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Determinants of reproductive health knowledge among agrarian women

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Abstract
Present study was taken up to find out the factors associated with Knowledge levels of the Agrarian women in the adopted villages of Maheshwaram mandal, RR district, Hyderabad with regard to Reproductive health issues. 300 women at different phases of life formed the sample for the present study. Significant positive correlation was observed between the personal demographic variables, Psychological wellbeing of the sample and Reproductive health Knowledge levels. Regression showed significant effect of personal demographic variables on Reproductive health Knowledge levels, except for the phase of women.

Keywords: Reproductive health; knowledge levels; wellbeing; agrarian families

Introduction
The determinants of health are the conditions in which people are born, grow, live, work and age, and the distribution of power, money and resources which impact on these conditions. The determinants of health encompass social, economic, political, environmental and cultural dimensions, and here we use the term "determinants" as shorthand to signify all of these complex factors.

Determinants are crucial influences on the health of women, children and adolescents. Women, children and adolescents often suffer from discrimination and unequal access to resources and realization of their rights, resulting in exposure to adverse socio- economic, political and environmental conditions- the direct cause of inequities in health for women, children and adolescents within and between countries. Determinants affect access and coverage of essential health interventions, but also impact on health directly, including through shaping behaviors.

For example, gender (in) equality is a key determinant of health. Manifestations of gender inequality (such as differential access to education and health services, forced and early child marriage, unequal labour market participation and remuneration, and violence against women and children) are major contributors to maternal and child mortality- while measures to address these factors can improve health outcomes for women, children and adolescents, and reduce disparities.

In industrialized countries, developmental and economic activities such as urbanization have different impacts (environmental, social, health, etc.) on vulnerable groups. Socio-economic and cultural factors (education, income, occupation, etc.) play a role in health and wellbeing, especially among women.

Women's health in India has assumed importance only of late, particularly after the International Conference on Population and Development held at Cairo, Egypt in September 1994 and the Fourth World Conference on Women, held in Beijing in September 1995. Both these conferences placed immense importance on women's health, empowerment and reproductive rights. Not discounting the importance of health needs and health status of men, the fact remains that over a lifetime the health of woman is usually worse than that of men. Moreover, certain health problems are more prevalent among women than among men and certain health problems are unique to women/ affect women differently than men. Furthermore, some environmental problems have a disproportionate impact on women compared to their male counterparts.

Gender inequality is a social creation and perpetuated through socialization. The difference between genders is more keenly felt in patriarchal societies like India where men are considered to be "superior" to woman just because of their sex. Being inferior to man denotes inferior status. In every aspects of life including health.

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At any given time, the health needs of men and women are different where woman with their biologically and culturally assigned roles have more health care needs than men. To elaborate, biologically they bear the burden of reproduction; women alone have to go through all the problems and discomforts related to pregnancy and delivery.

Culturally, in India, women are expected to be subservient to the male members of the household and work for the latter's happiness and satisfaction. Further, society expects them to play a very important role in providing informal health care to all members of the family. It is their responsibility to rear children on healthy times, teach them health habits prepare and feed the family members and care for the young, the sick, the aged and the disabled. At the end of her duties, she will get very little time to spend for herself and to consider about her health needs.

Generally, the term woman is used to refer to a female of at least fifteen years of age. But, health of a woman, thus defined, is intertwined with her health related experiences in the early years of life. According to the National Population Policy, 2000, in India, the complex socio-cultural determinants of women's health and nutrition have cumulative effects over a life time. Discrimination begins from the womb itself - sex selected abortion, feticides, attributing girl child low status from the time of her birth onwards. Discrimination against girl child leads to less childcare and malnutrition resulting in impaired physical development of the girl child. It is also said that nutrition in early adolescence is crucial to the woman's wellbeing and through her, to the wellbeing of children

Several researches across the world have revealed that reproductive morbidity and general ill–health are, for the most part, silently endured by women due to a combination of forces (cultural restrictions, gender inequalities, low educational levels, etc.) which serves to keep women's suffering invisible (Bang *et al.* 1989, Wasser 1989, Bang & Bang 1991, Brabin & Brabin 1995, Bhatia & Cleland 1995, Oomman 1996, Bhatia *et al.* 1997, Bhatia & Cleland 2000) [2, 15, 1, 3, 5, 11, 6, 7]. Although women's reproductive health has only recently gained social-scientific recognition in various countries, there is very little documented research. Equivocal findings report the centrality of social and cultural norms affecting quality of life (QOL) among women in India (Koeing *et al*. 1998, Sadana 1998, Bhatia 2000) [10, 14]. It is applicable to international conditions the world-over in which women in vulnerable groups are constrained by poor environmental, social and gender circumstances (WHO 1992, Karlekar 2000) [16, 9].

