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**The RESPOND Project Study Series:
Contributions to Global Knowledge**

Report No. 3

**Factors Affecting Acceptance of
Vasectomy in Uttar Pradesh:
Insights from Community-Based,
Participatory Qualitative Research**

Beth Scott, Options PEER Unit Consultant, Options UK

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Acknowledgments

Beth Scott works as a consultant in the Options PEER Unit for Options UK, London. Dawood Alam is senior technical advisor—behavior change communication and Shalini Raman is behavior change communication specialist with Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (JHU•CCP) and are based in New Delhi and Lucknow, India, respectively.

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Acronyms and Abbreviations

| | |
|---------|---|
| ANM | auxiliary nurse midwife |
| ASHA | accredited social health activist (community health worker) |
| GoUP | Government of Uttar Pradesh |
| IUD | Intrauterine device |
| JHU•CCP | Johns Hopkins Bloomberg School of Public Health Center for Communication Programs |
| NRHM | National Rural Health Mission |
| NSV | no-scalpel vasectomy |
| PEER | participatory ethnographic evaluation research |
| SBCC | social and behaviour change communication |
| UP | Uttar Pradesh |
| USAID | U.S. Agency for International Development |

Executive Summary

The RESPOND Project partners EngenderHealth and Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (JHU•CCP) are providing technical assistance to the Government of Uttar Pradesh (GoUP) to expand awareness of, acceptance of, and access to no-scalpel vasectomy (NSV) services.¹ A participatory ethnographic evaluation research (PEER) study was commissioned to understand the reasons for the low prevalence of vasectomy in Uttar Pradesh and to contribute to developing an approach for increasing demand for the procedure. Specific study objectives included:

1. Identifying levels of knowledge about, attitudes toward, and perceptions of NSV by various groups
2. Identifying how men who have undergone vasectomy and their partners are perceived by other community members
3. Understanding quality of care issues in private and public facilities and the role that financial reimbursements play in influencing a client to accept NSV
4. Assessing the nature of spousal communication around the decision to use family planning, and NSV in particular
5. Providing information that will enable the project to tailor messages to promote NSV in terms of the benefits of the method and the ways in which it can improve couples' lives

The PEER method is a qualitative anthropological approach based on the idea that trust with a community is essential for researching social life. Community members, therefore, are trained to carry out in-depth interviews with three friends and/or other peers selected by them. All questions are asked in the third person, in terms of what others like them say or do but never about themselves directly, so that respondents will feel free to speak about what they hear or know about others within their social network. The method allows for information to be collected over a short period of time and provides insights into how people understand and negotiate behaviour. The method tends to reveal contradictions between social norms and actual experiences.

The study was carried out in rural Kanpur, Uttar Pradesh, India, where 25 community members (13 women and 12 men) were trained in the PEER process. Following the training, they returned to their villages, and all 13 women and 10 of the men interviewed three of their friends (conducting 68 interviews in all), using interview guidelines developed during the training. Each peer researcher was to meet with his or her peers three times to discuss:

1. Family and family size
2. Family planning and family planning methods
3. Male sterilisation

¹ NSV is a refined approach for isolating and delivering the vas for male sterilisation. The technique uses vasal block anesthesia and specially developed instruments to access the vas without the need for either a scalpel to incise the scrotum or sutures to close an incision. NSV results in fewer complications, causes less pain than conventional vasectomy approaches, and allows quicker return to sexual activity.

Preferred Family Size and Its Rationale

Most study participants reported the ideal family to consist of two parents and two children (ideally one son and one daughter), usually cohabiting with the extended family, including the mother- and father-in-law and a brother- and sister-in-law.

A key driver for keeping the number of children low was a desire to provide for the family, to care for everyone and educate the children well. Having more than two children was considered costly and likely to result in family quarrels and tensions.

In the event of an unplanned pregnancy, it was common for the woman to obtain an abortion, in spite of the stigmas attached to this practice. If initiated early enough, medical abortion is used, or sometimes traditional herbal remedies. If the pregnancy is more advanced, couples reported going to clinical services for a surgical abortion together, often hiding their intention by telling others they were “going on an outing together.”

In the preferred family, it is considered the husband’s role to provide financially for everyone. Thus, well-paid jobs were particularly sought after, though in most cases men worked in manual labour. A wife’s duty is seen as being polite and caring, keeping the peace in the household and welcoming guests, being careful to look after the children, and balancing the household books. The wife must respect everyone, particularly her mother-in-law—who, if she is supportive, will guide the wife in maintaining a good household.

Family Planning and Family Planning Methods

Decision making around family planning appeared to be complex, as a range of players are involved, and stories often presented a different reality from that reported when respondents gave theoretical answers to questions. For example, many claimed that such decisions are taken by husbands and wives together, without the involvement of others. Examples, however, provided a contrasting view, one in which husbands or husbands and mothers-in-law made family planning decisions without much involvement of the wife. Such decision making drove a number of women to take control of their fertility, choosing to adopt contraceptive use in secret.

As a result, many women favoured female-controlled family planning methods. This practice was driven by a commonly held belief that pregnancy and family planning are primarily the concern of women, not of men.

A range of family planning methods were reportedly used, including oral contraceptives; condoms; the intrauterine device (IUD), especially the Copper-T; injectables; and female sterilisation. Male sterilisation was reported to be the least commonly adopted contraceptive method.

Information about family planning methods is circulated primarily by word of mouth—women discussing with each other their experiences with different methods. Accredited social health activists (ASHAs) were also important sources of information, though men reported trusting doctors the most.

Vasectomy

Both men and women reported negative attitudes toward vasectomy, sharing many stories of times when the procedure had not worked or had resulted in physical weakness, thus limiting a man's ability to provide for his family. Fears about weakness resulting from the procedure were common among both men and women and served as one of the main barriers to acceptance of NSV. Most of these stories appeared to come from the experiences of men in previous generations, though this did not stop them from acting as powerful deterrents to the adoption of NSV. (Female sterilisation, on the other hand, was widely accepted and common, with people reporting that women are happy to go for the procedure. Moreover, many believe that it matters less if women become weak afterward, as their place is in the home, not undertaking heavy work outside the house.)

Where stories were shared about men having undergone vasectomy more recently, the key driver appeared to be that the man's wife was seen as being too weak or sick to undergo sterilisation herself. In such cases, men commonly decided to go for NSV without discussing the matter with their wife or mother, as they feared that the women would try to persuade them not to go for the procedure. In some areas, men clearly were also adopting NSV after hearing of other men who had undergone the procedure recently with no problems.

Worry about the impact of NSV on men's sexual performance served as another barrier to use of the method and was more frequently expressed by women. Most participants did not know that sexual performance would not be affected and feared the procedure, believing that only a courageous man would go for NSV.

While some positive stories about vasectomy were shared, it was also noted that men would not tell other people if they had been sterilised, fearing being shamed and taunted by community members, who might refer to them using such words as *namard* (meaning infertile). Women also worried that a sterilised man would be thought of as a "slave to his wife."

Fear of failure of the procedure itself is another notable barrier to NSV acceptance. Overall, respondents were much more likely to report failed vasectomy cases than failed female sterilisation procedures. Failure of vasectomy cases can have severe consequences for women, leading to charges of infidelity and potential eviction from the family. This finding may play a role in women's implicitly encouraging low acceptance of NSV.

Most considered that it would be difficult to persuade a man to opt to undergo NSV, even if he were offered a financial reimbursement. However, when given more information about the procedure, many people thought that it might be possible to persuade a man to go for NSV, particularly if those who had experienced a successful sterilisation operation spoke with them and if doctors (the most trusted information source) provided such men with accurate information about the procedure. It was thought that most men would prefer to go to government rather than private services, given that they would receive a financial reimbursement at the former but not at the latter.

While more people spoke about the negative perceptions of vasectomy, some also provided insights into the potential benefits of or drivers for NSV uptake. Vasectomy was a desirable choice when a family is considered complete, since it is a permanent method. While female

sterilisation was often adopted instead, vasectomy might be considered when this and another factor exists. These other factors include worry over the health of the mother when a woman was considered too weak to undergo sterilisation herself—often after a cesarean delivery. In a few cases, men noted that given changing work patterns and a move to less heavy, labor-intensive work, men need not be so concerned about weakness following the procedure. The idea that NSV is a simple and painless procedure was most appealing to men as they reconsider NSV as a viable family planning method. Further to that, positive stories and examples of successful NSV cases were among the most powerful drivers for NSV uptake. After hearing such testimonials, many women were encouraged, and men were more open to go for the procedure.

Notably, many men and women were unable to say where vasectomy services were offered, though most knew they could obtain this information from an ASHA. Government services were almost unanimously the preferred provider, as they were considered of good quality, they were free, and if complications were to occur, one could seek compensation. With that said, complaints over long waiting times and decreasing quality of doctors at government facilities were also mentioned.

Recommendations

- Efforts to promote NSV should focus on couples who have completed their families.
- NSV should be promoted at or soon after the birth of a couple's second or third child, when they may have a strong desire to prevent further pregnancies and when men may be receptive to the benefits of NSV.
- Since men see doctors' opinions as credible and value them greatly, it is important to build on doctors as a trusted source of information in promoting NSV.
- Shopkeepers at medical stores and ASHAs can be trained to promote NSV and distribute informational materials when clients come to them for family planning methods.
- Positive testimonials about recent NSV experiences should be gathered for use in social and behaviour change communication messages and materials.
- The permanent nature of sterilisation needs to be emphasised, alongside a man's continued ability to provide for his family following an NSV.
- NSV's ability to free a man from the risk and worry of having to provide for more children should be promoted.
- Efforts to promote vasectomy should build upon women's notion that only very strong or courageous men go for NSV.
- The procedure should be promoted as simple and painless, but materials should be sure not to use the word "operation" in conjunction with NSV.
- Postprocedure fertility tests by service providers should be promoted, to enhance men's confidence in NSV.
- Programs not only should promote the benefits of NSV, but should also more widely disseminate information about NSV service providers and male sterilisation camps.²

² Male sterilization camps are organized by the Government of Uttar Pradesh to meet the family planning needs of male clients; these camps provide counseling in an environment of informed choice. They allow an opportunity for the few trained NSV providers in the state to reach clients on a given day, to maximize cost efficiency and provide increased access to this method.

These recommendations will be used by the RESPOND Project in providing technical assistance to the Government of Uttar Pradesh to expand awareness about, acceptance of, and access to NSV services. RESPOND's technical assistance is supportive of and synergistic with the state's planned interventions and activities and sets the stage for expansion and scale-up of NSV interventions across the state. Dissemination of this report's findings is planned with Government of India representatives, and it is hoped that these findings will be used to help the Government of India, as well as private-sector partners, address unmet need for limiting future births in Uttar Pradesh, in an environment of informed choice.

Introduction

The RESPOND Project

The RESPOND Project partners EngenderHealth and Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (JHU•CCP) are providing technical assistance to the Government of Uttar Pradesh (GoUP) to expand awareness about, acceptance of, and access to no-scalpel vasectomy (NSV) services.³ RESPOND's technical assistance is closely aligned with the State's National Rural Health Mission (NRHM) Action Plan for 2009–2010, is supportive of and synergistic with the State's planned interventions and activities, and sets the stage for expansion and scale-up of NSV interventions in 2010–2011 and beyond.

RESPOND's technical assistance follows a holistic Supply-Demand-Advocacy (S-D-A) Programming Model that complements the GoUP's strategic approach. On the supply side, strengthening service delivery components, NSV training, backstopping, and service site readiness will result in the increased availability of NSV service sites with skilled, motivated, well-supported NSV service providers. On the demand side, engaging communities and providing correct information about NSV will increase knowledge, improve the image of NSV services, and motivate couples to consider NSV. Advocacy is targeted at improving policies and creating a supportive environment for NSV services, with policies based on evidence, and maximizing resources to meet the needs of demand generation while ensuring quality NSV services. Together, these components are expected to lead to a better-resourced and more productive, supported, and sustainable program, and to the improved health of the Uttar Pradesh population.

Key Result Areas

The following are the key results areas for this effort.

Result 1: Increased supply of quality NSV services

- Increased public-sector capacity to provide quality NSV services
 - Training and following up with NSV providers
 - Facilitating readiness of NSV sites
 - Strengthening state capacity to scale up NSV trainings
- Greater participation of the private sector in NSV services

Result 2: Increased demand for NSV

- Formative research and social and behaviour change communication (SBCC) strategy development for NSV promotion
- Demand generation:
 - Orienting accredited social health activists (ASHAs) on NSV and strengthening their interpersonal communication skills

³ NSV is a refined approach for isolating and delivering the vas for male sterilisation. The technique uses vassal block anesthesia and specially developed instruments to access the vas without the need for either a scalpel to incise the scrotum or sutures to close an incision. NSV results in fewer complications, causes less pain than conventional vasectomy approaches, and allows quicker return to sexual activity.

- Improving NSV messaging through various channels and supporting public-sector SBCC efforts focused on NSV
- Support to the NRHM and the GoUP in improving community and mass media messaging

Result 3: Improved advocacy and policy in support of NSV

- Stakeholder sensitisation
- Coordination with concerned authorities to resolve barriers
- Facilitation of stakeholders' experience-sharing

The RESPOND NSV initiative in India began in October 2009 and will run for a period of three years. In the first year, the interventions were focused in three districts—Allahabad, Kanpur, and Meerut—with a plan to scale up to nine districts in the second year.

Promoting Male Sterilisation in Uttar Pradesh

This report presents the findings of a qualitative research project carried out with men and women in Kanpur District, Uttar Pradesh, India. While vasectomy was common in India from the 1950s through the early 1970s, by the late 1970s rates had begun to significantly decline, while at the same time, rates of laparoscopic female sterilisation increased (EngenderHealth, 2002). In recent years, to reverse this trend, India's central government has renewed its focus on vasectomy and hopes once again to increase the uptake of this family planning method among families with two or more children. The increased attention to vasectomy reflects the government's interest in shifting responsibility for family planning from women to men, in redressing gender inequity, and in attaining population stabilisation in a short period.

In 18 of the 29 states of India, there has been a perceptible shift in focus on male sterilisation in recent years. Nationally, the number of procedures performed in the public sector nearly doubled between 2006–2007 and 2007–2008, and vasectomy's contribution to the sterilisation mix rose from 2.5% to 4.5%. This increase can be attributed, for the most part, to the increased promotion and use of NSV. As part of the promotional approach, men are offered a reimbursement of 1,100 rupees (to cover transport and loss of earnings) for undergoing the procedure.

In Uttar Pradesh, however, vasectomy rates remain extremely low—the prevalence of vasectomy use is just 0.2%, one-quarter of the national average prevalence of 0.8%.

While awareness of vasectomy is high in India (IIPS & Macro International, 2007), misinformation about vasectomy is pervasive: In one study in rural Uttar Pradesh, while nine out of 10 men and women reported being aware of vasectomy, fewer than half of the men and only one-fourth of the women had correct information on the procedure (Khan & Patel, 2007). Misconceptions that vasectomy causes both physical and sexual weakness and requires long periods of rest following the procedure are common. Many providers, including auxiliary nurse midwives (ANMs), have little information on the details of the procedure and are reluctant to counsel on it (Varkey & Nithyanand, 2009). It has also been suggested that the majority of men believe female sterilisation to be easier to perform than male sterilisation and

believe the latter to have a greater chance of postoperative complications and a greater risk of failure (CORT, 2000). This study builds on the body of evidence already in existence to delve deeper into perceptions surrounding NSV.

Study Objectives

A participatory ethnographic evaluation research (PEER) study was commissioned to further understand the low prevalence of NSV in Uttar Pradesh and contribute to an understanding of how to increase demand for the procedure. Specific study objectives include:

1. Identifying levels of knowledge about, attitudes toward, and perceptions of NSV by various groups
2. Identifying how men who have undergone vasectomy and their partners are perceived by other community members
3. Understanding quality of care issues in private and public facilities and the role that financial reimbursements play in persuading a client to accept NSV
4. Assessing the nature of spousal communication around the decision to use family planning, and NSV in particular
5. Providing information that will enable the project to tailor messages to promote NSV in terms of the benefits of the method and the ways in which it can improve couples' lives

Results of this study will contribute to the development of a demand generation programme to promote NSV in Uttar Pradesh. Findings will be used specifically within the RESPOND NSV Initiative to inform SBCC messages and materials to increase demand for the method. Approval was granted from the Futures Group's Institutional Ethical Committee, serving as the in-country Institutional Review Board, to conduct this research, with the knowledge and approval of the GoUP.

The PEER Method

This study was conducted using the PEER method, in which members of a target community are recruited and trained to carry out in-depth discussions about the topic of interest with their friends and relatives.

Introduction to the PEER Method

The PEER method is derived from an anthropological approach that views building a relationship of trust with the community as essential for researching social life (Grellier et al., 2009). The PEER method is a way of training members of the target community (called “peer researchers”) to carry out in-depth conversational interviews with individuals selected by them from their own social networks. As the peer researchers have already established relationships and trust with the people they choose to interview, the interviews can take place over a relatively short period of time. An important aspect of the method is that all interviews are carried out in the third person. Peer researchers ask the interviewees to talk about what “other people like them” do or say; interviewees are never asked to talk about themselves directly. This enables people to speak freely about sensitive issues. The aim of the interviews is to collect narratives and stories that provide insights into how interviewees conceptualise, and give meaning to, the experiences and behaviour of “others” in their social network. All interviews are confidential, and peer researchers do not identify whom they have talked to, nor do interviewees identify whom they are talking about.

One of the key aspects of the PEER method is that it reveals the contradictions between social norms and actual experiences. This provides crucial insights into how people understand and negotiate behaviour and the sometimes hidden relationships of power (Price & Hawkins, 2002). The PEER approach elicits a rich and dynamic social commentary in the form of peer narratives. This information is important in building an understanding of social norms and expectations, which are important factors in both the acceptance and the adoption of new family planning methods such as NSV. Thus, even if the stories that the peer researchers collect and share are not externally verifiable as such, the stories still exist in the social consciousness and thus tell us how social life, norms, and perceptions are constructed.

The PEER method was chosen for this study for the following reasons:

- It generates in-depth, contextual data on a range of issues related to the research topic.
- Existing relationships of trust between peer researchers and their informants mean that findings are more detailed and insightful than if they had been gathered by an outside researcher.
- The PEER method involves the participation of the target group from the early stages of the research, building ownership and ensuring that questions are contextually relevant and worded appropriately.
- The method is particularly suitable for carrying out research on sensitive topics due to the use of “third person” questions, which enable respondents to talk about sensitive issues without personal attribution.

In studies such as this one, the PEER method has several advantages over other methods of formative research. Focus group discussions often produce normative statements (which refer to what people *should* do, according to local norms) or reflect dominant voices within the group. Quantitative sample surveys are useful for many purposes but cannot explain the *how* or *why* of social issues. In addition, people are often unable or unwilling to talk about sensitive issues openly in front of focus group moderators or survey interviewers, while they tend to be more comfortable discussing such issues with their friends.

The PEER method is therefore used to tease out the nuances of beliefs and behaviours to better inform communication interventions. However, it does not produce any findings that can be generalised to the entire population.

