CHAPTER V

FINDINGS, RECOMMENDATIONS AND CONCLUSION

5.0. INTRODUCTION

This study proposed to investigate the gender issues involved in the decision making process on reproductive health of women in randomly selected Tiruchirappalli District of Tamil Nadu covering a sample of 500 currently married women between 15-45 years selected through proportionate sampling method. Indices were developed for the components of reproductive health and data were analysis through tabular analysis. This Chapter presents the major findings, recommendations and offers conclusion of the study.

5.1. MAJOR FINDINGS

5.1.1. SOCIO - ECONOMIC AND DEMOGRAPHIC BACKGROUND

- More than three - fourths (77.0 per cent) of respondents were Hindus followed by Christians (14.0 per cent) and Muslims (9.0 per cent).
- Majority of respondents hailed from Backward Caste (45.0 per cent), followed by SC/ST (30.0 per cent), Most Backward Caste (21.0 per cent) and Other Caste (4.0 percent).
- Majority of respondents were literate (94.0 per cent) and majority of husbands were also literate (93.0 per cent).
- Respondents were mostly (82.0 per cent) homemakers. Majority of husbands were non - agriculture labourers (45.0 per cent).

- ❖ Nuclear family was predominant in 80.0 percent. Fifty one percent of respondents were living in rural areas and 49.0 per cent of respondents lived in urban areas.
- ❖ It was observed that majority (82.0 per cent) of respondents did not earn and they were homemakers. The remaining (12.0 per cent) of respondents earned Rs. 5000 – 10000 as monthly income.
- ❖ More than one-third (37.0 per cent) of the households earned less than Rs. 8000 per month, as they were engaged in agriculture and unskilled works. Nearly one-fourth (22.2 per cent) of households earned more than Rs. 28000 per month.
- ❖ Majority (93.0 per cent) of the households did not won land. Very few households (7.0 per cent) had their own lands. It was also in their husbands name.
- ❖ Regarding the age of respondents, one-third of them were distributed almost equally in each category i.e. 15-25, 26- 35 and 36-45 years (32.2 per cent, 34.2 per cent and 33.6 per cent respectively). Regarding husbands' age, majority of them came under the category of 22 – 32 and 33 – 42 years.
- ❖ It was found that fourteen per cent of respondents were married within the legal age of marriage i.e.18 years. Forty- five per cent of them married between 19 to 23 years and 42.0 per cent were married when they were above 23 years.
- ❖ Forty two per cent of husbands got married in the age of 26-30 years and one-third (33.6 per cent) in the age of 21-25 years. Fifteen per cent of husbands were married above the age of 30 years.
- ❖ Regarding the marital duration of women, it was 5 or less years for 36.4 per cent and it was more than 14 years (up to 26 years), in 30.0 per cent of cases.

- Regarding the family size, one-fourth (26.0 per cent) of the family size was 2 – 4 members and it was followed by 61.0 per cent of respondents family size being 4-6 members. Twenty nine per cent of respondents reported a family size of above 6 members.

5.1.2. MARRIAGE AND RELATED DECISIONS

- The legal age of marriage for a boy was known to 73.0 per cent of respondents. More than half (54.3 per cent) the respondents were aware of the actual legal age for girls.
- In the process of deciding the marriage, majority (87.8 per cent) of respondents had expressed that their consent was asked at the time of their marriage and the remaining (12.0 per cent) respondents were not at all consulted at the time of their marriage.
- Regarding nature of decision about their marriage, they stated that their parents just discussed with them (77.6 per cent) about marriage and remaining 22.4 per cent reported that they were not at all consulted at the time of their marriage.
- In nearly three-fourths (73.2 per cent) of cases, decision was taken by their parents as well as by their family members like uncle and other male members, who were supporting the family.
- It was observed that parents were the major decision makers, for the marriage of respondents rather than their own self- choice.
- About 41.0 per cent of women were not aware of any components of reproductive health at the time of marriage. Both awareness and level of awareness of 10 components of reproductive health were reported very low .
- The index based on different levels of satisfaction of married life, revealed that more respondents experienced medium or moderate level of satisfaction (46.0

per cent) while it was low for 40.0 per cent and high level of satisfaction for 13.0 per cent.

