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A Qualitative Investigation on the Effects of the Uttar Pradesh Population Policy on Women who Undergo Sterilization in Bahraich, Uttar Pradesh

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A Qualitative Investigation on the Effects of the Uttar Pradesh Population Policy on Women who Undergo Sterilization in Bahraich, Uttar Pradesh

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Abstract

The effectiveness of population policies is widely disputed by the international development community and is under constant scrutiny. While these policies have the potential to positively affect reproductive and child health indicators, they often focus too heavily on macro-demographic family planning goals and fail to acknowledge socioeconomic determinants of fertility indicators, often making for ineffective policy. Furthermore, target-based approaches have the potential to negatively impact women’s family planning choices and the quality of care they receive. This study seeks to analyze how the Uttar Pradesh Population Policy affects the decision-making process and experiences of women who undergo sterilization procedures in rural Bahraich, Uttar Pradesh. 10 women between the ages of 26-38 who had undergone a sterilization procedure within the last 5 years, and 5 accredited social health activists (ASHAs) were interviewed in order to obtain perspectives on first-hand experiences and the sociocultural and policy-related factors that influenced them. Results showed that family members, community health workers, personal desires, and overarching policy goals all influenced the women’s decisions, and her experience was sometimes negatively impacted by lack of quality healthcare workers. Additionally, women were not influenced by monetary incentives. Thus, the research calls into question the use of compensation packages for family planning methods, and shows the need for population policies to focus on reproductive and child health rather than meeting family planning goals.
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**Abbreviations**

ANM – auxiliary nurse midwife

ASHA – accredited social health activist

AWW – anganwadi worker

CHC – community health center

CSR – child sex ratio

DEHAT – Developmental Association for Human Advancement

DHFW – Department of Health and Family Welfare

FP – family planning

GOI – Government of India

HSDC – Health Survey and Development Committee

ICPD – International Conference on Population and Development

IMR – infant mortality rate

IUCD – intrauterine contraceptive device

LAM – lactational amenorrhea method

MHA – Ministry of Home Affairs

MHFW – Ministry of Health and Family Welfare

MTP – medically terminated pregnancy

NGO – non-governmental organization

NHP 2002 – National Health Policy

NPP 2000 – National Population Policy

NRHM – National Rural Health Mission

OBC – other backwards class
OC – oral contraceptive

PHC – primary health center

RCH – reproductive and child health

RLF – replacement level fertility

RTI – reproductive tract infection

SC – scheduled caste

STI – sexually transmitted infection

TFR – total fertility rate

UNICEF – United Nations International Children’s Emergency Fund

UP – Uttar Pradesh

UPPP – Uttar Pradesh Population Policy

WHO – World Health Organization
Introduction

Since British colonial times, India has maintained a deep-seated fascination with the undesirable effects of its own population growth on economic development. Eager to thwart the negative consequences of unrestrained population increases, the family planning (FP) program was born in 1952 one of the earliest in the entire world. To this day the FP program in India remains closely intertwined with the practice of curbing population growth rather than solely focusing on reproductive and child health (RCH). Within the FP program, female sterilization procedures have received a disproportionate amount of attention compared to other birth control options, and as a result is by far the most popular method of contraception in India, with an estimated 2 million women undergoing procedures annually. The amount of women who undergo sterilization varies greatly by state. For example, in India’s most populous state, Uttar Pradesh (UP), only about 17% of women have had the procedure, while 63% of their counterparts have in the southeastern state of Andhra Pradesh (Singh, Ogollah, Ram, & Pallikadavath, 2012).

In a country of 29 states and over 1.2 billion people, UP is home to roughly 16.5% of India’s overall population and outnumbers the next most populous state, Maharashtra, by about 87 million people. According to the most recent census figures, the current population of UP is about 200 million and it continues to grow annually at a rate of 20.09% (Directorate of Census Operations, Uttar Pradesh, 2011). In order to stunt this growth, which UP deems detrimental to its development, the Uttar Pradesh Population Policy (UPPP) was released in 2000, with the main objective of reaching replacement level fertility (RLF) of 2.1 by 2016. Unsurprisingly, the policy has failed to even approach this achievement, with latest reports showing a reduction of only .9 points from 4.3 in 1997 to 3.1 in 2013 over the course of more than a decade (Department
of Health and Family Welfare [henceforth DHFW], 2000) (Ministry of Home Affairs [henceforth MHA], 2013). This policy and population policies in general have in the past been met with substantial criticism, since they often focus too heavily on achieving quantitative goals, rather than ensuring quality care and human rights for some of the country’s most vulnerable citizens.

**Rural Indian Women and Sterilization**

The term “sterilization” refers to both laparoscopies and mini laparotomies. While the popularity of this procedure transcends social class, economic standing, and environment, rural poor women in India often undergo the procedure at a government-run institution, like a district hospital or primary health center (PHC). When making the decision to end her childbearing years, a woman faces a number of challenges. Before the operation, people in her community, including a local health worker who does not necessarily have her best interests at heart, or family members, including her husband or mother-in-law, with whom she may not share the same FP goals, have likely influenced a woman’s decision. Further, the quality of camp or hospital facilities and infrastructure varies widely with some having few to no problems, but others being inadequate and producing fatal or detrimental results. For example, in November 2014, 15 women died at a government-run camp in Chhattisgarh, where one doctor operated on 83 women in 5 hours against government protocols. While the women’s cause of death was never confirmed investigators concluded that the deaths were most likely due to “contaminated equipment or
adulterated medicines” that caused the women to go into toxic shock and vomit for hours before their deaths (Kalra, 2014). In the same month, a surgeon performing sterilizations at a community health center (CHC) in Bahraich punctured a bleeder in a woman, and her condition improved only after she was transferred to a trauma center in Lucknow (“Woman’s Health Worsens,” 2014). The stories of these women, while exceptional, highlight underlying systemic deterrents to limiting one’s family size responsibly and safely.