There is a growing amount of popular knowledge, attitudes, practices, social and health surveys (Ministry of Health and Family Welfare 1997, National Family Health Survey, Reproductive Health Survey 2000) [12, 9] in India demonstrating increasing rates of reproductive illness (Jejeebhoy & Rao 1992) [8], violence and abuse among women.

Operational definition
Knowledge: Knowledge is a familiarity, awareness, or understanding of someone or something, such as facts, information, descriptions, or skills, which is acquired through experience or education by perceiving, discovering, or learning.
According to Webster's dictionary, knowledge is 'the fact or condition of knowing something with familiarity gained through experience or association'. In practice, though, there are many possible, equally plausible definitions of knowledge. A frequently used definition of knowledge is "the ideas or understandings which an entity possesses that are used to take effective action to achieve the entity's goal (s).

Agrarian families: Families involved in Agriculture for their livelihood

Reproductive health: Reproductive health refers to the diseases, disorders and conditions that affect the functioning of the male and female reproductive systems during all stages of life.
Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or infirmity. Reproductive health deals with the reproductive processes, functions and system at all stages of life.

Wellbeing: Wellbeing, put simply, is about 'how we are doing' as individuals, communities and as a nation and how sustainable this is for the future. Personal wellbeing is a particularly important dimension which we define as how satisfied we are with our lives, our sense that what we do in life is worthwhile, our day to day emotional experiences (happiness and anxiety) and our wider mental wellbeing.

Research methodology: Sample was identified from the adopted villages (5) of Maheshwaram mandal, RR District, Hyderabad, through field survey and focused group interviews with the help of the AWWs, ANMs, and Women Self-help group leaders in the village.

Criteria for sample selection
• Women who were married and living with their husband
• Women who were having children (between 2 – 5 years)
• Women who were willing to be the part of the project

General objective: **Determinants of Reproductive Health Knowledge among Agrarian women**
Specific objectives
• To find out the demographic profiles of the Selected sample
• To find out the Reproductive health Knowledge levels and wellbeing among the Selected sample
• To study the relationship between Dependent (Reproductive Health Knowledge) and Independent variables
• To find out the significant impact of independent variables on dependent variable (Reproductive Health Knowledge) of the selected sample

Research tools details
1. SES scale developed by Aggrawal, *et al* (2005) was used to find out the SES of the Rural families. Scoring was given as per the norms provided in the manual. It is a standardized scale, used to assess the family background information of the individuals, which includes parameters like educational and occupational status of parents, number of siblings, material possession, kind of locality, presence of farm animals, land holdings, number of earning members in the family etc. The scale categorizes the sample on: Upper High; High; Upper middle; Lower middle; Poor and Very poor Socio Economic Status.

2. Reproductive health awareness checklist was developed by AICRP-CD, Hyd Unit (2017) to find out the Knowledge levels of Married women with regard to Reproductive health issues. The Reliability Value of the checklist is: 0.81. The checklist comprises of 5 dimensions:

i. **Pre-conception Health:** It is the First dimension and has 26 statements. It measures the knowledge levels of the sample in the following 4 areas: Preparation for Parenthood (7 statements); Factors that Boost Preconception Health (8 statements); Preparedness for pregnancy (5 statements); and Preconception Behaviours (6 statements).

ii. **Reproductive health problems:** It is the Second dimension and has 31 statements. It measures the knowledge levels of the sample in the following 4 areas: Menstrual problems (9 statements); menstrual hygiene practices (6 statements); Potential risks to health due to poor menstrual hygiene (4 statements); Gynecological problems (12 statements).