- ❖ The overall level of satisfaction of respondents indicated that 52.0 per cent (satisfied and very satisfied) of respondents reported that they were happy in their married life. More than one – tenth (11.6 per cent) of them were unhappy in their marital life due to uncaring husband, not having children and some financial problem.
- ❖ It was observed that, respondents who would abide by the decisions of their husbands and accept the socio-culturally constructed status of wife silentl,y felt satisfied in their marital life.
- ❖ Nearly one-fourth (23.0 per cent) of respondents did not desire sexual intercourse after the marriage due to fear and dislike, due to improper understanding about the first inter course after their marriage. Moreover deep rooted culture oriented predominance of men was an obstacle for women's freedom in deciding on their sexual desire as seventy-three percent of respondents felt that they could not take such a decision and husband alone can decide. They also felt that if women were to talk about their sexual desire then their behaviour would be suspected by their husbands.

5.1.3. ANTE NATAL, NATAL AND POST- NATAL

- ❖ Registration of pregnancy at the third month of last pregnancy was reported by seventy-one per cent of respondents. Antenatal examinations were high at sixty-two per cent medium at twenty-four per cent, low level at eight per cent of cases and five per cent of respondents did not undergo any examinations.
- ❖ The impending sign of pregnancy was known to sixty-four per cent of respondents. Natal and postnatal issues of pregnancy were not known at

fourteen per cent, known at moderate and high level of twenty-seven and fifty-nine per cent of cases respectively.

- ❖ Majority (96.0 percent) of pregnant women visited hospitals for antenatal care.
- ❖ Husbands were predominantly involved in decision making on getting medical care for pregnant women (62.0 per cent). Free and independent decision of women in getting medical care was very limited (14.0 per cent).
- ❖ Respondents experienced problem in getting money from their husbands to meet the expenses for medical care in thirty-nine per cent of cases. Husband alone decided on spending the money for medical care in fifty-nine per cent of cases.
- ❖ Respondents faced problems in getting husbands' support (34.0 per cent) and getting permission to go to hospital (13.0 per cent). The role of husbands in caring for the pregnant women for getting medical care was not at the expected level and it implied lack of their responsibility.
- ❖ Respondents faced problems from other sources (70.0 per cent) in getting medical care during the last pregnancy such as appropriate time to go to hospital (50.0 per cent) and caring children and household responsibility while going to the hospital (48.0 per cent). The availability and attitude of doctor, and accessibility to hospital were less (20.0 per cent) reported problems.
- ❖ One-fourth (26.0 per cent) of respondents had experienced physical health problems before delivery during the last pregnancy. Psychological problems were experienced by twenty-nine per cent of respondents.
- ❖ 92.0 per cent of the last delivery took place in health institutions. Husband's role in deciding the place of delivery was at a higher (41.0 per cent) level. Women's decision on place of delivery was limited (20.0 per cent) due to their

low status in the family. Being the earning member, head of the family, behaviour of deciding alone, and knowing about hospital facility and being educated were the reasons for husband deciding the place of delivery in 61.0 per cent of cases.

- ❖ Regarding opinion on respondents' self-decision making on reproductive health aspects , many can decide on treatment facility, taking desired food, rest at desired time and health check-up which ranged from fifty-four to fifty-six per cent. But they could not decide on medical expenses, choice of hospital and doctor. This indicated the societal trend of women being denied freedom in deciding on pregnancy care.
- ❖ The impact of husband's behaviour on respondents during the last pregnancy was assessed. They reported physical problems like husband's beating leading to injury (64.0 per cent) and compelled sexual intercourse resulting in body pain and bleeding (25.0 per cent). Other health problems such as stomach pain (14.0 per cent) etc. were the reported health problems.
- ❖ Respondents reported psychological problems due to husbands' unfavourable behaviour during the last pregnancy such as worries (30.0 per cent), feeling bad (38.0 per cent), stress (36.0 per cent), getting angry (17.0 per cent), others problems like irritation, crying, hatred, fear, suspicion, quarrelling, loneliness, intolerance, mental agony and torture (10.0 per cent).
- ❖ Treatment of postnatal complication is depended more on husbands because they decided on the treatment for reasons such as husband being the earning member (32.0 per cent), deciding authority (27.0 per cent), head of the family (12.0 per cent), working and knowledge about medical care facility (10.0 per cent).

- During last pregnancy respondents reported that expected things from husbands did not happen in fifty-two per cent, because husbands did not care (39.0 per cent), addict to alcohol and economic problems of family (13.0 per cent each) and husbands' busy work schedule (7.0 per cent). Negative attitude towards wife and quarrelling behaviours of husband, physical tortures, disliking female child and suspecting wife were also found to be the reasons.
- Respondents faced domestic violence during the last pregnancy such as speaking angrily (62.0 per cent), scolding with filthy language (49.0 per cent), beating and kicking (25.0 per cent), refusing to give money for household expenditure (27.0 per cent), scolding when wife refused to satisfy sexual desire (20.0 per cent) and suspecting wife (12.0 per cent).