Field Study Question and Purpose

As the expiration date of UP’s current population policy nears and the window for revisions approaches, the importance of ensuring women’s access to quality FP services increases becomes increasingly urgent. The question that this study seeks to answer is: how does UPPP affect the decision-making process, lived experience, and quality of care that women receive while undergoing sterilization procedures? Additionally, how is the decision-making process impacted by sociocultural factors and other Government of India (GOI) policy?

While UPPP contains many objectives, this study will specifically focus on its target-based emphasis on macro-level demographic FP goals, success in achieving them, and the aspects of the policy that affect the experience of rural poor women.

Field Study Methodology

The study employed a qualitative approach to investigate the goals outlined above using semi-structured interviews. All interviews were conducted with the help and support of staff members from the Developmental Association for Human Advancement (DEHAT), a Bahraich-based non-governmental organization (NGO) that works to ensure child’s rights in the area. The researcher interviewed an array of stakeholders in the sterilization process in order to gain an
inclusive and realistic perception, including local women who had been sterilized, accredited social health activists (ASHAs), a physician, an NGO official, and a policy expert.

In total, the researcher interviewed 10 women in the Chittaura Block of Bahraich who had been sterilized within the last 5 years. The researcher identified the women with the help of DEHAT staff and the auxiliary nurse midwife (ANM) responsible for Chittaura Block. The women were between 26-41 years of age and each had 4-7 children. Their experiences differed in that they had been sterilized at different times and in both private and government institutions. A female native Hindi translator helped to conduct all interviews at the women’s homes in Chittaura Block in order to ensure their comfort, level of understanding, and the accuracy of the communications. Women were interviewed in the presence of their families and peers. In some cases, family members interjected, but in those cases the women were always directly asked the question again, in and effort to ensure that their opinions were heard.

Additionally, one physician and 5 ASHAs were interviewed in order to gain the perspective of those who are directly involved in and influence women’s decision-making processes and sterilization experiences. All health workers were identified with the help of DEHAT and Bahraich District Hospital staff, and interviewed at Bahraich District Hospital. The physician was interviewed in English, while all other health personnel were interviewed in Hindi with the help of a DEHAT staff member. The policy expert was located in Mumbai and was interviewed in English over the phone.

Three different questionnaires were developed for this study. The questionnaire for the sterilized women aimed to understand their decision-making processes and personal experiences with the procedure, and included questions regarding those who influenced the women, their personal motivations, their experiences at the sterilization camps, and how the procedure has
affected their lives. The questionnaire for the government health workers endeavored to gauge the extent of their FP knowledge and understand how UPPP affected their motivation to recommend women to the camps by asking about the training they received, their involvement in the decision-making process for sterilized women, and their job requirements. Finally, the questionnaire for the physician was created to help understand the proceedings from a medical perspective by inquiring about the intricacies of the procedure itself and local women’s access to healthcare. Sample interview questions can be found in the Appendix.

All interviews took place between April 16 and May 7, 2016. Each interview lasted approximately 20 minutes, was recorded on the researcher’s telephone, and later translated with the help of a native Hindi speaker. Prior to beginning each interview, all subjects gave verbal consent to being interviewed. To protect confidentiality, the names of the sterilized women and ASHAs have all been replaced by a pseudonym, in accordance with religious significance, if necessary.

Field Study Setting

This study was conducted in Bahraich, UP, a rural district that borders Nepal. Bahraich has a population of 3,478,257 people, of which about 65% are Hindu and 35% are Muslim (“Bahraich District,” 2011). The district has a sex ratio of 891 that has steadily been improving, and 58.6% of the population is literate (MHA, 2013). Bahraich has been ranked as one of the top 275 most backward districts out of 640 total in India (Center for Science and Environment, 2003).¹ The Chittaura Block of Bahraich, where all of the interviewed sterilized women reside, largely comprises people from SCs (scheduled castes) and OBCs (other backwards classes) (“BPL List – Blockwise,” 2002). The researcher was able to effectively gain access to her target

¹ The term “backwards,” in an Indian context, is used to refer to underdeveloped or inequitable regions.
population by conducting this study in a rural, low-income, and underdeveloped area. Bahraich also provided access to local health workers and NGOs who were familiar with the region’s history of FP.

Women in the region who choose to undergo sterilization do so at public institutions, including PHCs, CHCs, or the District Hospital, or one of the private hospitals nearby. The District Hospital and local PHCs and CHCs hold multiple camps per month throughout the region where sterilizations are performed throughout the day. About 6% of women in Bahraich have been sterilized while about 16.6% use any modern contraceptive method. Of modern methods, condoms are the most popular, being used among 7.2 % of women in Bahraich. Traditional birth control methods are also very popular among women in Bahraich. Of the traditional methods employed, periodic abstinence was the most popular, with 17% of women using this method, followed by 9.4% using Lactational Amenorrhea Method (LAM), and 2% using withdrawal. As a result of the unreliability of traditional methods and the lack of awareness about modern methods, there is an immense unmet need for both spacing (19.8%) and limiting (19.4%). The total fertility rate (TFR) in Bahraich is 4.9, much higher than UP’s average in 2013 of 3.3 (MHA, 2013).

Overview of Family Planning in India

History of Family Planning Program in India

“The first reason why family planning fails is the obsession of the experts with the techniques of contraception. The belief that just about any problem can and will be solved by some new tool or technique is as Anglo-American as apple pie.”

-Demerath, as cited in Rao, 2004
• **1943:** HSDC recommends state assistance for FP services to combat increasing population.
• **1959:** State FP committees are established nationwide.
• **1968:** States compete with one another to meet sterilization targets quickly.
• **1971:** MTPS become legal.
• **1975:** Indira Gandhi declares the Emergency, National Population Policy released.
• **1978:** UNICEF declares “Health for All” initiative at Alma Ata.
• **1994:** India becomes a signatory to the ICPD.
• **2005:** NRHM released with the goal of improving overall health.