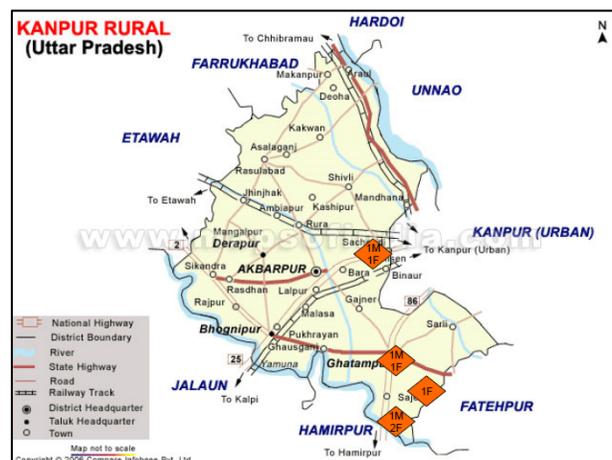
Peer Researcher Recruitment and Training

A total of 25 peer researchers (13 women, 12 men) were recruited for this study. Two men dropped out of the study before receiving training in the PEER methodology; thus, in the end, there were 23 peer researchers (13 women, 10 men). To ensure that the researchers were as representative of their communities as possible, few criteria were applied; while participation as a peer researcher was limited to 22–45-year-olds, it was emphasised that the volunteers need not be formally educated and should not already have experience as community educators. Volunteers were recruited from among three clusters of villages, so that it would be possible for them to travel to Kanpur for four days of training. Where possible, one man and one woman (where possible, not a couple⁴) were recruited from a single village. The distribution of peer researchers across their communities is illustrated in Figures 1a and 1b.

Figure 1a: Kanpur Nagar: Villages where peers were recruited (triangles represent villages where recruitment took place)



Figure 1b: Kanpur Dehat: Villages where peers were recruited (triangles represent villages where recruitment took place)



⁴ Note that while efforts were made to ensure that both parties in a married couple were not recruited together (due to concerns that they may be more likely to influence each other and their discussions with friends), this was not possible in all cases, as often women are not allowed to travel outside their villages without being accompanied by their husband.

The peer researchers attended a four-day training workshop (see Appendix 3), at which they developed interviewing skills and, in partnership with a PEER trainer and a male and a female facilitator, designed their own sets of qualitative interview questions, based on the issues they felt to be important relating to family and family size, family planning, and male sterilisation specifically. The participatory nature of designing the research tools ensured that the study was framed within the conceptual understanding of the peer researchers and addressed topics in such a manner that they felt comfortable in discussing the issues with their friends.

All interview questions were developed in the peer researchers' first language and incorporated commonly used words and phrases rather than technical language (e.g., in the case of "family planning methods," questions talked about "methods to stop having more children"), ensuring that both peer researchers and the PEER team were clear about the specific meaning of each question and its component words. Nonliterate PEER team members were encouraged to draw pictures to remind themselves of the questions.

Often, people who are nonliterate have extremely good memories; this was clearly demonstrated in the study. Since the questions are relevant to their lives, the peer researchers were able to recount clearly what was talked about. If they had been requested to ask technical questions that they did not really understand, their recall would not have been as good.

Neither the peer researchers nor the interviewees received financial incentives for participation, given concerns of the Institutional Review Board over the ethics involved in financial payments. The peer researchers received a travel allowance and a small *per diem* when they attended training and debriefing sessions. The characteristics of the peer researchers and the friends they interviewed are shown in Table 1.

Table 1: Characteristics of peer researchers and interviewees

| | Women (n=52) | Men (n=40) |
|----------------------------|--|---|
| No. of participants | <ul style="list-style-type: none"> • 13 peer researchers • 39 interviewees (all women) | <ul style="list-style-type: none"> • 11 peer researchers • 29 interviewees (all men) |
| Age | <ul style="list-style-type: none"> • Peer researchers: 22–45 years • Interviewees: 21–48 years | <ul style="list-style-type: none"> • Peer researchers: 28–45 years • Interviewees: 25–70 years |
| No. of children | <ul style="list-style-type: none"> • Peer researchers: 0–3 • Interviewees: 1–6 | <ul style="list-style-type: none"> • Peer researchers: 0–4 • Interviewees: 0–4 |
| Education | Peer researchers <ul style="list-style-type: none"> • Illiterate: 3 • Primary: 0 • Secondary: 8 • Graduate: 1 • No information: 1 Interviewees <ul style="list-style-type: none"> • Illiterate: 8 • Primary: 5 • Secondary: 19 • Graduate: 4 • No information: 3 | Peer researchers <ul style="list-style-type: none"> • Illiterate: 2 • Primary: 2 • Secondary: 5 • Graduate: 2 • No information: 0 Interviewees <ul style="list-style-type: none"> • Illiterate: 7 • Primary: 6 • Secondary: 9 • Graduate: 6 • No information: 1 |

Note: Complete information was not obtained for all peer researchers and/or their friends.

Data Collection

Data collection was carried out from September 18 to September 29, 2010. During this time, the peer researchers debriefed regularly with facilitators (a male facilitator supported the male peer researchers, and a female facilitator supported the female peer researchers), so that on average, a peer researcher only had to remember a story for 24–48 hours. Facilitators asked the peer researchers in-depth questions about the interviews they had carried out since the previous supervision session. The facilitators recorded detailed notes of the narratives.

During the supervision process, the facilitators were able to build up a strong rapport and relationship of trust with the peer researchers. This enabled the facilitators to probe more deeply into issues raised by the interviews. When interviewees had not given enough in-depth information about a specific question or topic, the facilitators encouraged the peer researchers to talk themselves about what they thought their communities felt about this or to share stories they had heard, thereby allowing the facilitators to gain information about topics not explored in enough detail in peer discussions. With the PEER methodology, it is not problematic to use information provided by interviewees as a prompt to initiate further discussions with peer researchers. The peer researchers all came from the same communities as the interviewees and the PEER method is based on exploring general beliefs and perceptions within communities. It seeks to identify and reveal what people in general (as opposed to specific individuals) say, believe or do in certain situations or around certain issues. As a result, asking peer researchers to discuss issues raised by interviewees in more depth provides a greater and more detailed understanding of community beliefs than is sometimes possible during individual interviews.

During the data collection period, each peer researcher interviewed (in most cases) three friends on the three themes outlined below:

1. Preferred family size and its rationale
2. Family planning in general, and specific family planning methods
3. Male sterilisation

Interviewing the same person on several occasions aids peer researchers' recall and allows for intensive probing of each interviewee around the three identified key themes.

These themes emerged from early brainstorming sessions, in which peer researchers were split into small groups to make note of key ideas that came to mind when they thought about such topics as daily life, family size, and family planning, as well as the idea of sterilisation more specifically. At the end of the first day of training, the PEER facilitation team took all of the ideas and words generated by the peer researchers and divided them into three emergent themes. These themes, besides covering all of the peer researchers' ideas, also made sense as they built gradually from the broad notion of families and family size toward the more specific subject of interest—male sterilisation.

Copies of the final questions (in English) are shown in Appendix 1. Broadly speaking, Theme 1 explored:

- Perceptions of a preferred family
- Family size and decisions to stop family growth

Theme 2 explored:

- Awareness of, perceptions toward, and use of different family planning methods
- From where people get family planning information and services

Theme 3 explored:

- Male sterilisation specifically
- Its prevalence, attitudes toward it, and experiences with it

Given that correct knowledge of male sterilisation was predicted (and in workshops, appeared) to be low, at the end of Theme 3, the peer researchers also shared an informational statement about NSV, to explore whether male sterilisation might be accepted in their communities.

Rather than asking for personal information, peer researchers asked their friends questions in the third person: about what other people say or do in relation to particular issues. This enables interviewees to feel more comfortable to share their thoughts, as they do not have to share personal information, opinions, or experiences. However, some interviewees still chose to respond in the first person, demonstrating the ease with which they spoke with their friend, the peer researcher.

Data Analysis

The data (debriefing interview narratives) were analysed thematically by an experienced social scientist. The main analytical framework was developed in advance of the fieldwork and was based on key themes identified as essential to fulfilling the objectives of the research (e.g., obtaining a clear understanding of the context within which individuals make decisions about family planning, and about vasectomy in particular). During the process of data analysis, the original analytical framework was adapted to enable incorporation of new and emerging themes and insights.

The narrative data were coded thematically and broken up into “text units” (stories or paragraphs), which enabled quotations to be selected that capture the essence of each code. Initial ideas arising from the data, along with areas where further clarifications and/or insights were needed, were shared in a peer researcher analysis workshop, giving the peer researchers themselves a chance to provide input to and guide the analysis process. The workshop was also used to develop “personas” that could be used in a communication campaign. These personas are included here in Appendix 4.

This report includes quotations from the narrative data obtained by the peer researchers. Quotes are used extensively throughout the report. After each quote, we provide in brackets a respondent identifier: The acronyms PRM and PRW refer to “peer researcher, man” and “peer researcher, woman,” respectively; F refers to the peer researcher’s friend. Hence, [PRM3, F2] would indicate that Friend 2 of Male Peer Researcher 3 is being quoted, while [PRW3, F2] would indicate Friend 2 of Female Peer Researcher 3. As described in Table 1, in this study men spoke only to men and women only to other women. Thus, there is no need to specify the sex of their friends.

Initial ideas arising from the data, along with areas where further clarifications and/or insights were needed, were then shared in a peer researcher analysis workshop, giving the peer researchers themselves a chance to provide input to and guide the analysis process. The workshop was also used to develop “personas” that could be used in a communications campaign. These personas are included here in Appendix 4.

Limitations to the Study

PEER studies require peer researchers to give up a substantial amount of time to engaging in training and interviewing their friends. These efforts are much appreciated, and general expenses (e.g., travel) are covered, but the method is highly dependent on the goodwill and commitment of the peer researchers. Often, peer researchers have multiple demands on their time, and it is not always possible for them to speak to three friends on three separate occasions. In this study, all of the female peer researchers spoke with three friends; however, not all of the men managed to do this. In deciding upon the number of peer researchers to train, such a possible shortfall in interviewees was taken into consideration and allowed for. As a result, the findings of the study were not jeopardised because slightly fewer than the maximum number of interviews were completed.

This study required both men and women to discuss issues that are not normally talked about with non-family members. All peer researchers found it easy to discuss Theme 1 with their friends. Male peer researchers found Theme 2 the most difficult to discuss, and women peer researchers found Theme 3 the most challenging. However, despite this, no peer interviewer or any of their friends refused to talk about any of the themes, and the quantity and quality of information obtained for all three themes was more than sufficient to provide insights into community perceptions of the issues addressed by these themes.

While beyond the scope of the study, it would have been interesting to conduct further research exploring health service providers’ views on NSV, to find out if it is a method they recommend or if biases may exist. Given that providers are seen as an important source of information on family planning and NSV, it would have been useful to gain a better understanding of their perceptions of the method.

Results

Overall, even in discussions about male sterilisation, women tended to speak more freely and give more in-depth answers than did men; they shared many more stories and examples than their male counterparts. Their greater awareness of stories and examples indicated that women discuss family planning much more frequently and freely with each other than men do, and this impression was supported by male interviewees' and peer researchers' stated viewpoint that men did not have the time to chat about such things with their friends. However, in spite of men's shorter answers and fewer stories, a large amount of data was still generated across the three themes, providing good insights into family planning decision making, favoured methods, and attitudes toward male sterilisation in particular. While less information was gleaned about family planning and information sources, some insights were also generated about these areas.

This section starts by exploring the main topics discussed in Theme 1 interviews, sharing findings relating to a preferred family and the preferred roles of family members. This is followed by discussions about family planning decision-making, family planning methods and finally male sterilisation.

A Preferred Family

Most men and women alike defined a preferred family as being small and educated, with a good, regular income. Together, these values were thought to lead to a happy, tension- or worry-free family within which the needs of all family members are met and everyone listens to, respects, and loves one another.

Composition of a Preferred Family

While not discussed by many respondents and discussed more by females than males, there were clear disagreements regarding the composition of the preferred household. While some valued the presence of parents- and siblings-in-law in the household (a joint household), others looked more toward a nuclear family consisting only of the father, mother, and (two) children, ideally either boys or one girl and one boy. Opinions did not correlate with factors such as levels of education or income, but rather appeared to reflect personal experiences of family life, with hints of tensions or differences with parents-in-law appearing in the statements of those preferring a nuclear family:

Husband and wife and only two children. No need of parents-in-law! [Said with force]
[PRW5, F3]

Mostly, however, joint families were preferred, either with just parents-in-law living in the household or with both parents-in-law and the brother- and sister-in-law. In addition, the presence of parents-in-law was felt, at least in theory, to *give strength to the family* [PRM10, F2], to relieve parents of some of the burden of running the household, and also to offer guidance through their own life experiences:

If there are parents-in-law, then it is better, because then some responsibility can be taken by the parents-in-law. Then there is less of a burden on the husband and wife. [PRW5, F1]

Parents-in-law play a very important role in a family, because they are experienced, so they advise very well what to do, what not to do. [PRW3, F3]

Desire and Demand for Son and Daughter to Complete the Family

It was also evident that many people, particularly those of the older generations, felt it was important that mothers had not only daughters, but sons also. In this vein, even if a couple had two or three children already, there would be pressure to continue to increase the family size until the wife bore a son:

People wish to have a son. If someone has two daughters, then they want one son. If the next baby is also a daughter, they still want a son. [PRM4, F1]

I was ignorant about family planning, so I have four children. If I had known that my next two babies would be girls, then I would have tried not to deliver those babies. [PRW4, F1]

This demand can be so high that women who continue to give birth to girls may be beaten by their husbands, often supported by their mothers:

A wife had three daughters and one son. She again became pregnant again and this time she delivered twins and both were girl babies.... Then her husband beat his wife and said "why have you again delivered a girl baby? We already have three." [PRW9, F1]

Thus, in spite of a clear preference for small families, the desire for male children may result in increased family size, with women continuing to bear children until either they give birth to a son or until some adverse event occurs, such as a wife returning home to her parents or worse:

In our sister-in-law's family, there was one woman who had one girl and again she delivered a girl. Then her relatives started shouting and they abused her. Then she committed suicide in a pond, but the husband was silent and didn't say anything to any relatives. [PRW5, F2]

That said, several female respondents also stated that there should be both sons and daughters in a family and that if a family has only sons, they should keep trying to have a girl. While a preference for boys may still exist, there appears to have been a shift in desire for only male children:

There is one woman who has two sons and then she doesn't want more children. Then she told her mother-in-law, I don't want more children, and her mother-in-law said, "You have only two sons, if you have one girl also, then the family will be complete." [PRW1, F1]

I have many children. I didn't want this, but I didn't know what to do to stop having more children. Some of my family members told me that two boys and two girls are very good, there should be two boys and two girls in a family, because if one son and one daughter will die, then at least one son and one daughter will remain with you. [PRW3, F3]

The Rationale for Preferred Family Size

While previous generations favoured larger families, most respondents spoke of the importance of small families, some talking of how agricultural outputs had dwindled in recent years and others of how daily provisions are more costly than they used to be:

In many, many years before this, people had more children, but now there should be small families, because what we could buy with 50 rupees years ago, we now can't buy those things even with 200 rupees. [PRW1, F2]

Thus, small families (1–2 children, occasionally three) are favoured primarily for economic reasons, with both men and women worrying about how they will be able to provide food, clothes, medicine, and (most importantly) education for their children if their family is too big:

If we have more children, then we will not be able to achieve life's goal—being successful and having all facilities at home. In this expensive time, when doctors prescribe an apple or porridge, how can a person buy all these things if they have many children? He will not be able to give his family a good education, a good lifestyle, good food. [PRM8, F1]

This concern is further highlighted by the emphasis that women in particular placed upon “fulfilling the needs” of all the family members and the importance to all of having a peaceful, loving, happy family with few quarrels and/or disagreements—something easier to achieve in a small family:

In a happy family, each and every member should live with love and affection, understand everyone. [PRW5, F1]

If in a family there are more children, there is daily fighting, and resources become very limited. [PRW4, F2]

Not only is it easier to provide for a small family, but it is also easier to listen to and share the opinions of all; thus, a small family is more likely to be free of the quarrels that are thought to be much more common in larger households.

Conversely, large families were thought to be less happy:

In our community, most of the families are not happy, because they have more children. [PRW3, F3]

Our family is very big. Some have clothes, some do not. Even with my children, it is very difficult for us to arrange sufficient food for the children each day. My children are not going to a good school for their education. [PRW9, F3]

However, while some felt that even parents-in-law were beginning to appreciate the value of a small family, it was clear that many of the older generation, who (as discussed later) can be key influences in decisions about limiting family size, still favour larger families, particularly when early babies are girl children.

Furthermore, later discussions on the adoption of family planning methods suggested that men would prefer smaller families in theory, but that they may be more preoccupied with

sexual intercourse in practice, risking further pregnancies instead of discussing and/or using available family planning methods (see the Family Planning section).

In a preferred family, all family members, not just the father and/or the children, are educated. The father is educated, hence he can make good decisions, get a job with a regular income, and thus provide for his family and keep the peace; the mother is educated, hence she too can take good decisions (in the running of the household) and also encourage and support the children's education and learning; and the children are given a good education so that, in their time, they are able to get good jobs (and, if boys, support their parents):

In a good family, education is the most important thing. The entire society benefits if the person is educated—he will speak well, and others may learn from him. [PRM9, F2]

All should be educated in the family. In an educated family, there is no fighting. [PRM10, F1]

However, to provide a good education for children, the family should be small, otherwise children may not be able to be educated beyond primary school. Indeed, there is a cyclical effect, whereby if one comes from a more wealthy family, he or she has a better chance of a good education, which will in turn generate more wealth:

If a person is born in a well-off family, then he gets education and becomes good. [PRM1, F2]

Now the family should be small so we can educate the children. In older days, the income of [the] father-in-law was good because of agriculture, but now at this time there is no income for the parents-in-law, so now there should be the small family. [PRW4, F1]

Family Planning Decision Making

Family planning and decision making concerning family size and choice of contraceptive methods is complex, with stories and examples (more commonly shared by women than men) tending to contradict answers given to questions asked. For example, women might respond that it was only the husband and wife who could, together, take the decision about how many children to have, but then they share stories of women or couples who wanted to stop at two children but whose mothers-in-law intervened, persuading them to have another child. Such differences in response suggest discrepancies between theory and practice, between the “ideal” and “actual” decision-making process and outcome. These are explored within this section, which attempts to untangle some of the complexities surrounding family planning decision making in an effort to highlight *who* needs to be targeted and with *what* kinds of motivational messages if the uptake of male sterilisation is to rise in rural Kanpur and beyond.

Decision Making around Family Size

When asked directly about who makes the decision on when to stop having children, almost all men and more than half of the women responded that it was a joint decision between the husband and wife:

Only the husband and wife can make the decision, because it is their responsibility to arrange each and everything for their children, so only they can make the decision. [PRW5, F2]

The husband and wife make the decision regarding number of members [children] because they know their income, etc. They should expand the family according to their income. [PRM5, F1]

Others conceded that the parents-in-law might try to influence the decision or be asked for their opinion. Most reported, in direct contradiction with earlier statements about the strong influence of mothers-in-law in general household decision making and decisions about family size, that while in-laws could put forward their thoughts, ultimately it was the couple themselves who were the sole decision makers:

Sometimes we should oppose the decision of the parents-in-law. Of course, we should take the opinion of mother-in-law and father-in-law, but if husband and wife think they have very limited resources and no other income sources, then there is no wrong in them opposing the decision of their parents-in-law. [PRW7, F2]

Yes, elders also play an important role, but they cannot force a couple to have more children; they can just state their opinions; nowadays, they cannot force. The husband knows how much he earns. [PRM5, F1]

However, the stories and examples⁵ shared by respondents⁶ portray a different picture, one in which decisions about family size are almost exclusively made by either the husband (who has ultimate responsibility for providing financially for his family), the mother-in-law (who guides the family) or the husband and the mother-in-law together; a woman may mention to her husband her desire to stop having more children, but ultimately the decision, in most cases, appears to be out of her hands:

Then she told her husband, "I have two children and I don't want a third." Her husband asked if she had asked her mother-in-law. She said no, and he said to discuss it with her mother-in-law. [PRW1, F3]

The pregnant lady wanted to abort the child, just because of her husband and mother-in-law; she delivered the baby. [PRW8, F1]

Examples in which the couple themselves decided (together) whether they wanted more children or not were extremely rare:

My mother-in-law wants only one child, but we (husband and wife) took the decision for two. [PRW4, F1]

Three key factors appear to contribute to the level of involvement of parents-in-law (and more specifically, mothers-in-law) in family planning decision making:

- Whether it is a nuclear or a joint household
- The husband's employment status and/or level of education
- The strength of the relationship between the husband and his mother

⁵ Note that many of the stories indicate that the notion of family planning is only considered in the context of unwanted pregnancy, something that is discussed later. It appears that only when an unplanned pregnancy occurs does a couple start to consider that they do not want more children.

