

Chapter 6

SUMMARY AND CONCLUSIONS

Present chapter summarizes the study. It draws conclusion and provides suggestions. This chapter includes the following heads:

- 6.4 Summary
- 6.5 Conclusions
- 6.6 Suggestions

6.1 Summary

The study entitled “Assessment of Awareness and Impact Study of IEC Aids regarding Gender Health Inequity among Women of Jawan Block, Aligarh, U.P.” was conducted with the objectives to assess the awareness regarding gender health inequity among rural women and to ascertain the impact of Information Education Communication on rural women. For this purpose, a sample of 450 adult married women and of age 18 – 40 years was targeted from selected villages (Chherat, Sumera, Naguala, Kasimpur, Jawan Sikandarpur, Jawan Vajidpur, Faridpur, Chanduakha) of Jawan Block using proportionate stratified systematic sampling design. Information regarding demography, gender health inequity and health status of rural women was collected through a self prepared interview schedule, observation, anthropometric measurements, biochemical examination, clinical history. IEC aids like flash cards, flipbooks, posters, story cards and innovative games in personal approach and group approach were used for creating awareness among rural women. Data was collected in three stages first - pre IEC period, second - IEC period, third - post IEC period. Response rate was 88%. After collecting data, coding, editing and compilation was done. The analysis was made by

using statistical package for social sciences (SPSS) version 17. Different statistical tools i.e. frequency and percentages, wilcox signed rank test, spearman correlation (r_s) were employed to systematically present the information and to develop the relationship among the various variables. Variable wise results are presented in the succeeding sections –

6.1.1 Demographic characteristics of rural women

- Majority of the women (32.1%) were in the age group of 18 to 24 years.
- Higher proportion (41.4%) of women had never been to school as compared to 10.4% of the husbands who had never attended any school. Women who attended school, majority of them (19.2%) had completed 12 or more years of education.
- Majority of women (60.9%) were not involved in any kind of occupation. Majority of women's husbands (23%) were self employed.
- Majority of women (62.4%) belonged to nuclear family.
- Majority of women (95.7%) belonged to Hindu community. Majority of women (48.5%) were from schedule caste. Majority of women (52.5%) belonged to poor class.

6.1.2 Gender health inequities among rural women and impact of IEC

A. Menstruation

- Before IEC, majority of women (66.4%) did not know about menstruation and other had misconception. After IEC, majority of rural women (76.8 %) were

aware about physiological process of menstruation. These improvements were statistically significant ($p < 0.01$).

- Before IEC, majority of women (80.1%) bathed daily. After IEC, number of women was increased (92.9%) who bathed daily. These improvements were statistically significant ($p < 0.01$).
- During monthly menstrual cycle, before IEC, most of the rural women (81.3%) used old cloth without washing. After IEC most of the rural women (73.5%) used old cloth after washing during monthly menstrual cycle. These improvements were statistically significant ($p < 0.01$).
- Before IEC, majority of women (90.9%) changed daily menstrual absorbent. After IEC, more women (98.7%) started to change daily absorbent and did not reuse it. In this case, no significant improvements ($p > 0.01$) were observed.
- Before IEC, majority of women (35.9%) were having restrictions on eating and in performing daily household chores (15.9%). After IEC majority (79.3%) of women had no restriction among them. These improvements were found to be significant ($p < 0.01$).

B. Marriage

- Majority of women (42.9%) got married between ages 15 to 17.
- Before IEC, higher proportions (35.6%) of women were aware about right age of marriage. After IEC majority of women (88.6%) were aware about right age of marriage. These improvements were statistically significant ($p < 0.01$).

- Majority of women (48.7%) were not in favour of early marriage. After IEC, number of women was increased (90.2%) who were not in favour of early marriage. These improvements were statistically significant ($p < 0.01$).
- Before IEC, majority of women (69.9%) were not aware about the effect of early marriage. After IEC, most of the women became aware about stop development (20.2%), weakness (13.9%), early pregnancy death and disability (29.8%) and RTI/STD (1.3%). These improvements were statistically significant ($p < 0.01$).