iii. **Family planning:** It is the Third dimension and has 17 statements. It measures the knowledge levels of the sample in the following 3 areas: Family Planning Methods (5 statements); Purpose of following Family planning methods (4 statements); Contraceptive related problems (8 statements).

iv. **Sexually transmitted diseases:** It is the Fourth dimension and has 36 statements. It measures the knowledge levels of the sample in the following 5 areas: Awareness about HIV/AIDS & related problems (8 statements); Awareness about RTI/STD related problems (11 statements); Awareness about transmission of HIV / AIDS (9 statements); Preventive methods for HIV/AIDS (3 statements); Preventive methods for RTI/STD (5 statements).

v. **General:** It is the Fifth dimension and has 30 statements. It measures the knowledge levels of the sample in the following 3 areas: Services Related to Reproductive Health (10 statements); Awareness about marital laws & legal rights (9 statements); Awareness about Reproductive rights (11 statements).

There are all together 140 statements (all 5 dimensions). Each statement is arranged on 3 point scale ie aware is marked as 3; aware but not sure 2; Not sure as 1. The total scores were further grouped as Low, Average and high. Higher the score, higher is the level of Knowledge in that particular dimension. Psychological wellbeing scale, developed by Chassney, 2014**:** It comprises of 5 dimensions: Physical, Social, Emotional, Spiritual and Intellectual. Each dimension has 10 statements and the statements are scored on a 4 point scale: Rarely is given a score of one, Sometimes is given a score of 2, Most of the time is given a score of 3 and Always is given a score of 4. Minimum score is 10 and 40 is the maximum score. Based on the scores, it categorized as Very good; Good; Average and Poor. The Reliability Value of the scale is: 0.74

Demographic data on married women:
- There were 961 married women from the selected 5 clusters of adopted villages. Out of 961 married women, 41% (390) were having children below 2 years; 37% (357) were having children between 2-5 years; 8% (80) were Pregnant for the 1st time and 8% (80) were married, but without children.

Table 1: Stage& age wise distribution of Agrarian women (N= 300)

Stage	16 -19 yrs N & %	20– 25 yrs N & %	26– 30yrs N & %	31 –35yrs N & %	Total sample
Married women without children	42 (56%)	33 (44%)	-----	-----	75
Pregnant women (First time)	17 (23%)	37 (49%)	21 (28%)	-----	75
Married women with children below 2 yrs	-----	30 (40%)	32 (43%)	13 (17%)	75
Married women with children between 2 – 5 yrs	-----	25 (33%)	33 (44%)	17 (23%)	75
Total	59 (20%)	125 (42%)	86 (28%)	30 (10%)	300

- The above table depicts the Age wise distribution of the sample. Out of the total sample 300, less than half (42%) of the sample were in the age range of 20-25 yrs; 28% were in the age group of 26-30 yrs; 20% were in the age group of 16-19 yrs and remaining 10% were in the age group of 31-35 yrs.

Table 2: Stage & Education wise distribution of Agrarian women (N= 300)

Stage	Illiterate N & %	Primary school N & %	Secondary School N & %	Inter N & %	Degree Continuing N & %	Total sample
Married women without children	6 (8%)	11 (15%)	30 (40%)	17 (22%)	11 (15%)	75
Pregnant women (First time)	9 (12%)	13 (17%)	38 (51%)	11 (15%)	4 (5%)	75
Married women with children below 2 yrs	7 (9%)	25 (33%)	30 (40%)	8 (11%)	5 (7%)	75
Married women with children between 2 – 5 yrs	5 (7%)	17 (22%)	27 (36%)	23 (31%)	3 (4%)	75
Total	27 (9%)	66 (22%)	125 (41%)	59 (20%)	23 (8%)	300

- The above table depicts the Education wise distribution of the sample. Out of the total sample 300, less than half (41%) of the sample completed secondary school; 22% completed Primary school; 20% completed Inter; 9% were illiterate and 8% were found to be pursuing their degree.