In order to understand the present state of FP services in India, one must consider its long history of overlap with population policy. From early beginnings amidst the founding of the Health Survey and Development Committee (HSDC), FP has never simply been a scheme to assist women in achieving their desired number of children at their own pace. Instead, the idea that overpopulation is directly associated with stagnant economic development has always factored into decision-making in regards to women’s health, with its roots having strong ties to colonial-era policies and the eugenics movement. According to Dr. Srinivasan (2006) at the International Institute for Population Sciences, the Indian FP approach can be divided into six major time periods: the clinic approach (1951-61), the extension education approach (1962-69), the high intensity approach (1969-75), the coercive approach (1976-77), the recoil and recovery phase (1977-94), and the RCH approach (1995-present).

In 1943 the GOI formed HSDC to improve India’s overall health services. After observing in the latest census an increase in births accompanied by a decrease in deaths, HSDC called for state assistance for FP services in a report containing eugenics-fueled language:

> A continued high birth rate among these classes, if accompanied by a marked fall in the rate of the more energetic, intelligent and ambitious sections of the population, which make much the largest contribution to the prosperity of the country, may be fraught with serious consequences to national welfare. (as cited in Rao, 2004).
In reality, these events can all be attributed to British colonialism: health policy that succeeded in reducing deaths, The Permanent Settlement Act, and the destruction of the cottage industries were the main contributors to widespread poverty, though the committee simply brushed it off as an effect of population growth. In its second five-year plan, GOI took HSDC’s advice and concluded that the population increase was indeed slowing economic development. Thus, in 1959, state FP committees were established nationwide, despite parallel bodies for overall health not yet existing. These committees created rural and urban clinics and ensured that FP methods started to be taught in medical training programs for doctors and nurses. Both the central and state governments began disseminating the idea that a small family was preferable and beneficial to society. In 1961 the GOI appointed the Health Survey and Planning Committee to assess the progress made since HSDC was established, and decided that FP efforts required more widespread implementation efforts than previously attempted. This realization contributed to the addition of the ANMs, whose responsibilities included influencing women’s FP decisions, promoting RCH and overall health, and supporting the PHC system. Thus, PHCs were equipped with ANMs, a lady doctor, health assistants, and FP personnel. This period was largely defined by foreign assistance. At the recommendation of the UN Family Planning Mission, the IUCD was widely promoted across the country, available at PHCs, which by then, had become inextricably linked with FP services. While the IUCD caught on to some extent, the IUCD initiative is widely considered a failure because India lacked a basic health infrastructure, including screening, counseling, and check-up services necessary to support such an ambitious enterprise.

In the fourth plan, released in 1968, the idea that population growth was out of control and would be the downfall of the country had entered the minds of the middle class through
media campaigns and propaganda. Ignoring the desperate need for advancement of the primary healthcare system, GOI allocated Rs. 3 billion to FP services alone while overall health services received only Rs. 4.335 billion. Although female sterilizations were already practiced, vasectomies were emphasized as well in order for states to more easily meet the sterilization goal of 14.9 million procedures. In addition, although abortion rights continue to be fought for in the US to this day, the GOI willingly legalized MTPs (medically terminated pregnancies) in 1971 as an extra measure to help reduce the TFR (Rao, 2004).

In 1976 India went through one of the most controversial periods in its history when Sanjay Gandhi, son of then-Prime Minister Indira Gandhi, instituted a widespread sterilization program during The Emergency declared by his mother. In a statement released by Mrs. Gandhi in 1976, she said, “Some personal rights have to be held in abeyance for the human rights of the nation: the right to live, the right to progress” (as cited in Rao, 2004). With new district-level targets for sterilizations 8.3 million men underwent vasectomies in the 1976-77 program year (Haub & Sharma, 2006). Life was made extremely difficult for poor citizens, who were denied government permits, rural credit, school admissions, and housing if they failed to undergo sterilization. Maharashtra was the only state to actually implement a compulsory sterilization law, but it is widely accepted that others would have if Gandhi had not been voted out of power. Despite most states not instituting compulsory laws, reports of coercion, kidnapping and riots all resulted from the atmosphere of fear and government pressure to meet targets across the nation. In total, 1,774 people died in sterilization procedures.

With the ousting of the Congress Party in 1977, the Janata Party stated that its commitment to FP would remain, but solely in a voluntary fashion. FP still accounted for 0.6% of the total budget in the fifth five year plan, and future recommendations of The Working Group
on Population Policy were still made in demographic terms, rather than focusing on socioeconomic development or overall health. This also began the shift in which the FP program became primarily focused on women.

In 1994 India became a signatory to the International Conference on Population and Development (ICPD) in Cairo, which addressed topics like education, reduction of child and infant mortality (IMR), reduction of the maternal mortality rate (MMR), and access to RCH services. Women dominated the discussions, disputing the postulation that population policies are integral to RCH by speculating that such policies focus too heavily on demographic considerations and target goals, and thwart the advancement of women’s health services. (Rao, 2004).

Although some states like UP have implemented their own target-based population policies, India has since eliminated targets for sterilization and IUCDs on a national level, and focused more efforts on RCH and overall health services through the National Population Policy (NPP 2000), National Health Policy (NHP 2002), and National Rural Health Mission (NRHM 2005). While NPP 2000 and NHP 2002 pledged to meet unrealistic goals such as reaching an IMR of 30 by 2010, NRHM 2005 is more attuned to problem-solving strategies and programs than specific outcomes (Srinivasan, 2006). Its Mission Document states: “The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water” (Ministry of Health & Family Welfare [henceforth MHFW]: 1, 2005). NRHM also introduced ASHAs, who are present in each village and selected by the Panchayat\(^2\), in order to support the ANM and further community health initiatives. This demonstrates the changing mindset of health and development planning over the last sixty years.