C. Pregnancy

- Before IEC, 37.9% of women considered two to be the ideal number of children. After IEC, majority of women (86.6%) were in favour of two children. These improvements were statistically significant ($p < 0.01$)
- Before IEC, majority of women (46.2%) considered one boy and one girl as ideal gender composition of their children. After IEC, number of women (60.9%) was increased who considered one boy and one girl both as ideal gender composition of their children. These improvements were statistically significant ($p < 0.01$).
- Higher proportion of women (36.1%) had more than three children.
- Before IEC, majority of women (85.9%) did not know about the right age of pregnancy. After IEC, most of the women (83.6%) considered < 22 as right age of pregnancy. These improvements ($p < 0.01$) were statistically significant.
- Majority of women's (31.3%) first pregnancy occurred before the age of eighteen. and majority of women (31.3%) had one pregnancy.

- Among majority of women (51.8%) births of two children occurred within less than 18 months and among.
- Before IEC, majority of women (61.1%) were not aware regarding the interval between births of two children. After IEC, majority of women (66.4%) were aware about > 36 months of interval between births of two children. These improvements were statistically significant ($p < 0.01$).
- Majority of women (53.8%) reported that their last pregnancy was wanted.
- Majority of women (53.8%) were aware about bad consequences of closed birth interval. After IEC, more women (79.8%) became aware about it. These improvements were statistically significant ($p < 0.01$).
- Before IEC, only 2.8% of women had complete information, 56.6% of women had incomplete information, 40.7% of women were not aware about antenatal care. After IEC, 28.8% of women had complete information and 66.9% of women had incomplete information about it. These improvements were statistically significant ($p < 0.01$).
- Majority of women (75.5%) got incomplete antenatal care for the recent live birth of their children.
- Most of the women's (56.6%) deliveries were done at home. by local birth attendant of the village.
- Before IEC, majority of women (46.7%) favoured home for delivery while remaining women were aware to avail hospital delivery. After IEC, only 4% of

women favoured home for delivery, most of the women became aware of government hospital (56.3%), private hospital (10.4%), CHC (4%) for delivery.

D. Contraception

- Before IEC, majority of women (63.1%) were aware about contraception. After IEC, 97.5% of rural women became aware about contraception. These improvements were statistically significant ($p < 0.01$).
- Majority of women (59.3%) were not using any contraceptive before IEC. After IEC, majority of rural women started to use contraceptives like female sterilization (13.6%), male sterilization (2.8%), contraceptive pills (6.3%), IUD (4.0%), injectable (2.0%), condom (27.3%), Rhythm (1.8%). These improvements were statistically significant ($p < 0.01$).
- Reasons for not using contraception among women were husbands' disapproval (9.8%), do not have need (26.3%), not have information (21%), non availability (1.5%) and feel shame (0.8%).
- Before IEC, majority of women (41.7%) and their husbands both took decision regarding use of contraceptives. 65.9% of women and their husbands both took decision. These improvements were statistically significant ($p < 0.01$).
- Side effects of contraception among women were irregular menstruation (10.9%) allergy (2.8%), amenorrhea (1%), lower abdomen pain (1%) and weakness (0.8%).

- Before IEC, 2.3 % of women were sharing their problems related to contraception with husbands, after IEC 15.9% of women were sharing their problems related to contraception. These improvements were statistically significant ($p < 0.01$).

E. Abortions

- Before IEC, 11.1% of women favoured abortions while 35.1% of women were against it. After IEC 3.5% of the women favoured abortion, 75.3% of women were not in favour of it. These improvements were statistically significant ($p < 0.01$).
- Majority of women (78.8%) experienced none of the abortion, 13.4% of women of all interviewed women had experienced one abortion over their lifetime, 7.8% of women had experienced two abortions.
- Main reason for seeking abortion among rural women was ‘don’t need any more daughter’ (10.6%), ‘don’t need any more child’ (9.8%), doctor’s advice (.8%).
- Considerable proportion of women (14.5%) had sought pregnancy termination from private hospitals.
- Health problem faced by women who practiced abortion over a life time, among them, 7.1 % of women reported incomplete abortion followed by severe bleeding (2.5%), chronic pain (2.0%) and infertility (0.5%).
- Before IEC, majority of women (59.8%) were not aware about consequences of abortions on women’s health. After IEC, only 15.7% of women were not aware

about it. Remaining women were aware. These improvements were statistically significant ($p < 0.01$).

