



ISSN (E): 2277- 7695

ISSN (P): 2349-8242

NAAS Rating: 5.03

TPI 2018; 7(8): 01-07

© 2018 TPI

www.thepharmajournal.com

Received: 01-06-2018

Accepted: 03-07-2018

Dr. Nasreen Banu

Principal Scientist, AICRP- H.Sc
(All India Coordinated Research
Project – Home Science), Human
Development Component,
PGRC, PJTSAU (Professor
Jayashankar Telangana State
Agricultural University),
Rajendranagar, Hyderabad,
Telangana, India

Dr. K Yashoda

Research Associate, AICRP-
H.Sc, Human Development
Component, PGRC, PJTSAU,
Rajendranagar, Hyderabad,
Telangana, India

Correspondence

Dr. Nasreen Banu

Principal Scientist, AICRP- H.Sc
(All India Coordinated Research
Project – Home Science), Human
Development Component,
PGRC, PJTSAU (Professor
Jayashankar Telangana State
Agricultural University),
Rajendranagar, Hyderabad,
Telangana, India

Reproductive health knowledge of rural mothers from agrarian families

Dr. Nasreen Banu and Dr. K Yashoda

Abstract

Present study was taken up to find out the Knowledge levels of the Rural mothers (with children below 2 years) in the adopted villages of Maheshwaram mandal, RR district, Hyderabad with regard to Reproductive health issues. 75 Married women (First time pregnant) formed the sample for the present study. Checklist was developed to find out the Knowledge levels of rural mothers. Based on the results, Knowledge based Intervention programmes were organized. Impact assessment showed significant improvement in the Knowledge levels of the sample, reflecting the effectiveness of the Intervention programme.

Keywords: Reproductive health; intervention programme; knowledge levels; agrarian families

Introduction

Reproductive health covers all aspects of women's health. It is an umbrella concept, consisting of several distinct, yet related issues such as abortion, child birth, sexuality, contraception and maternal mortality. Biological, social, cultural, economical and behavioral factors play an important role in determination of reproductive health (Singh *et al*, 1995) [3]. The social construction of sexuality and the resultant gender relation plays a crucial role in shaping women's life and health conditions.

Over 75% of Indian population resides in rural area in India. Approximately 30% of women are married between the ages of 15 - 19 years. This is normally followed by closely spaced pregnancies. The state of Rajasthan located in northwestern India, has highest level of early marriage in India, almost one out of every three girls between the ages of fifteen to nineteen is married. The prevalence of early marriage and general lack of literacy among many Rajasthan girls has created an urgent need of effective sexual and reproductive health education programs. (Singh, 2004) [4]. There is a overwhelming evidence that child marriage is occurring in Rajasthan in large numbers, despite laws against it. Large numbers of girls from poor households are pushed into early marriage, which is consummated almost immediately after menarche (Santhya & Jejeeboy, J.S., 2003) [2]. Early marriage leading to early motherhood is associated with serious health problems to adolescent mothers and their offspring.

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

Intervention: An **intervention** is a combination of programme elements or strategies designed to produce behavior changes or improve health status among individuals or an entire population.

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.

Maternal health: It refers to the health of women during pregnancy, childbirth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death.

Child health: It is a state of physical, mental, intellectual, social and emotional well-being and not merely the absence of disease or infirmity. Healthy children live in families, environments, and communities that provide them with the opportunity to reach their fullest developmental potential.

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.

It's a quasi-experiment study. It is an empirical interventional study used to estimate the causal impact of an intervention on its target population without random assignment.

There were 357 married women having children between the age group of 2-5 years in the selected clusters of 5 villages of Maheshwaram mandal and 75 formed the sample for the present study. The following criterion was used to select the sample. Purposive sampling procedure was used.

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 participate in the project

General objective: Promoting Reproductive health Knowledge among Rural mothers from Agrarian families

Specific objectives:

- To find out the demographic profiles of the Selected sample
- To find out the Knowledge levels of the Selected sample with regard to Reproductive health
- To develop suitable IEC material for promoting Reproductive health among the selected sample
- To conduct Knowledge based Intervention programme to the selected sample
- To assess the impact of the Intervention programme on the Knowledge levels of the selected sample

Research strategy adopted: In order to achieve the above objectives, Knowledge based Intervention programmes were organized for the Married women, using the developed IEC material.