Table 3: Stage & Occupation wise distribution of Agrarian women (N= 300)

Stage	House wife N & %	Fully involved in agriculture N & %	Partially involved in agriculture N & %	Petit business N & %	Total
Married women without children	15 (20%)	37 (49%)	20 (27%)	3 (4%)	75
Pregnant women (First time)	38 (51%)	7 (9%)	27 (36%)	3 (4%)	75
Married women with children below 2 yrs	17 (23%)	25 (33%)	26 (35%)	7 (9%)	75
Married women with children between 2 – 5 yrs	9 (12%)	33 (44%)	28 (37%)	5 (7%)	75
Total	79 (26%)	102 (34%)	101 (34%)	18 (6%)	300

- The above table depicts the Occupation wise distribution of the sample. Out of the total sample 300, thirty four percentage of the sample were fully involved and equal percentage were partially involved in agriculture; 26% were housewives; and only 6% were running petit business.

Table 4: Socio Economic Status of the Rural Family (N=300)

Socio economic status classification	Score	Married women without children (N=75)	Pregnant women (First time) (N=75)	Married women with children below 2 yrs (N=75)	Married women with children between 2–5 yrs (N=75)	(N=300) No & %
Upper High	>76	------	------	------	------	------
High	61-75	3 (4%)	2 (3%)	2 (3%)	2 (3%)	9 (3%)
Upper middle	46-60	12 (16%)	8 (10%)	9 (12%)	13 (17%)	42 (14%)
Lower middle	31-45	42 (56%)	45 (60%)	48 (64%)	45 (60%)	180 (60%)
Poor	16-30	18 (24%)	20 (27%)	16 (21%)	15 (20%)	69 (23%)
Very poor	<15	------	------	------	------	------

- The above table depicts the Socio Economic Status of the sample. Out of the total sample 300, more than half (60%) of the sample were in lower middle income level; 23% were in poor economic status; 14% were in upper middle income level and only 3% were in high income group.

Table 5: Reproductive Health Knowledge among Agrarian women (N=300) – Pretest scores

S. No	Reproductive Health awareness dimensions	Category	Score	Married women without children (N=75) No & %	Pregnant women (First time) (N=75) No & %	Married women with children < 2 yrs (N=75) No & %	Married women with children 2 – 5 yrs (N=75) No & %	Total (N=300) No & %
A	Preconception Health (26 statements)	High	53-78	18 (24%)	24 (32%)	22 (29%)	20 (27%)	84 (28%)
		Average	27-52	44 (59%)	40 (53%)	42 (56%)	44 (58%)	170 (57%)
		Low	< 26	13 (17%)	11 (15%)	11 (15%)	11 (15%)	46 (15%)
B	Reproductive health problems (30 statements)	High	61-90	25 (33%)	27 (36%)	29 (39%)	28 (37%)	109 (36%)
		Average	31-60	35 (47%)	36 (48%)	34 (45%)	39 (52%)	144 (48%)
		Low	< 30	15 (20%)	12 (16%)	12 (16%)	8 (11%)	47 (16%)
C	Family planning (17 statements)	High	35-51	15 (20%)	24 (32%)	26 (35%)	26 (35%)	91 (30%)
		Average	18 - 34	43 (57%)	37 (49%)	37 (49%)	39 (52%)	156 (52%)
		Low	< 17	17 (23%)	14 (19%)	12 (16%)	10 (13%)	53 (18%)
D	Sexually transmitted diseases (36 statements)	High	73-108	25 (33%)	26 (35%)	28 (37%)	28 (37%)	107 (36%)
		Average	37-72	35 (47%)	35 (46%)	33 (44%)	34 (45%)	137 (46%)
		Low	< 36	15 (20%)	14 (19%)	14 (19%)	13 (18%)	56 (18%)
E	General (30 statements)	High	61-90	12 (16%)	10 (13%)	11 (15%)	13 (17%)	46 (15%)
		Average	31-60	38 (51%)	41 (55%)	41 (55%)	41 (55%)	166 (54%)
		Low	< 30	25 (33%)	24 (32%)	23 (30%)	21 (28%)	93 (31%)
	Grand total	High	279 - 417	19 (25%)	22 (29%)	23 (31%)	23 (31%)	87 (29%)
		Average	140 - 278	39 (52%)	38 (51%)	37 (49%)	39 (52%)	154 (51%)
		Low	< 139	17 (23%)	15 (20%)	15 (20%)	13 (17%)	59 (20%)