6.1.3 Association between demographic characteristics and gender health inequity among rural women

- Significant association was found between age of women and pre IEC use of absorbent material, restrictions during menstruation, number of children, birth interval, awareness regarding antenatal care, awareness of contraception, use of contraception, sharing problem with husband at $p < 0.01$ and awareness regarding menstruation, awareness regarding right age of marriage, gender preference, place of delivery, opinion on abortion at $p < 0.05$. Remaining variables were insignificant with age.
- Significant association was found between education of women and pre IEC awareness regarding menstruation, use of absorbent material, change of absorbents, awareness regarding right age of marriage, opinion on early marriage, effect of early marriage, number of children, age of pregnancy, awareness regarding birth interval, awareness regarding antenatal care, place of delivery, opinion on abortion and consequences of abortions at $p < 0.01$, consequences of closed birth interval, restrictions during menstruation, sharing problem with husband at $p < 0.05$. Remaining variables were insignificant with education.
- Significant association was found between occupation of women and pre IEC use of absorbent material, awareness regarding right age of marriage, gender preference, birth interval, use of contraception at $p < 0.01$, awareness regarding

menstruation, number of children in family, place of delivery, sharing problems with husband at $p < 0.05$. Remaining variables were insignificant with occupation.

- Significant association was found between religion of women and pre IEC awareness regarding menstruation, bathing during menstruation, use of absorbent material, restrictions during menstruation, effect of early marriage, birth interval and consequences of closed birth interval at $p < 0.01$, gender preference at $p < 0.05$. Remaining variables were insignificant with religion.
- Significant association was found between socio economic status of women and pre IEC awareness regarding menstruation, use of absorbent material, change of absorbents during menstruation, awareness regarding right age of marriage, opinion on early marriage, effect of early marriage, number of children, age of pregnancy, birth interval, awareness regarding antenatal care, place of delivery, consequences of abortions at $p < 0.01$, consequences of closed birth interval, awareness regarding contraception, bathing during menstruation, sharing problem at $p < 0.05$. Remaining variables were insignificant with socio economic status.
- Significant association was found between age of rural women and post IEC use of absorbent material, change of absorbents, restrictions during menstruation, opinion on early marriage, number of children, gender preferences of child, consequences of closed birth interval, use of contraception, sharing problem with husband at $p < 0.01$. Remaining variables were insignificant with age.
- Significant association was found between education of rural women and post

IEC use of absorbent material, awareness on effect of early marriage, number of children, gender preferences of child, consequences of closed birth interval, antenatal care, use of contraception at $p < 0.01$, change of absorbents, place of delivery, bathing during menstruation, opinion on abortion at $p < 0.05$. While remaining variables were insignificant with education.

- Significant association was found between occupation and post IEC restrictions during menstruation, antenatal care, decision regarding contraception at $p < 0.05$, use of absorbent material, awareness on effect of early marriage, number of children, gender preferences of child, birth interval, use of contraception, sharing problem at $p < 0.01$. Remaining variables were insignificant with occupation.
- Significant association was found between religion of rural women and post IEC bathing at time of menstruation, use of absorbent material, awareness on age of marriage, awareness on effect of early marriage, age of pregnancy, use of contraception at $p < 0.01$, restrictions during menstruation, place of delivery, sharing problem with husband, opinion on abortion at $p < 0.05$. Remaining variables were insignificant with religion.
- Significant association was found between socio economic status of rural women and post IEC awareness regarding use of absorbent material, awareness on effect of early marriage, number of children, gender preferences, birth interval, antenatal care, awareness of contraception, use of contraception, decision regarding contraception at $p < 0.01$, age of pregnancy, sharing problem at $p < 0.05$. Remaining variables were insignificant with socio economic status.