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.

Research findings

Demographic data on married women:

There were 961 married women from the selected clusters of adopted villages, Maheshwaram mandal, RR district. Out of 961 married women, 37% (357) were having children between 2-5 years and 75 formed the sample for the present study.

Table 1: Age wise distribution of the Selected sample (N=75)

16 -19 yrs	20– 25 yrs	26– 30yrs	31 –35yrs
N & %	N & %	N & %	N & %
-----	25 (33%)	33 (44%)	17 (23%)

The above table depicts the Age wise distribution of rural mothers with children (between 2 -5 years). Out of the total sample 75, less than half of (44%) were in the age range of 26-

30 yrs; 33% were in the age group of 20-25 yrs and the remaining 23% were in the age group of 31-35 yrs.

Table 2: Education wise distribution of the Selected sample (N=75)

Illiterate	Primary school	Secondary school	Inter	Degree Continuing
N & %	N & %	N & %	N & %	N & %
5 (7%)	17 (22%)	27 (36%)	23 (31%)	3 (4%)

The above table depicts the Education wise distribution of rural mothers with children (between 2 -5 years). Out of the total sample 75, thirty six percent of the sample completed

Secondary school; 31% completed Inter; 22% completed Primary school; 7% were illiterates and only 4% were pursuing their degree.

Table 3: Occupation wise distribution of the Selected sample (N=75)

House wife N & %	Fully involved in agriculture N & %	Partially involved in agriculture N & %	Petit business N & %
9 (12%)	33 (44%)	28 (37%)	5 (7%)

The above table depicts the Occupation wise distribution of rural mothers with children (between 2 -5 years). Out of the total sample 75, forty four percent of the sample were fully

involved in agriculture; 37% were partially involved in agriculture; 12% were housewives; and only 7% were running petit business.

Table 4: Socio Economic Status of the sample (N=75)

Socio economic status classification	Score	Rural mothers with children between 2 – 5 yrs (N=75)
Upper High	>76	---
High	61-75	2 (3%)
Upper middle	46-60	13 (17%)
Lower middle	31-45	45 (60%)
Poor	16-30	15(20%)
Very poor	<15	----

The above table depicts the Socio Economic Status of Rural mothers with children (between 2 - 5 years). Out of the total sample 75, more than half of (60%) the sample were in lower

middle income level; 20% were in poor economic status; 17% were in upper middle income level and only 3% were in high income group.

Table 5: Reproductive Health Knowledge scores of rural mothers with children (between 2 -5 years) - Pretest scores

S. No	Reproductive Health awareness dimensions	Category	Score	Rural mothers with children (between 2 -5 years) N=75 (No & %)
A	Preconception Health (26 statements)	High	53-78	20 (27%)
		Average	27-52	44 (58%)
		Low	< 26	11 (15%)
B	Reproductive health problems (30 statements)	High	61-90	28 (37%)
		Average	31-60	39 (52%)
		Low	< 30	8 (11%)
C	Family planning (17 statements)	High	35-51	26 (35%)
		Average	18-34	39 (52%)
		Low	< 17	10 (13%)
D	Sexually transmitted diseases (36 statements)	High	73-08	28 (37%)
		Average	37-72	34 (45%)
		Low	< 36	13 (18%)
E	General (30 statements)	High	61-90	13 (17%)
		Average	31-60	41 (55%)
		Low	< 30	21 (28%)

The above table traces the pretest scores of rural mothers with children (between 2 – 5 years) with regard to Reproductive Health. The Self structured Checklist covers 5 dimensions. With regard to Preconception Health dimension, out of 75, more than half (58%) of the sample obtained Average scores; 27% obtained High scores and 15% obtained Low scores. With regard to Reproductive health problem dimension, less than half (52%) of the sample obtained Average scores; 37% obtained High scores and 11% obtained Low scores. With regard to Family planning dimension, more than half (52%) of the sample obtained Average scores; 35% obtained High scores and 13% obtained Low scores.