⁶ Interestingly, *only* women gave examples of the family size decision-making processes. This suggests that this is a subject that women discuss freely with their friends, given that the decision is largely out of their hands, while men do not speak with each other about it, given it is readily accepted that they will be the key decision maker.

In short, in a joint household, the parents-in-law will at least try to influence the decision, while in a nuclear household, the husband or couple will decide independently; when the husband has a poor education or income, he has little say in any decision making in the household, including the number of children he will have; and where the husband looks to his mother for regular guidance and/or affirmation, he will rely more upon her opinion:

Sometimes the husband and wife, and sometimes the parents in law [decide the family size]. If a husband earns well, if he is totally dependent on himself, then he can make the decision. Otherwise, the parents-in-law interfere. Sometimes, a husband is good but he is under the thumb of his mother, so in that case, the mother-in-law interferes in every decision. [PRW9, F2]

Conversely, in situations in which the husband earns well, he is more independent and free to make decisions for himself, though he may still seek the opinions of his mother, wife, and/or a health worker.

Decision Making around Contraceptive Choices

In common with decisions around family size, the majority of the men and more than half of the women claimed that a husband and wife would decide together about what method of family planning to adopt. Again, however, there were strong indications that in reality this is often not the case, with both men and women reporting that while wives may bring up discussions about contraception, often suggesting a particular method to adopt, their husbands often reject such suggestions:

He mentioned that most of the time women take the initiative, but husbands do not accept, as they fear the expenses in getting the method or complications if the method goes wrong. [PRM2, F1]

My friend mentioned that his wife had decided to go for [female] sterilisation, but he [the husband] did not allow her to go. [PRM6, F2]

Most of the time, husband decide, because generally women ask their husband “can we use this method or not?” [PRW2, F1]

As is discussed further in the section describing attitudes toward the various family planning methods, such rejection by males appeared to be particularly driven by fears about negative side effects of available contraceptive options, with men tending to show a much higher awareness of the negative attributes of technologies than of the positive features:

Even I talked to my husband. Then he said, “Also, I don’t want a child for the next two years because I want further education,” but my husband told me I am very weak, so don’t take pills, “and you never go outside of the home so if you take the pills you will become hot [garmi] because of the pills”... My husband said “The Copper T [IUD] is also not good because it goes inside the vagina and my brother’s wife used this Copper T, then there was lots of bleeding, she became weak and she faced so many problems... [PRW3, F?]”⁷

⁷ Note that this newly married couple, while not wanting children yet, are now not using any family planning method.

Generally, men don't want to use any method, because they have fear about methods.
[PRW4, F2]

This negative awareness may in part be driven by mothers-in-law, who, a few women noted, were likely to focus on problems associated with contraceptives, and to whom a couple of men reported they may turn to for advice:

If we discuss this with our mother-in-law, then generally the mother-in-law says that "some lady faced this problem, then you will become weak so don't do this." If you ask the mother-in-law, she generally responds with the negative, don't use this or this... [PRW3, F1]

While not discussed directly by respondents, such a focus on the negative aspects of family planning methods by mothers-in-law is perhaps not unexpected in a culture where the older generations often still favour larger families and thus attempt to influence couples to continue having children even after the birth of a son and a daughter.

Given seemingly high levels of rejection of family planning methods by both husbands and mothers-in-law, many women shared stories of making decisions about and adopting contraceptives without discussion with their partners or other family members. Such decision making is further legitimised by a belief that family planning is primarily the concern of women rather than men, given that the mother must carry, give birth to, and raise the children:

A newly married wife started to use Mala D [contraceptive pill brand] without informing anyone in the family; she even didn't talk to her husband about it. Then one day her mother-in-law caught her when she was taking the pills. Then her mother-in-law asked the son, and the son said, "Mother, I don't know, I didn't buy the pills for her." Then they asked the wife, who said, "I don't want a child at least for one or two years, so when I went to my parents' home, there I bought the pills." Then the mother-in-law and her husband said "OK." The wife thought if she talked about methods with her husband and mother-in-law, they would refuse, so it's better to start to take pills without informing them. [PRW4, F2]

Most of the time, it is a matter for women, because if she will not use anything, then she has to suffer, and there is less of a role for the husband. [PRW5, F2]

A number of women even said that men were actively uninterested in family planning; that while they theoretically expressed a desire for a small family, when it came to the intimacies of the relationship they were solely interested in the act of intercourse, not worrying about the potential consequences of an unplanned pregnancy:

Generally, men have the least interest in the consequences of sex; they just are interested in the intercourse, and when the wife tells her husband "now I don't want to be pregnant," and then the wife says this again and again, "I don't want...I don't want...I don't want," then men give some attention, otherwise they have no interest in the consequences. That's why generally women prefer to use family planning, not husbands—all the methods are for women because they worry about the consequences of intercourse; men are only interested in the intercourse, not the aftereffects. [PRW3, F2]

This apparent dominance of wife-centred decision making was further supported by a clear tendency for women involved in this study to be more willing and/or able to discuss family

planning decision making than were the men, who also clearly demonstrated much lower levels of awareness about the different contraceptive methods available.

In short, traditionally, it appears that men and mothers-in-law are the key decision makers when it comes to when and which method of family planning a couple will adopt. However, with the growing availability of female-controlled methods, increasingly women appear to be taking the decision into their own hands, even if this means adopting contraception without their families knowing. Occasionally, there are examples of couples deciding together; however, the couples may hide their decision from mothers-in-law, who are believed to oppose family planning in favour of large families.

Interestingly, as will be discussed further in the separate section on male sterilisation, the adoption of this method represents the one time in which the decision appeared to be almost entirely taken by the man, who, worrying about his wife's weakness and thus vulnerability, takes the decision to undergo NSV himself rather than risk his wife's health. Again, such decisions seem to be taken against the wishes of, and in secret from, the mother-in-law (his mother) and frequently even his wife, whose reaction(s) to such a suggestion is greatly feared.

Unplanned Pregnancy

While respondents universally talked about a theoretical ideal of having two children, it was apparent that many couples fail to adopt any family planning method. They only seriously contemplated contraception in response to the event of an unplanned pregnancy, something that women (but not men) reported to occur with some frequency. While it is not clear why this is the case, it may reflect a lack of awareness about family planning, negative male attitudes toward contraceptive methods, and/or women's fear of discussing contraception with their husbands and (especially) their mothers-in-law. What is clear is that the event of an unplanned pregnancy can act as an important trigger to the adoption of contraception, with a couple who might have been taking a somewhat fatalistic attitude toward family planning previously suddenly deciding to use contraception:

If someone has an unplanned pregnancy, then she will go for abortion, and after abortion directly for an operation [female sterilisation]. [PRW9, F3]

Respondents cited three potential responses to unplanned pregnancy—getting an abortion, carrying the pregnancy to term and keeping the child, or carrying the pregnancy to term and giving the child to others to take care of. All three outcomes were widely felt to be undesirable, though abortion was the most common response, particularly if the couple had already achieved their desired family size. While a large number of men reported that abortion was not common, some of them and the majority of women conceded that it was a frequent occurrence:

Abortion is common nowadays, nobody can know about it, one can go and get it done... [PRM9, F1]

He suspects the majority of people; they go for abortion, since it is done within two to two-and-a-half months, so nobody knows. [PRM2, F2]

Most of the time people go for abortion. Smart people are cautious and do not allow such a situation to occur. Nowadays, it is easy also. You can do it, and nobody would know. [PRF5, F1]

While abortion was highly stigmatised, with some people (especially, but not only, Muslims) believing it to be killing a child, others worried that the procedure could result in heavy bleeding, weakness, and—in extreme cases—death. As discussed in the final analysis workshop and indicated from peer interviews, abortion is also viewed negatively because people believe unplanned pregnancies are a sign of ignorance, now that people are expected to know about family planning:

They think the abortion is to kill a child [mahapap], and it is very unethical to kill a child, so I will, no, never do this type of mahapap. [PRW4, F2]

[Abortion] causes a bad name in the society, so people do not go for it... After abortion, wives become weak due to heavy bleeding. [PRM8, F1]

He knew a family where the wife had taken abortion pills and huge bleeding happened, which caused the death of his wife. His friend did not look favourably on abortion. [PRM3, F1]

In spite of these concerns, as mentioned above, abortion remains common. The frequency of abortion and the shame associated with it demonstrates how people attempt to hide behaviours that are deemed socially unacceptable. A similar pattern can be said of NSV, in that men may cover it up or not admit to having undergone the procedure.

Interestingly, while stories indicate that women go for IUD insertions or sterilisation either with the ASHA and/or a female relative/friend and not with their husband, in the case of surgical abortion there were strong indications that, for the most part, husbands accompany their wives, perhaps (though this is not stated) to avoid having others find out about the event. The way men talked also suggested that they may also obtain medical abortion pills on behalf of their wives. In this manner, couples clearly often take decisions together regarding what to do in the case of an unplanned pregnancy, although there were examples of women hiding their pregnancy from their husbands and deciding to abort by themselves.

Family Planning Information Sources

When asked about sources of information about family planning services, men and women cited mass media (TV and radio) and two primary types of interpersonal channels—health care personnel (doctors, ASHAs, auxiliary nurse midwives [ANMs], and Anganwari workers [village-level health workers]) and close family and friends. Stories and examples given about family planning methods and decision making further emphasised the importance of family, friends, and word of mouth within communities in influencing knowledge, attitudes, and behaviours.

Mass Media

A significant number of respondents, particularly women, cited TV and/or (to a lesser extent) radio as a source of family planning information, reporting that they had heard about oral contraceptives, the IUD, and in one case the injectable via mass media. However, both men

and women tended to report having difficulties recalling the content of TV and/or radio commercials, with interpersonal communication channels being greatly preferred:

I saw a programme about pills on TV, but I am not very clear about pills. [PRW2, F1]

Radio and TV are other sources of information, but none of my friends remember any information they heard. [PRM6, F1]

Further, people tended to report preferring and trusting interpersonal communications channels more:

If we saw anything on TV, then we would never adopt, but if we get information from ASHA or some health centre, then we have more trust. [PRW4, F2]

Talking to each other face-to-face, one-to-one, is better. Sometimes newspapers, they miscommunicate. If the person is from the village, they will have the accurate or complete knowledge. [PRM1]

Health Professionals

Women were most likely to cite ASHAs and, to a lesser degree, ANMs as highly trusted and reliable information sources on family planning. An ASHA appeared to be a trusted information source for two main reasons—she is from the village and therefore is known, while she also supports women and accompanies them when they need to visit health facilities:

ASHA is the resource centre. [PRW5, F3]

She said health centre, ASHA, aganwadi worker, but we have more trust in ASHA, because she gives information, and she also goes with us to the health centre whenever we need. And if we face any problem, then again ASHA goes with us. That's why we always take ASHA's advice and we don't do anything without informing her. [PRW3, F1]

While men also often cited ASHAs as the most trusted and known source of information regarding family planning methods, a significant proportion of men did not trust them, fearing that they might share personal things with other people in the village. As a result, some men trusted ANMs more than ASHAs, since while ANMs know everyone in the community well, they come from outside the locality:

They trust most the ASHA, as she is known to all. Since they are known people, a man can also talk to them. [PRM6, F1]

A known ANM is the most trusted source, as they are not from the village. The ASHA is from the village, and during fighting, etc., she may tell people what someone uses, so people are suspicious of her. [PRM3, F2]

In light of a heavy reliance on ASHAs and ANMs for family planning information, a few respondents raised concerns that there were not male equivalents to ASHAs and or ANMs that men could talk to, indicating that some men might feel uncomfortable talking about such issues with women:

There is no mechanism for men with whom they can discuss issues. The government should recruit males like ASHAs, with whom men could discuss such issues [family planning]. [PRM9, F1]

Most women go for the operation [female sterilisation] because there are ASHAs and ANMs to help the women, but there is no such type of male worker who can motivate men. The ASHA and ANM, they don't talk to men about methods. [PRW4]

Men sometimes described female doctors who took an empathetic approach to them. This, combined with the high frequency with which men (as well as women) described ASHAs as the most trusted information sources for family planning advice, suggests that the sex of the messenger might not be as important as one might expect. While rarely cited as a key information source by women, men often referred to doctors as the most trusted information source, believing them to be the most educated and informed information channel:

People go to the government hospital and if there is a lady doctor at the hospital, they prefer to ask her. If the husband accompanies his wife, he also will consult the lady doctor—she nicely talks to the patient and she explains everything very well, and it is very easy to remember what she says. [PRM3, F1]

People trust government hospitals because the doctor explains well, whereas ASHAs, they have limited knowledge regarding family planning, so they explain only what they know. [PRM10, F1]

Friends and Family (Word of Mouth)

A final but critical source of information, for women in particular, was friends and family. When talking directly about sources of family planning information, and indirectly about the sharing of family planning decision making, many women demonstrated a strong reliance on the experience of others in educating them about available contraceptive options:

The woman has a very close friend or close relative, and any woman's friends are relatives. They tell any experiences or if they are using any methods, then women do the same thing. Then a woman feels that as the woman has her own experience, it is good for her or not. Thus, the first method a wife uses is generally whatever her close friend or relatives use. [PRW3, F1]

A few women use the injection and Copper T [IUD] because someone in their family or some friends have already used that method. [PRW5]

Men, however, appeared to talk about such matters with friends much less frequently: There was no reference to “word of mouth” when men were asked about forms of communication; they showed a tendency to share far fewer stories and examples about family planning decision making and methods than did women, coupled with lower correct awareness of available contraceptive methods. In these discussions, men emphasised that family planning was a woman’s business and that while men want fewer children, they leave it to women to choose and adopt the method. This belief is further supported by women’s stories from discussions with friends that highlighted a lack of male engagement in family planning (see the decision-making section).

Men also suggested that as well as family planning being women’s business, they did not have the opportunity and/or time to discuss such matters in the manner that women did. Women, they felt, are able to get together and chat after they finish the housework, while men must work hard all day to bring in a household income. However, men still thought that the

experiences of others were critical in promoting the uptake of family planning methods, NSV in particular. Further, we saw in discussions about family planning decision making the influence that wives and, in particular, men's mothers can have in determining practice. As a result,, while men might rarely discuss family planning methods, word-of-mouth communications are still critical in promoting the adoption of NSV. This is discussed further in the male sterilisation section, where a specific subsection explores communication and influences for encouraging increased rates of NSV uptake.

Family Planning Services and Methods

In the second theme of interviews, men and women both spoke to their friends about awareness about, use of, and attitudes toward different family planning methods. Understanding current family practice and attitudes will allow us to explore the range of alternative family planning options against which male sterilisation must be positioned and provide insight into attributes that are valued in a “good” family planning method. Thus, this section of the report explores attitudes toward the full range of available family planning methods.

In discussions about family planning methods, respondents indicated high uptake of contraceptives, yet the prevalence of unplanned pregnancy (discussed above) suggests otherwise. However, the qualitative nature of this study means that we cannot truly comment on the prevalence of contraceptive uptake. Thus, our focus here is on people's attitudes toward family planning methods over prevalence of use (though experiences are shared in the form of stories).

Sources of Contraceptive Services

Respondents discussed a range of providers, ranging from shops, ASHAs, and private nurses within villages, through subcentre-level primary care centres, to hospitals (both public and private). Oral contraceptives, along with condoms, were reported to be easily available (at no cost) from ASHAs or (at a cost) from shops, and could also be obtained (again freely) at primary health centres; for more provider-dependent procedures (injectables, IUDs, male and/or female sterilisation), it is necessary to go to primary health centres and/or hospitals. Overall, men were much more likely to talk about hospital-based services than any others, while women focused more on the role of ASHAs and primary health centres in providing family planning methods. This perhaps reflects the men's focus on IUDs and sterilisation, while women tended to be willing to explore a fuller range of methods, particularly those methods that they can more easily adopt without the knowledge of other family members.

ASHAs were the single most important personnel when it came to women's obtaining contraceptives. Because the ASHA lives in the village, her services are easily accessed, and she provides free condoms and oral contraceptives. Not only do ASHAs provide certain contraceptives, but they accompany men and women to health centres and hospitals when they need higher level services, and they are among the most trusted sources of family planning information:

She met with an ASHA and the ASHA give her Mala D [the pill]. She never told this to her husband. [PRW3, F2]

Use the pill, available from ASHAs in the village; women can easily go and get it. [PRM7, F1]

We have more trust in ASHA, because she gives information as well as goes with us in health centre when we need, and if we face any problem then ASHA goes with us. That's why we always take ASHA's advice and we don't do anything without informing her. If we go to the health centre alone, then we waste most of our time finding out about the doctor's services—where is the doctor, where is this, where is that?... [PRW2, F1]

ASHA also takes cases for sterilisation and delivery. If anyone does not want to go for sterilisation, she provides condoms. The other important thing is that if ASHA accompanies the case, she helps in getting money from the hospital. [PRM3, F1]

They also get [contraceptive] supplies from ASHAs of the villages and ANMs of the subcentre. ASHAs and ANMs are known people, the chances of failure are less, they will give proper suggestions. [PRM7, F3]

Thus, even when services are sought from hospitals and health centres, the role of the ASHA is critical.

While it is clear that IUD insertion, as well as male and female sterilisation, require services from primary health centres or hospitals, it was less clear from the data what determined which of these would be used for what reasons. While women tended to talk more about the services of primary health centres, men would talk about hospital services in the same manner, both discussing the same sorts of positive and negative attributes of each.

Overall, government services were usually preferred to private clinics or hospitals. The most important reason for this appeared to be financial. – Government services were free, services are covered by a form of warranty, and, in the case of sterilisation, people are given payments to undergo the operation:

People from lower strata like government services, where they get money from the government hospitals. Hence, they like government services. In government hospitals, you can take action also; if a method fails, you can get money from the government. [PRM3, F1]

People also go to the private hospitals, but there [you] cannot get money, so they prefer to go to the government hospitals. [PRM2, F1]

Furthermore, people generally seemed to think that the doctors were good (particularly at the Women's Hospital in Kanpur):

People most trust the Women's Hospital of the city, as doctors in this hospital explain things well and provide good advice. Doctors are good in this hospital. [PRM8, F4]

Men particularly liked it when female doctors were available within government facilities. The reasons for this were not clear, but they appeared to relate primarily to the gentle nature of female doctors, rather than to any concern about women being examined by men.

An exception to the preference for government-run services was when women and/or couples did not want to risk others finding out their business. In such cases, usually abortion, a preference was shown for private nurses, clinics, and hospitals:

When we want abortion and we want nobody to know this, then we go private clinics.
[PRW3, F3]

Men also reported that those who were educated and/or who could afford it would also use private clinics and hospitals for sterilisations. Often, reasons for this were not given, though a couple of men suggested their main advantage to be that while no incentive was paid for the operation, the chances of failure were lower:

If the person is educated, they prefer to go to the private hospital. Private hospitals are more reliable, and the chances of failure are less [PRM2, F2]

Government nurses are casual sometimes, hence the chances of failure are high. [PRM2, F2]

A preference for private services, if affordable, might also be explained by some of the negative features of government hospitals and primary health centres described by the respondents. A few participants complained that doctors were not always available, so that you might have to come back another day, or that the facilities could be dirty and/or the nurses rude:

Many times, the doctor is not available at the block-level hospital. The women may have to come back if the doctor is not available. [PRM6, F1]

Generally, people prefer to go to a hospital; there, we can find all information. But because of smell and dirtiness, I do not like it in the hospital. [PRW1, F2]

In this hospital, nurses are rude, they do not talk properly, they do not use the right words for the people. [PRM8, F4]

Just as private clinics and hospitals were reportedly favoured when people did not want others to find out about abortions, a couple of women reported preferring to buy family planning commodities from shops, rather than obtain them from ASHAs or ANMs. Such occurrences were mostly reported when women were adopting contraceptives secretly and did not want to risk their husbands or mothers-in-law finding out. As discussed in the methods section, some people also preferred to buy condoms from shops rather than obtain them from ASHAs, as the quality of government condoms was perceived to be poor.

