CHAPTER – 8

CONCLUSION

Most of the studies relating to reproductive health are based on the concept that reproductive health is purely a biological phenomenon. On the other hand, a few studies which emphasized the non-biological factors related to reproductive health reveal that better reproductive health status is a product of biological, social, cultural, demographic and economic situations.

We have used a combination of structural-functional theory, neo conflict theory and radical feminist theory to help us to explain the rationale of the behaviour of our sample mothers belonging to three different religions and having different age structure, educational level and occupational and income status. All the actors in the system have been playing their roles according to normatively prescribed manner but under a radically changing value system. The changing value system in turn also changed the normative behaviour pattern of our actors which sometimes put them in anomic situations. We found that sometimes there were mismatches in roles, the change agents not pursuing their role as expected and the clients sticking to their traditional ways of behaviour, both of which were unacceptable under the new value system ((thanks to Habermas’s purposive rationality and communicative exchanges). In fact this has been responsible for the underachievement of the targets in the government’s reproductive health care programmes. Overarching all these events is the patriarchal system that
influences all the variables that contribute to the behavioural system and, in turn, the reproductive health care system.

In the present research, we have focused on the socio-cultural foundations of reproductive health behaviour of rural women in Kerala. We tried to find out the link between reproductive health and socio-cultural attributes. The present study analysed the socio-cultural aspects of reproductive health of a sample of women in the reproductive age group of 15 to 49 years.

The main objective of the study was to analyse the socio-cultural dimensions of reproductive health of women in rural Kerala. This has been broken down into several sub-sections for operationalisation of our concepts and variables for empirical application.

Thus, the specific objectives of the study are:

1. To identify the influence of socio-cultural factors in reproductive health
2. To assess the socio-cultural differentials in the reproductive health of mothers.
3. To examine the different socio-cultural behavior patterns in the field of reproductive health.
4. To identify the factors in the socio-cultural system responsible for the different forms of reproductive behavior.
5. To assess the extent of utilization of medical facilities in rural areas and the socio-cultural factors that influence it.
6. To find out the extent of reproductive health awareness regarding family planning techniques and their use and the factors influencing them.

Hypotheses

On the basis of the above objectives, we formulated three major hypotheses for testing and verification of the relationship between the two sets of variables. Actually, each hypothesis represents a family of hypotheses, for example, each item in the socio cultural system, like age, education, occupation, income and religion can be associated with items in the dependent variables, like type of disease, type of treatment, type of hospital, type of prenatal, natal and post natal problems and their treatment, attitude towards different types of diseases, family planning attitudes and behavior, etc. These are examined and their relationships established in the concerned chapters.

Our major hypotheses are:

1. Socio cultural factors have significant influence on problems of reproductive health and pattern of illness.

2. There is significant relationship between socio cultural background and behaviour relating to reproductive health care

3. There is significant relationship between socio cultural background and attitude and behavior towards family planning.

The study was conducted in three districts of Kerala (Kasaragod, Malappuram and Ernakulam). From these three districts the sample required for the study was taken which consisted of 300 respondents, 100 from each
district. A scientifically prepared and pre tested interview schedule was used for collecting the field data.

The socio cultural variables used in the study were current age, education, income, religion, age at marriage, type of delivery and place of delivery. On the basis of these variables analyses were done in chapters 5, 6 and 7. Chapter 5 dealt with the socio-cultural dimensions of reproductive health problems which included reproductive health problems and reproductive morbidity conditions. Chapter 6 dealt with socio-cultural dimensions of reproductive health care since reproductive health care is an integral part of reproductive health in the socio-cultural perspective. Chapter 7 dealt socio-cultural factors in acceptance of family planning methods. The present chapter summarises the major findings of the study and conclusions drawn from them. Scope for further research and limitations of the study are also mentioned.

The respondent’s social and cultural characteristics, the reproductive health problems they had experienced concerning their last childbirth and prevalence of different symptoms of reproductive morbidity are presented in Chapter 5. The socio-cultural differentials have shown much influence on the occurrence of reproductive health problems during pregnancy, delivery and after delivery. The influence of some of these factors on the treatment taken for the reproductive health problems related to childbirth has been described.
The hypothesis put forward in Chapter 5 is that “socio cultural factors have significant influence on problems of reproductive health and pattern of illness”.