With regard to Sexually transmitted diseases dimension, less than half (45%) of the sample obtained Average scores; 37% obtained High scores and 18% obtained Low scores. With regard to General dimension, slightly more than half (55%) of the sample obtained Average scores; 28% obtained Low scores and 17% obtained High scores.

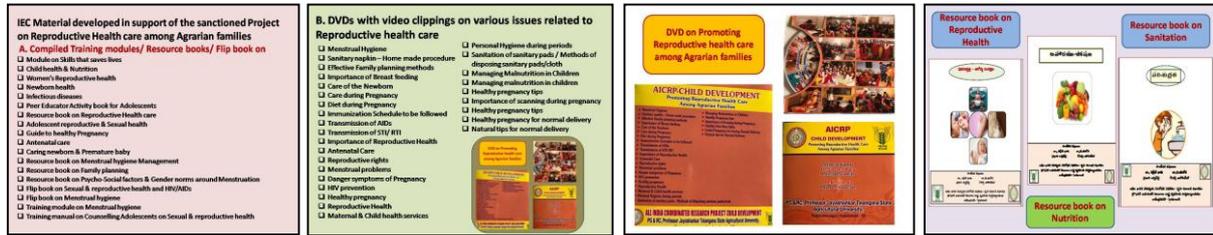
Planning & preparing educational material for conducting Awareness programmes on issues concerning Reproductive Health care among married women: Based on the bench mark issues and pre-assessment results, videos, brochures, leaflets, resource books and educational posters were planned /

developed on selected thematic areas.

Educational posters mainly focused on: Adolescent Reproductive health; Balanced diet during Pregnancy; Birth control facts; Benefits of Breast feeding; Comprehensive nutrition; Condom use; Contraception choices; Healthy pregnancy; HIV prevention; Transmission of AIDS;

Transmission of STI/ RTI; Reproductive rights; Reproductive problems; Reproductive health; Antenatal care; Immunization schedule; Menstrual hygiene; Menstrual problems; Menstrual education; Neonatal health; Sanitary napkin; STI symptoms

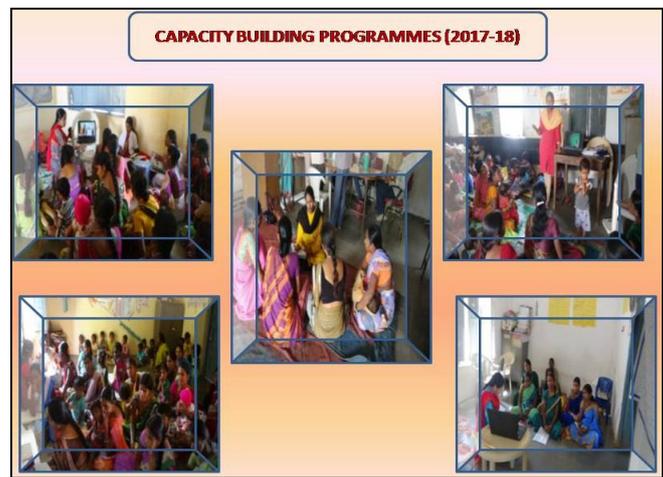
IEC material developed in support of the objectives



Some of the intervention strategies used for promoting Reproductive Health Knowledge among the sample was: group exercises, role plays, open ended stories, Brain storming, Group activities, Situation analysis, Case studies, Responding to real life situations and Group discussions etc.

Conducting programmes on Reproductive Health care: Knowledge based Capacity building programmes (25) were conducted for married women from the adopted villages on issues concerning Reproductive Health care.