Contraceptive Methods

Overall, a strong preference for female-centred methods of family planning was observed, both among men and (especially) women, as they have control over using these:

Generally, men don't want to use any method, because they have fear about methods... Men and women both think that man is the earning member of the family, so everyone tries not to give any type of problem to men that would hinder his ability to earn. Because he is the earning member of the family, you must not create a problem for him, so he does not use male family planning methods. Because of this thinking, husband and wife do not even think to use or even discuss male methods. [PRW4, F2]

That's why generally women prefer to use the family planning, not the husband—all methods are for women, because they worry about the consequences of intercourse; men are only interested in the intercourse, not the aftereffects. [PRW3, F2]

Such preference for female methods is also seen among men who perceive family planning as the responsibility of women and who demonstrate fear associated with the potential failure of condoms and male sterilisation, as well as pain and risks associated with an operation.

Not unexpectedly, women showed much greater awareness about the various methods available than men and were able to share more stories and experiences about their use: Women clearly discuss family planning methods openly with their close female relatives and friends, and such discussions prove instrumental in their selection of a method. Thus, there were clear patterns of clustering observed, where in one locality IUDs might be the seemingly most adopted method, and in another female sterilisation or oral contraceptives might be favoured. As a result, it is difficult to give an indication of which methods were most and least favoured overall, though IUDs, the pill, and female sterilisation appeared to be the most commonly used methods.

Many women indicated that switching methods is common—some women might experience problems with one method and, after discussing this with friends, change to something different. However, men appeared greatly unaware of such “experimentation” and focused on the negative attributes of all methods that they knew, an awareness that appeared to limit their acceptance of any family planning method at all.

Condoms were less favoured overall (though awareness of them was high), while both awareness and use of other methods (such as the injectable, natural family planning, and abstinence) appeared lower. Adoption of male sterilisation was especially low, with many sharing examples of failed cases and/or resultant male weakness (both physical and sexual). As discussed earlier with unplanned pregnancy, abortion appeared to be a particularly common method of family planning, with many couples apparently not even considering the adoption of contraceptives until such an event occurred.

IUDs

IUDs were universally referred to as the “Copper T,” and overall levels of awareness and use appeared high in spite of reported problems associated with the IUD. Commonly cited concerns included the onset of heavy bleeding, feelings of nausea or sickness, and, most frequently, the risk of expulsion or movement of the IUD into the body. This last factor seemed to be a particularly pronounced concern, with many respondents sharing stories about such occurrences from their localities:

Copper T is not liked. My friend says it comes out while lifting weight, and sometimes it fails. [PRM2, F1]

One woman used the Copper T. After some time, the thread became broken and the Copper T went inside the body, and there was this discharge of white mucus from the vagina, so I have no trust in the Copper T. Actually, trust is the matter of everyone's experiences. [PRW5, F2]

Copper T suits somebody and does not suit somebody [else]. Because of the Copper T, some women became sick and sometimes Copper T shifts from its place and goes inside the body... but generally women prefer Copper T, as they become worry-free [as it is a long-lasting method, in comparison with, for example, oral contraceptives]. [PRW1, F1]

A couple of men also raised concerns that sometimes even after the IUD was removed, a woman may still be unable to conceive, while others worried that it *spoiled the uterus* and/or indicated incomplete or incorrect knowledge about the method:

Copper T is the least used method, as my friends mentioned that women are not able to conceive even after having it removed. [PRM9, F1]

Copper T is not preferred at all; it is harmful to the body. My friend mention that the uterus of a woman was spoiled after she got Copper T. [PRM6, F2]

My friend mentioned about a family who uses Copper T, but they go to replace it every 3–4 months... yes, he mentioned that. [PRM6, F2]

Associated with these stories of problems, there were indications that while the IUD was often one of the first methods adopted, women frequently changed to alternative methods, usually the pill or (if the family is complete) female sterilisation. There were also indications that IUDs were more popular in the past but that perhaps uptake is now diminishing in association with the increased availability of other family planning methods.

Among those women who liked the Copper T, no real reasons were given, simply that it was a good method and/or that their friends had not experienced problems with it; a small number cited its main advantage to be its semipermanent nature. Interestingly, however, a couple of men cited reasons for preferring it on occasion. Such reasons included its being easily available (though a woman must go to the block hospital for insertion), having fewer side effects than other methods, and lasting for many years:

According to me, most of the women use Copper T, because it has less side effects and people can use it for a longer period—five or 10 years. [PRM10]

Oral Contraceptives

A key benefit of oral contraceptives appeared to be their easy availability. While for methods such as the IUD or female sterilisation, you must go to a health centre or hospital, pills (and condoms) are easily available from ASHAs (who give them out for free) or local shops (where one may pay between Rs. 2 to Rs. 300). This ease of accessibility makes it easier for women to adopt family planning in secret, without telling their husbands or mothers-in-law:

Generally, women use Mala D [brand of oral contraceptive]. I know five women who take the Mala D. They take because it's the decision of woman, so if she takes the pills, then she doesn't depend on anyone for the pills. [PRW4, F1]

Some women take the pills. They trust only in pills, because their husband doesn't think about stopping the children, that's why women arrange the thing for themselves so they don't become pregnant. [PRW5, F1]

While easily accessible, oral contraceptives do also have their disadvantages. Both men and women cited concerns around women forgetting to take them, especially when traveling away from the home, as well as experiences of side effects, including increased blood pressure and feelings of nausea and unease:

If we go somewhere for an outing or we go to the home of some relatives and that time we do not have the pills with us, then that means pills are not a good choice. [PRW3, F2]

People may forget to take pills. If they go to a function at any relative's place, they may not carry the pills along with them. Meanwhile, if they have sex, the woman can get pregnant. [PRM10, F3]

Some women said that because of Mala D, they felt vomiting and uneasiness. A newly married woman started to take pills, then she felt uneasiness and vomiting. [PRW4, F1]

Pills cause tension, they increase blood pressure, hence woman may not take interest in work, they may not follow their husband's instructions. [PRM3, F1]

A few women also talked about prolonged use of oral contraceptives resulting in the formation of *lumps* in the stomach:

My elder sister-in-law took pills for a long time, and because of the pills a lump developed in her stomach. To remove the knot, the doctor advised her to have an operation. The doctor removed her uterus, too, because of some complications. Now everyone in my family is afraid of pills. [PRW1, F1]

Condoms

Many men were in favour of condoms, highlighting how they are easily available, are cheap or free, and can be used as and when required:

Condoms are the most liked method, as they are used when required and are easily available at subcentres or from ASHA. [PRM3, F1]

Condom is good, as it is easily available. Some of the condoms are cheaper, and it is available free of cost as well. [PRM10, F1]

However, some men did talk of fears or stories of condoms bursting, being uncomfortable, and/or causing irritation. Such concerns were also cited by women, who were especially worried about the risks of condoms breaking, fearing becoming pregnant. Women did not talk about the positive aspects of condom use:

Condom is least used, as it causes irritation, small blisters develop; it bursts also. [PRM10, F1]

People do not like condoms also. One of the neighbours was using the condom, it burst and got stuck inside. Her husband took her to Kanpur and spent 1,000 rupees to take it out. [PRM3, F1]

In my neighbourhood, a husband started to use condom and one day, during intercourse, the condom broke. Then his wife became afraid because she already had three children. After that incident, the wife had an operation [for sterilisation]. [PRW5]

Such concerns also extended to worries that in the heat of the moment, condoms may not be used, in turn contributing to the strong female preference for female-controlled family planning methods:

Women don't want to use condoms because if her husband said that he will use the condom, but during the intercourse they become so excited that at that time they don't want to use condom, then the wife becomes pregnant. So the wife prefers the pills, because for this she is not dependent on the husband. [PRW4, F3]

Thus, women seemed to have a more negative attitude toward condoms than men, who seemed more ambivalent. Men were more concerned about the potential side effects on women of other contraceptive methods.

Female Sterilisation

Along with the pill and IUD, female sterilisation appeared to be one of the most favoured modern contraceptive methods among both men and women. There were indications that often it was the default method of choice once the desired family size had been met, with few respondents seeming to be able to give clear reasons as to why female sterilisation might be adopted rather than other female-methods. Instead, they focused on simply why it was better than male sterilisation. Thus, there are signs of an existing social norm that dictates female sterilisation to be *the* contraceptive that will be used once a family is complete.

However, it also appears that the increasing availability of other contraceptive choices is challenging this norm and that the uptake of female sterilisation may be declining. Many women reported/shared stories about first trying other methods such as the pill, condoms, and/or the IUD before finally undergoing sterilisation:

ASHA informed me about Copper T [IUD]. Then I used Copper T and had lots of bleeding, so I met with ASHA and told her that I have lots of bleeding, then ASHA gave me pills. Then I felt the problem of vomiting, so ASHA gave me condoms, but many times during intercourse we did not have the condom. Then ASHA told me, use the injection. Then I said "No, now I have no trust in any method." Then I directly went for an operation. [PRW4]

After my second baby, again I used the Copper T, but the second time heavy bleeding started. Then I removed the Copper T... After this I had the operation [for sterilisation]. Now, in my neighbourhood, four women had the operation. When we went to the hospital for the operation, that time I had some fear, but now I am very, very happy. [PRW4, F1]

My friend said nobody is going for sterilisation nowadays, they prefer other methods. Those who have any problem with pills, etc., they may go for sterilisation. [PRM2, F3]

Among Muslims, neither male nor female sterilisation is adopted, with respondents reporting the procedures to be against their religion:

Nobody goes for sterilisation in our community, as our religion does not allow us to go for sterilisation... Our elders say that instead of pills, we use Copper T or injection. [PRM10, F3]

While female sterilisation is still a commonly adopted method among non-Muslims and is far more popular than male sterilisation, a number of respondents, especially females, cited its main disadvantage as being fear of the operation:

One of my daughters-in-law said “neither I nor my husband will go for operation [sterilisation]. I am afraid of the operation.” [PRF2, F2]

Nobody wants to go for sterilisation, any operation nobody wants, people are afraid of undergoing surgery; even educated people do not want to go. They prefer to go for any other option like pills, condoms, etc. [PRM2, F1]

However, while people reported fearing operations in general, there was a widespread belief that female sterilisation is safer than male sterilisation:

The thought of villagers is that female sterilisation is less harmful than male sterilisation. [PRW12, F1]

Further, while both male and female sterilisation are widely believed to result in weakness, there is significantly less concern about this impact on women, whose role is in the home, than upon men, whose daily work brings in the household income and tends to involve heavy labour:

Female sterilisation is good because women have easier work in comparison to men. If a man goes for an operation [male sterilisation] and because of weakness he faints or is unable to perform his duty, then who will earn for the family? [PRW10, F3]

Male sterilisation is less common, but female sterilisation is high. Female sterilisation is high [because] women are restricted to the household, which work is not heavy, so it is easier for them, but we as males do outside work, which is heavy, so we do not do it [male sterilisation]. [PRM3, F1]

This said, a significant minority of men still felt that, especially given the availability of alternative family planning methods, women should avoid female sterilisation given they still have household responsibilities:

Regarding female sterilisation, my friend said that even women are also scared of female sterilisation. They think they will remain sick after the female sterilisation. This will have impact on their daily work. They will not be able to work. This is their opinion. [PRM2, F2]

Female sterilisation, it makes the woman weak. She carries a lot of family responsibilities, hence it is difficult to go for this method. [PRM2, F3]

Interestingly, this concern was not cited by women, who only talked about a general fear of the operation, not about its after effects.

While people feared surgery, and some worried about postoperative weakness, there were only a few stories (shared by men) about the negative consequences of female sterilisation—a couple of failed operations and one case where a woman died after the operation:

My friends mention that in their village both male and female sterilisation failed. The woman who had adopted female sterilisation, she became pregnant after one year. [PRM9, F1]

His friend said that female sterilisation fails; even women die after the surgery. He knew a case where a woman's [fallopian] tube had been rotten. The family had no money to get her treatment done; the woman died. [PRM4, F2]

This apparent absence of stories or gossip relating to female sterilisation, coupled with the dominant environment of women being in the home, might explain the view held by some men that, while the whole community would come to know if a male was sterilised (which is mostly perceived in a negative light), a woman's sterilisation would remain a secret within the household:

About female sterilisation, his friend said that nobody would know if she was sterilised. She can go quietly to the hospital and get the female sterilisation done. [PRM3, F2]

About female sterilisation, his friend said that one can keep this confidential, so nobody can tease and crack jokes against them. [PRM4, F1]

In summary, in spite of some concerns and fears about female sterilisation, it appears to be a commonly adopted family planning method, one that was met with few side effects or problems, thus making it a favoured option among both men and women.

Other Methods

Other less-talked-about methods of family planning included the injectable and use of either the withdrawal or rhythm methods, both of which were identified by many to be very risky, but the latter of which appeared to be utilised by a number of couples. Abstinence was also mentioned by some, but it was generally thought to be unrealistic. Hence, of all the natural methods, the rhythm method was most likely to be practiced:

Me and my husband never have relations before 8–10 days menstruation cycle and after, and now we have two children, so this means we are very little interested in [sexual] relations. [PRW2, F1]

You can not use anything and use condoms during 15th–18th day of the menstrual cycle. This method is not at all reliable. His wife got pregnant immediately after delivery. He was following the same method. They were in trouble. [PRM2, F1]

There are some natural methods, but no one uses these methods. For example, if after intercourse, women clean their vagina with water and even ... not go to bed for sleep, then she never becomes pregnant, or, if a couple do not have relations before six days and after six days of the menstruation cycle. [PRW4, F1]

Reported uptake of the injectable contraceptive was low, and it is possible that people were actually confusing it with the implant (though this is not currently widely available in India), given that most of the few people that talked about it reported that it lasted for five years:

In my neighbourhood, a woman used the injection and now she is free from worry for five years and she has no problem. [PRW4, F3]

With pills, sometimes women forget to take the pills, but with injection women become tension free for five years. [PRW1, F2]

Since the implant is not currently available in India, it is not clear what contraceptive method people were referring to above. Most likely, such comments demonstrate incomplete awareness of the features of different contraceptive methods.

While uptake of the injectable contraceptive was low, experiences reported were generally positive, with men and women alike particularly valuing the long-term freedom from worry (as indicated in the quotes above). Given that the injectable and the implant are not currently available through government services, if women are indeed using either of these methods, they must be purchasing them privately. What is evident is that inaccurate knowledge about several methods exists.

Male Sterilisation

Overall, male sterilisation was clearly seen to be one of the least, if not *the* least, preferred and used methods of family planning, a method associated with fear and weakness. Correspondingly, there was a tendency to describe sterilised men in negative, often derogatory ways. In those areas where known positive experiences of male sterilisation were described, this appeared to be changing attitudes and increasing the uptake of NSV. However, given the stigma attached to male sterilisation, even men who had had positive experiences with the procedure might well choose not to reveal or admit this to others in the community, thus limiting the spread of positive stories that seem so important to increasing acceptance.

Given the emphasis on negative attributes of male sterilisation, this section starts by exploring the barriers to increasing uptake. Next, we will explore perceived benefits of, and drivers to, increasing uptake of male sterilisation, before discussing the decision-making process and who might persuade men to undergo NSV, attitudes toward the NSV concept presented to respondents, and a description of sterilisation services.

While in the training workshop, men feared that women would not be able to talk to their friends about the topic of male sterilisation, in practice women actually discussed it more freely than men did and shared many more stories and examples about vasectomy than did the men. This suggests that, as with the topic of family planning generally, women discuss male sterilisation with their friends more than men. While no clear reasons for this were given, it may reflect a male concern about being stigmatised or judged by others if admitting to having undergone the procedure, preventing their discussing the topic with friends. Given the tendency of women to talk more freely than men, female quotes are more often presented here than male ones, though the short answers men did provide suggest that these quotes adequately reflect both male and female opinion.

Barriers to Male Sterilisation

Fear of Weakness

Resistance to male sterilisation was high not only among men but also among women, with both men and women reporting that it was better and easier for a woman to undergo sterilisation. The greatest driver behind such resistance related to concerns about *weakness* that would result from male sterilisation. While respondents cited that female sterilisation also

results in weakness, it was widely believed that this has less impact on women than men, given that it is the husband who must do heavy work and bring in an income to support the family. Indeed, both men and women were extremely fearful that a man would become weak if he underwent sterilisation:

Male sterilisation, people think it causes weakness. They would not be able to carry out heavy work, so they do not go for this method. [PRM10, F3]

Men do heavy work related to agriculture, male sterilisation causes weakness, so this means they will not be able to do heavy work. They should not go for it. We have seen men in the villages who are sterilised and become weak. [PRM6, F3]

Mother and wife will never allow her son/ husband to go for an operation. They fear that he will become weak and become unable to work. [PRW4, F2]

If any man gets sterilised, then people think that this man is weak in his life, because there are many examples in the village that the men who got sterilised, they seem too weak to work hard in comparison to others. [PRW12, F3]

Sometimes even when men were prepared themselves to go for sterilisation, their wives argued against it in the face of such fears:

I would never allow my husband to go for an operation. I have delivered two babies, so my husband said, "I can go for [male sterilisation] operation," but I said "No, we will use condoms, but you will not go for the operation." He works in a factory, there he works hard from morning to evening, that's why I will not allow my husband to go for the operation. [PRW5, F2]

Impact on Sexual Performance

As well as physical weakness, people reported that male sterilisation might result in reduced sexual performance, a concern talked about more frequently by women than men:

Husbands prefer not to go for male sterilisation. Even their wives do not want them to go for male sterilisation, because of the belief that male sterilisation causes weakness. Men and women are both concerned about their sexual performance; hence, woman prefers to go for female sterilisation. [PRM8, F1]

Wife can motivate the husband for operation, but wives fear that after the [male sterilisation] operation, their husband will lose his potency and the pleasure they have before the operation will not be possible after the operation. [PRW1, F2]

Men think that if they go for the operation, then they will become weak. A man works hard, either he is a farmer or labourer. Even husband and wife think that after the operation they will not enjoy their sex life. I asked why a couple will not enjoy their sex life, then my friend laughed and said, "because the tightness of the penis reduces after the operation so they will not enjoy." [PRW5, F2]

Associated with this perceived reduced sexual performance, men in particular reported that sterilised men might be described by others as infertile or "without manliness" (*namard*), barren (*napunsak*), and/or a eunuch (*hijra* or *chhakkha*). Women also noted that people would think that

a sterilised man was “*the slave of his wife*” [PRW3]. Box 1 (page 34) presents a series of quotes provided describing perceived community responses to sterilised men. The quotes demonstrate men’s anxiety about being taunted by other community members:

Regarding male sterilisation, his friend said that people laugh and make fun of the men who accept sterilisation. Some of them say “now [you] will not be able to satisfy your wife sexually...” People think he’s not a man now, he’s sexually dysfunctional. People in a village know about them, somebody would disclose their status while quarrelling, in a village people taunt them. Then the entire village would know about their status. [PRM4, F1]

Thus, even when there are examples of male sterilisation that have not resulted in any problems, they may not be known in the community, as men may choose to keep the fact that they have undergone vasectomy to themselves.