Here, the researcher analysed the reproductive health problems and their socio-cultural determinants. Pregnancy related complications were found to be higher among the adolescents and among the higher age groups. This shows that the young age groups who were in their teens and the upper age group who were in the ‘risk’ category experience reproductive problems comparatively higher than those in the other age categories. Delivery complications were found to be more among the higher age groups and less among the younger age group respondents. This may be due to their failure in conducting periodic check-ups during pregnancy period, which can be due to their illiteracy. Post delivery complications were found to be high among youngsters and less among the middle age group of 30-34 years. This may be due to the fact that they are not approaching hospitals for their post natal check-ups which may be due to their illiteracy and ignorance.

Pregnancy, delivery and post-natal complications were higher among respondents having higher age at marriage. As age at marriage increases the pregnancy, delivery and post delivery complications also increases.

The relation between educational attainment and pregnancy related complications showed that complications during pregnancy were found to be higher among post-graduate respondents. Delivery complications were found
to be more among the graduate respondents and post delivery complications were found to be higher among illiterates. As the level of education increases their age at marriage also increases. In turn, this may delay marriage and pregnancy. Late pregnancy will lead to complications during pregnancy and during delivery. At the same time poor awareness, lack of nutritious food and proper rest and lack of concern over health might have contributed to the poor respondents having problems after delivery.

It was also noticed that pregnancy related complications were found to be higher among respondents who were business persons. Delivery and post delivery complications were found more among the respondents who are doing white collars jobs. Here a positive relation was found between the type of occupation and reproductive health problems. This may be due to the type and nature of occupation they are engaged in that might have led to their lack of involvement in getting timely medical check-ups and proper medication as the nature of their occupation demands more time and involvement of the respondents in their jobs. So they are not getting sufficient post-natal care and rest.

Complications from pregnancy, delivery and post delivery among different religious groups were found to be more among the Christians who have more pregnancy, delivery and post delivery complications, while it was lesser among Muslims. Here also a positive relation was found between the religious groups and reproductive health problems. This may be due to the
fact that Hindus and Muslims are depending more on Ayurvedic and traditional medicines that help to increase their physical health, by increasing the vitamins and proteins in their tissues as well as iron and folic acid in their blood, thereby giving them healthy and complication-free body condition. At the same time in the case of Christians who are depending more upon modern medicine are not giving due importance to the traditional mode of pregnancy care and inadequate antenatal care visits. This might have contributed to their complications at all levels of childbirth when compared to Hindus and Muslims.

Relation between the respondents’ income and reproductive health problems showed that pregnancy and post delivery complications were found to be more among the higher income group of Rs.5001-10,000 while delivery complications were found to be more among above Rs.10,000 income group. The reason may be that as an increase in the respondents’ income occurs they will have better educational level, which in turn, may lead to an increase in the age at marriage and better job placements.

With regard to the treatment taken during pregnancy, it was found that post graduates and graduates as well as higher income category respondents of above Rs.10,000 per month have taken frequent treatment during pregnancy. This again shows that their higher education and better economic level led to better awareness among respondents regarding health aspects. In the case of illiterates and semi-literates, due to lack of awareness, they are
neglecting such problems and they justify these problems as common to all pregnant women. Educational level increases income level and due to better awareness and better income they are giving serious concern to their pregnancy-related ailments. Here, the relationship between higher educational level and greater reproductive health awareness was found to be significant.

It was also noticed that irrespective of religious background all respondents had taken treatment for clinical conditions. However, in the case of common gynecological problems Christians were found to have undergone treatment more than other religious groups. It may be pointed out that the Christians are a well organized and strong knit religious group and they are having family and peer group networking through their Sunday church gatherings and through such relationships they are getting advises and awareness regarding the seriousness of the problems.

Gynecological problems were found to be higher among the high age group of 40-44 years. This may be due to the fact that the respondents in their higher age are facing menopausal disorders combined with lack of post natal care and rest.

Gynecological problems were found to be higher among 20-24 ages at marriage group. This may be due to the fact that since the respondents are not giving much concern to their reproductive health, they are ignoring the symptoms, even major ones. Respondents who were married in their teens
also reported gynecological problems but they also mentioned that they were unprepared and unprotected during their first sexual activity.

Gynecological problems were found to be higher among the Christian community. Hindus and Muslims are depending more on Ayurvedic and traditional medicines for improving their general health especially gynecological health and this begins from the time of their conception and lasts for more than one month after their delivery. But Christians are more depending upon modern allopathic medicine and they don’t take post-natal care properly. This shows the cultural variation has an influence on the gynecological problems of the respondents.