Capacity building programmes



Impact of Knowledge based Intervention

Table 6: Reproductive Health Knowledge scores of Rural mothers with children (between 2 -5 years) - Post assessment Scores:

S. No	Reproductive Health awareness dimensions	Category	Score	Rural mothers with children (between 2 -5 years) N=75 (No & %)
A	Preconception Health (26 statements)	High	53-78	45 (60%)
		Average	27-52	29 (39%)
		Low	< 26	1 (1%)
B	Reproductive health problems (30 statements)	High	61-90	36 (48%)
		Average	31-60	35 (47%)
		Low	< 30	4 (5%)
C	Family planning (17 statements)	High	35-51	40 (53%)
		Average	18 - 34	33 (44%)
		Low	< 17	2 (3%)
D	Sexually transmitted diseases (36 statements)	High	73-108	37 (49%)
		Average	37-72	33 (44%)
		Low	< 36	5 (7%)
E	General (30 statements)	High	61-90	42 (56%)
		Average	31-60	30 (40%)
		Low	< 30	3 (4%)

The above table traces the post-test scores of rural mothers with children (between 2 -5 years) with regard to Reproductive Health Knowledge.

With regard to Preconception Health dimension, out of 75, more than half (60%) of the sample obtained High scores; 39%

obtained Average scores and only 1% obtained Low scores. With regard to Reproductive health problem dimension, less than half (48%) of the sample, obtained High scores; 47% obtained Average scores and only 5% obtained Low scores.

With regard to Family planning dimension, more than half

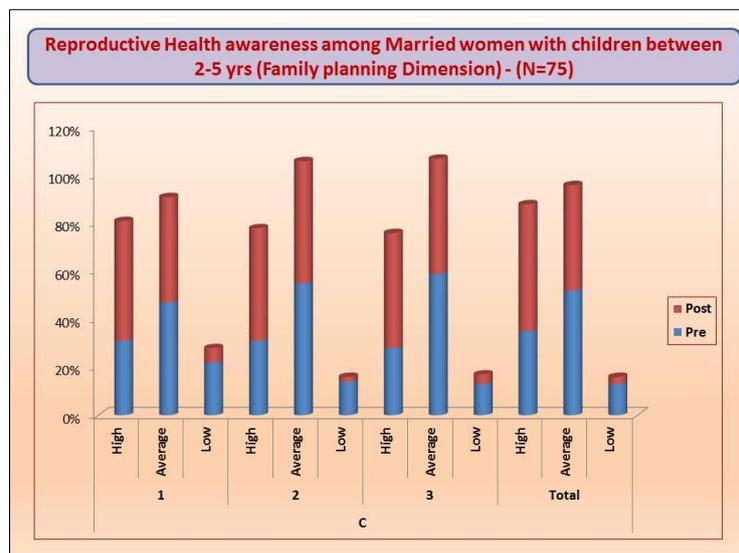
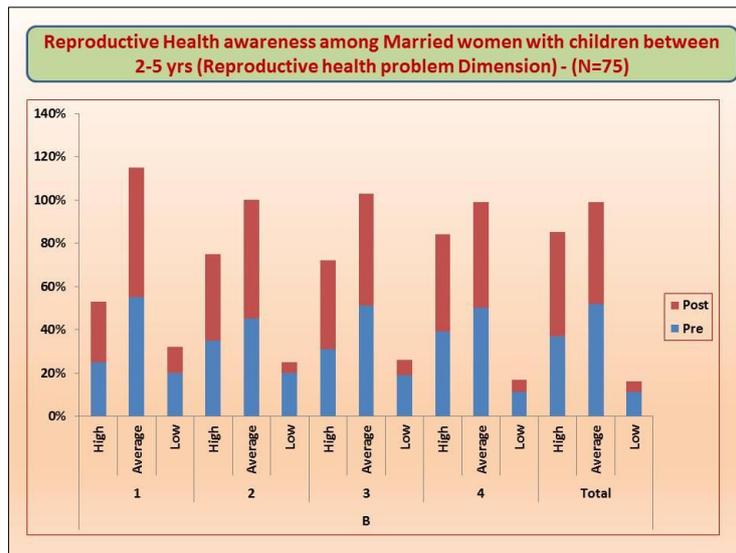
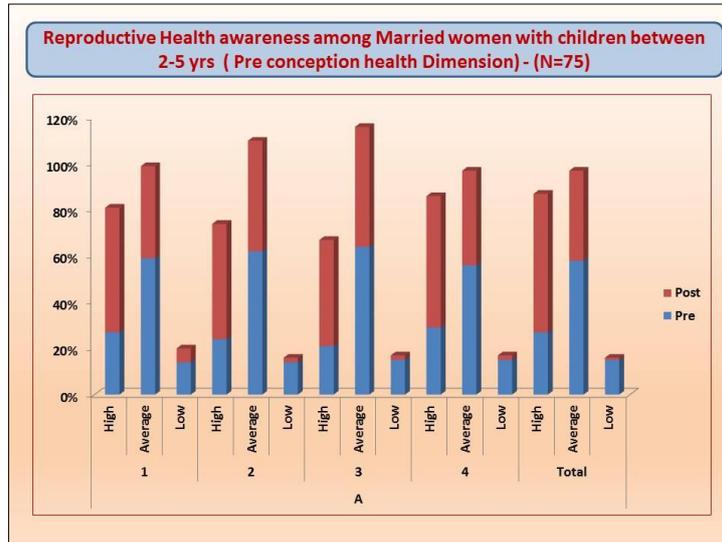
(53%) of the sample obtained High scores; 44% obtained Average scores and only 3% obtained Low scores.