5.1.4. CONTRACEPTION

- At the time of marriage, respondents had known about female sterilization and IUD at the moderate level of forty-six and forty-seven per cent respectively. Male sterilization and male condom were known to twenty-six and thirty-eight per cent of respondents respectively. The knowledge on temporary contraceptive methods such as pills (21.0 per cent), emergency contraceptive pill and injectable (15.0 per cent each), abstinence and withdrawal (13.0 per cent each), female condom (8.0 per cent) and implant (2.0 per cent) were known at a low level.
- Husbands informed their wives about contraceptive methods in twenty-seven per cent of cases, which indicated low level of interpersonal communication about contraceptives. They were informed more about condom (73.0 per cent) and the next about IUD (30.0 per cent). But very less about tubectomy (3.0 per cent), safe period (1.0 per cent) and abstinence (2.0 per cent).

- ❖ Forty percent of respondents used the contraceptive method. Those who decided on using contraceptive methods on their own were at thirty-nine per cent. Husband decided in forty-four per cent and both husband and wife decided in sixteen per cent of cases. Apart from the family members, Doctors and nurses also were decision makers in two per cent of cases.
- ❖ Husband being the primary decision maker for the use of contraceptives for the following reasons: already used contraceptive method (13.0 per cent), they have decided to give spacing between children (12.0 per cent), to avoid conception and for the good health of women (9.0 per cent each).
- ❖ Regarding respondents' opinion on discussion about reproductive health matters with their husbands, a higher proportion of women had discussed about medical treatments (81.0 per cent), followed by physical health problem (80.0 per cent), family planning (77.0 per cent), mental health problem (71.0 per cent), sexually transmitted infection (59.0 per cent) and sexual desire (52.0 per cent), in the decreasing order of importance.
- ❖ On reproductive health matters such as sexual relationship with husband (74.0 per cent), selecting contraceptive method and intercourse during illness of wife when she dislikes it (81.0 per cent each), number of children (77.0 per cent), spacing between children, abortion and desired sex of child (80.0 per cent each), joint decision of both husband and wife was predominant.
- ❖ Women were compelled by their husbands for frequent intercourse (46.0 percent) which varied from low level at twenty-three per cent, moderate at thirty-four per cent and more frequent at forty-three per cent. Respondents felt that compulsion could not be prevented in seventy-six per cent of cases due to negative and threatening behaviour of husbands.

5.1.5. ABORTION

- Analysing the data on respondents' knowledge, experience and complications of induced abortion it was found that thirty nine per cent of them were informed about induced abortion. Regarding the knowledge on post induced abortion complication threat to the life of mother (38.0 per cent), stomach pain (21.0 per cent), excessive bleeding (26.0 per cent), back pain (5.0 per cent) and uterus problem (10.0 per cent) were reported, revealing knowledge on post induced abortion complication to be less among women.
- Seventeen percent of respondents had experienced induced abortion seventy one per cent experienced it one time, two times by twenty-four per cent and three times by five per cent. They had undergone induced abortion for reasons such as don't want female child (40.0 per cent), immediately conceived (16.0 per cent), deformity of foetus (12.0 per cent) and compulsion of husband and ill health of mother (4.0 per cent each).
- Majority (78.0 per cent) of respondents were not informed about MTP Act. They had not understood the circumstances under which abortion can be done as only twenty-two percent of respondents had known about MTP Act and its provisions.
- Regarding last induced abortion eighty-three per cent of induced abortions were performed in hospital and the remaining seventeen per cent were performed in non-institutional places i.e. home and other places.
- The higher proportion of induced abortions was performed in institutions by trained persons (81.0 per cent) such as Doctors, Nurses and Trained Dai. Eleven per cent of respondents had used tablets to abort the foetus. About twenty-one per cent of induced abortions were performed by non – doctors.

- On decisions regarding induced abortion husband (42.0 per cent) and family members (38.0 per cent) were the important decision makers. Self-decision making by women was at fifteen per cent and the decision taken by relatives was at two per cent.
- Respondents, who had last induced abortion experienced the post abortion psychological problem of mostly feeling very bad and guilty conscience of having committed a sin (48.0 per cent) and worry (28.0 per cent). Depression, feeling of guilt, and feeling of their inability to avoid abortion, were also reported each in five per cent.
- Regarding the opinion on freedom to decide on the person to perform abortion, husband alone decided (56.0 per cent). It had to be discussed with husband (5.0 per cent).
- On the respondents freedom to decide on the place, they opined that they were unable to decide on the place of performing abortion because husband had to decide (65.0 per cent), it was a joint decision (26.0 per cent), women were afraid to decide (10.0 per cent), women's suggestion would lead to quarrel (7.0 per cent), cannot decide without discussion with family member and some thought they did not have the right to decide the place of performing abortion (8.0 per cent each). It seems that women's role in deciding the place of performing abortion was very limited.