Fear of the Procedure

As already discussed, men had a greater tendency to report negative attributes and fear of all family planning methods. This fear became accentuated when it came to male sterilisation, a procedure described as an “operation” that the men must undergo themselves. Women, and a couple of men, cited that men tend to be more afraid of operations than women, reporting that their fear and cowardice could be a major obstacle to their undergoing male sterilisation:

No man will come readily for the [male sterilisation] operation. Generally, men get information from ASHLAs that they will get the Rs. 1100, but even then they do not go to the camps.⁸ Men are very cowardly. They worry about their life only. [PRW5, F1]

Men fear male sterilisation and they think if women have no problem, then why should we worry, go get themselves operated on. Even if men have sufficient information about male sterilisation, they pretend that they do not know anything about it. [PRW8, F2]

Conversely, women reported that:

Only a very courageous man can take the decision about the male sterilisation. [PRW2, F3]

Men who go for operation? Only a strong man can go. [PRW3, F1]

⁸ Male sterilization camps are organized by the Government of Uttar Pradesh to meet the family planning needs of male clients; these camps provide counseling in an environment of informed choice. They allow an opportunity for the few trained NSV providers in the state to reach clients on a given day, to maximize cost efficiency and provide increased access to this method.

BOX I: What People Say About Sterilised Men—Sample Quotes

Overall, respondents felt that sterilised men were likely to be laughed at and referred to in a negative light by other community members.

Key Hindi words used to describe sterilised men included: *chakka*, *napunsak*, *Hijra*, and, most commonly, *namard*.

Broadly speaking, these words translate into: eunuch, infertile, barren, and man without power.

The quotes below represent a sample of the negative comments used to refer to sterilised men:

Regarding male sterilisation, his friend said that people laugh and make fun of men who accept sterilisation. Some of them say he would not be able to satisfy his wife sexually. People think he is not a man now, he is sexually dysfunctional... [PRM4, F1]

There are many things people say about a man who is sterilised. People tease him that he is not a “man,” he is like a eunuch. [PRM3, F1]

My friend said “who would be willing to cut his private parts?” People who are sterilised are called barren. Nobody wants to call himself barren or a eunuch. Manliness is an identity. [PRM2, F2]

People fear that they will lose their manliness. They will be called eunuch. [PRM2, F2]

They say they are infertile man. [PRM4, F2]

They call them man without power. [PRM9, F1]

They see him as without manliness. [PRM7, F1]

People say he loves his wife too much; he is the slave of his wife. Now he is not a man, he is a eunuch. [PRW3]

While sterilised men were mostly described negatively, a significant minority reported that people they knew would not laugh and that some might look upon a sterilised man in a more positive light. Such people appeared more likely to also report knowing positive examples of men undergoing vasectomy in their localities. These people, however, did not tend to give strong, positive descriptions of a sterilised man, rather mostly simply reporting the absence of a negative reaction toward them or describing them as “good”:

It is good, those who have undergone male sterilisation recently are happy. [PRM5, F1]

Nobody laughs at them. I know two males who have undergone male sterilisation recently. [PRM5, F2]

Nobody will speak badly about the person. [PRM8, F1]

People say they are good people; they have good family. [PRM8, F1]

Fear of Failure

Not only were men afraid of the procedure itself and of potential postoperative weakness, but there was a real fear that NSV could fail. Indeed, overall, respondents were much more likely to report cases of failed vasectomy than of failed female sterilisation. As the quote below shows, failure of male sterilisation has very severe consequences for women, leading to charges of infidelity and subsequent eviction from the family. This is a highly significant finding and is likely to play a major factor in women implicitly encouraging low acceptance rates of NSV:

In my elder sister-in-law's family, one woman became pregnant after her husband got operated on for male sterilisation. The husband said to his wife, "You have had illicit relations with some other men." His wife said, "I have not had any relations with anyone. If you want, we can go for a check-up and investigation," but the husband was not interested in any check-up and threw his wife from the home. The wife delivered the baby in her parents' home; no one supported the wife. [PRW5, F3]

One of his neighbours who is now around 60 years old, around 20 years back his wife became pregnant after the operation [vasectomy]. [PRM2, F1]

Most of these reported cases of failure seemed to come from previous generations; nevertheless, in the absence of more awareness of positive experiences, these stories remain a powerful deterrent to the adoption of NSV.

Availability of Other Methods

Combined with a fear of weakness and/or failure, the availability of alternative family planning methods acts to deter men from undergoing male sterilisation, with both men and women questioning why, given the existence of other methods, men would go for NSV:

If pills and Copper T are available, then why think about male sterilisation? [PRM19, F1]

Men think male sterilisation is not the only option; they prefer other temporary methods like Copper T, pills, and condoms. [PRM6, F1]

People do not choose male sterilisation as they have other temporary options, like pills, etc. [PRM8, F1]

In our area, many people don't get sterilised, because [male] sterilisation is not the only instrument of family planning. There are many other instruments available, like female sterilisation, pills, loop, Copper T, condom, etc., that control the birth of the child. Many people here know about other instruments of birth control [PRW11, F1]

In this village, there are many people who are educated [about family planning]. They don't believe in male sterilisation and to prevent childbirth they think about other methods. [PRW12, F1]

Alternative methods will be especially preferred when a couple do not feel their family is yet complete, but are looking to space their children appropriately, and temporary over permanent methods are preferred.

Benefits of and Drivers for Male Sterilisation

While more people spoke about the negatives of male sterilisation, a significant minority talked about times when men would decide to become sterilised and in this manner provided insights into the potential benefits of and/or drivers for NSV.

“Complete” Families and the Desire for Permanent Methods

While male sterilisation is not a commonly adopted method, a significant proportion of respondents, male and female, signalled that as a permanent method of contraception, it could be desirable when the family was thought to be complete and no more children were desired:

If they are using a temporary method, it may fail, so it is better to go for permanent methods. [PRM4, F2]

People will be motivated to go for male sterilisation once they realise they have completed their family, and they are sure that they do not want any more children. Then they can go for permanent methods. [PRM5, F2]

A small family is a happy family, so people go for sterilisation. Men or women can go for sterilisation. Sterilisation is good after two children. [PRW7, F2]

However, as indicated by the preceding quotes, a desire to complete the family and stop having more children acts more as a driver to adopt male or female sterilisation, not male sterilisation specifically. As has been discussed, respondents tended to express a preference for females to undergo the procedure rather than men. Thus an additional trigger is needed to facilitate the final adoption of NSV.

One such trigger might be awareness of or experience with problems associated with other family planning methods, especially given that the availability of alternative contraceptive options acts to deter men from adopting male sterilisation:

Male sterilisation is good, as it is permanent. In the case of Copper T, there is a chance of infection. In case of pills, you have to take it multiple times. If you have completed your family, you should go for male sterilisation, my friend said. [PRM3, F2]

“Weak” Women

Perhaps the most common trigger for the adoption of vasectomy was when a couple had completed their family and wanted a permanent family planning method, but men felt their wives were too weak (often as a result of undergoing a caesarean) to undergo sterilisation themselves. Indeed, it is under such circumstances that many of the positive male sterilisation experiences were often shared:

A man had the operation himself because his wife was sick. She became pregnant many times, and every time she aborted her child. Then her husband decided to have the operation. Other family members did not want to allow him, they said “use the condom or other methods, there is no need of an operation,” but the husband said “pills and other methods do not suit my wife,” so he went for the operation. They have never faced any problems. [PRW7, F2]

One relative of my aunty went for an operation. His wife had three daughters and so he said, "You delivered three babies, now you are very weak, so I am thinking that I should go for the operation. You have to not get pregnant again, it is very important." Then the husband underwent the operation. Now they have no problem, and they are happy. [PRW1, F3]

My friend mentioned one person who was poor. His wife was weak and his children were weak. His wife was too weak to go for female sterilisation; he was not able to afford expenses. He went for male sterilisation. [PRM3, F1]

As will be discussed in the decision-making section, under such circumstances, fearing that their wives would not agree to their undergoing the procedure, some men went for vasectomy without informing any of their family members:

In my locality, a woman always got sick, so her husband went for the operation without asking anyone in his family. When his wife came to know, she said, "My husband did not tell me anything about it, because if he had asked me, I would never have allowed him to have the operation. That's why he did not inform me." The husband went to ASHA for the operation, so his mother and father shouted so much at the ASHA. Now everything is fine. The husband and wife have no problem, even their sex life is normal. [PRW5, F2]

After her third baby, which was delivered by a caesarean operation, the wife wanted to be operated on herself for sterilisation, but the doctor said, "No, I will not operate on you, because you already were operated on for delivery of baby." Then her husband went to the City with ASHA for his own operation for sterilisation without informing anyone in the family, but when his mother came to know this then she went to ASHA's home and shouted at ASHA, "just because of you, my son will become weak."... But today, the man has no problem, and the husband, wife, and mother-in-law, all are happy. Even the man said "I am very happy, I have no problem, and I am worry free." [PRW4]

Changing Work Patterns

As discussed, there is a widespread fear that male sterilisation will weaken the man and that he will then not be able to work and/or provide for his family. This fear is clearly one of the most powerful drivers against male sterilisation. However, in a few cases, men noted that in some circumstances, they need not be so concerned about weakness. If they work in an office or factory, the work may be less heavy, and in recent years, the agricultural sector has become less labour-intensive:

Intelligent people will go for it. This is the era of the tractor, all facilities are there, so where is the question of lifting heavy weight, etc.? [PRM3, F3]

If he [is] working in a factory and does not do heavy work, he will likely to go for male sterilisation. [PRM3, F1]

Associated with this, there were a few cases in which couples decided to adopt male rather than female sterilisation, feeling the man's work burden to be less heavy than that of the wife.

Financial Reimbursements for Transportation Costs and Wages Lost

Overall, most respondents, particularly men, felt that the current reimbursement amount of Rs. 1100 (US\$25) was insufficient to motivate men to undergo male sterilisation:

Rs 1100 is too little, it should be increased. It will encourage poor people to accept male sterilisation. They can start a shop, etc., for their livelihood. [PRM10, F3]

Rs 1100 is nothing. If government pays Rs. 10,000 to 15,000, people will be motivated. They can open a shop or put this money in the bank. [PRM9, F1]

If a man doesn't want it, even if the Government gives Rs 1100 or Rs 2000, he will not go for the [male sterilisation] operation. They will not be ready for an operation in any case. [PRW3, F1]

Only a few respondents felt that this amount would motivate some poor men to undergo male sterilisation. However, later, the provision of a Rs 1100 payment certainly encourages men to go to government rather than private hospitals for NSV.

Simple and Painless Procedure

Of all of the content about NSV that was shared with respondents at the end of their discussions about male sterilisation (Theme 3), the idea of a *simple* and *painless* procedure was the most appealing to men and to some women:

His friend said this is painless and there is no blood loss also. It is good. People will like these things. If the doctor also guarantees that nothing is going to happen [no failure], then a man will accept this method. [PRM3, F1]

People will like the simplicity of the method. [PRM5, F2]

People may like this method as it is painless. [PRM4, F2]

Yes, if women have this information about male sterilisation, that there is no pain, no stitches, then surely they will convince their husbands to be in favour of the operation [male sterilisation]. [PRW3, F3]

However, while some women also shared this view, more of them (in particular, the friends of peer researcher F10) doubted the possibility of the procedure really being so simple and pain-free:

[Laughing] Without a cut, without stitches, sterilisation is possible? I do not believe it. Then how is it called an operation? It is not possible. [PRW10, F1]

I do not believe that without cut and stitches this operation is possible. [PRW10, F2]

Awareness of Positive Case Examples

Awareness of cases of male sterilisation that had been successful was, although unfortunately rare, one of the most powerful drivers of improving attitudes toward and even increasing uptake of vasectomy. This is seen in a number of the quotes in the section above that share positive examples of male vasectomy and in the clear pattern where the eighth female peer researcher and all her friends talked about knowing men who had undergone the procedure

successfully. These women also shared how awareness of successful case examples had encouraged other men to undergo the procedure:

In my village, a man went for the operation and he has not faced any problem after the operation, he said the operation was very simple... On my mother's side, seven men got themselves operated on in a government hospital. All are well and have no problem. Now people have a positive attitude toward the sterilised man. [PRW8, F1]

A man got himself operated on and he has no problem. Now he motivated many men for the [male sterilisation] operation. [PRW8, F3]

While these examples were mostly shared by women, the men themselves, when asked about who can persuade a man to go for sterilisation, frequently highlighted the importance of knowing people who had successfully undergone the procedure:

A friend who has already accepted male sterilisation can persuade easily. He can share his experience and clarify doubts regarding male sterilisation for the person who is interested in male sterilisation. People will believe more those who have already accepted. [PRM5, F2]

In my opinion, the best person to persuade a man would be an acceptor from his village. He can tell him his experiences after NSV. He can clarify his doubts. [PRM3, F3]

The importance of testimonials was further reinforced in the analysis workshop, at which men emphasised the power of hearing about positive experiences of NSV in persuading them to go for the procedure. While doctors were said to be important when it came to explaining and dispelling myths, the most powerful tool was felt to be a man who had undergone the procedure and could demonstrate to all that he was still fine after adopting NSV.

The role of acceptors in promoting male sterilisation is discussed a little further in the section below, which explores information sources and potential communication channels for promoting NSV.

Male Sterilisation Decision Making and Influencers

Male sterilisation represents the single case-example in which men were often found to take the decision without consultation with the wife or other family members. This appears to reflect three things. First, a significant minority of men believe strongly that they cannot be influenced in their decision making by any others:

Nobody can persuade a man. If he has knowledge, he can motivate himself. This friend believed that a man would not even listen to doctors. [PRM2, F3]

Others cannot persuade a man, it must be his own decision to go for male sterilisation. He is the sole earning member in the family. [PRM8, F1]

Second, associated with the above, some men will not be influenced to adopt by their wives nor other family members, fearing what other community members will think of them should they adopt the procedure⁹:

Neither mother and father nor wife can inspire the man to go for sterilisation, because a man thinks about what the people of the village will think about him. [PRW11, F1]

Finally, being aware that wives and family members might resist a man's decision, fearing the side effects discussed above, some men choose not to discuss their decision with anyone and instead go directly for sterilisation and only share the news after the event.

This said, there were times when the decision was discussed with others, sometimes resulting in the man going for sterilisation and other times leading to nonadoption:

My one uncle was in the police. He had two children. One day, he discussed with his wife, "you will go for an operation or will I?" Then the wife said, "As you wish." So the husband said, "I have no problem, you care alone for your children, most of the time I live outside, so I think that I should go for the operation." Now the uncle has no problems because of the operation. His wife and other family members are very happy. [PRW1, F2]

In a family, a husband was ready for male sterilisation, because some man told him, "if you go for sterilisation, then the government will provide you a house." But when his mother came to know about her son's decision, she said "you are my only son and you have only two daughters, and because of the [male sterilisation] operation, if something goes wrong after the operation, then my generation will be finished. If you go for operation, then I will finish my life, I want more grandsons." His wife had the same opinion. Then the man did not go for operation. Now his mother and wife are very happy, and the daughter-in-law takes the pill." [PRW1, F3]

Furthermore, a significant proportion of both men and women felt that, armed with the right information, a wife would sometimes be able (if she wanted to) to persuade her husband to go for NSV:

The wife can persuade a man. First, she can discuss with her husband and can suggest that he should find out more from the doctors. She can also say that pills are giving her some trouble, so she can suggest that he find other methods, like male sterilisation. [PRM10, F1]

I think if a woman has this information [see NSV concept at the end of T3 question guide], then she can convince her husband to have the operation. [PRW4, F1]

However, it appeared that most of the time, for the wife to truly be able to influence her husband to adopt male sterilisation, she must either be herself weak and/or unhealthy or be experiencing problems with alternative contraceptive methods:

A man can motivate himself. His wife can persuade him if she is weak and not suitable for operation. His wife may convince him, saying that we do not want any more children; expenses will be more if they have more children. [PRM3, F1]

⁹ Remember also that not only might community members refer to a man as infertile or a eunuch if he is sterilised, but they might talk about his being under the thumb of his wife. While not explicitly discussed by the respondents, this probably adds to male resistance to involving wives in decision making about NSV.

A wife can motivate, but only under one condition—when they complete their family and she is not well. [PRW10, F1]

Ultimately, the belief is that men alone make the decision as to whether to go for male sterilisation. However, as discussed in the following section, there are still ways to influence the man's decision through others.

Information Sources

While rarely raised as a concern by women (who had little to say regarding communicating to men about NSV), men frequently cited that there was not enough campaigning around male sterilisation, stating that such action was needed to ensure that men had the right information and were motivated to go for NSV:

For promoting male sterilisation, extensive communication is required, so that people have correct knowledge. [PRM3, F2]

Extensive communications campaigns the way they did with polio will be helpful to generate awareness among people. [PRM10, F2]

I am not very happy the way they do communication related to the [male sterilisation] camps. They just put up a few banners; very few people come to know about the camps that are being organised. [PRM4, F2]

There were clear indications that further communications about where to access male sterilisation services and the occurrence of sterilisation camps are needed:

A shortcoming is that the communication is weak. Hardly any people know about the camps. [PRM6, F1]

In terms of information sources, a number of people referred to the success of the polio campaign, while many others talked about the important role of doctors and acceptors can play in promoting the adoption of NSV.

Doctors

Doctors were cited, by men, as being trustworthy and important personnel for ensuring that men have the correct information about the procedure:

Correct information, particularly about taking a rest for a week after male sterilisation, will be helpful. Weakness is probably caused because a man does not take rest after male sterilisation. If the doctor explains the method well, men will accept male sterilisation. [PRM8, F1]

A doctor can also motivate him to go for male sterilisation. People believe that doctors would give them good advice. [PRM3, F1]

However, while some felt that doctors could persuade men to go for sterilisation, a significant minority highlighted that actually men only liaise with the doctor after they have already taken the decision to go for NSV:

Doctor can motivate but later on. First, friends will help him to take the decisions. People do not go to the doctor before they decide. First they take the decision. [PRM9, F1]

A couple of respondents suggested that doctors should visit the villages:

People will prefer it if there is no health problem, no other disease, then people will prefer male sterilisation, but it requires clarifications to the prospective clients. Doctors can go to the villages for the clarifications, people will believe them. [PRM8, F1]

One man also suggested that doctors could promote male sterilisation at the time of abortion:

Yes, doctors can help the couple. People believe doctors; whatever they say, people will follow them; doctors are qualified people, they know better. In case a couple has consulted a doctor for abortion, at that time doctor can suggest for male sterilisation. [PRM3, F2]

Acceptors

While doctors were frequently cited as a source for clarifying information and correcting misconceptions about male sterilisation, in terms of actually persuading men to go for NSV, testimonials, particularly from friends, were perceived by men to be the most powerful communication tool:

Friends who have already accepted male sterilisation can persuade easily. He can share his experience and clarify doubts regarding male sterilisation of the person who is interested for male sterilisation. People will believe more to those who have already accepted. [PR5, F2]

Close friends who have already undergone male sterilisation will be helpful to motivate others. He can share his experiences after the male sterilisation. [PRM4, F2]

ASHAs

While highlighted as an important source of information regarding other family planning methods, ASHAs were rarely cited directly as a source of information (for men) about male sterilisation. Occasionally, people described how women might go to ASHAs to get the correct information before trying to persuade their husbands to undergo NSV:

If ASHA tells correct information related to male sterilisation [to the wife], she can tell the facts related to male sterilisation to her husband. [PRM4, F2]

ASHA should motivate the wives for male sterilisation. [PRW10, F3]

ASHAs also seemed to be critical in telling people where to go for male sterilisation services and telling them about the occurrence of sterilisation camps, also often accompanying men for the procedure:

Only ASHA babu tells the people where they have to go for sterilisation. Many people don't know where [they] have to go for sterilisation, even I don't know. [PRW11, F2]

ASHA and ANM take them; they do not know where to go for sterilisation. Most of the rural people do not know about the places where sterilisation services are available. [PRM6, F3]

Male Sterilisation Services

A significant proportion of both men and women were unable to say where male sterilisation services were offered, though they knew that such information could be obtained from ASHAs, who would also accompany men for NSV and will visit them at home postoperation to check up on them:

Men go for [the male sterilisation] operation with ASHA. [PRW10, F3]

ASHAs take them to the nearest government hospital. They also accompany the interested clients to the hospital. ASHAs are familiar with the rules and regulations of the hospitals, which is helpful for getting things done there. [PRM6, F1]

For male sterilisation, usually ASHAs or ANMs take them to the nearest block-level government hospital. ASHAs come and ask their condition after few days. If there is any complication, they take him to the hospital again, help him get medicines. [PRM4, F1]

Thus, ASHAs play a critical role in increasing access to male sterilisation services and making the NSV experience easier and less stressful.