With regard to the relation between education and the gynecological problems it was found that the gynecological problems were more among graduate respondents. It was also noticed that 100 percent of the post graduate respondents have no gynecological problems at all. This may be due to the fact that because of their high level of education and better awareness they might have consulted the doctors at proper time.

Majority of the respondents have faced menstrual problems in one form or other, ranging from irregular periods to heavy bleeding. Apart from biological reasons several social and cultural factors are also responsible for this. The study also revealed that the menstrual problems have increased after marriage. This may be due to the fact that gender disparity and patriarchal structure of modern families might have forced women to look after the well-
being of the family by giving them best part of the food cooked and consuming only leftovers, which is scanty in nutritious value.

The relation between income and menstrual problems showed that as the family income increases menstrual problem after marriage decreases. This may be due to the fact that even though they are giving priority to the health of the family due to high economic level they can afford to take nutritious food and lower their workload by utilizing modern household gadgets.

The above findings show that our hypothesis that “socio cultural factors have significant influence on problems of reproductive health and pattern of illness” is acceptable.

The respondent’s socio-cultural dimensions of reproductive health care are presented in Chapter 6. Our hypothesis here is “there is significant relationship between socio cultural background and behaviour relating to reproductive health care”.

Just like the influence of biological factors on women’s reproductive health, the socio-cultural factors also play a great role in reproductive health care. For example, avoidance of pregnancy in adolescent period, creating more awareness about the possible health problems related to childbirth - care during pregnancy, delivery and post delivery period, etc. - have much influence on better reproductive health of mothers.

The researcher analysed the socio-cultural aspects of reproductive health care in connection with maternal reproductive health care indicators -
antenatal, natal and post natal. There is no doubt that better antenatal care will reduce maternal mortality and morbidity. The results pointed out that women from better socio-cultural background received better antenatal care (ANC). This is supported by many other studies reported earlier.

Relationship between religion and number of antenatal care showed that Hindu respondents had taken ANC visits more frequently when compared to other religious groups which showed their better awareness and positive attitude towards health care.

The number of antenatal care visits showed that monthly visits were higher among high income and highly educated groups, because the increased level of education increases their need for undertaking ANC visits, which in turn increased their positive attitude towards ANC visits. Thus, when income level is considered, high income group women were found to visit ANC more than the low income group women. That is women with formal education high income and living in better standards are likely to do more frequent visits. At the same time poor respondents made ANC visits rarely because of being unaware of the value of such visits and having to depend upon their husbands or other male members of the family to take them to the health care centres. They were also afraid that they will have to spend money on medicines and checkups if they consult with the doctors.

The relation between income and medical treatment availed during pregnancy showed that the respondents in the below Rs. 1000 income group
had availed medical treatment lesser than the higher income group of above Rs. 5001-10,000. This low intake of medical treatment on the part of lower income groups shows their lack of awareness regarding the necessity for such medication as well as their inability to pay the expenses of medical treatment. Religion-wise analysis showed that medical treatment availed during pregnancy was higher among Hindus and Muslims and lesser among Christians.

The analysis also brought to light the fact that more respondents having higher education had undergone medical check-ups during their pregnancy period than those who are having lower education.

This shows that the educated respondents were more concerned about their health than the illiterates and semi-literates. Apart from lack of education the other reasons for not going for medical check-ups as reported by the respondents were financial constraints and lack of support from husband, strict seclusion norms which prohibit woman from visiting health centre and lack of awareness regarding the importance of regular medical checkups.

The relationship between place of ANC and educational attainment showed that mother and child hospitals were preferred more by the educationally lower level respondents whereas private hospitals were preferred by all the graduate and post graduate respondents. This showed that educational attainment of the respondent is a determinant of their preference of place of ANC.
The relation between income and place of ANC showed that the highest income group respondents approached private hospitals for pregnancy care (90.3%) while the low income groups (56.4%) approached mother and child hospitals run by the state government for receiving ANC.

In the case of religion more Muslim women approached private hospitals than Hindus and Christians. The reasons for this seem to be that more Muslims in our sample were found to live close to private hospitals some of which were small ones. Hence they went to these hospitals.