5.1.6. INFERTILITY

- About eighty-one per cent of respondents opined that infertility was a problem in the family. The nature of problem varied from conflict in family life (48.0 per cent), harassment (13.0 per cent), social stigma (18.0 per cent),

remarriage/divorce (11.0 per cent) and blaming/scolding as impotent and diseased (8.0 per cent).

- ❖ Reason for blaming women alone for infertility, as reported by respondents, was that they were responsible for childbearing (30.0 per cent) and not blaming men in order to save man's prestige (19.0 per cent). Women's dependency on family (15.0 per cent), historical mind set towards infertility (11.0 per cent), social stigma such as superstitions/ belief/culture orientation (38.0 per cent) posed problems for barren women.
- ❖ Regarding challenges faced by barren women in their family, relatives and society, respondents reported that barren women were abused as "Maladi" in family (30.0 per cent), relatives (11.0 per cent) and society (62.0 per cent).
- ❖ Respondents reported social stigma in family (23.0 per cent) and society (18.0 per cent) because barren were deemed to be inauspicious and hence they were not respected. It led to quarrel by husband and in-laws in family (20.0 per cent) and relatives (5.0 per cent), husband remarried and they were separated from family (11.0 per cent) and relatives (2.0 per cent).
- ❖ It was reported that barren women faced harassment in family (18.0 per cent), from relatives (78.0 per cent) and society (32.0 per cent), like humiliation, husband's indifferent treatment, depression in family (7.0 per cent) and character assassination, loneliness, being ignored and avoided in social functions, insecurity and helplessness were reported as challenges faced by infertile women from relatives (10.0 per cent) and society (4.0 per cent).
- ❖ More than half the respondents (53.0 per cent) were aware of assisted reproductive techniques. ICST (63.0 per cent), IVF (44.0 per cent), surrogacy (40.0 per cent) and GIFT (8.0 per cent) were familiar to the respondents.

- ❖ Only eight per cent of respondents had undergone treatment for infertility. Husband and wife had taken joint decision for treatment in forty-eight per cent of cases, husband alone decided in thirty-three per cent and wife alone decided in eighteen per cent.
- ❖ Medical examination for infertility was done for both husband and wife in fifty-eight per cent of cases and for wife alone, in forty-three per cent of cases.
- ❖ Medical examination has been done for wife alone in certain cases mostly because husbands were not willing to be examined (6.0 per cent), husband insisted on wife to be examined first (29.0 per cent), and husband or mother-in-law forcing women to undergo medical examination (12.0 per cent).
- ❖ Husbands alone (48.0 per cent) decided the place and doctor for the medical examination of infertility in majority of cases. 43.0 per cent reported joint decision of both husband and wife while self-decision of wife was found to be less at ten per cent.

5.1.7. ANEAMIA

- ❖ Only forty-four percent of respondents were aware of symptoms of anemia. 24.0 per cent of respondents had taken treatment for anemic problem. Wife (43.0 per cent) enjoyed more chance in decision making for treatment of anemia, compared to husband's (20.0 per cent) and joint decision (34.0 per cent).
- ❖ Majority (79.0) of respondents reported that husbands did not allow them to take decisions because they preferred to be the only decision makers.
- ❖ Twelve percent of respondents were used to take food after the husband eating food. Women's practice of eating food, after the husband was mainly due to the culture (60.0 per cent), insistence of elders (10.0 per cent), respect to husband (25.0 per cent) and love (13.0 per cent).

5.1.8. MENSTRUAL HYGIENE MANAGEMENT (MHM)

- The knowledge on menstrual hygiene was known to sixty-one per cent of respondents. They understood the menstruation hygiene as cleanliness (85.0 per cent), changing napkins frequently (39.0 per cent), bathing two times every day (3.0 per cent), and use of napkins and not cloth (23.0 per cent).
- There was a higher proportion of husbands (42.0 per cent) being the decision makers, for treatment of menstruation problems, compared to self-decision by wife (29.0 per cent) and joint decision of both husband and wife (25.0 per cent). Husbands' role in decision making was more than wife. Assistance of husband to wife in terms of accompanying while going to hospital for treatment was reported in seventy-seven per cent of cases.
- Respondents who avoided sexual intercourse, during the menstruation period was sixty-five per cent. If wives refused to have sex during menstruation, husbands behaved aggressively (75.0 per cent), compulsion (76.0 per cent) angry (91.0 per cent), scolding and beating (52.0 per cent), and refused to speak (14.0 per cent).

