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Knowledge on reproductive health care in Agrarian families

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ABSTRACT

The study was aimed to perceive the knowledge on reproductive health of rural women by interviewing 300 women belonging to Agrarian families (age group of 20-45 years) who were randomly selected from five villages of Vadipatti taluk, Alanganallur block of Madurai district. The socio-economic status scale developed by Agarwal *et al*. (2005) was used to study the socio-economic status of rural farm women, Reproductive health knowledge checklist and Maternal and child health checklist prepared by PJTSAU AICRP-CD component was used to assess the knowledge regarding reproductive health. Wellbeing assessment tool developed by Mc Kinley Health Center at the University of Illionois was used to assess the well being of women. The results indicated that majority of the rural farm women had good knowledge and some of them had average knowledge on reproductive health. Even though the agrarian families were having good knowledge regarding reproductive health, there is a need to put efforts to improve the health and hygiene aspects such as hygienic napkin usage and disposal. Required resource material should be developed for empowering agrarian families quality life style regarding hygienic life through giving various interventions like napkin production which in turns helps for economic empowerment. Education and SES status predicts the knowledge regarding reproductive health. Hence, the farming community especially the rural women should be educated with creating awareness about the reproductive health and the availability of different services provided by the government so that they have the healthy reproductive life.

INTRODUCTION

Women's health is a major interest of investigation today. Rochon *et al.* (1998), demonstrated that, the inequities of scientific discovery in disease processes between women and men. Women's responses to infections, diseases, medications, and therapeutic interventions are often much different from those of men. Clinical trials have traditionally lacked gender comparisons or have under represented women. The health of such individuals is often assessed in terms of their knowledge parameters of women's health.

The WHO defines reproductive health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health involves all of their productive processes, functions and systems at all stages of human life. According to World Health Organization (WHO, 2005), women characterized by significant

physiological, psychological and social changes that put them for high risk sexual and reproductive health problems. This has partially been because they were considered to be relatively healthy, without a heavy "burden of disease". Women's are at a critical stage in life, during which people undergo extensive biological, psychological and social changes (Fatusi and Hindin, 2010). A person's sexual and reproductive health care plays an integral role during this transition and can pose serious challenges for women. Their sexual and reproductive health can affect mental health and other health factors, have long-term implications on educational attainment, employment potential, economic wellbeing and a person's overall ability to reach their full potential (WHO, 2012; Conde-Agudelo *et al.*, 2005; Chandra-Mouli *et al.*, 2013 and Patel *et al.*, 2007). Thus reproductive health contributes enormously to physical and psychosocial comfort and closeness between individuals. Poor reproductive health is frequently associated with disease, abuse, exploitation, unwanted pregnancy and death.

Knowledge about early and unprotected sexual activity and misconceptions about HIV/AIDS are prevalent among rural people thus the concern about women sexual and reproductive health has grown due to unprecedented increasing rates of sexual activity, early pregnancies and sexually transmitted infections (STI) including human immune deficiency virus (HIV) among adolescents. So reproductive health services have been recognized as an appropriate and effective strategy to address reproductive health needs of women. Nevertheless, the needs of the young people remain poorly understood or served in many parts of the world. Despite 35% of the world population being in the 10–24 age groups, the reproductive health (RH) needs of women have neither been researched nor addressed adequately (Ayalew *et al.*, 2008). However, the overall health status, particularly the status of reproductive health, still remains unsatisfactory (Hasan, 2005).

In India, majority of live in rural parts of the country *i.e.* nearly 75% of the population lives in rural areas. These rural women especially belonging to agricultural families are mostly engaged in agricultural activities and also as laborers. The nature of work the women is usually involved drudgery and they are expected to do all domestic chores. That is not only they cope with the responsibility for child bearing and child rearing and meeting the daily requirements of the family by way of cooking, cleaning, look after poultry and cattle. They also provide nursing care to the sick, old and disabled in the family. All these factors contribute to health problems of the women.

However, few attempts have been made particularly in rural settings for addressing their critical concerns or providing them with the necessary RH services. As "age-appropriate" interventions to a particular setting are desirable to address the diverse needs and contexts of women RH, studying their knowledge, services utilization and associated factors is relevant to design appropriate programme interventions and strategies in the rural area. Keeping all these issues in mind an attempt was made to find out the level of knowledge regarding reproductive health with the following objectives :

– To determine the knowledge/ practices of reproductive health among married women.