\(^2\) Village-level body of local government
The history of FP in India is filled with failed policies and programs, human rights violations, and slow progress, but it has made significant improvements and continues to do so to this day, employing a comprehensive view of health and the factors that affect it.

**The Importance of Spacing and Success in Family Planning Programs**

While it seems that India’s current FP program has its flaws and in some instances is ineffective, to dismiss it as a lost cause would be a disservice to women everywhere. This section outlines the importance of spacing methods, health infrastructure, and community engagement to FP initiatives in a rural Indian context.

Child spacing has been proven to reduce negative maternal, perinatal, and infant outcomes regardless of location, socioeconomic background, and environments (Whitworth & Stephenson, 2002). Srivastava (1990) found that in UP, the IMR for children who had been born less than 2 years apart was 219 while the IMR for those who had been more than 2 years apart was significantly less at 40. Whitworth & Stephenson (2002) found that in India, short birth intervals (<18 months) were associated with high risk of mortality, especially in the post-neonatal period, when the risk of mortality increased by 237%. This percentage declined as a child aged, with the risk lowering to 84% in the neonatal period and 71% in the toddler/childhood period. In contrast, heightened mortality risk for long birth intervals (>36 months) was found to be negligible. Allowing the mother time to regain adequate nutrition levels, reducing the need for multiple young children to compete for resources, and reducing the exposure to infectious disease more often suffered by younger child have all been cited as reasons for this phenomenon.

About 30% of births in UP occur fewer than 24 months prior to the mother’s previous delivery, and 34% between 24 and 35 months (Borda, 2008). A 2013 survey found that the IMR
in UP is 68. While this figure can be attributed to a number of socioeconomic, policy, and environmental reasons, it is important to note that of the 37.6% of the population who use any modern method of contraception, only 1.1% use the IUCD/Copper-T, 3.6% use contraceptive pills, and 13.2% use condoms. Female sterilization is the most used method of contraception in UP, with 18.4% of currently married women ages 15-49 using it (MHA, 2013).

According to the World Health Organization (WHO), providers should follow specific guidelines in order to ensure success in FP programs. These guidelines include:

- Providing a broad range of methods;
- Providing complete and accurate information about all the methods offered;
- Ensuring that providers have the technical skills necessary to provide the methods safely;
- Ensuring that providers are trained in appropriate counseling techniques and use them effectively;
- Ensuring that providers communicate with clients in effectively and culturally appropriate ways;
- Providing follow-up care to ensure the continuity of services;
- Providing an adequate logistics system to ensure continuity of supply;
- Providing convenient and acceptable services to clients;
- Accessing and meeting the needs of clients (WHO, 1994).

In order for a community to accept reversible contraceptive methods as effective and trustworthy, women must have a wide array of reliable options from which to choose. Providers must ensure that details such as the delivery and counseling arms of the program are not overlooked, and that women are receiving quality care. These steps are crucial so that women trust the system and are well versed in the potential side effects of their chosen intervention.
Women are also more likely to continue using a contraceptive method if they receive proper counseling at every step in the process.

**Uttar Pradesh Population Policy**

In 2000, the government of UP released a statewide population policy with the primary goal of achieving RLF of 2.1 by 2016. Other objectives included increasing the age of marriage from 16.4 to 19.5; reducing maternal, infant, and child mortality; and combatting RTIs, STIs, and AIDS. Reaching this goal necessitated achieving a 2.2-point reduction from the 1997 level of 4.3, that is, a reduction to 2.1. To accomplish this, UPPP implemented contraceptive and sterilization usage targets, with the goal that 36.5% and 15.6% of couples use limiting and spacing methods respectively by 2016 (DHFW, 2000). UP made laudable progress with use of the spacing method, but is still less than half way toward meeting the point reduction goal and well short of the established percentage goal relating to the use of limiting method. In 2013, the TFR was 3.3. Those using the limiting method only number 18.7%. Conversely, the shining star of the program seems to be progress in effectively implementing use of spacing methods, including condoms, OCs, and IUCDs, which exceeded the target of 15.6% and stands at 17.9% (MHA, 2013).

While not directly mentioned in UPPP, UP still employs the usage of compensation packages for women who undergo sterilizations and IUCDs. Intended to “compensate the acceptors of sterilization for the loss of wages for the day on which he/she attended the medical facility for undergoing sterilization,” the monetary incentive for sterilization procedures in UP increased from Rs. 600 for procedures performed in government institutions and no incentive for those in private institutions to 1400 Rs. and 1000 Rs., respectively, in light of increases in cost of living and necessity of meeting Millennium Development Goals (MHFW, 2013) (Kumar, 2014).
Investigation of Rural Indian Women’s Sterilization Experience

Decision-Making Process

Decision-making in FP has changed substantially in the last 50 years for rural Indian women. While the average rural family once limited its family size to seven or eight children, the GOI has made significant progress in implementing small family ideals through media campaigns and other efforts. On advising her clients, Riddhi, an ASHA from Bahraich, said, “I explain that if you have two boys and one girl, you have the perfect family. This is what you can afford and you should only have kids if you can give them futures” (Riddhi, personal interview, April 30, 2016). Dr. Atul Mishra, an anesthesiologist at Bahraich District Hospital, said, “Before four [children], no one wants to have sterilization…. Even after four they won’t go, sometimes,” attributing this occurrence to the couple’s perceived level of productivity relative to their family size (Dr. Mishra, personal communication, April 16, 2016). All of the 10 women interviewed for this study had between four to seven children, and the average number of children per family was 4.8 (All sterilized subjects).