With regard to Sexually transmitted diseases dimension, less than half (49%) of the sample obtained High scores; 44% obtained Average scores and only 7% obtained Low scores.

With regard to General dimension, more than half (56%) of the

sample obtained High scores; 40% obtained Average scores and only 4% obtained Low scores.

Reproductive Health knowledge scores of Rural mothers with children (between 2-5 years) – Dimension & category wise



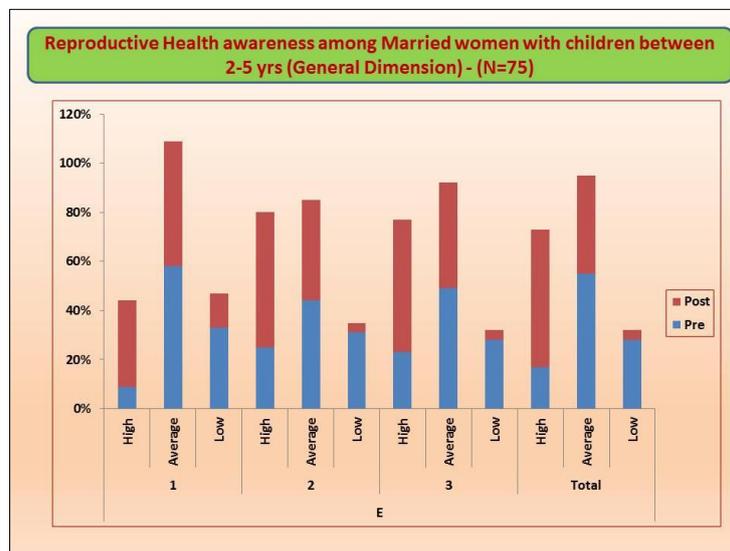
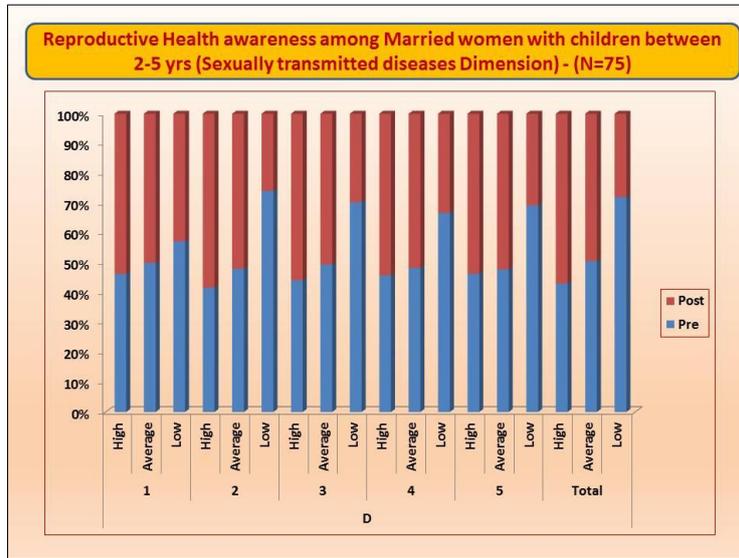