– To understand the level psychological well being of married women.

MATERIAL AND METHODS

Study design:

The study is a descriptive survey of the knowledge/ practices and psychological well being of married women about reproductive health care. It is descriptive because a quantitative analysis was used to analyze the results elicited by the questionnaires.

Population and sample:

The study is designed to assess the knowledge / practices and psychological well being of married women about reproductive health care, hence the focus on married women. Out of the wide range of married women, the main focus was on the married women who are having children below five years in Vadipatti taluk, Alanganallur block of Madurai district namely Ayyur, Errampatti, Keelachinnanampatti, Kovilpatti and Periyailanthaikulam.

Sample and sampling techniques:

In this study, purposive sampling method was used. Sample comprised of 300 married women who are having children below five years from agrarian families of selected five villages from Alanganallur block of Madurai district.

Data collection methods :

– Baseline survey was conducted using structured questionnaire. The background information such as MMR, IMR, place of delivery, breast feeding practices, infanticide, birth control measures in rural families were collected. Maternal and child health status were assessed with the help of Maternal and child health checklist.

– Collected detailed background information of the village and respondents through different sources such as Deputy Director of Health Service, Primary Health Center, Anganwadi, Village Administrative Officer, Union Office, Transact walk and Participatory Rural Appraisal (PRA). PRA techniques were used for resource mapping, seasonal calendaring and time lines so as to widen the knowledge about villages.

– The data was obtained from the respondents through the administration of questionnaires during survey work. The respondents' were contacted in their home in the five chosen villages at Alanganallur block of Madurai district.

– Participants were told that participation in the study was voluntary and also they were not to provide any form of identification on the questionnaire so as to maintain confidentiality.

– Questionnaires were administered to the respondents' and ample time given for them to answer the questions on the questionnaire.

Data processing and analysis:

Data collected was entered into Microsoft Excel 2007 spread sheet and imported to SPSS (Statistical Package for Social Sciences) version 20 for analysis. Results were presented with simple statistical tools.

Tools used:

Socio-economic status (SES):

Socio-economic status was assessed by using by Aggrawal scale (Aggrawal, 2005). It consisted the parameters such as SES of family, types of family and sizes of family, age, gender, family possessions, land acquisition, number of animals, ordinal position and parental education, etc.

Reproductive health knowledge checklist (Prepared by PJTSAU AICRP-CD component):

It consisted of 33 statements and 3 point scale was used for scoring. Higher scores indicate good reproductive health knowledge. Reproductive health knowledge : The respondents were asked questions which covered the expectations about male and female fertility, reproductive organ, legal age for marriage, FP, STI and HIV/AIDS and menopause, menstrual cycle etc.,

Maternal and child health checklist (Prepared by PJTSAU AICRP-CD component):

It has three subtests namely health, hygiene and nutrition. It consisted of totally 45 statements. 3 point scale was used for scoring. Higher scores indicates good maternal and child health knowledge.

Wellbeing assessment tool (Developed by Mc Kinley Health center at the University of Illionois):

This tool consists of 50 statements with 5 subset those are Physical Health, Social Health, Emotional Health, Spiritual Health and Intellectual Health. 5 point scale was used for scoring.

OBSERVATIONS AND ANALYSIS

Based on the socio-economic status results indicated that, 80 per cent of the women belonged to lower middle category and the remaining 16 per cent belonged to the poor category. Only few of them belong to upper middle category. None of the women were belonged to upper high, high and very poor category. The study conducted by Gupta *et al*. (2015) showed that the socio-economic status had statically significant association with adequate

Table 1 : Socio-economical status of the selected participants **(n=300)**

Socio-economic status classification	Range	Frequency	Percentage
Upper high	> 76	0	0
High	61-75	0	0.00
Upper middle	46-60	8	2.67
Lower middle	31-45	242	80.67
Poor	16-30	50	16.67
Very poor	<15	0	0

knowledge.

