ही काय बोलता?

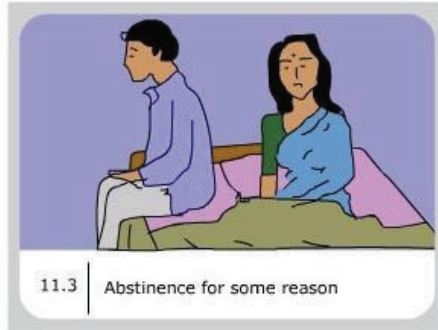
### 11.2 Abstinence for some reason

Sometimes husband and wife may decide of not having sex for some days-may be during pregnancy, immediately after delivery or may be there is some religious function at home. What are more such reasons when they don't have sex? When did this happen in your case? Out of both of you, who brings out such topic? How do you talk to each other? Who takes the decision? What is your wish? Do you tell that to your husband?

काही कारणासाठी एकमेकांशी शारिरीक संबंध न ठेवणे- अबोला

कधी कधी असे ठरते नवरा बायकोत की आपण काही दिवस संबंध नको ठेवायला- समजा गरोदरपण आहे, नुकतीच डिलीवरी झालीय किंवा देवाचे काही आहे अशी अजून कोणकोणती कारणे असतात ज्यामुळे संबंध ठेवत नाही? तुमच्या बाबतीत असे केव्हा झाले होते? दोघांपैकी कोण हा विषय काढता? कसे बोलता एकमेकांशी? कोण ठरवते? तुमची इच्छा काय असते? त्यांना ते सांगता का?





### 11.3 I don't want to have sex now- how should I tell my husband?

For various reasons a woman may feel like not having sex, what do you do at such times? Do you talk to your husband? How? What does he say? Finally what happens?

आता मला नकोय संबंध-गडी माणसाला कसे सांगणार ? वेगवेगळ्या कारणांसाठी बाईला असे वाटू शकते की आता संबंध नकोत. अशा वेळी तुम्ही काय करता ? बोलता का मालकांशी ? कसे बोलता ? ते काय म्हणतात ?

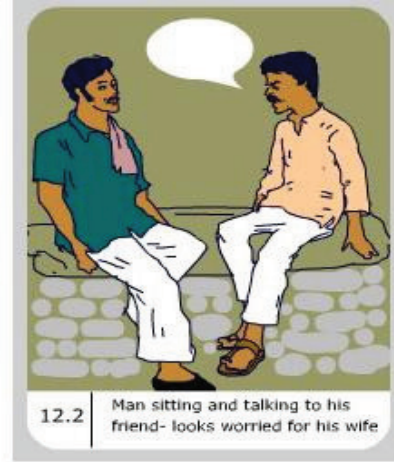
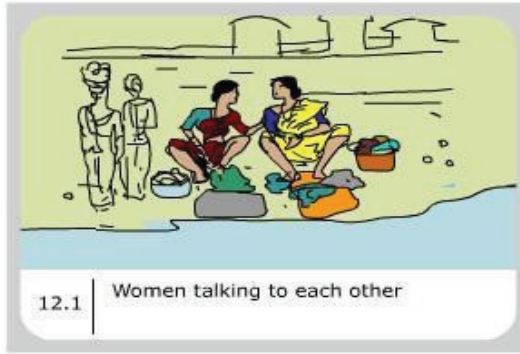
### 11.4 Sometimes there may be some problems related to sexual relations- physical problem or psychological- do you have any such problem? If yes, what?

Sometimes husband and wife don't talk to each other about it freely. When did you talk to each other about it? What was your husband's reaction on it? What did you do to solve the problem? Who did it? Did you have to take any treatment? Did you talk to each other about that?