In terms of service providers themselves, most respondents said that male sterilisation was available at block-level and private hospitals, a few also reporting (incorrectly) that the procedure could be conducted at primary care centres or at the subcentre. A number of respondents also referred to the male sterilisation camps without necessarily saying where these were held.

Government hospitals were almost unanimously the preferred service provider for male sterilisation. While women and many of the men were only able to say that the government hospital was simply where men went for NSV, some men gave more in-depth responses about what was good and bad about this service provider.

Overall, government hospitals were perceived to be good. Men reported liking the doctors and appreciating that the services free, that you received a payment for going, and that in the case of complications, you could seek compensation:

His friends went to the district hospital. They liked the doctor, who was friendly to them. He just finished the surgery while having a general conversation with my friend and my friend did not even notice it. They got Rs 1100 also. [PRM5, F1]

They go to a block-level hospital. They get money for sterilisation, and there are no expenses from their own pocket. [PRM4, F1]

They go to a block-level hospital. They get good food after the operation. If complications happen, they can go to court for compensation. [PRM3, F1]

However, there were also reported downsides to going to government hospitals for NSV, which echoed complaints from the more general family planning discussions. There were complaints of long waiting times and decreasing quality of doctors, leading to negligence,

something that would be a particular concern in the face of high levels of awareness of failed cases of male sterilisation:

Block-level hospitals, as they get money there. However, his friend mentioned that there is a long wait—you have to spend the entire day if you go to the government hospital. In private hospitals, this is not the case, but there you would not get the money that the government gives for the operation. [PRM3, F2]

Government hospital, his friend mentions that now people do not like to go to these hospitals, as many negligence cases have been reported in these hospitals. Doctors do not take care of the patients. [PRM8, F1]

If they get a good doctor, then men may think of going for male sterilisation. Now if the quality of the doctor is not good, people are losing faith in them. This is because of increasing negligence cases, many in all sorts of treatment. [PRM9, F2]

Thus, while few people were able to comment on the quality of services, some men suggested that people would rather go to private hospitals, but that finances prevented them from doing so:

[In] some of the places, “compounders” [not trained doctors] are also providing sterilisation services—doctors explain [to] the compounder how to do it and he does it, but in private hospitals it does not happen, there doctors perform everything... People who have money, they go to the private hospitals. [PRM3, F1]

While a number of respondents referred to men going to “camps” for sterilisation (camps that were promoted by ASHAs, who would accompany the men going), few people were able to give any details about them. The few men who did talk about them, however, suggested that the camps themselves were good and that the main problem associated with them was that people did not find out about them, as promotional efforts were poor:

Camps are organised for male and female sterilisation once in four to six months. These are fine, clients get money there. But the only shortcoming is that the communication is weak. [PRM6, F1]

Discussion and Recommendations

Given the words and experiences of the peer researchers and their friends, what meaningful actions might be taken by the RESPOND Project and Government of Uttar Pradesh to increase demand for and uptake of NSV services in rural Kanpur? (In Appendix 4, we provide some sample **personas and associated storylines** to aid in the development of credible characters and NSV adoption stories that might be used in promoting NSV.)

Key Potential Touch Points for Promoting NSV

It was clear that (at least in theory) couples have strong preferences for small families, with two or a maximum of three children, and that the driving factor behind this is a desire for a peaceful, educated, and well-provided for (by the husband) family. A family with this number of children is seen to be *complete*, a term repeatedly used by respondents when talking about good families and/or the drivers of family planning. When a family is complete, a couple may either risk an unplanned pregnancy (which then has a high likelihood of being terminated, at significant cost and psychological impact to the woman and/or couple) or seek out *permanent* methods of contraception. There is currently a general tendency towards female-controlled methods adopted without the consent of and/or discussion with husbands, and a clear pattern of men adopting male sterilisation only under the combined conditions of having completed their families and perceiving their wives as too weak to undergo female sterilisation. This suggests a potential communication (and service provision) touch point for promoting male sterilisation at or soon after the birth of a second and/or third child.

At this juncture, women are perceived to be weak, but when there is a strong desire to prevent any further pregnancies, frequently men (as well as women) present themselves at services and, in the case of births in health care settings, doctors (the communication channel men most trust) are most likely to be present. **Thus, with a woman (perceived) too weak to undergo female sterilisation, men are likely to be most receptive to information about the benefits of NSV at this time.**

Another opportunity for NSV promotion is to provide shopkeepers and ASHAs with simple messages and materials about male sterilisation. Should printed materials be provided, these could include powerful testimonials from adopters alongside simple assurances about the procedure from qualified doctors. **Such materials and messages could also be shared by the ASHA when women and/or couples come to her to discuss changing contraceptive methods after experiencing problems with their current method.**

Reducing Barriers to and Promoting NSV: Information Needs and Messaging

Key barriers to the adoption of male sterilisation included:

- Fear of side effects and/or method failure
- Stigma attached to sterilised men
- The availability of alternative family planning methods
- Low awareness of where to access NSV services

Fear of Side Effects and Stigmatisation

The fear of side effects (primarily physical and sexual weakness) and the potential failure of NSV, alongside the perceived stigmatisation of sterilised men, appeared to be in great part driven by the spread of tales of men who had had negative experiences with male sterilisation. The fact that the majority of these stories appear to refer back to men sterilised in previous generations does not detract from the power of their influence. Thus, **the importance of collating and sharing more positive testimonials cannot be underestimated.**

The main concerns about male sterilisation related to fears of operations and postoperative side effects, including physical and sexual weakness. Concerns about physical weakness were particularly pronounced, given the male role in the household of providing for his family, keeping everyone fed and well-educated. Associated with this, we saw a strong desire for small, educated families free from worry. Thus, **it is important to emphasise the permanent nature of sterilisation alongside a man's continued ability to work and provide for his family post-NSV, as well as the power of NSV to free a man from worries about risking having to provide for more children.**

Another mechanism to reduce stigma and encourage adoption might be to **build upon women's perception that only a very strong or courageous man would undergo NSV, in an effort to reposition undergoing male sterilisation as being central to, rather than in direct opposition to, the notion of manliness.** This would further emphasise the role of the good husband as keeping his family small so that he might fully support them and provide his children with a good education.

Promoting the simple, painless, and stitch-free nature of NSV and avoiding use of the word "operation" will also help to increase acceptance of male sterilisation by reducing the level of fear associated with the procedure.

Given fears of failure and the large number of failed male sterilisations talked about by respondents, **it would also be helpful to try to obtain recent data on failure rates, to reassure people by demonstrating what actual failure rates are. (These will be significantly lower than what people think.)** (Other approaches for reducing fears associated with risk of failure are discussed under service provision, given the potential importance of the characteristics of personnel conducting NSV in determining levels of trust.)

However, it must be remembered that even with low rates of failure, the consequences for women of failure of vasectomy are severe. Pregnancy resulting from unsuccessful NSV carries with it the possibility of a wife's being accused of being unfaithful to her husband. This is likely to result in her expulsion from the household. Thus, it is ethically essential that information is provided on failure rates and that preprocedure counselling promotes the importance of the postprocedure semen analysis test three months after NSV, to confirm that the procedure was successful. This is likely to remain a key challenge to promoting NSV.

One means of reducing this risk is to ensure that clients are that the risk of pregnancy continues for three months following NSV and that other methods of contraception are provided during this period. Another is to emphasise that vasectomy does indeed carry a small

risk of failure and that a very small number of men may still be able to impregnate their wives after the procedure. Finally, if possible, **services should be encouraged to offer postprocedure tests**, which would provide greater confidence in the NSV procedure.

Competition—The Availability of Alternative Family Planning Methods

Increasing knowledge about the variety of methods available and **emphasising the permanent, risk-free nature of male sterilisation would help improve the perception of male sterilisation in relation to other methods**. In particular, **ASHAs could be encouraged to promote the advantages of male sterilisation when a woman or couple is looking to change methods and have completed their families**.

The Potential Role of Monetary Reimbursements

While the reimbursement rate of Rs 1100 was not deemed by most to be high enough to persuade men to undergo NSV, it might become a more powerful driver once attitudes toward male sterilisation are improved. Thus, **promoting the provision of financial reimbursements may still help to position the procedure more positively**. **The financial reimbursement, however, should not form the central message of any communication campaign**.

Improving Awareness of NSV Service Providers

Overall levels of awareness about where to go for NSV services were low. While not stated explicitly, this is likely to act as a barrier to improving uptake of male sterilisation, particularly when men have decided to undergo the procedure but might have to ask others to ascertain where to go for a vasectomy. At such times, the opportunity for others (particularly mothers-in-law) to persuade a man to change his mind about obtaining NSV may be increased. The few men who described the sterilisation camps were satisfied with the service itself but felt strongly that efforts to promote them were inadequate. As a result, **communication interventions are needed not only to improve attitudes toward and increase demand for NSV, but also to support the translation of this demand into effective promotion of sterilisation services**. Enhanced promotional efforts may increase the viability of male sterilisation camps as a cost-effective means of delivering NSV.

Key Channels of Communication for Promoting Male Sterilisation

Data suggested that to date, promotion of NSV and sterilisation services has been extremely limited, restricted to minimal advertising of sterilisation camps. Men reported that few people would have been exposed to these messages. This project seeks to rectify this and implement a communication campaign to increase demand for and awareness of NSV services.

Men appeared much less likely than women to discuss family planning with friends and relatives or obtain information about family planning services from them. Men tend to view family planning as a female concern and believe themselves too busy to talk about such matters. Thus, promotional messages must appeal directly to men and to men's interests.

Direct Involvement of Satisfied NSV Acceptors

The most powerful communication tool for promoting NSV appears to be the use of “adopters” in promotional efforts. Given the weight that men place on one-to-one/face-to-face communication and the lack of recall and trust associated with mass media, **a critical part**

of any NSV promotion campaign is to identify sterilised men prepared to speak out to other men about their experiences. These men could also be offered training to play a wider role of “family planning advisor” for men, acting in a sort of ASHA-like role for men. However, given the low prevalence of vasectomy and the stigma associated with sterilisation among men, it may be difficult to encourage them to speak out; even an incentive of Rs 300 for referring another man for NSV might not be sufficient to encourage a man to do so. As a result, creative ways to encourage them to speak out are likely to be needed.

Alternatively, it could be possible to adopt a phased approach to campaigning, initiating promotional efforts in those areas where adoption rates already appear to be increasing.¹⁰ It is likely to be significantly easier to identify men prepared to talk about their experiences in areas where sterilisation is already becoming more normalised and where attitudes toward NSV and sterilised men are more positive. As a social norm of acceptance develops in one area, positive experiences and messages will then start to diffuse into surrounding villages, which could be targeted next.

With doctors seen as the most trusted source for family planning and, most importantly, male sterilisation information, **a powerful communication tool would be to work with doctors who perform NSV to encourage them to conduct outreach visits to men’s workplaces, especially those where the work is not necessarily perceived to be “heavy” (for example, factories and offices).**

Given men’s role in providing for the family, **it will be essential to emphasise the absence of physical side effects following NSV and to match this with messages that emphasise the uptake of NSV as enabling a man to fulfil his role as a “good” husband**—reflecting moral and physical strength, embracing his responsibility to ensure that the size of the family is appropriate to their financial means, and enabling increased opportunities for his children to access education and thus improve their life opportunities.

Engaging Women in Influencing NSV Decisions

While men are the ultimate population for NSV, women still need to be engaged in communication efforts, particularly given that they:

- Appear as likely as men to have negative attitudes toward male sterilisation
- Tend to favour the adoption of female-controlled family planning methods, so as to be in control of their own fertility and avoid worrying their husbands
- Can play a critical role in influencing whether their husbands adopt NSV
- Face extremely severe consequences if NSV is unsuccessful

Thus, **women too need to be persuaded of the benefits of male sterilisation. Armed with the correct information about NSV, they may be better equipped to discuss these benefits with their husbands. ASHAs and providers of family planning methods are key players here and should be encouraged to discuss NSV with every woman who already has two children and who approaches them for contraception.** Providing them with

¹⁰ For example, the peer researcher identified here as PRF8 seems to live in such an area. Other areas might be identified by working with service providers to access anonymised data that indicate where those men who have come for NSV in the last year resided.

simple promotional leaflets that include messages from doctors and testimonials from adopters may also be useful, enabling them to demonstrate to husbands that it is not just their wives and/or ASHAs talking about the benefits of NSV, but trained medical personnel and men who have had the procedure. Women may read these leaflets themselves and/or pass them to their husbands, who can then further consider NSV in their own time, discuss it with others, and (if important) argue to others that it was not their wives who influenced them to adopt NSV, but the words of the doctor.

The messages being used to increase the acceptance of NSV are likely to be similar for men and women, though an additional message appealing especially to women might be that **NSV provides freedom from worry at the time of intercourse, without the side effects of some other methods.** This may be useful, given that women:

- Liked the more long-acting nature of the IUD, but were concerned about side effects when using it
- Often found that, at the time of intercourse, it was difficult to get men to use condoms

Mothers-in-law represent a potential obstacle in the promotion of male sterilisation (or even any family planning method), given their tendency to encourage couples to have more than two children. While it can be extremely difficult to get mothers-in-law to change their viewpoint, there were signs that their influence may be waning over time. While mothers-in-law might be targeted in a general campaign, it is unlikely to be worth investing significant time and resources into developing materials aimed specifically at them.

Male Sterilisation Services

The vast majority of respondents favoured government services for the provision of family planning services, except when people did not want to risk other community members' finding out their business. In such cases, they preferred to utilise private providers. Given the stigma associated with male sterilisation, one would expect that men would prefer to go to private providers for NSV, even if that meant they did not obtain the Rs 1100 incentive. Nevertheless, the majority of men reached in this study said they were more likely to utilise government providers, especially in light of the provision of the incentive.

Whether NSV is provided by government or private providers, men perceive doctors as the most trusted information sources. **Where the provision of services by doctors is not possible, additional efforts will be required to increase men's trust of the practitioners providing NSV.** Finding mechanisms to reduce waiting times, perhaps by arranging appointments through ASHAs, will also help to improve the service experience.

Currently, NSV is mainly provided at the block-level hospitals, although sterilisation camps are periodically organised at subcentre health centres. **If such camps were better advertised, an increase in the number of sterilisation camps might help to drive uptake of NSV upward,** given that many men would then not have to travel so far to undergo the procedure. In addition, because hospitals are associated with more serious operations than subcentre health centres, offering NSV at a health centre might make it seem to be a more minor procedure than is currently perceived.

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APPENDIXES

Appendix I

OPTIONS PEER STUDY TOUR ITINERARY RESPOND PROJECT KANPUR, INDIA September 2010

- Sept. 12** Arrival in Delhi, transfer to Kanpur, evening introductions with Shalini & Dawood
- Sept. 13** Introductions to RESPOND Project, NSV Project, PEER, and PEER training process
- Sept. 14** Full-day PEER workshop
- Sept. 15** Full-day PEER workshop; evening reviewing ideas and developing themes
- Sept. 16** Full-day PEER workshop; evening refining questions for study
- Sept. 17** Full-day PEER workshop
- Sept. 18** Debriefing post-PEER workshop; introduction to principles of peer researcher debriefing
- Sept. 19** Rest
- Sept. 20** Day 1 (T1) data collection, consultant demonstrates one male and one female debriefing session. Dawood and Shalini each complete two further debriefs and consultant reviews these to offer feedback; evening translations with Dawood
- Sept. 21** Day 2 (T1) data collection (4x each); early morning translations with Shalini
- Sept. 22** Day 3 (T1) data collection (4x each); early morning translations with Shalini

Appendix 2

Conversational Interview Questions

Theme 1: Preferred Family

Today I would like to talk to you about the family and what we think about preferred families in this locality...

1. Describe a family considered to be a preferred family in this locality.
 - What makes their structure preferred? (Anything else...)
 - Describe one such family you know of
2. In a family, how do people think the role of the wife is important?
 - What makes a good wife? (Anything else...)
 - Describe one such wife you know of
3. In a family, how do people think the role of the husband is important?
 - What makes a good husband?
 - Describe one such husband you know of
4. What is the role of the mother-in-law in making a preferred family?
 - Why?
 - Describe an example when a mother-in-law helped make a preferred family
5. In this locality how many members do people think there are in a happy family?
 - Why?
 - Describe a particularly happy family you know of?
6. In this locality, who among the family members affect the decision of family size?
 - Anyone else?
 - Is there an example you can share about the decision to stop having more children?
7. Among this locality what are the consequences of unplanned pregnancy?
 - Why?
 - Tell me a story about a time a woman had an unplanned pregnancy

Theme 2: Family Planning

Last time we talked about family and began to speak about family planning. Today I would like to discuss the ways a couple can prevent having more children. Is this OK?

1. In this locality how do people come to know about how to stop having more children?
 - Which is the most trusted way to find information?
 - Describe some family planning information you have seen or heard in your locality
2. Where do people in this locality go to get services to help them stop having children?
 - Why?
 - What do people like most about these services?
 - What do people like least about these services?
3. In this locality what are the methods to stop having children people adopt?
 - Why?

- What do people like most about these methods?
 - What do people like least about these methods?
4. In this locality what are the methods to stop having children people do not adopt?
 - Why?
 - Tell me about a time when someone had a negative experience with such a method.
 5. Who decides what methods of stopping having children a couple in this community uses?
 - Who else?
 - Why?
 - Tell me about a time a couple was choosing what method to use

Theme 3: Male Sterilisation

Finally we want to discuss sterilisation specifically, to understand who practices it and what people in this village think about it

1. In this locality what do people say about sterilisation?
 - What do they say about female sterilisation?
 - Why?
 - What do they say about male sterilisation?
 - Why?
2. In this locality what are the places men like to go for male sterilisation?
 - Why?
 - What about places they do not like to go?
3. What causes a man who is not sterilised to go for sterilisation?
 - How?
 - Tell me about a man who decided to go for sterilisation
5. What things/causes stop a man from becoming sterilised?
 - Why?
 - Tell me a story about a man who decided not to go for sterilisations
6. Who can persuade a man to have male sterilisation?
 - Why?
 - Can a wife persuade her husband to be sterilised?
 - Why?
 - Tell me about a time a wife talked to her husband about male sterilisation
7. What do people in this locality say about men who have been sterilised?
 - Why?
 - What did people say about him the last time a man was sterilised?

NSV is a newer form of male sterilisation. It involves no cutting, is less painful and results in few complications and a quicker return to sexual activity than the old method. It is safer than and as effective as female sterilisation. In this area the government will also pay 1100 rupees to a man who undergoes NSV.

Do you think people in this area will adopt this idea? Why?