Selected women's overall knowledge was evaluated by summarizing all reproductive health-related responses. Accordingly, the knowledge about reproductive health of the selected women, 65 per cent of them were having good knowledge and the remaining 35 per cent of them belonged to average knowledge. None of the women's were found in poor reproductive health knowledge category.

The reason might be that efforts made by the Asha worker and most of the farm women had registered their names in the anganwadi center through which they obtained the minimum knowledge on reproductive health and its services. Our finding is in line with findings by Dangat and Njau (2013) who revealed in their study that two-third of their total number of 316 adolescent respondents have adequate knowledge about reproductive health care. Our results is also in par with what was Enuameh *et al.* (2015) who found in their study that 87.7% females and 82% males in their study had sufficient knowledge about the aspects of reproductive health care. However, this in contrast with Agyekum and Kayi (2013), who revealed that knowledge about reproductive health, disease related to reproductive health as well as family planning, was very low among adolescents in their study.

With regard to the maternal and child health knowledge of the selected women, fifty three per cent of them shown good maternal and child health knowledge and 47per cent belonged to average category. None of them were found in poor category.

With respect to health, fifty three per cent of the respondents had average level of knowledge and 46 per cent showed good knowledge. Regarding hygiene, fifty per cent had average and remaining fifty per cent had good knowledge. 52 per cent of them had average knowledge and 48 per cent had good nutritional knowledge.

Women's level of maternal and child health knowledge is paramount. Advocating and increasing awareness about Reproductive Health (RH) care is also crucial to the success of any women reproductive and maternal health effort. Hence, this study represented an initial effort to assess the knowledge status of women in

Table 2 : Reproductive health of the selected participants **(n=300)**

Reproductive health knowledge category	Range	Frequency	Percentage
Poor knowledge	33	0	0
Average knowledge	34-66	105	35
Good knowledge	67-99	195	65

Table 3 : Maternal and child health knowledge of the selected participants **(n=300)**

Range	Maternal and child health checklist category	Frequency	%
< 45	Poor/Low	0	0
46-90	Average	142	47.33
91-135	Good/high	158	52.67

Table 3a : Component of maternal and child health of the selected participants **(n=300)**

Component of maternal health and child care	Level of knowledge			Total
	Poor (%)	Average (%)	Good (%)	
Health	--	161(53.70)	139(46.30)	300(100.00)
Hygiene	--	150(50.00)	150(50.00)	300(100.00)
Nutrition	--	156(52.00)	144(48.00)	300(100.00)

Table 4 : Psychological well being of the selected women selected participants **(n=300)**

Wellbeing assessment tool category	Range	Frequency	Percentage
Very good	51-200	2	0.67
Good	101-150	26	8.67
Average	51-100	272	90.67
Poor	1-50	0	0.00

rural setting. It shows that majority of them were having good awareness. Barkat (2003) reported that study from India showed significant association with RH knowledge of the rural adolescents. Pujar *et al.* (2017) also found in her study that, level of knowledge on reproductive and maternal health by farm women's had medium level of knowledge (99.3%) whereas very small percentage (0.7%) of women had high level and none of them had poor knowledge.

Reproductive health knowledge is important for women as woman's health and well being. So psychological well being of the selected women, majority (90 %) women showed, an average wellbeing level and the remaining eight per cent of them belonged to good wellbeing. Few of them were found in very good wellbeing level category. None of them had poor wellbeing. Haque *et al.* (2015)in his study revealed that, 88 per cent of rural women had good knowledge and favorable attitude as well as well being.

Conclusion:

In general, it was found that RH knowledge amongst rural women in the study area remained average to good as evidenced by the results. Influence of SES status indicated that well to do families were found to be predictors of RH knowledge even though the agrarian families were having good knowledge regarding reproductive health, there is a need to put efforts to improve the health and hygiene aspects such as napkin usage and disposal of napkins. Required resource material should be developed for empowering agrarian families quality life style regarding hygienic life through giving various interventions like napkin production. This in turns helps them for economic empowerment. The farming community, especially the rural women should be educated with creating awareness about the reproductive health and the availability of different services provided by the government so that they have healthy reproductive life. This study indicates the greater responsibilities for the educators to educate the rural women on the issues of reproductive health because it is a major or the central issue of women's health.

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