Motivators

The women’s decision-making processes were motivated most frequently by personal reasons, cultural reasons, and people in their communities. Among personal reasons, women cited financial constraints or simply not wanting to have any more children as their motivation for getting the procedure. Motivators within their communities included family, friends, and health workers. Husbands and sisters most often played a role in the decision-making process, but one woman also cited her in-laws as motivators. Often, a mixture of all of these factors influenced the decision: one woman said, “My husband did plan for my kids, and the moment we had enough, he told me we could not afford more. He was quite confident that we could only
care for four kids, so that’s why we went for the procedure” (Sridevi, personal communication, April 22, 2016). Only two women cited an ASHA or ANM as their primary motivator, but health workers still play a role in many women’s decision-making processes, since each one is required to refer 22 women to get sterilized per year (Manisha & Adithi, personal communications, April 27, 2016) (Hemali & Dipti, group interview, April 30, 2016). One ASHA said that if she failed to meet her goal she would be scolded and would not receive payment. Four of the five ASHAs interviewed said that they recommended sterilization over other methods, and that they recommended sterilization most often. For each woman whom health workers refer to the procedure, they receive a bonus of Rs. 200. Women are supposed to receive money for having the procedure, too, but none cited the cash incentive as one of their primary reasons of motivation. All of the women wanted to have the procedure, and none reported being forced by anyone to do so (All sterilized subjects) (All ASHAs).

Women’s families were not always supportive of their decisions to undergo sterilization. Despite the widespread acceptance of small family ideals, there are still some families that prefer to have many children (All ASHA) (All sterilized subjects). In these situations, conflict can arise within the family. One woman with seven children, two of which are boys, said that when her husband wanted her to have an eighth child, she decided to have the procedure without his knowledge because she knew that they did not have the financial means to support another child, and he was furious: “My husband didn’t talk to me after the procedure for a really long time…. He was really angry at me…. After the procedure, [he] told me, ‘I don’t care if you die or live.’ [He] didn’t care if I went and did work. He refused to help me get medicines and I had to get them myself.” Her nearby husband retorted, “It didn’t really affect me if she was dead”
(Sanjana, personal communication, April 22, 2016). Two other women also went against the wishes of their husbands and got the procedure, though their reactions were less intense.

**Knowledge of Options**

“We didn’t ask for other [methods] because we’ve heard that pills and injections can lead to low hemoglobin levels. We’ve also heard that if you get the Copper-T, you may even die.”

-Manisha

The GOI offers a wide range of contraceptive methods, including condoms, OCs, IUCDs, and most recently injectables, but none of the women interviewed had used a temporary method prior to being sterilized. Seven of the ten women knew about other methods and were offered the methods by a health worker, but cited side effects, lower rates of pregnancy prevention, or lack of necessity as reasons for choosing not to use them. Side effects are a major factor when using a temporary method due to the rural Indian women’s lifestyle and culture. Said one woman, “people tell me that you will bleed a lot and it gets painful and messy in the summertime” (Sridevi, personal communication, April 22, 2016). For women living in a country where sanitary products like pads and tampons are used predominantly by wealthier women, reproductive tract infections (RTIs) are very common and additional bleeding is considered an unwanted burden. Fertility remains very important to Indian culture, and many women use festivals or moon cycles to monitor their menstrual cycles. For this reason, most women do not prefer methods that cause irregular or excessive bleeding (Dr. Arole, personal communication, March 18, 2016). Women also cited ease and convenience as their reason for preferring permanent methods: “It was a matter of doing it once and for all. You don’t have to worry about anything afterwards” (Rekhadevi, personal communication, April 27, 2016).

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3 Referring to injectable birth control
Of the women interviewed, none had considered that their husbands could have undergone a vasectomy in lieu of them having a tubectomy. Women attributed this to both cultural and economic reasons. As one woman concluded, “Men don’t really get the procedure; it has to be the woman” (Sanjana, personal communication, April 22, 2016). Agriculture is one of the main industries in Bahraich, so many men have physically demanding jobs. When asked why their husbands did not have the procedure, a few women responded with questions of who would earn for the family. After being told that men can still work after having the procedure, the one woman responded, “Men have to lift heavy weight to earn, because [agriculture] is one of our main occupations. Women prefer to stay at home and do small jobs and men have to lift heavy things, so women prefer to get the procedure” (Sanjana, personal communication, April 27, 2016).

Sterilization Experience

Transportation

All of the women interviewed underwent the procedure in Bahraich City, which is located about 14 km from Chittaura Block. Eight of them went to Bahraich District Hospital and 10 of them went to a nearby private hospital. Nine of the women traveled via a tempo, a small vehicle similar to an auto rickshaw, while one woman took a train from the nearby town of Risia to get to the camp. Seven women returned via tempo, while three returned via ambulance. All of the women paid for the transportation fees with their own money, but some were confused about whether ASHAs were provided a transportation stipend for this purpose by the government, since transportation expenses were very costly at Rs. 100 each way (All sterilized subjects). When probed on this subject the ASHAs said that they did not receive any such stipend (Hemali & Dipti, group interview, April 30, 2016).
Camp Experience and Reflection

When asked what their expectations for the camp were, a common answer given by multiple women was that they had none; they “just didn’t want to feel any pain and…were worried about if [they] would live or die” (Manisha, personal communication, April 27, 2016). While others did not express as extreme sentiments, many did report feeling fear before the operation. Every woman interviewed received a physical examination, and reported having both urine and blood taken from them for hemoglobin and albumin tests as per GOI guidelines (MHFW, 2006). They all either signed a form or gave their thumbprint if they were illiterate. Multiple women reported that the nurses did not assist them other than giving them pain medication, and forced them to leave as soon as possible. Because of the rushed atmosphere, one woman fainted after trying to stand up. While the women had discussed the procedure before with their friends, families, and health workers, the doctor personally explained the procedure and gave advice to only one of the ten women. According to Rekhadevi, “The doctor advised me not to pick up heavy things, but he was in such a rush that I didn’t understand much.” Nine of the ten women said they would recommend the procedure to others, and that they were happy with the results, but one woman said, “It’s really hectic. It becomes really painful. I wouldn’t advise anybody to go through it” (personal interview, April 27, 2016). After the procedure, women said that they felt content with their decision and they worried less, knowing that they could not have any more children. Only one woman expressed regret, and wished that she had used a temporary method, since she still wanted to have more children.