Appendix 3

PEER Researcher Workshop Agenda

Note: This represents the workshop as it was actually delivered, rather than planned. The peer training process aims to be flexible depending on the needs of the particular group being trained.

DAY I

| Time | Activity | Description & Notes |
|-------------|--------------------------------------|---|
| 09:30 | Arrivals | Participants arrive; Chai provided |
| 10:00–10:30 | Spider Game | Ice-breaker game that introduces principles of group working: DAWOOD introduces the game explaining that each participant will, one at a time: <ul style="list-style-type: none"> • Wrap the string around their finger (so that it is quite tight if coming from another person) • Say their <i>name</i>, <i>where they're from</i>, and their <i>favourite activity</i> • Keeping the string around their finger, throw the ball to someone else, who will repeat the above Once everyone is included in the web: <ul style="list-style-type: none"> • Ask everyone: <i>What does this represent? What does it mean?</i> [Connectedness, reliance upon each other, many people make a whole, all equal...] IF THERE IS TIME, untwine the string person by person until a ball has been reformed |
| 10:30–11:00 | Study Introductions and Expectations | DAWOOD introduces the RESPOND Project and the PEER Team: RESPOND is working with the Gov. of UP to increase family planning use. <i>We want to work with you to understand those things that affect family planning.</i> SHALINI asks everyone why they think they are here? [DAWOOD notes down responses] SHALINI explains <i>we are here to learn from you, to learn about your communities. Don't worry, you don't need any special skills; we will tell you all you need to know to help us.</i> DAWOOD explains: <ul style="list-style-type: none"> • The importance of PEER (friend research) and how this is the first project of this kind in this area. • Information you share will us will help us to improve family planning in this area, helping us to promote appropriate services to people so that they can have the number of children they desire. • It is easy to hear the views of community leaders and health workers, but more difficult to hear the views of everyday community members. • PEER is about involving everyday people like yourselves, so that they can learn and share village gossip and experiences that can help us to improve and promote family planning services. |

PEER Researcher Workshop Agenda, DAY 1 (cont.)

| Time | Activity | Description & Notes |
|-------------|--|---|
| 10:30–11:00 | Study Introductions and Expectations (cont.) | <ul style="list-style-type: none"> At the end of these four days of training, you will speak with three of your friends (whoever you feel most comfortable with) to gather gossip and experiences relating to family and family planning. Shalini & I will meet with you so that you can share with us what you have found. No right or wrong answers, just opinions and gossips. We are not from your communities, so we cannot be the experts. No names are used, gossips are shared anonymously. You will not ask gossips of your friends directly, but rather ask them to share things they have heard about other people “like them.” After your discussions with friends, we will all come together so that you can hear what others have learned. We will ask you to help interpret what these things mean for the future, so that we can promote things right. Participating in this project will help you gain skills and experiences that might help you in your everyday lives; you will learn things about your community that you perhaps never knew. We will give you a certificate at the end to show you were trained and participated in this important piece of work. |
| 11:00–11:15 | Ground Rules | <p>SHALINI: Explain that each day we hope to run from 10:00–16:00 with three breaks, a short one mid-morning and mid-afternoon and a longer one for lunch. Point out bathrooms and fire exits, etc.</p> <p>SHALINI: Ask participants to come up with ground rules that can help us to ensure:</p> <ul style="list-style-type: none"> The workshop runs smoothly. Sessions don’t run over (we aim to finish by 16:00 each day, but that depends on you). Everyone gets what they want/need. Everyone has a good time. <p>(e.g. time-keeping, listening, one person talks at a time, respect, full participation by all, mobiles off, say when you don’t understand...)</p> <p>Write these up on a large paper to hang on the wall prominently.</p> |
| 11:15–11:30 | Snack Break | |
| 11:30–12:30 | Brainstorming Themes | <p>DAWOOD: We want the peer researchers to help us define topics from which we will develop questions for the study. While there will eventually be three themes, for now we will break into four groups (2x male, 2x female) to brainstorm things that spring to mind when we consider four topics:</p> <ol style="list-style-type: none"> Daily Life and Roles Family, Roles, and Family Size Pregnancy (includes planned and unplanned) Family Planning (includes sterilisation) <p>As a large group, explain that in their smaller groups we want them to list <i>important things</i> about each of these four topics, one topic at a time. For example, under family and family size, I might think about number of children, sons, daughters, mother, father, mother-in-law, big, small... At the end of the exercise, each group will share their thoughts with the wider group, explaining <i>why</i> what they have listed are important.</p> |

PEER Researcher Workshop Agenda, DAY 1 (cont.)

| Time | Activity | Description & Notes |
|-------------|--|--|
| 11:30–12:30 | Brainstorming Themes (cont.) | <p>Break into four groups across the two rooms. Give each group a large piece of paper with one topic written at the top. Each group will have 15 minutes to brainstorm the first topic. SHALINI & DAWOOD should drift between two groups each, supporting them as necessary.</p> <p>After 15 minutes, the groups will discuss a new topic. They will have 10 minutes to review what the other group(s) have listed under this topic and add to it.</p> <p>NOTE: If groups are struggling, we may change to each group spending 30 mins. and 20 mins. on just two topics, in which case two groups do themes 1 and 3, and two groups do themes 2 and 4.</p> |
| 12:30–13:00 | Ideas Sharing | <p>SHALINI: Now the group reconvenes and we go through each of the four topics so that:</p> <ul style="list-style-type: none"> • Each group can explain the ideas they have added to each theme. • The group can highlight (using a *) the most important ideas under each theme. • The participants can debate ideas they are less sure about; facilitators can put brackets around things on which there is not agreement or that seem less important. |
| 13:00–13:45 | Lunch | |
| 13:45–14:00 | Energiser: Numbers game | <p>DAWOOD: In this game, we need to, between us, count to 25, with only one person reciting any given number in the sequence. One person will say “1” before someone else will say “2,” someone else “3,” etc. If two people say a number at once, we must start again.</p> <p>After 10 minutes, irrespective of where we have got to in terms of counting, stop the game and ask people what this game teaches us? → Importance of nonverbal communication.</p> |
| 14:00–14:45 | Daily Life Mapping | <p>SHALINI: As a large group, say that we are going to ask people to split into four <i>different</i> groups (2x male, 2x female groups) to chart out their daily lives, what an average person does on an average day from when they get up to when they go to bed. They can draw images to illustrate their charts.</p> <p>Each group will spend 15 minutes working as a group and should be ready to share their chart with the wider group afterwards. Then we will spend the remaining time sharing and discussing the charts, focusing on differences between them and the reasons for these differences.</p> |
| 1445–1500 | Tea Break | <p><i>BEFORE BREAK, break into three mixed-gender groups and explain next activity, so that they can simply get straight stuck in.</i></p> |
| 15:00–15:50 | Role Plays 10 mins. intro 20 mins. prep 20 mins. show & discuss | <p>DAWOOD: Each group is to spend 20 minutes developing a five-minute role-play on one of the three remaining themes we have discussed (themes to be drawn from a hat). If possible, everyone should have a role, even if as either narrator or silent if they don’t wish to talk.</p> <p>Then each group will present their role play, with the wider group feeding back and discussing this:</p> <ul style="list-style-type: none"> • Is this play true to life? • What does it tell us? • Is it the same for everyone or is it different for some? |

PEER Researcher Workshop Agenda, DAY 1 (cont.)

| Time | Activity | Description & Notes |
|-------------|----------|--|
| 15:50–16:00 | Wrap-up | SHALINI: Briefly: <ul style="list-style-type: none"> • Thank everyone for working so hard, we are learning lots already. • Asks how everyone has found the day. • Explain that we will spend the next three days using these ideas to develop things for you to chat to your three friends about. |

PEER Researcher Workshop Agenda, DAY 2

| Time | Activity | Description & Notes |
|-------------|---|--|
| 09:30 | Arrivals | Participants arrive; Chai provided |
| 10:00–10:15 | Recap | SHALINI: Review Day 1. <ul style="list-style-type: none"> • What did we do? • What did we learn? • What was enjoyed (what was not)? |
| 10:15–10:30 | Energiser: Similarities game | BETH: Explain: Everyone except one person (SHALINI) sits in a big circle, one person stands in the middle. Person in middle shouts out a characteristic about his/herself shared with some others in the circle. Everyone sharing that characteristic must stand up and run to a new chair (not the one beside them). The person in the middle should also try to make a dash for a chair. The person left without a chair must now shout out a characteristic and repeat the process. |
| 10:30–11:00 | Intro to “Good Chats” | DAWOOD: Today we want to start thinking about, from the ideas you came up with yesterday, how we can discuss these issues with our friends. Initiate free group discussions about what makes chats easy/hard. Discussions might cover: <ul style="list-style-type: none"> • The importance of talking to people you feel comfortable with • Sensitivity of topics: Are people comfortable to discuss the things we discussed yesterday with people they know? Why? [<i>This is important, so that we can get rid of “ideas” that are not deemed possible to talk about.</i>] • Making sure people have enough time • Importance of listening (and not interrupting) • Not asking for personal information • Not judging/feeling judged • Asking nice “wide” questions (that allow people to share much rather than little information) • Nonverbal cues such as eye contact and body language |
| 11:00–11:15 | Body outlines 2x male groups 2x female groups | SHALINI: Thinking about a good conversation and the skills we just discussed in six small groups, we would like you to now draw images of what a good conversationalist would look like. After tea, we will share our images with the others. Groups to brainstorm, on the basis of what we have discussed about good interviewing, and to draw an image of a good interviewer. What features must they have? Why? |
| 11:15–11:30 | Tea | |
| 11:30–12:00 | Body Outlines Sharing | Each group to spend 5 minutes sharing and discussing their image with the wider group. |

PEER Researcher Workshop Agenda, DAY 2 (cont.)

| Time | Activity | Description & Notes |
|-------------|----------------------------------|--|
| 12:00–12:30 | Role Plays & Recap | <p>DAWOOD & SHALINI will now demonstrate a “bad” and a “good” interview, after each one asking peer researchers to highlight positives and negatives of each one. Note the positives and negatives on two separate flipchart sheets. 5 mins. per demonstration, 10 mins. feedback. <i>For sample script, see separate sheet.</i></p> <p><u>Features of bad interview</u> include:</p> <ul style="list-style-type: none"> • Don’t set up in advance, forced upon person even though not a good time • No introduction to study • Asking directly about the person, not third person • Interrupting • Judging • Closed questions (yes/no) • No probes or seeking of stories/gossips • Push respondent to answer questions they don’t want to • Scribble notes down all the time, little eye contact • Defensive body language • Rushed <p><u>Features of good interview:</u></p> <ul style="list-style-type: none"> • Set up in advance, being clear how long will take • Good introduction: what study is about, no personal information, asking for community perceptions and gossip not things about yourself, don’t have to answer if not comfortable, offer cup of tea • Permission to continue • Third person • Wide/open questions • Lots of probing • Come back to tricky questions later rather than pushing • Asking for lots of examples • Minimal note-taking, look attentive • Lots of nodding/umming to show attentiveness • No judgements |
| 12:30–13:00 | Summarise “Good Chat” Principles | <p>This formalises learnings from morning sessions, reiterating the key principles of good discussions with friends (can add to the flipchat if helps):</p> <p><i>General Principles:</i></p> <ul style="list-style-type: none"> • Set up interview in advance • Give nice introduction (we will talk more about this tomorrow) • Don’t ask personal questions, only about “other” people • Relaxed manner • Listen rather than talk (do <u>not</u> give advice or your opinion, do <u>not</u> correct people) • Don’t interrupt, value silence • Reassure the respondent as you go along: give nods, smiles, etc. • Take only a few notes, you can always expand these after the discussions if you are worried you will forget (we will talk about this tomorrow) |

PEER Researcher Workshop Agenda, DAY 2 (cont.)

| Time | Activity | Description & Notes |
|-------------|--|---|
| 12:30–13:00 | Summarise “Good Chat” Principles (cont.) | <p><i>Types of Questions</i></p> <p>You want to encourage people to talk freely and to get examples and gossips that are easier for you to remember. To do this, you want to follow a <u>three-part rule</u> to each question:</p> <ol style="list-style-type: none"> Ask a nice wide-open question (one that doesn’t influence the answer they give) Follow this with follow-up questions: “W WORDS”: Why? When? Where? Who? What? How? Tell me more... Ask for an example/gossip or two that they have heard of in their community. |
| 13:00–13:45 | Lunch | |
| 13:45–14:00 | Engergiser | BETH: Heads, Shoulders, Knees, & Toes |
| 14:00–15:30 | Question Development (All themes to start, then just T1) | <p>First 30 mins. (14:00–14:30):</p> <p>DAWOOD/SHALINI introduce the idea of developing questions: We want to take the ideas you generated yesterday and think about questions we might want to ask about these. To develop a question, essentially, we want to introduce a W word into the sentence. To make sure it is not directed at a single person, you will ask about “people” rather than “you”. Remember, we want to develop <i>open/wide</i> questions that encourage people to speak, rather than just say yes or no. <i>If some people prefer, they might like to think about drawing images to represent the question to remember, too, as sometimes pictures are easier to remember.</i></p> <p>As a big group, develop one or two questions together, remembering to keep it in the third person. Then ensure that you have added a follow-up and asked for a gossip or example [<i>this hammers home the formula for the three-part question, so that early on it becomes a habit</i>]</p> |
| 15:00 | Tea | <p>Second 30 mins. (14:30–15:00):</p> <p>Break into six smaller groups. Ask each group to work on turning the other ideas into questions for 30 minutes or so (two groups per theme, one male, one female). They can get a cup of tea to take to their groups. Keep reminding the groups how to form a question:</p> <ul style="list-style-type: none"> Use a W word. Think of the answer and consider how you would ask a question to get this. <p>Then Tea (15:00–15:15)</p> <p>Final 30 mins. (15:15–15:45)</p> <p>Reconvene as a big group and go through the question list for Theme I <i>only</i>, discuss good and bad questions so that you are left with a list of the strongest questions—make sure that ALL questions are in the third person. <i>ASK whether anyone would like to develop pictures to help them remember the questions? [Then we can do this on Day 3–4]</i></p> |

PEER Researcher Workshop Agenda, DAY 2 (cont.)

| Time | Activity | Description & Notes |
|--------------------------------------|--|---|
| 15:45–16:00 | Homework & Wrap-Up <i>Note—while this is happening, we need to write out the questions for T1 and photocopy</i> | DAWOOD: Thank everyone for the hard work. Ask people to practice asking the short-listed Theme 1 questions (remembering the three-part rule) with each other on the journey home and also with a relative whom they will not use for the study. Make sure people have a set of questions or images so they ask the right questions. Halfway there folks; aren't we doing well?! |
| Overnight for Dawood, Shalini & Beth | | Go through all the questions that were developed, select the most promising, and identify gaps. Check the question list against the study objectives to ensure that everything is covered. Discuss need for images (as agenda for days 3–4 will depend on this). |

PEER Researcher Workshop Agenda, DAY 3—Actual

| Time | Activity | Description & Notes |
|-------------|--------------------|---|
| 09:30 | Arrivals | Participants arrive; Chai provided |
| 10:00–10:30 | Recap Yesterday | DAWOOD: What did we do yesterday? What did we learn? 1. Art of good conversation: <ul style="list-style-type: none"> • Relaxed • Listening • Open mind, nonjudging • Soft heart • At a suitable time, prearranged • Asking about others, not oneself, easier to talk • Body language: eyes down to show respect, nodding to encourage them • Encourage more talk by saying: Tell me more...And then... 2. Art of good questions: <ul style="list-style-type: none"> • Wide questions that encourage people to talk • Use of the W Words: → <u>W</u>hy, <u>W</u>hat, <u>W</u>hen, <u>W</u>here, <u>W</u>hich, <u>W</u>ho, <u>W</u>ow • Three parts to each question: <ol style="list-style-type: none"> 1) Main question 2) Follow-up 3) Story, gossip, or example |
| 10:15–10:45 | Energiser | Repeat a game from yesterday |
| 10:45–11:30 | Review Questions | SHALINI: Take large group through the lists of questions they developed for all three themes yesterday. |
| 11:30–11:45 | Break | |
| 11:45–13:15 | Interview Practice | DAWOOD: Explain that you want people to divide into groups of three, women in one room, men in another. <i>Remind them of the three-step rule: Question–Follow-up–Story/Example/Gossip!</i> |

PEER Researcher Workshop Agenda, DAY 3—Actual (cont.)

| Time | Activity | Description & Notes |
|-------------|---------------------------------|---|
| 11:45–13:15 | Interview Practice (cont.) | <p>They are going to practice their interview skills and the questions they have developed. Between the three of them, they will practice asking questions from all three themes. So:</p> <ul style="list-style-type: none"> • For 10 minutes, one person interviews a second person on T1, person 3 observes. • Then the third person will feedback what was good and bad for 5 mins. • Then swap: • Second person interviews the third on T2 for 10 mins., person 1 observes and feeds back for 5 mins. • Finally, third person interviews the first person, person 2 observes and feeds back for 5 mins. <p>[Total = 10 mins. overall intro; in groups—15 mins. per theme, thus 45 mins.]</p> <p>In final 20 minutes, discuss whether the questions were good or not. Do any need changing? Why/How?</p> <p>What did they find easy? What did they find up difficult?</p> |
| 13:15–14:00 | Lunch | <i>Write up and copy copies of all three themes final questions (nine copies of each.</i> |
| 14:00–14:15 | Energiser | Grab-the-seat game again? [The one where one person stands in the middle and shouts out a characteristic...] |
| 14:15–14:45 | Study Intros & Informed Consent | <p>SHALINI: Principles & Demonstration</p> <p>At end of this session, explain the next one.</p> |
| 14:45–15:15 | Practice Intros | <p>Set up six sets of chairs facing each other in lines in each room.</p> <p>Divide the women and men into pairs to practice study introductions for 5 mins. each.</p> <p>Bring group back together for second half (last 15 mins.) of session to discuss.</p> |
| 15:15–15:30 | Tea | |
| 15:30–15:45 | Note-taking | <p>Some people will worry about how to remember what they are told.</p> <p>Don't worry as:</p> <ul style="list-style-type: none"> • You will interview each friend about one theme at a time. When you have conducted three chats on T1, we will come and see you, so you don't have to remember much for long. • As you are asking for gossips and examples, it is easier to remember what people say. <p>But to help, you can take either simple notes or draw simple pictures. Don't try to write every word said, just use key words/images to remind you of what people said. If you are worried about forgetting, you can write up longer notes or draw more pictures after the discussion. So:</p> <ul style="list-style-type: none"> • Take only little notes/few pictures. • Write only things to help you remember fuller answers. • Save writing longer notes till after the interview. |

PEER Researcher Workshop Agenda, DAY 3—Actual (cont.)

| Time | Activity | Description & Notes |
|-------------|-----------|--|
| 15:45–16:00 | Wind-down | <p>So people, we have nearly finished, and you have helped to write guides for all the discussions—well done!!!</p> <p>Tonight, practice one theme that you did NOT practice asking the questions for today. If you practiced T1, stand here; if you practiced T2, stand here; and if you practiced T3, stand over there. Distribute questions.</p> <p>We would like you to practice a <i>full</i> interview at home, including the introduction and remembering to ask lots of follow-up questions and for many examples.</p> <p>Tomorrow, we will discuss how it went and make plans for next steps, when and where we will meet you for debriefings, etc.</p> |