- The above table traces the pretest scores of Agrarian women with regard to Reproductive Health Knowledge. The Self-structured Checklist covers 5 dimensions.
- With regard to Preconception Health dimension, out of the total 300 sample more than half (57%) of the sample obtained Average scores; 28% obtained High scores and 15% obtained Low scores.
- With regard to Reproductive health problem dimension, out of the total 300 sample less than half (48%) of the sample obtained Average scores; 36% obtained High scores and 16% obtained Low scores.
- With regard to Family planning dimension, out of the total 300 sample slightly more than half (52%) of the sample obtained Average scores; 30% obtained High scores and 18% obtained Low scores.
- With regard to Sexually transmitted diseases dimension, out of the total 300 sample less than half (46%) of the sample obtained Average scores; 36% obtained High scores and 18% obtained Low scores.
- With regard to General dimension, out of the total 300 sample more than half (54%) of the sample obtained Average scores; 31% obtained Low scores and 15% obtained High scores.
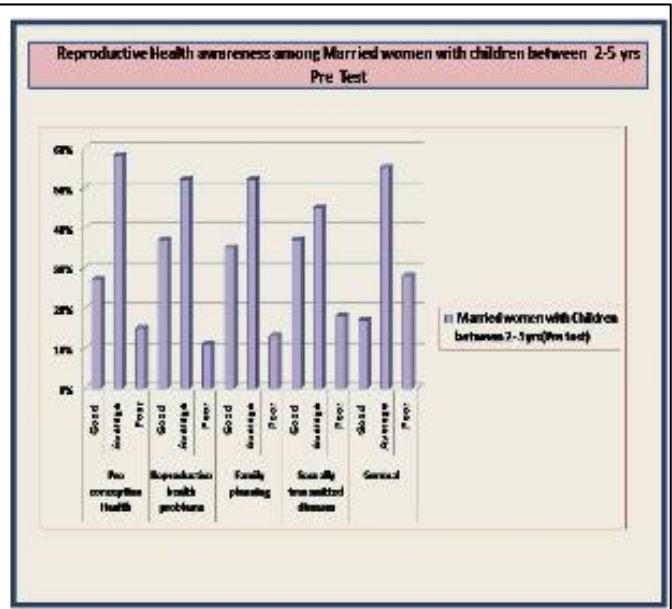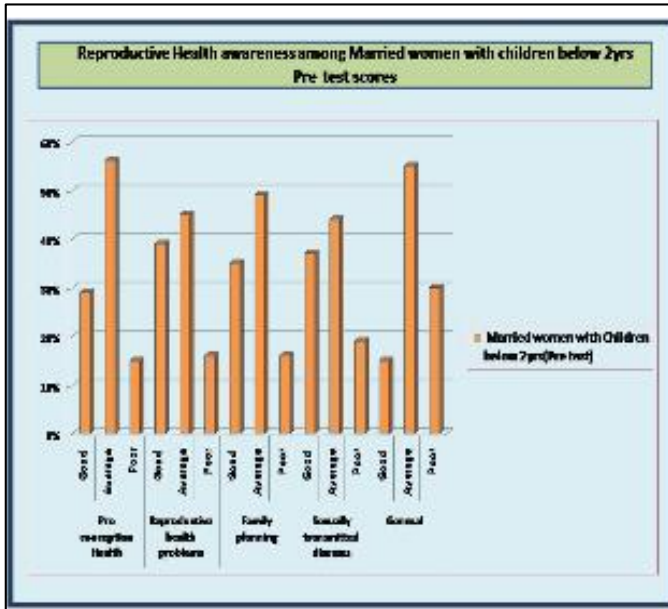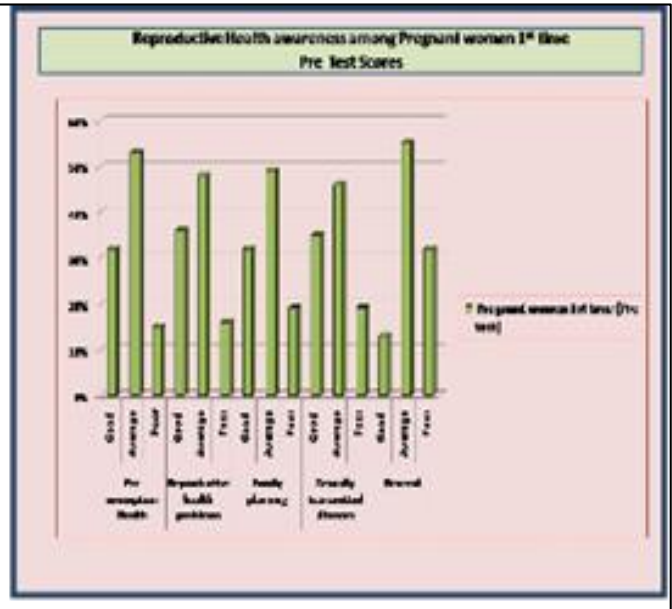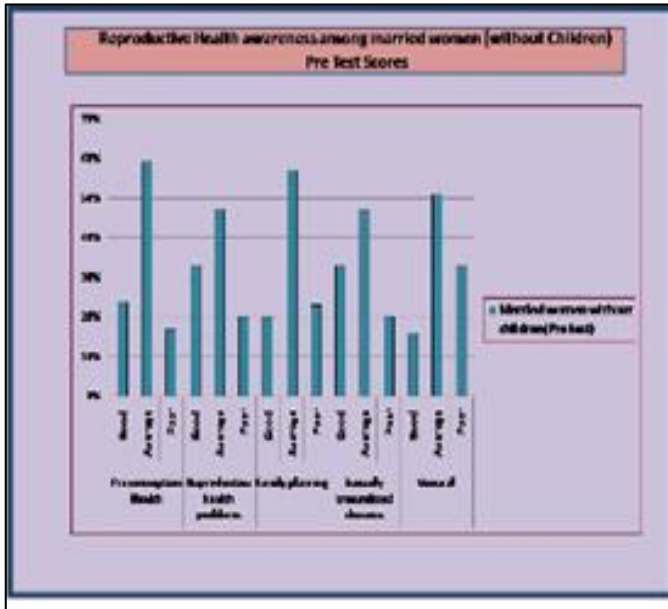
Table 5: Psychological wellbeing among Agrarian women (N=300) Pretest scores