6.1.4 Health status of rural women and its association with gender health inequity practices

A. Health Status of rural women

- Majority of rural women (67.2%) possessed normal BMI ($18.5 - 24.99 \text{ kg/m}^2$) and majority of rural women (56.3%) had moderate anaemia (7.0 - 9.9 g/dl).
- Rural women were suffering from pain in joints and back ach followed by constipation (8.6%), diarrhoea (6.8%), fever (4.3%) and tuberculosis (2.5%).
- Rural women were suffering from menstrual problems like oligomenorrhoea (21.2%), menorrhagia (11.1%), delayed cycle (8.3%), polymenorrhea (2.0%) and genital infection (2.0%).
- Higher proportions of rural women (43.7%) were suffering from lower RTI.

B. *Association between health status of rural women and gender health inequity practices*

- Significant association was found between body mass index of rural women and bathing, use of absorbents during menstruation, age of marriage, age of pregnancy, number of pregnancies, birth interval, received antenatal care, place of delivery, use of contraceptives, sharing problems, practice and number of abortion at $p < 0.01$, place of abortion at $p < 0.05$. While remaining variables were insignificant with body mass index of women.

- Significant association was found between anaemia among women and change of absorbents at $p < 0.05$, number of children, age of pregnancy, number of pregnancies, birth interval, received antenatal care, place of delivery, use of contraceptives, sharing problem at $p < 0.01$. Remaining variables were insignificant with anaemia among women.
- Significant association was found between common illnesses among women and change of absorbents at $p < 0.05$, number of children and pregnancies, birth interval, received antenatal care, place of delivery with $p < 0.01$. Remaining variables were insignificant with common illnesses among women.
- Significant association was found between menstrual problems among rural women and place of delivery at $p < 0.05$, restrictions during menstruation, birth interval, number of pregnancies, number of children, practice of abortion at $p < 0.01$. Remaining variables were insignificant with menstrual problems.
- Significant association was found between RTI among rural women and use of absorbents during menstruation, age of marriage, number of children, age of pregnancy, number of pregnancies, received antenatal care at $p < 0.01$, bathing at time of menstruation, practice, number and place of abortion at $p < 0.05$. Remaining variables were insignificant with RTI.

6.2 Conclusions

Women in rural areas of Jawan Block still hold traditional beliefs and misconception regarding menstruation and most of them do not have proper knowledge regarding menstrual management therefore follow some unhygienic practices. However, bathing

practice was satisfactory among women but practices regarding use of absorbent material were unsatisfactory before IEC. Self imposed restrictions were also found among rural women. Study also found the significant effect of IEC (Information Education Communication) on rural women regarding menstruation among women. After conducting IEC, more women became aware regarding physiology of menstruation, more women started to bathe daily and restrictions were decreased among women. Regarding, use of absorbent women started to wash and dry the cloth before using.

Further, early marriage was common among rural women of Jawan Block. Most of women were married early but some of these women did not favour early marriage. Few women favored early marriage due to traditional beliefs and custom of society. Significant numbers of rural women were not aware about right age of marriage and the effect of early marriage on health of women. Study also observed that IEC (Information Education Communication) had significant effect on rural women in increasing awareness regarding marriage issues. After conducting IEC, more women became aware regarding age of marriage for girl, more women were against early marriage and women became aware regarding ill effect of early marriage on women.

Moreover, unsafe reproductive behaviour was also observed among rural women of Jawan Block. Most of rural women desired two and three or more children. Son preference was still strong among rural women, however women desired for daughters also but not like son. Rural women were not aware regarding the birth interval between two children and right age of pregnancy. The attitude and knowledge regarding reproductive issues were reflected in their practices. Among rural women, most of the pregnancies occurred before reaching at right age of pregnancy and significant number of

women had more than three pregnancies at short interval between two births. Study also showed incomplete awareness regarding antenatal care among rural women. However, most of the rural women took antenatal care, but it was incomplete. The study concluded that home and unsafe delivery was still widely prevalent in the rural areas of Jawan Block. Women believed more on '*Dai*' (untrained women in village who conduct delivery) as compared to doctors especially government staff working in CHC or government hospital. In increasing awareness regarding reproductive behaviour, IEC (Information Education Communication) had significant effect on rural women of Jawan block. After conducting IEC, more women became aware regarding age at first pregnancy, number of children, birth interval, complete antenatal care and availing hospital facility for delivery. Women became aware regarding ill effect of closed birth interval on women.