Experience with Health Workers

“The ASHA is just a name. She never comes here and she loves to just sit in her house.”

-Kavita
Since the hospital camps are often hectic and doctors do not directly counsel the women, ANMs and ASHAs are responsible for follow-up care, including bringing the women medicines, advising them to rest and not lift heavy items, and telling them to take a liquid diet for a few days, but not to drink milk. Additionally, the ANM is supposed to visit all sterilized women after seven days in order to follow up on their condition and to remove their stitches. All of the women were aware that they should follow these guidelines. Four of the women reported feeling pain after the procedure, but were not always supported by the health worker. One woman’s husband called the ANM to ask for medicines and she responded, “Why did you do the procedure if you knew it was going to hurt so much?” (Radha, personal communication, April 22, 2016). Interestingly, none of the women mentioned stitch removal when discussing follow-up care.
Receipt of compensation became a major issue after the procedure. All of the women interviewed were promised amounts of money ranging from Rs. 300-1400, and only six received any money. While many women did not know the government-mandated amount that they should have received, or that it was dependent on whether the institution she attended was public or private, some were very aware of the reasons that they had not gotten any money: said one woman who received Rs. 600, “The ANMs like to keep the money for themselves. We know that the government provides money for us, but the ANMs won’t share it” (Kavita, personal communication, April 27, 2016). Oftentimes, mentions of ANMs and ASHAs were met with mistrustful and derogatory comments.

The Impact of Population Policy on Sterilization Experience

UPPP claims that “The status of women, gender equity, literacy, reduction of infant and maternal mortality, improved health and nutrition status of mothers and children have long been recognized as key determinants of fertility behaviour and are the central issues of population policy,” (DHFW, 2000) yet it has done little to improve quality of life for its most vulnerable populations with its overly ambitious macro-demographic goals and failure to even address other relevant issues like MTPs and its abysmal sex ratio. While UPPP also claims that it is necessary to meet RLF in order to avoid placing “enormous pressure on natural resources” and “[frustrating] all attempts to improve the quality of life of the people,” it never outlines the theory on which it apparently operates that assumes population growth will upset development goals. While population theories have been disputed widely over the years, this paper does not subscribe to neo-Malthusian theories and instead seeks to examine UPPP and its effect on the
decision-making process and sterilization experience of rural poor women, as well as make recommendations for policy improvement through a human rights lens.

**Sex Discrimination**

One of UPPP’s primary goals is to reduce the IMR, yet it barely touches on the issue of female feticide. UPPP employs data from the 1991 census, at which time the sex ratio in UP was 879. While it acknowledges that UP’s sex ratio has been steadily declining since 1901, it does not propose any action against female feticide other than to enforce the already existing law that criminalizes the practice. While only ten women were interviewed for this study, it is interesting to note that the sex ratio among their children was 846, contributing to the regional discrepancy between male and female children.\(^4\) Furthermore, the sex composition of all of their families included at least two boys, yet three women had either one or no girls. Of the 5 ASHAs interviewed, all reported that they modified their FP recommendations for women based not only on the number of children they had, but also on the number of sons.

Social change can take decades to observe, but efforts to increase the value of girl children have been made over the years by NGOs like DEHAT and other government-sponsored development programs. Sex preference has been a long-standing cultural phenomenon in India, but further improvements have been made, as evidenced by the increase in girls education and empowerment programs, and the criminalization of female feticide. On a local level, ASHAs should be utilized as grassroots motivators for social change. This could include holding local meetings to educate women on the value of girl children, one-on-one consultations to counsel mothers about their children, and encouraging women to cease bearing children after reaching their desired family size, regardless of gender.

\(^4\) Sex ratio = (Number of females / Number of males) x 1000
Use and Knowledge of Other Methods

Lack of awareness and underuse of spacing methods is still a rampant problem in UP. Of the ten women interviewed, three of them did not know about any other methods of contraception, and had not been offered them by a local health worker. As it is not the responsibility of the women’s community to educate her, the shortcoming falls on the local ASHAs and ANMs who fail to promote alternative spacing and limiting methods, as well as the state government for not encouraging her to do so. One of the primary reasons the seven women who knew about other contraceptive methods cited for not using them was fear of side effects. While side effects are a valid concern, they are most often manageable and not life threatening. According to a study published by the WHO (1994), Indian women who received IUCDs and were interviewed four years later were more likely to have continued usage if the side effects had been properly explained to them. It was also discovered that those who discontinued usage due to side effects would have been less likely to do so had they received the same counseling that their counterparts who continued usage had. UPPP acknowledges that “communication has a major role to play in facilitating the informed choice at both familial and community levels,” yet many of the women interviewed were either misinformed or unwilling to adjust their lifestyles to the side effects (DHFW, 2000). Furthermore, ASHAs had their own qualms with recommending spacing methods, and varied their advice based on personal factors. One ASHA reported that she does not recommend OCs because she thought that most women would prefer other methods. This lack of methodology and personal involvement in the method recommendation process fails to consider individual women’s needs. While no ASHAs reported that they were influenced specifically by their monthly FP targets when recommending sterilizations, other high-focus states like Gujarat, in which targets are also implemented, have seen issues wherein ASHAs are
not paid, threatened, given negative evaluations, or told to forge records if targets are not met ("India: Target-Driven Sterilization Harming Women,” 2012).