S. No	Psychological Wellbeing	Category	Score	Married women without children (N=75) No & %	Pregnant women (N=75) No & %	Married women with children < 2 yrs (N=75) No & %	Married women with children (2 – 5 yrs) (N=75) No & %	Total 300 No & %
A	Physical Health	Very good	35 – 40	12 (16%)	11 (15%)	9 (12%)	14 (19%)	46 (15%)
		Good	30-35	41 (55%)	36 (48%)	30 (40%)	26 (35%)	133 (44%)
		Average	20-30	22 (29%)	22 (29%)	27 (36%)	27 (36%0	98 (33%)
		Poor	< 20	----	6 (8%)	9 (12%)	8 (11%)	23 (8%)
B	Social Health	Very good	35 – 40	13 (17%)	15 (20%)	27 (36%)	27 (36%)	105 (35%)
		Good	30-35	32 (43%)	25 (33%)	28 (37%)	22 (29%)	107 (36%)
		Average	20-30	30 (40%)	35 (47%)	20 (27%)	26 (35%)	111 (37%)
C	Emotional Health	Very good	35 – 40	11 (15%)	11 (15%)	23 (31%)	22 (29%)	67 (22%)
		Good	30-35	36 (48%)	20 (27%)	30 (40%)	20 (27%)	106 (35%)
		Average	20-30	28 (37%)	37 (49%)	22 (29%)	33 (44%)	120 (40%)
		Poor	< 20	----	7 (9%)	----	----	7 (2%)
D	Spiritual Health	Very good	35 – 40	19 (25%)	14 (19%)	25 (33%)	22 (29%)	80 (27%)
		Good	30-35	34 (45%)	28 (37%)	30 (40%)	31 (41%)	123 (41%)
		Average	20-30	22 (29%)	33 (44%)	20 (27%)	32 (43%)	107 (36%)
E	Intellectual Health	Very good	35 – 40	10 13%)	3 (4%)	16 (21%)	14 (19%)	43 (57%)
		Good	30-35	25 (33%)	30 (40%)	22 (29%)	24 (32%)	101 (34%)
		Average	20-30	36 (48%)	30 (40%)	25 (33%)	30 (40%)	121 (40%)
		Poor	< 20	4 (5%)	12 (16%)	12 (16%)	7 (9%)	35 (12%)
Grand total		Very good	176 - 200	13 (17%)	11 (15%)	20 (27%)	20 (27%)	68 (23%)
		Good	151 - 175	33 (44%)	28 (37%)	28 (37%)	24 (32%)	114 (38%)
		Average	101 - 150	27 (36%)	26 (35%)	23 (31%)	29 (38%)	111 (37%)
		Poor	< 100	2 (3%)	10 (13%)	4 (5%)	2 (3%)	7 (2%)