Further, rural women of Jawan Block had incomplete awareness regarding contraception and significant numbers of women were not using contraception. Husbands' disapproval was one of a main reason for not using contraception. Using contraception was the responsibility of women but she could not take decision alone regarding use of it. Women had side effects of contraceptives but most of the women did not share their problems with their husbands. Study also observed that IEC (Information Education Communication) had significant effect on rural women in increasing awareness regarding contraception. After conducting IEC, more women became aware about contraception and started to use contraceptives. More women alone or with their husband took decision regarding use of contraception. If women had problems with use of contraceptives they shared their problems with their husbands.

No use of contraception leads to abortion. But rural women in Jawan Block, rarely experienced abortion and did not favour it. Aborting girl child and limiting family size were main reasons among women who experienced abortion. Even, among these women, most of them were not accessing safe abortion. Use of hard material in vagina was quite common among rural women to abort their child. They faced post abortion morbidity also. Further, most of the women were not aware regarding effect abortion on health of women. Study also found the significant effect of IEC (Information Education Communication) on rural women regarding abortion among women. After implementing IEC, more women became against abortion and its ill effect on health of women.

Findings suggest that the awareness building component of the IEC succeeded in reaching a large number of women, as well as in reducing gender health inequity among women.

Study explored that demographic characteristics were significantly associated with some categories of gender health inequity among women and in other categories of gender health inequity, these characteristics were significant. Likewise these characteristics also had significant association with increase in awareness in some categories of gender health inequity. Moreover, study pointed out that anaemia was highly prevalent among rural women. Women were also suffering from menstrual problems, common illnesses and lower RTI. These problems were associated with gender health inequity. One or more gender health inequity was significantly associated with one or more health problem.

Eventually, study concluded that rural women were not completely aware regarding gender health inequity. IEC aids flip book, flash cards, posters, puppets, story cards,

games were capable to provide knowledge and overcome the knowledge/practice gap. But, only when, integration of gender needs to be done from the planning stage - *Firstly*, identify and understand the issue of gender health inequity, *secondly* identification the socio – cultural reasons for this, *third* planning of actions. In this context and short duration of implementation; the changes achieved by the IEC were promising.

6.3 Suggestions

Keeping in view the findings of study following steps are being proposed for execution for making women's life free from gender health inequity -

- Gynaecologists working in this region should utilize the opportunities of clinical consultations to discuss gender health issues with their female patients and educate them.
- Women's access to safe delivery should be provided at the PHC level.
- Husband's attitude is one of the determinants of achieving gender health equity; therefore it is needed to conduct awareness among husbands in order to bring change in their point of view regarding the issue.
- Television was the most commonly used mass media in the area under study therefore this media can be used as an agent of change by introducing new television shows like 'Satyamev Jayate', 'Kyuki.... Jeena Isi Ka Naam Hai' (Because... That's What Life Is) highlighting women's issues, especially for promoting awareness among women about gender disparity, motivating them for organizing themselves.

➤ Women feel insecurity, uncertainty and vulnerability within home and outside home. However, government already made many legislations regarding women but there is the need of strict implementation of these laws. In this connection local level committees should be made effective for providing women supportive environment.

➤ Keeping the socio - cultural status of women and existing governmental policies in view, in order to curb the gender health inequity, programme planning should be based on three ‘E’s’:

Education: To realize their potential in a way that fosters a right based environment through interventions.

Economic Empowerment: To help in skill formation for increasing confidence of women.

Entitlement: To go into the structure of ownership. It may be at self, family, community and policy level.

Lastly, dedication and commitment at local level will certainly prove helpful in bringing positive changes in the women’s lives which is essential for economic growth and sustainable development of country. Since we all have the same vision and mission of a happy and healthy society, it is necessary to come together to protect our women, to love her, to give her freedom, affection, nourishing food and to welcome her to save mankind.