कधी कधी संबंधाच्या बाबतीत काही अडचण असू शकते- शारिरीक किंवा मानसिक- असे काही आहे का तुमच्या बाबतीत ? असल्यास काय आहे विचारा आणि बरेचदा एकमेकांशी मोकळेपणाने बोलले जात नाही-तुम्ही त्याबद्दल एकमेकांशी कधी बोललात, काय बोललात, त्यावर ती व्यक्ती काय म्हणाली ? त्यासाठी पुढे काही केले का ? कोणी केले ? त्यासाठी काही उपचार घ्यावे लागले का ? त्याबद्दल बोललात का ?

## 12. Communication with others

बरेचदा असे होते की असे नाजूक विषय आपण इतरांबरोबर सुद्धा बोलतो- जसे बाई तिच्या जिवाभावाच्या मैत्रिणीला, शेजारणीला काही गोष्टी सांगत, पुरुष त्याच्या जोडीदाराबरोबर मन मोकळे करतो. कधी कधी घरात आईबरोबर सगळ्या गोष्टी जास्त बोलल्या जातात. काही वेळेस गावातल्या नर्स, डॉक्टर ह्यांच्याबरोबर काही गोष्टीची चर्चा होते. या सगळ्याबद्दल आपण आता बोलू या.



12.1 A woman is washing clothes at the riverside and whispering something to another woman. What are the topics women whisper to each other at such time? Do they talk about family matters, about husband or do they vent out their feelings? Do you have such a friend? What all do you talk to her?

बाई-नदीवर कपडे धुते-दुसरीबरोबर काहीतरी कुजबुजतेय

असे कोणकोणते विषय असतात जे नदीवर बायका एकमेकींना कुजबुजत सांगतात? घरगुती विषय- नवऱ्याबद्दल सांगतात का? किंवा मन मोकळे करतात का? तुमची अशी कोण जिवाभावाची मैत्रिण आहे? काय काय बोलता तिच्याशी?

12.2 Man is sitting with his friend. He looks worried for his wife. When wife has some problem or may be there is some matter to worry between husband and wife, do men talk about such subjects to their friend? Does your husband share his feelings and worries to anyone? To whom? What all does he talk?

पुरुष-संध्याकाळी-चावडीवर दुसऱ्या मित्राबरोबर बोलतोय-काळजी-बायकोचा विषय

बायकोला काही त्रास आहे किंवा नवरा बायकोमध्ये काही काळजी आहे असे विषय पुरुष मित्राशी बोलतात का? तुमचे मालक पण त्यांच्या मनातल्या गोष्टी कोणाला सांगतात का? कोणाला सांगतात? काय काय सांगतात?

12.3 Husband and wife-wife asks something to her husband to which he says, "Let us see what mother says"

Communication between you and your husband or decision making...in issues like this how much participation does your mother-in-law have? How much does she talk about issues like, you going to stay at your mother, where you should have your delivery, spacing between children, how many children you should

have etc. How much does your husband talk to her?

नवरा-बायको- बायकोने काहीतरी विचारले- नवरा म्हणतोय- आई काय म्हणते बोलून बघू  
तुमच्या दोघांचे एकमेकांशी बोलणे, काही निर्णय घेणे या सारख्या गोष्टींमध्ये सासूबाईचा किती सहभाग असतो ? माहेरी राहायला जाणे,  
डिलीव्हरी कुठे करायची, पाळणा लांबवणे, किती मुले हवीत अशा सगळ्या गोष्टीत सासूबाई किती बोलतात ? मालक त्यांच्याशी किती  
चर्चा करतात ?

12.4 Woman is thinking whether she should ask the village nurse or her mother-in-law to talk to her husband.

Sometimes a woman may feel, "How should I talk to him about this!" Does it happen in your case? For what subjects? What do you do at such times?

बाई-सिस्टरना सांगू का सासूबाईशी/ ह्यांच्याशी बोलायला ?

काही वेळेस बाईला वाटते की एखादी गोष्ट मालकांशी कशी बोलू ? चित्रातील बाई विचार करतय की सिस्टरना सांगू का सासूबाईशी/  
ह्यांच्याशी बोलायला ? असे होते तुमच्या बाबतीत ? कोणत्या विषयांसाठी ? काय करता अशा वेळी ?