The disproportionate emphasis of limiting procedures over spacing methods also contributes to the escalating phenomenon of sterilization regret among women. One study in which over 30,000 women from various regions and socioeconomic backgrounds across India were interviewed in 2005-2006 found that about 5% of sterilized women ages 15-49 reported sterilization regret. Factors that increased chances of regret included number of years since sterilization, sex composition of children, and child loss. Young age (<25) was also found to have a positive association with sterilization regret, and is becoming a trend as shown by the lowering of average age at sterilization from 27 in 1992-1993 to 25 in 2005-2006 (Singh, et al, 2012). The average age among the women interviewed for this study was 32.8, but two women were only 26. These women both had two male and two female children, displaying a common trend among women wherein they begin having children soon after they are married and undergo sterilization shortly after reaching their desired family size, without using spacing methods in between births. In UP, 4.4% of or 2,113 sterilized women reported regret. One of the 10 women in the subject pool for this study regretted choosing sterilization, demonstrating one of the potential consequences for high unmet need for spacing methods (All sterilized subjects) (Singh, et al, 2012).

Underutilization of vasectomies is also an issue. When asked why their husbands had not had the procedure, women justified their answers by separating their roles into separate spheres. These justifications often ignored the realities of the procedure and scientific fact. Women frequently questioned who would earn for the family if complications were to arise, when in reality, only one death has ever been attributed to a vasectomy in the entire history of the
procedure. According to the American Urological Association (n.d.), many factors make this procedure suitable for men from various environments and socioeconomic backgrounds:

Given that vasectomy and tubal ligation have equivalent contraceptive effectiveness and that vasectomy enjoys advantages compared to tubal sterilization of lower cost, less pain, greater safety and faster recovery, vasectomy should be considered for permanent contraception much more frequently than is the current practice in the United States and most nations of the world.

While vasectomy acceptors during the period following The Emergency when FP became more closely tied with women’s health, resurrecting the procedure’s popularity would help to place some of the FP pressure currently reserved for women on their husbands. In all of its 43 pages about population and FP issues, UPPP includes only one small section on “Involvement of Men” in a short paragraph. This section acknowledges that “involvement of men in family planning has sharply declined in the past two decades,” but in its target of meeting 41.5 million acceptors of limiting methods, it fails to specify how many of those acceptors should be men (DHFW, 2000). While it is important to note that the report acknowledges the need for education campaigns and counseling services for vasectomies, the fact that FP should be the responsibility of both men and women requires further emphasis.

A Broken System

In order to meet RLF, UPPP calls for 36.5% of couples to use a sterilization method by 2016. At a local level ASHAs, ANMs, and AWWs help to meet this target by fulfilling their own government-mandated goals and influencing women’s decisions about their FP choices. Prior to the interviews this study hypothesized that rural poor women would be disproportionally represented as sterilization acceptors due to the monetary incentive, but none of the women
interviewed cited the monetary incentive as their primary motivator for undergoing the procedure. Because many women were unaware of the amount they should have received and some even seemed indifferent, the conclusion follows the incentivizing of sterilization procedures created more confusion, resentment, and corruption than it did motivation. Women cited a small desired family size, poor socioeconomic standing, and wanting to provide stable lives for their living children as reasons for undergoing the procedure, consequently, the results indicate that while money was a factor it was not the incentive payments but rather family economics that influenced the decision-making process. In other words, women would have accepted sterilization services regardless of the government monetary incentive because they wanted to improve their socioeconomic standing and provide for their living children. This raises a question regarding the best use of the money designated for the compensation package designated for the sterilized women. Each compensation package that GOI reserves for sterilized women could be put towards increasing the quality of regional healthcare by increasing the number of ANMs and doctors and improving infrastructure. This would ensure that more women receive proper counseling services before and after the sterilization procedure, as well as improve upon the quality of care women already receive. Increasing the availability of doctors in the region would also help to address the large unmet need for both spacing and limiting methods in the region, which MHA estimates to be 19.8% and 19.4%, respectively (2013).

Furthermore, 9 out of 10 of the women claimed that they did not receive the full and correct monetary amount promised to them as per MHFW guidelines. The ANM is supposed to facilitate the handling of the women’s money, yet she often is unavailable or does not frequent certain villages due to her responsibility towards such a large clientele base. The ANM responsible for Chittaura Block was contacted, but unavailable for interview as she was scared
that it was under the premise of prosecuting her for allegedly failing to deliver money to many of
the sterilized women after their procedures. The attitudes among women who claimed that they
had not received their money ranged from indifferent to angry. None of them, however, knew
how to go about demanding their money, which was supposed to either be deposited into their
bank accounts or given in cash. This lack of agency accountability is not attributed to ineptitude,
but rather acceptance of widespread corruption prevalent in assorted levels of government
schemes, lack of knowledge and resources to go about creating change due to low levels of
education, and low social status within their communities. When asked if she knew how to get
the Rs. 1400 she was promised, Sanjana responded, “No I don’t know anything about it, I just
know it comes to us. I don’t know how to read or write, so how can I know how to get my
money? The most I can do is go to the dai⁵ and ask her” (personal communication, April 22,
2016). If the GOI continues to offer incentives for FP procedures, the alleged corruption must be
addressed by holding ANMs accountable and increasing community awareness of the rights of
sterilized women. Empowerment programs and increasing the amount and quality of educational
opportunities for girls will contribute to social change, but rights-based seminars and widespread
educational campaigns must also be incorporated so that women not only are aware of their
rights, but also receive complete information which will enable them to make knowledgeable
decisions and feel empowered to act in their own interests.

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⁵ Dais are traditional Indian birth attendants.
Conclusion

Statement of Findings

UPPP has the potential to positively impact RCH but may be impeded by its focus on macro-demographic FP goals and target-based strategies. The purpose of this study was to evaluate how UPPP impacts the decision-making processes, lived experiences, and quality of care received by women who underwent sterilization in Bahraich, UP by analyzing women’s stories and discussing FP and healthcare issues with other stakeholders. This study concludes that UPPP’s attempts at thwarting population growth have achieved mixed results and are not significantly furthered by the arguably unnecessary spending on compensation packages intended for the sterilized women. Additionally, families are still wary of spacing methods and male sterilization for medical and sociocultural reasons and due to lack of encouragement from community health workers and peers.