5.1.9. HIV/AIDS PREVENTION

- Forty-eight per cent of respondents reported that they advised their husbands to use condoms to prevent HIV/AIDS.
- More than half the respondents (52.0) had reported their inability to advise their husbands to use condom for reasons such as that would result in quarrel (64.0 per cent), afraid to tell (74.0 per cent), not having freedom to tell (68.0 per cent), husband would not listen and difficult to explain (87.0 per cent), husband would not accept (60.0 per cent) and it might create suspicion (35.0 per cent), husband would get angry (72.0 per cent), dissatisfaction in the use of condom (48.0 per cent) and could not compel the husband (29.0 per cent).

5.2. RECOMMENDATIONS

- Knowledge on Reproductive Heath Rights, Sexuality, Conception, Safe Motherhood, Contraception, Abortion, Reproductive Tract Infections, HIV/AIDS, Anemia and Menstrual Hygiene Management should be imparted through Primary Health and Sub-Centres, Accredited Social Health Activists, Women Self- Health Groups and Community Based Organisations, to ensure the access to reproductive health information.
- Awareness cum gender sensitization programs should be given to adolescents, to understand scientifically physical and psychological changes, nutrition, personal hygiene, menstrual hygiene management at school level, through adolescent health promotion programmes.
- Government Health Departments should develop gender sensitive Information, Education and Communication (IEC) materials, about reproductive health rights and its components, to disseminate knowledge at different levels.
- Legal literacy should be provided to persons who are under reproductive age group (15 – 49 years) about legal age at marriage to prevent child marriages. The Pre-Natal Diagnostic Techniques Act, Medical Termination of Pregnancy Act, Protection of Women from Domestic Violence Act must be widely disseminated at gross root level, through networking with various health Promotion stakeholders such as NGOs, PHCs, Autonomous Women's Groups, Women Self Help Groups, Youth Associations, Doctors Associations and National Service Schemes.
- Gender sensitization trainings and workshops should be organized periodically to the health policy makers, planners, programme managers, project officers, health professionals and field extension workers, to understand the reproductive

health needs of couples in general, to develop and execute gender neutral reproductive health policies and programmes.

- ❖ Community level gender sensitization programmes should be conducted to the male partners to enable the individuals to realize the needs of sharing responsibilities and develop the attitude and behaviour, to respect conjugal rights mutually and increase the male participation in reproductive health matters especially to prevent intimate partner violence, protect women from acquiring HIV/AIDS, RTI, STI and to prevent induced abortions.
- ❖ Capacity building workshops for women should be organised at community level, for enabling them to realize their capabilities and to participate in decision making process of reproductive health matters, to safeguard women's reproductive health rights and their reproductive health.

5.3. CONCLUSION

The research study had explored the interconnections between women's access to information, attitude, perception and practices about reproductive health and its rights, especially challenges and prevailing gender issues in women's decision making on reproductive health matters. This study analysed the factors, influencing the women's reproductive health decision making process and also how gender is an epicentre for operating the women's decisions making process in reproductive health matters. The study also traced existing gender issues in reproductive health decision making process and the predominant role of gender structured institutions like family, culture, religion, which position women as inferior, powerless in spousal relations. However, reproductive health matters like marriage, safe motherhood, fertility, safe sex, contraception, abortion, nutrition are primarily connected with women's biology and psychology practically and it is a pity that women are unable to control over their

body and sexuality, due their position under the gendered stratified society and patriarchal domination over reproductive health affairs. The systematic gendering process, through constructions of gendered family and sexual hierarchy sustains the unequal power relations and the emergence of male control over women's reproductive health decision making process. This unequal status of women in society and family, has limited the access to knowledge and information about their reproductive health and their sexuality. This limited access to knowledge and lack of control in reproductive health, restrain women's self- choices and deny the freedom to participate in the decision making process. The finding of this study has revealed the extent to which women are alienated from reproductive autonomy because patriarchal, gendered mind sets of husbands control each and every aspect of reproductive health decision making process of women, such as access to information, say over sex, deciding the number of children, spacing, using contraceptives, right to abortion, free from sexual coercion and violence. Exclusion of women from reproductive health decisions has not only paved the way to violation of women's reproductive rights but also affects women's health in general and particularly increasing the reproductive health morbidity and mortality. In order to empower women in reproductive health decision making process, it is necessary to analyse the existing gender relations and social construction of women within the households and communities and create an enabling atmosphere in which the reproductive needs of women could be approached in reproductive rights perspective, as mentioned in Cairo document, to achieve gender equality in reproductive health.