- The above table traces the scores of Agrarian women with regard to Psychological Wellbeing. The scale covers 5 dimensions.
- With regard to Physical Health dimension, out of the total 300 sample less than half (44%) of the sample obtained Good scores; 33% obtained Average scores; 15% obtained very Good scores and only 8% obtained Poor scores.
- With regard to Social Health dimension, out of the total 300 sample less than half (37%) of the sample obtained Average scores; 36% obtained Good scores; and 35% obtained very Good scores.
- With regard to Emotional Health dimension, out of the total 300 sample less than half (40%) of the sample obtained Average scores; 35% obtained Good scores; 22% obtained very good scores and only 2% obtained Poor scores.
- With regard to Spiritual Health dimension, out of the total 300 sample less than half (41%) of the sample obtained Good scores; 36% obtained Average scores and 27% obtained very good scores.
- With regard to Intellectual Health dimension, out of the total 300 sample less than half (40%) of the sample obtained Average scores; 34% obtained Good scores;

57% obtained very good scores and 12% obtained poor scores.
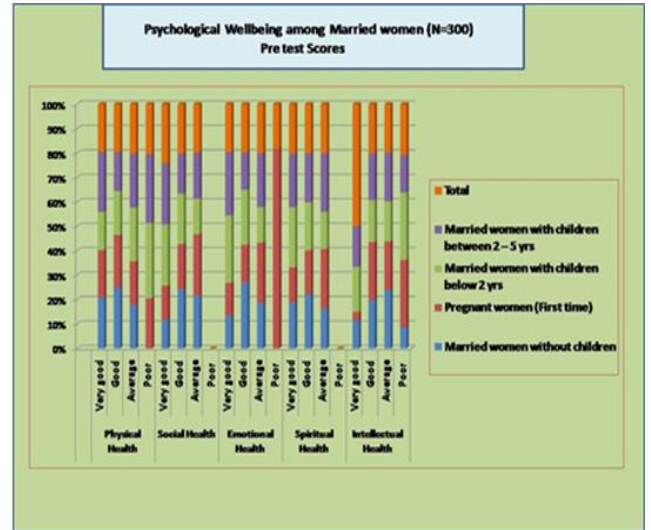
Correlation between demographic variables and Reproductive health awareness

Parameters		PH	RHP	FP	STD	GH	TOTAL
Age	Pearson Correlation	.511 (**)	.560 (**)	.600 (**)	.568 (**)	.502 (**)	.784 (**)
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000
	N	300	300	300	300	300	300
Education	Pearson Correlation	.350 (**)	.362 (**)	.339 (**)	.388 (**)	.392 (**)	.412 (**)
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000
	N	300	300	300	300	300	300
Occupation	Pearson Correlation	.024	.056	.047	.069	.005	.013
	Sig. (2-tailed)	.673	.337	.413	.234	.927	.828
	N	300	300	300	300	300	300
SES	Pearson Correlation	.418 (**)	.357 (**)	.329 (**)	.387 (**)	.383 (**)	.247 (**)
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000
	N	300	300	300	300	300	300
Women in different phases	Pearson Correlation	.012	.033	.095	.017	.024	.498 (**)
	Sig. (2-tailed)	.835	.572	.102	.766	.674	.000
	N	300	300	300	300	300	300

** Correlation is significant at the 0.01 level (2-tailed).
PH: Preconception health RPH: Reproductive health problems FP: Family planning
STD: Sexually transmitted disease   GI: General Issues (Reproductive rights; marital laws)

- All the demographic variables: Age, Education, Occupation and Socio-Economic Status showed significant relationship with all the five dimensions of reproductive health awareness.
- With regard to Women in different phases, only women with children (between 2 – 5 years) showed significant

relationship with all the dimensions of reproductive health awareness.