Limitations

The researcher was limited by the language barrier, which prevented her from probing for further information and expanding upon the women’s responses during the interview process. While the women were all asked questions directly by a female native Hindi-speaker from DEHAT, their husbands, in-laws, and peers accompanied them at times, which may have influenced their answers. Additionally, the researcher was oftentimes perceived as an outsider, so the women and ASHAs may have held bias towards her.

While all efforts were made to translate the interviews accurately and completely by listening to the recordings and referring to notes, differences in language and dialect inhibited the researcher from achieving completely accurate direct translations.
Finally, due to the small subject pool, qualitative data is not representative of all rural poor Indian women who have been sterilized, and quantitative data does not provide statistical significance.

**Suggestions for Further Study**

Suggestions for further study include a study regarding socioeconomic determinants of fertility and the impact on a region’s TFR when such factors are improved. The study at present analyzed UPPP in relation to the women’s sterilization experiences, but did not evaluate other aspects of FP or if UPPP succeeded in its goals not directly related to FP. Additionally, an evaluation of community perceptions or effectiveness of ASHAs, ANMs, and AWWs would contribute to a rights-based appraisal of rural healthcare services and how they could be improved to meet the needs of vulnerable populations.
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Secondary Sources


Appendix: Interview Guides

Questionnaire for Sterilized Women - English Translation

Basic Information

1. What is your name?

2. Who all is in your family?

3. How many children do you have?
   a. How many boys?
   b. How many girls?

4. How old are you?

5. How old were you when you got married?

6. How old were you when you had the tubectomy?

Knowledge of other methods

7. Did you know about other forms of contraception?

8. Did you use a temporary method before getting sterilized?

9. Did a health worker offer you other forms of contraception?
   a. Why didn’t you decide to use IUCD, OC, condoms, or another method?

Decision-making

10. Why did you decide to have a tubectomy?

11. Which family members or friends influenced your decision?
   a. Husband, mother-in-law, other family members, friends?
12. Which government health worker influenced your decision to have a tubectomy?
   a. ASHA, ANM, Anganwadi, or doctor?
   b. Did they promise you any rewards or gifts?
      i. Did you receive these?

**Experience at the camp**

13. Where did you go for the procedure?

14. How did you get to the camp?

15. How did you get back to your home?

16. Did the government provide transportation or reimburse you for travel expenses?
   a. Did you receive any money for having the procedure?

17. What were your feelings going into the camp?

18. What did you expect the camp to be like?

19. Did the doctor explain the procedure to you?

20. How did the staff handle you, physically?
   a. Did they hit you?

21. Did you receive a physical examination?

22. Did the hospital staff draw blood from you?

23. Did the hospital staff take a urine sample from you?

24. Did you receive counseling before or after the procedure?

**Knowledge of legal rights**

25. Do you know that it is within your rights to sue them if they do not perform these procedures?

26. Did you sign a consent form OR did someone read you your rights?
Reflection

27. How has having a tubectomy affected your life?
28. Are you content with your decision to have the procedure?
29. Would you tell others to go to sterilization camps?
30. Why didn’t your husband have a vasectomy, instead?

ASHA Questionnaire – English Translation

Basic Information

1. What is your name?
2. How old are you?
3. Where do you work?
4. How long have you been an ANM/ASHA?

Family Planning Knowledge

5. What kind of training did you receive on family planning-related issues? For example, counseling, communication, motivation, etc.
   a. Who trained you?
   b. When was the training?
   c. How long did the training last?
   d. What were the main topics covered?
   e. Do you think that the training helped you to deliver family-planning services?

Family Planning Advisory Practices

6. Which family planning methods do you recommend to women?
   a. Why do you recommend these methods?
7. How do you decide which method suits each women best?
a. Do you recommend different methods for younger vs. older women?

b. Do you recommend different methods for women who have had one child vs. more?

8. Do you use any kind of checklist that indicates health status when assigning certain methods?

9. How do you prepare women who are going to be sterilized?

10. Does the government provide you with a transportation stipend for women who are having the procedure?

11. How are the women treated at sterilization camps?

12. How many women are you required to refer to get sterilizations and IUCDs per year?

   a. How much money do you receive for each woman you refer?

   b. What happens if you fail to meet your target?

13. Do you ever offer gifts or rewards to women to make them want to undergo sterilization?

   a. IF YES: What do you promise them?

   b. Do you always give the women the rewards you promise them?

14. Do you enjoy your job?

   a. IF YES: Which aspect of your job do you most enjoy?

**Physician Questionnaire**

1. What is your name?

2. Where do you practice?

3. What is your specialty?

4. Do you advise women on family planning issues?

5. What kinds of contraceptive methods do you recommend to your clients?
6. In your opinion, which method is best suited to rural poor women?

7. Which method do women seem to be most receptive to?

8. At what point in a woman’s life do you recommend she be sterilized?

9. Have you observed a change in the demographics of women who undergo sterilization in the last thirty years?

10. When a woman comes to you for a sterilization procedure, who has most often recommended that she be sterilized?

11. How do you prepare a woman who is about to undergo sterilization?
   a. Do you do a physical examination?
   b. Do you do a blood test?
   c. Do you do a urine test?
   d. Do you counsel the women before or after the procedure?

12. Are there any dangers for women who undergo sterilization if they have abnormal hemoglobin or albumin levels?

13. What is the most common reason for complications during female sterilization?

14. Why do men prefer not to undergo sterilization?

15. In your opinion, do you think that the GOI places too much emphasis on female sterilization?

16. Do you ever encounter situations in which an ANM, ASHA, or Anganwadi worker has given false information to a woman about sterilization?

17. What are some common misconceptions that women have regarding sterilization?