Table 7: Reproductive health Knowledge scores (Pre & Post) Rural mothers with children (between 2 – 5 yrs) N=75

Dimensions	Sub- Dimensions	Raw scores		Mean		SD		Mean differences (P1-P)	T value
		(P)	(P1)	(P)	(P1)	(P)	(P1)		
1. Pre-conception Health (includes 4 dimensions)	A (PP)	933	1058	12.44	14.11	3.30	3.48	1.67	4.39**
	B (PCH)	1035	1205	13.8	16.07	3.51	3.52	2.27	9.51**
	C (PP)	647	761	8.63	10.15	2.28	2.18	1.52	6.06**
	D (PB)	819	964	10.92	12.85	3.08	2.74	1.93	2.17**
	Total	3434	3988	45.79	53.17	11.17	10.37	7.38	5.01**
2. Reproductive health problems (includes 4 dimensions)	A (MP)	1192	1231	15.89	16.41	4.66	4.40	0.52	0.06NS
	B (MHP)	817	873	10.89	11.64	3.36	3.01	0.75	1.04**
	C (PR-MH)	552	594	7.36	7.92	2.11	2.08	0.56	0.03NS
	D (GP)	1728	1786	23.04	23.81	6.10	6.24	0.77	0.04NS
	Total	4289	4484	57.19	59.79	14.42	13.95	2.6	8.25**
3. Family planning (includes 3 dimensions)	A (FPM)	666	768	8.88	10.24	2.81	2.70	1.36	1.28**
	B (PFPM)	562	631	7.49	8.41	2.48	2.17	0.92	7.92**
	C (CP)	1120	1208	14.93	16.11	4.42	4.10	1.18	0.03NS
	Total	2348	2607	31.31	34.76	8.49	7.88	3.45	5.35**
4. Sexually transmitted diseases (includes 5 dimensions)	A (HIV/AIDS)	1038	1076	13.84	14.35	3.77	4.04	0.51	0.04NS
	B (RTI/STD)	1367	1453	18.22	19.37	4.54	4.55	1.15	3.61**
	C (T- HIV/AIDS)	1243	1361	16.57	18.15	5.05	4.95	1.58	9.94**
	D (PM- HIV/AIDS)	440	465	5.87	6.2	2.04	1.93	0.33	0.03NS
	E (PM - RTI/STD)	729	760	9.72	10.13	3.13	2.99	0.41	0.03NS
	Total	4817	5115	64.23	68.2	16.82	16.23	3.97	1.04**
5. General (includes 3 dimensions)	A (RHS)	1213	1373	16.17	18.31	4.88	5.56	2.14	2.02**
	B (M&LR)	1142	1420	15.23	18.93	5.09	4.83	3.7	2.46**
	C (RR)	1459	1779	19.45	23.72	6.79	6.34	4.27	2.37**
	Total	3814	4572	50.85	60.96	15.66	15.49	10.11	7.75**