Correlation between reproductive health awareness and psychological well being

Parameters		PSWB1	PSWB2	PSWB3	PSWB4	PSWB5	PSWB TOTAL
PH	Pearson Correlation	.817 (**)	.823 (**)	.824 (**)	.860 (**)	.838 (**)	.911 (**)
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000
	N	300	300	300	300	300	300
RHP	Pearson Correlation	.781 (**)	.812 (**)	.829 (**)	.844 (**)	.835 (**)	.897 (**)
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000
	N	300	300	300	300	300	300
FP	Pearson Correlation	.761 (**)	.833 (**)	.813 (**)	.822 (**)	.800 (**)	.880 (**)
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000
	N	300	300	300	300	300	300
STD	Pearson Correlation	.804 (**)	.840 (**)	.833 (**)	.856 (**)	.842 (**)	.913 (**)
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000
	N	300	300	300	300	300	300
GI	Pearson Correlation	.761 (**)	.807 (**)	.792 (**)	.792 (**)	.793 (**)	.862 (**)

	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000
	N	300	300	300	300	300	300
GRHWTOTAL	Pearson Correlation	.551 (**)	.727 (**)	.638 (**)	.659 (**)	.638 (**)	.697 (**)
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000
	N	300	300	300	300	300	300

** Correlation is significant at the 0.01 level (2-tailed).
PH: Preconception health RPH: Reproductive health problems FP: Family planning
STD: Sexually transmitted disease   GI: General Issues (Reproductive rights; marital laws)

- All the five dimensions (Preconception health, Reproductive health problems, Family planning, Sexually transmitted disease & General Issues) of reproductive health found to have significant relationship with all the five components of psychological well-being (Physical health, Social health, Emotional health, Spiritual health, Intellectual health)

Impact of demographic variable on reproductive health awareness

Parameters	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta	B	Std. Error
Age	55.987	4.083	.655	13.714	.000**
Education	13.113	2.666	-.178	4.919	.000**
Occupation	7.760	3.014	-.093	2.574	.011**
SES	22.324	3.891	.203	5.737	.000**
PHASE	5.173	3.110	.076	1.663	.097

Dependent Variable: GRHWTOTAL

Regression analysis showed only Age, education, occupation and SES to be impacting reproductive health awareness, however, phase of women showed no significant effect on reproduction health awareness.

Based on the Research results following Recommendations were framed

- Sexual and reproductive health rights refers to the right to have control over and decide freely on matters related to sexuality free of coercion, discrimination and violence and reproductive health.
- It is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice.
- It is a challenging task to raise awareness regarding reproductive health care issues in women because of the taboos regarding the discussions on issues like safe sex, unsafe sexual practices, on family planning methods etc. Hence Every Village needs to have a counselling center attached to AWC/ PHC
- Awareness camps need to be organized by the State Maternal Health & Family welfare department to appraise the Married women & Rural Adolescent girls about the effective methods to be followed for menstrual hygiene, safe pregnancy and delivery of the healthy child
- All women should have access to accurate, informed choices for reproductive health planning and pregnancy spacing.
- Parents and educators should support and improve the learning, development, and health of children and adolescents.
- Health professionals should provide tailored, non-judgmental, and confidential sexual and reproductive health services to at risk population: pregnant teens, pregnant women with HIV/ RTIs etc

Conclusion

- Sexual and reproductive health rights are critical for empowering women and girls to realize their rights and their access to health services.
- The ability of women and girls to exercise their sexual and reproductive rights to make free and informed choices about their sexual and reproductive life, is a central component of gender equality.
- Ensuring sexual and reproductive health rights can advance the empowerment of women and girls around the world, and ultimately contribute to achieving gender equality.

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