PEER Researcher Workshop Agenda, DAY 4

| Time | Activity | Description & Notes |
|-------------|--|---|
| 09:30 | Arrivals | Participants arrive; Chai provided |
| 10:00–10:30 | Review Interviewing Principles | <p>BETH: How did the homework go?</p> <ul style="list-style-type: none"> • Review three parts to every question • Easy things? • Hard things? |
| 10:30–11:30 | Final Question List (30 mins.) & Role Plays (30 mins.) | <p>DAWOOD: Take participants through the final question list... Remember the three-part rule.</p> <p>So, remember:</p> <ul style="list-style-type: none"> • We have three sets of questions. • We will speak to three friends about each of these topics, speaking to them one topic at a time. • So that you don't have to remember so much, we will visit you when you have spoken to your three friends the first time. Then you can share with us what stories they told you. • After that, we will give you the questions for the second theme, which you will speak to the SAME three friends about. Again, you will meet us. • Finally, you will discuss the third set of questions with your friends. <p><i>Ask volunteers to demonstrate a good interview using these questions (if necessary, DAWOOD or SHALINI can be the respondent). Tell them not to worry if they are the same as the questions they have been practicing, just fewer. After each demonstration, we have time to ask the wider group for feedback about what was good and what was bad.</i></p> |
| 11:30–11:45 | Tea | |
| 11:45–12:00 | Engergiser | |

PEER Researcher Workshop Agenda, DAY 4 (cont.)

| Time | Activity | Description & Notes |
|-------------|---|---|
| 12:00–12:30 | Introducing the Study | <p>DAWOOD: Before you can speak with your friends, you must be able to introduce the study correctly and make sure that they are happy to discuss these things with you.</p> <p>Key things you need to say:</p> <ol style="list-style-type: none"> 1. About the study: I am working on the RESPOND Project, which is working with the Gov. of UP to improve family planning in the State. To do this, we need to understand what our communities know and/or think about such things. 2. I would like to ask you some questions, but there are <u>no</u> right or wrong answers, only opinions and experiences. 3. I will not ask you about yourself, but rather that you share stories from this locality as a whole. I will not take down any names, so everyone will remain anonymous and everything you say confidential. 4. Talking with me is voluntary, so you do not have to talk about anything you do not wish to discuss. 5. I would like to sit with you three times for about 30 minutes each time. <p>Then you ask them, "Is it ok for me to continue?" If you say all this to your friend and they agree, you can continue.</p> |
| 12:30–13:00 | Note-Taking | <p>SHALINI: Some of you might also be worried about remembering all that your friends have to say. Don't worry. Remember:</p> <ol style="list-style-type: none"> 1. We will meet with you when you have spoken to your friends about one theme, so there are few questions to remember about and only for a short time. 2. Asking for stories and gossips will help you to remember what they said. 3. If you want, you can write some notes or draw pictures to help you remember. BUT, you shouldn't take lots of notes in the discussion, as you will not focus on the person you are speaking with and they will not feel relaxed. Rather, you should write the notes or draw some images <i>after</i> the chat. We will give you a notebook to do this. 4. If <i>really</i> necessary, you can write down key words or draw just a few images that help you remember during the discussion, but just a few words that remind you what was said. You should not write down everything they say. |
| 13:30–15:00 | Picture Development OR Continue to Practice | <p>BETH & SHALINI: Give each individual a pen and paper. Read out the first question and ask them to draw an off-the-top-of-the-head image that reminds them of the question (NOT a potential answer). If they don't all want to draw, they can tell someone else what image will remind them and have them draw it.</p> <p>At the end of each theme, review the images for each question and select the image most commonly depicted.</p> <p>DAWOOD: For those not involved in image development, continue with role plays and perhaps small group interviews. Discuss all the questions and the three-part question idea in yet more depth. <i>Practice makes perfect!</i></p> <p><i>If appropriate, you could also start to arrange visits to those who aren't involved in picture development, if people get frustrated with practicing.</i></p> |

PEER Researcher Workshop Agenda, DAY 4 (cont.)

| Time | Activity | Description & Notes |
|-------------|--|---|
| 15:00–15:15 | Tea | |
| 15:15–15:45 | Logistics/Next Steps | DAWOOD & SHALINI |
| 15:45–16:00 | Review T1 Questions & Image Prompts THANK YOUUS!! | Go through T1 questions and images—for each question, hold up the associated image and get the whole room to cite each question and its follow-up components. (Essentially, drumming into them the questions they have to remember for T1.) Then remind them that we will take them through T2 and 3 again when we meet with them over the next few days. |

Personas, Storylines, and Analysis Workshop Minutes

Adapted Personas

(Adapted from the stories developed in the final analysis, taking in findings from Theme 1 interviews conducted by peer researchers.)

These “personas” combine the positive personality characteristics of potential characters that might be used to promote NSV in rural Kanpur, along with the skeletons of potential story-lines sharing the decision to adopt and experiences of NSV.

In both examples, the men are in their early 30s, their wives a little younger, in their mid-20s. Both couples live in small villages outside Kanpur.

Couple 1: Roshan & Sarla

Roshan has a degree and is a lucky man—he has a government job. He is well-respected in his community, thanks to his job and the gentle, respectful nature of his beautiful but simply dressed wife. People see that he provides well for his family, but he still worries about how he will educate all of this children; his wife is pregnant with their third child. They hadn't intended to have a third child, their family had been the perfect four, but when they went to stay with Sarla's parents over Divali, she had forgotten to take her pills and now, well now, they have a third child on the way. Some people would abort the child, but Roshan and Sarla are respected in the community; what would people say if they killed the child? No, they will keep the child, but after that there will be no more. Roshan knows there will be no more too, because when Sarla got pregnant, he decided to brave NSV. That was four months ago, and he is fine, he rested for a week, but since then has had no weakness or pain. Sarla and his mother were against him going, fearing he would become weak and lose his good job, but the ASHA explained the procedure nicely and Sarla agreed. His mother remained ardently opposed to the idea, but now she can see that he is fine, that they are all happy and that he will be able to raise his family well without worrying about more children. Roshan and Sarla were so happy with the procedure that they're even telling everyone about it. Some people are whispering about them, but they don't care, and anyway, most people are listening to what they have to say, Roshan being such an educated and successful man. Many of the women are even talking about what a courageous man Roshan must be, as only very brave men agree to undergo male sterilisation.

Couple 2: Rajat & Roshni

Rajat and Roshni are happily married, they are a good couple, and their two children are healthy. Rajat finds time to spend with his wife and children, and Roshni quietly looks after them all and listens carefully to the words of her mother-in-law, even when she tells her daughter-in-law what to do. Mostly, then, there is little tension in the household, and there are few quarrels. But life is hard.

They have a small plot of land for agriculture, but it is not enough, and Rajat is unable to find work in the village. Soon, his first child will be going to school, but he is worried about how he will be able to ensure that his son goes to a good school and has all the materials he needs to

study well. Certainly, they cannot increase the size of the family; Roshni tried the pill, but found she often forgot to take it, and she is afraid of the Copper T. Sometimes they use condoms, but at other times they do not have one at hand or do not want to spoil things. This is how Roshni became pregnant again last year. It was a terrible time, and the peace in the household was destroyed, many quarrels arising regarding what to do. Rajat was so upset at the news of the pregnancy and could not imagine how he would take care of his family or what the community would say, surely they would gossip about how uneducated he was to let this happen, about how he was a bad husband who could not provide for his family. He was adamant they must go for an abortion. As for Roshni, she shared these worries, and she also wondered how her body would cope with another pregnancy, the last birth had been so difficult and had made her so weak. But how could she go for abortion? This would be to kill the child, and her mother-in-law would create so many problems if she found out, especially since Roshni had not yet borne a son. Perhaps it would be easier to continue with the pregnancy. So they argued a lot about what to do, and the tension in the household grew.

Eventually, Rajat and Roshni both agreed that an abortion was the only answer; they simply could not afford to cut the cloth into smaller pieces, and it is essential that their two daughters are educated, so that they can make a better life for themselves. Of course, though, they couldn't tell Rajat's mother and father or risk being shamed in the community, so they prepared to go for "an outing" together and to end the pregnancy.

So you see, they did not want to go through this again. Thus, when someone told them about NSV, that vasectomy is not like in the past, that it can be quick with little pain or resultant weakness, they discussed the procedure seriously. Rajat was unsure, but Roshni, in her gentle manner, making sure she did not argue, persuaded him—after all, he would not have to worry about condoms ever again, or increasing his family; and the money he would get would be higher than that she would get for going for sterilisation herself. They could use that money to feed the children milk or put it in a savings account for their education.

Now they have two children and are free from worrying about their family size increasing or having to undergo another operation that people might find out about; and Rajat's mother, when she found out about his operation, was not angry when she could see that he was OK. She would have liked to have a son, but she understood, and she and her husband were proud that Rajat was taking such responsible steps to make sure he could provide for his family. Rajat only told his close friends about his operation, but they were understanding, and two are even considering the procedure themselves now.

Analysis Workshop Minutes, Including Personas and Peer Researcher Stories about NSV

I. Welcome and Introduction

Brief round of introduction

II. Character Profiles (Vyaktitva Chitran)

Four different groups were formed. Each of the male groups discussed character profiles of men and women. Similarly, both the female group also discussed character profiles of the men and women. Hence, there were four presentations of the character profile.

| Items | Group 1: Men participants on man | Group 2: Men participants on woman | Group 3: Women participants on man | Group 4: Women participants on woman |
|---|---|--|--|---|
| Name and Age | Rahim, 35 | Bhavna, 30 | Prakash, 25 | Asha Devi, 35 |
| Appearance (features, clothing, and body language) | Healthy | Healthy, calm, and social | Simple dress and healthy body, cheerful and positive attitude | Decent |
| Language spoken | Polite | Simple | Simple | Polite |
| Job/ Occupation | Job that brings prosperity | Housewife: Looking after family and children | Private job | Housewife: Completes household work; look after in-laws, children and husband |
| Family composition | More number of people in the family (many children) | Two children and husband | Parents, wife, brother, and one daughter | Two children |
| Education level/literacy | Intermediate | High school | Intermediate | 5 th Standard |
| What are his/ her core values | To look after the family with responsibility or happy family | Education of the children | Respect to elders, speak truth, satisfied with whatever he has | |
| What he/she does for leisure/fun | Leisure according to available resources | Watching TV | Watching TV, spending time with the family | Watching movies at home |
| What he/ she worries about | Money, ration for the family, good education for the children, respect in the society, respect for elders | Worried about nutritious food for the children and wear good dresses, better education of the children, husband's health, good source of earning | Low income, difficulties in making the house, higher education of the children, health of the mother | Happiness of the family, my in-laws and husband remains happy |
| What brings him/her greatest happiness | If the children are successful and get a job; if any illness is cured; sufficient income through etc. | Dresses and ornaments | When gets salary and goes out with the family | Togetherness in a family; going out with husband |
| Dreams and aspirations for self and family | God keeps everybody happy, keeps everybody wealthy, everybody—children and elder—all get love and affection | Not more than two children and husband remains healthy always | Dream of making the a doctor, no hurting to the parents | Going to various places with husband |
| Who do he/ she talk openly | Closest friend and relatives | With her husband or close friend | Parents, wife and special friends | Husband, mother or close friend |
| What is his/ her relationship with spouse | honest and noble relationship | Better coordination and loving relationship | Good understanding among themselves | Interacting politely with husband |

Discussion during participants' presentation:

Age: Participants argued that the age for marriage is increasing. Now men marry at around 22–24/25. Now it is changing in the society.

It was decided that ideal age for men who can go for NSV will be 30 years and their wives' age could be 25 years.

Number of children: Couple has only one child but is worried about their low income in a private job and not owning house and wanting a higher education for daughter. So does not want to have more children.

Consensus on the name of the character: Participants proposed names for men like – Roshan, Raj, Rajat and for women - Rachna, Shrishti, Shraddha, Sarla, Roshni

Out of these names Rajat (for man) and Roshni (for wife) were selected. The names are meant to be universal so that they can apply to any community or religious group.

III. Storytelling

Three separate groups were formed to come up with a story of a real family where the man has undergone NSV. The story should illustrate all the situations that man has faced while deciding about NSV.

Story 1: Rajat and Roshni lives in a village. He has small land for agriculture. There is no job in the village. He has three children. He is in a difficult situation and not able to look after his family properly. His wife was concerned about the family. She thought that her family should not increase. She discussed this with her husband. Both of them discussed and Rajat agreed to go for NSV. Rajat discussed this with his close friends. It is now two years that he is fine. The family is happy.

Story 2: Rajat is living in a village. He has three children—one daughter and two sons. He was not able to earn properly to take care of his family. Hence, he thought to go for NSV. He discussed this idea with his friend. After that, he discussed this idea with his wife Roshni. His wife agreed with his idea. He went for NSV. When he came back, his parents started fighting with him, and out of anger his parents separated him from the family. After this, people started laughing at him. But he did not care.

Story 3: Rajat and Roshni have two children, and Rajat's parents are not living with them, as they are no more. Roshni remains sick, so she was not able to go for female sterilisation after these two children. Hence, her husband decided to go for NSV. He went to a government hospital. After that, he started facing problems. He was not able to ride his bicycle and got weak. He had pain in his stomach. He attributed all this to the NSV and said that if he had only gone with a different method, things would have been better.

IV. Discussions with the participants

Why people have many children even though they prefer small family?

- Boy or girl preferences, if the family has a boy they want to have girl or vice versa.
- Sometimes they have a child by mistake, as they do not have enough information related to contraceptive methods or are sometimes away from home at a wedding or elsewhere and do not have the method (like condom or pill) and forget.
- Children are given by God, the belief that it is not for us to stop. Some of the communities, like Muslim community, want to have more children. In case of a fight or quarrel, then they have big numbers to fight on their side.
- Lack of education is another reason. Those with aspirations to have better family, wants to provide good education to the children will have less. Those less educated may still feel that more sons means more income/ support in old age
- Don't think about methods or are afraid of them (even condoms—can break and get stuck inside the body).
- Some of the couples practice abstinence. But participants argued that it is difficult to abstain in a marriage. Not realistic.

When these unplanned pregnancies happen:

- Majority of men (70%) may not want the pregnancy but woman will say God has given the baby and so we should keep. Women make that decision (say male participants). Women have to go with what the man say in the end (say female participants)
- Terminates 30% (estimate suggested by couple group members): happens more often when the husband and wife have a good relationship and decide (man). Sometimes she can hide and go with friend or family member (woman). Go to different facilities based on what their income is. First to chemist. Then, if not successful or if they don't have money for chemist, they go to government hospital.
- There is some stigma against abortion—seen as taking a life. Also shame that there has been a pregnancy despite awareness about family planning—already have few kids.
- There is stigma about having many kids when someone does not have space or money. Used as an insult in time of conflict. “Look at him, no money and has so many kids”.

Why are men shy to talk about family planning issues?

Family planning is women's business. Men don't get pregnant! Men want fewer children to provide food, education, etc. BUT leave the method to women. They do not have the opportunity and time to discuss this like the women do. Women have time and opportunity (men's perception). After completing household work, they usually meet and discuss such things among themselves. Whereas among men, conversations of this sort with others (peers) that lend themselves to initiating conversations regarding family planning and knowing more about it are not at all common.

A place to reach men is in their workplace?

Talk to colleagues and others whom they talk about politics, house building, cricket, etc. Even if there was time, they do not talk about sex or family planning, etc. (women said this and the men sheepishly agreed that it was true).

Women start the conversations at home about family planning (men). If there were open conversations at home, then we would not have this problem at all! (Women)

ASHA tells the women about family planning, women can tell the same to the men, but man will listen and do ultimately what he feels like. Reinforcement of information from a close friend of men is possible and helpful. Proof of NSV from someone they meet and hear testimonial, that would be the most powerful—people have info but need a real-life example to believe. People do not believe what they see on TV (“TV wale jhoot bolthe hain [TVs tell a lie]”).

V. Addressing myths and misconceptions:

Doctor should explain—a sympathetic doctor.

A friend or a colleague who has done and demonstrated that he is fine, that is effective. We need to make NSV popular and normal. Only then will people start to discuss it normally and make it more normal. We can use TV and radio and print for more educated, but not for the poorest. For the poorest, you need economic incentive.

Whose responsibility is this—the governments or the families? It is government’s responsibility. Who raises the children? Families. Who benefits from population control? Government. Opinion divided. If someone has more than two kids, jail.

VI. PEER Process Experiences

- Learned about NSV.
- Discussions about various issues were very enjoyable.
- Learned about some new things—that men can also access family planning.
- Whether this programme moves forward or not, us PEERS and those we have talked to will at least have been sensitised to start to think about this.
- Thought female sterilisation was better than NSV. Learned now.
- Friends see me in positive light after the conversations.
- Got closer to my friends talking about these issues.
- We learned a lot from those we talked to.
- Looking at what an ideal family people said was, we learned a lot from it. All the issues come in this.
- Learned from my friends that they thought that NSV was not a nice thing. They felt their men would not be able to work after that.
- Meeting each other was really nice.
- Not just NSV. I feel like men and women should have sterilisation.
- Good that we talked about the woman also having a right to have her husband consider family planning choices.
- Those we talked to were first very hesitant, we also, but that broke and we became comfortable talking. People even started to ask me to tell them more about NSV, so I need to know more about it.
- Training programme helped them talk to friend and know how to get information.

- Need more information in the communities. What we currently have is not enough information.
- Those who are running after their daily bread they do not have the knowledge and thinking space to worry about such issues as we are raising with them. How do we reach these people? That is what I wonder.
- It was really nice to meet new people and openly talk about these issues. Also, when we went out, we talked about those issues with our friends that we never thought about discussing before.
- Most of the peers said that they enjoyed the process, they learned a lot. A few women said that they have some hesitation in starting, but now they are very comfortable. One man said “he did not like one thing why we (RESPOND) want to promote NSV when women have no problem to go for female sterilisation. One man again said there should be 50% male sterilisation and 50% female sterilisation.

VII. NSV technical presentation

It was interesting that the men and women were very attentive through this session and asked questions as well. There was no shyness or hesitation to discuss the issues. Everyone was keen to know.

Appendix 5

Consent Form for Individual Interviews (Verbal)

Good morning/afternoon/evening. My name is . I am helping the RESPOND Project in Uttar Pradesh. Thank you for taking the time to talk with me.

The RESPOND Project and the Ministry of Health, Medical and Family Welfare, Uttar Pradesh are conducting a study to understand concerns and views of men and women related to family planning with specific emphasis on male sterilisation. The RESPOND project have asked some people like me to help them understand what people like us think about family planning. They have asked me to talk to a few of our friends to find out what people like us think about family planning. I will NOT be asking you to tell me things about yourself or about your family – just what **other people like you** say about family planning. Please do not tell me the names of anyone you talk about – or if they are your relatives.

This is NOT a test. So there is no write or wrong in our discussion – all I would like you to tell me is what other people like you say about family planning. Your name will not be used in any way. However, some people from the RESPOND Project and the Ministry of Health may read my notes what you have told me.

If you are happy to talk to me about this I would like to agree a time to meet that is a good time for you. If you do enjoy talking to me the first time then I will ask you if you would talk to me another two times at a time that is also good for you. Your participation is voluntary and there is no penalty of any kind if you decide not to participate. You may participate once and then not again. Or you may ask me to stop at any point during our discussions.

There is no risk as such in the conversation we would have. We will decide a suitable time for the conversation to avoid any kind of interference with your routine work. Each time we talk it will take about one hour. There are no direct benefits of our conversation but it would help RESPOND and the Ministry of Health and Family Welfare, Uttar Pradesh to better understand the family planning needs of men and women and then design effective communication messages for the people of Uttar Pradesh. I am not being paid by RESPOND and I cannot pay you for talking to me as well.

If you are happy to talk to me we can agree a place to go where no one can hear us talking.

Are you happy to talk to me this time? Yes No

Do you have any questions? Yes No

Is there a place we can go where we can talk? (Suggest a place if the participant does not.)

If you have any questions about this, you can contact: Mr. Dawood Alam or Dr. Shalini Raman of The RESPOND Project at 11-2685-1948.

“I have read this form to my friend and he/she has agreed to talk to me.”

Signature of Peer Researcher

Date