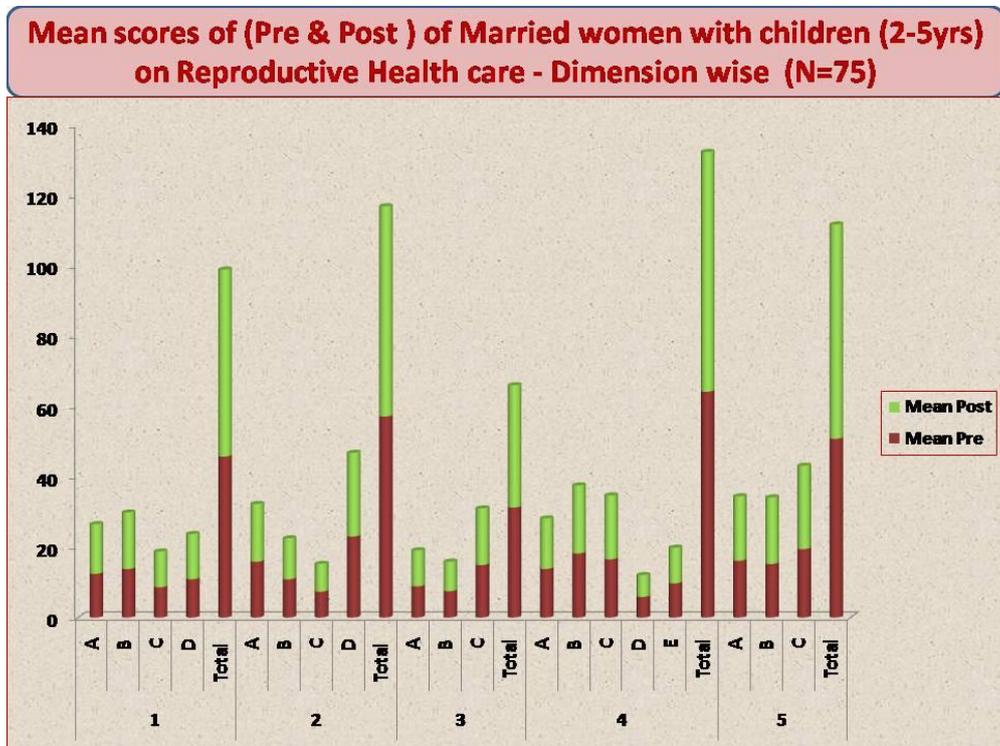
Note: ** at 1% level of significance

Abbreviations

1. Pre-conception Health	A:Preparation for Parenthood	B:Factors that Boost Preconception Health	C:Preparedness for pregnancy	D:Preconception Behaviours	-----
2. Reproductive health	A:Menstrual problems	B:Menstrual hygiene practices	C:Potential risks to health due to poor menstrual hygiene	D:Gynecological problems	-----
3. Family planning	A:Family Planning Methods	B:Purpose of following Family planning methods	C:Contraceptive related problems	-----	-----
4. STD	A:Awareness about HIV/AIDS & related problems	B:Awareness about RTI/STD related problems	C:Awareness about transmission of HIV / AIDS	D:Preventive methods for HIV/AIDS	E:Preventive methods for RTI/STD
5. General	A:Services Related to Reproductive Health	B:Awareness about marital laws & legal rights	C:Awareness about Reproductive rights	-----	-----

The above table presents the Pre & Posttest (Raw scores, Means, SD and T values) Scores of Married women (with children between 2-5 yrs) with regard to Sub-dimensions under Reproductive Health Care. The table shows the progressive increase in the total raw scores across pre-test to post-test, along with the increase in the mean differences, which shows the impact of intervention programme.

T values between the two means of pre-test and post-test was found to be highly significant, as the calculated values were found to be greater than the tabulated value. The results reflect the effectiveness of Intervention programmes on the Knowledge levels of Married women with reference to Reproductive Health.



Conclusion

Rural Indian women need accurate health education about Gynecologic and reproductive morbidity to reduce the stigma and embarrassment of RTIs. Health services should be improved and made more accessible so that women feel comfortable in seeking treatment and are not deterred by concerns over privacy and confidentiality. Women tend to consider many symptoms as normal, do not seek treatment until discomfort is quite high and so apparently remain infected for a long time.

In India, married women, lack basic knowledge about reproductive health and HIV. Gender inequalities affect their capacity to influence when, where and how sexual relations should form, rendering them vulnerable to coerced or unwanted sex, and placing them at high risk for adverse reproductive health outcomes. Hence Intervention is very much needed to promote reproductive health among married women.

References

1. Santow G. Social roles and physical health: The case of female disadvantage in poor countries, Social Science and Medicine. 1995; 40(2):147-61.
2. Santhya GK, Jejeeboy JS. Sexual and reproductive health of married adolescent girls. Economic and Political Weekly. 2003; 38(41):4370-76.
3. Singh KS, Prasad R, Verma BR, Pandey A. Psychosocial cultural and service factors affecting reproductive morbidity among rural women in Maharashtra. International Institute for Population Sciences, 1995, 1-26. Singh AJ. Mobile clinic approach to tackle reproductive health problem of women in north India. Bull PGI, 2004, 38-66-70.