The study showed that socio-economic and cultural variables like age, education, income and religion determine the attitude towards pregnancy check-ups, selection of ANC centers and treatment availed during pregnancy period. The relation between place of delivery and age showed that the proportion of delivery at home was highest for higher age group of above 45 years. The study also revealed that a vast majority of the respondents in the Muslim community had delivered their child at home. These women prefer to deliver at home for reasons such as support, familiarity, tradition as well as the feeling that birth is a normal phenomenon that does not need an institutional setting. The very young age group and the older age group who are considered to be the risk category preferred govt. hospitals because of their belief that government hospitals with experienced and highly qualified doctors and nurses can handle delivery complications better than private hospitals.
Our research findings showed that the respondents have higher age at marriage, higher education and respondents with husbands having higher occupational status and high income preferred institutional deliveries over home deliveries. Even in institutional deliveries they preferred private hospitals. This may be due to the fact that as the educational level increases their economic level also increases so that they can afford private hospitals for delivery. As the level of education increases preference for institutional delivery and delivery in private hospitals also increase.

In the matter of relation between place of delivery and type of delivery it was found that private hospitals had undertaken more caesarian type deliveries when compared to the govt. hospitals. The high proportion of caesarean deliveries in private hospitals could be either for their economic benefit or to avoid complications at the time of delivery. The reasons for respondents preferring private hospitals may be due to their better economic background or to suit their high social background and also because of a feeling that going to a private hospital is a status symbol.

The relation between the type of delivery and health problems related to childbirth showed that the vast majority of the respondents who had health problems during pregnancy had undergone caesarian type delivery. When the relation between gynecological morbidity type of delivery was analysed with socio cultural variables it was found that respondents who had undergone caesarian type deliveries were found to have more gynecological problems.
In the matter of health care after delivery the study found that there is a lack of knowledge and awareness among rural women about health issues and problems. Education may also play a major role in increasing the awareness about the reproductive health problems of rural women. Better educated women are more aware about reproductive health problems than non-educated women. Here the relationship between higher educational level and greater reproductive health care awareness is proved.

Thus our hypothesis that there is significant relationship between socio cultural background and behaviour relating to reproductive health care stands verified. Socio-cultural variables like age at marriage, education, occupation, religion and income do have positive relation with the place and type of delivery, health problems related to child birth, gynecological morbidity and health care at home after delivery.

In chapter 7 the socio cultural factors in acceptance of family planning methods are examined. The relevant hypothesis tested in this chapter is this:

“There is significant relationship between socio cultural background and attitude and behavior towards family planning”.

The relation between age and awareness about reproductive health problems consequent on the use of contraceptives showed that majority of the respondents in the age group of 20-24 has awareness about contraceptive methods as possible causes of reproductive health problems.
The respondent’s age and awareness about use of family planning methods and related reproductive health problems showed that respondents having high age at marriage were found to have more awareness than their counterparts with lower age at marriage. Education also plays a major role in increasing the awareness about the reproductive health problems in the use of family planning methods in the case of rural women. Educated women are more aware about family planning-related reproductive health problems than non-educated women.

It was also noticed that respondents having high income and Christian respondents were more aware about their reproductive health problems related to use of contraception than the lower income groups and other religious groups. This may be due to the cultural and economic barriers that have prevented them from acquiring awareness either through education or through health workers.

The analysis on the use of contraception for spacing showed that the use of contraception was found more among respondents in the middle age group of 25-29, those having higher age at marriage of above 25 years and also those in the higher educational category. This shows that as education increases use of contraception also increases. Better knowledge and awareness enhance and encourage the respondents’ use of contraception.

The relation between income and use of contraception for spacing showed that the prevalence rate of contraceptive use is lower among the low
income group and higher among high income group. Here we found that as income level increases the contraceptive use also increases. As the level of income increased, the awareness about contraceptive measures also increased because, as the income increased, women were able to get better educational facilities and better awareness through the modern communication media and technologies. The prevalence rate in the use of contraception is also found to be low among Muslim respondents. This may be due to the religious restrictions on the use of contraception method to control fertility.

The relation between age and the type of contraceptive method used to prevent pregnancy also showed that vast majority of the respondents were using either temporary or permanent methods of contraception for birth control. Permanent method of birth control was found to be high among the respondents in the higher age at marriage of 20-24 years and having higher secondary level of education.

The relation between education of husband and the type of contraception used showed that a vast majority of the respondents having husbands with higher secondary level education preferred permanent type of contraception.

When the occupation and the type of contraception was cross tabulated it was found that irrespective of publicity and awareness through mass media and PHC’s for promoting condom and IUDS, majority of the respondents, irrespective of occupation, opted for permanent solution like PPS for
controlling their fertility. This showed their preferential attitude towards PPS which was expressed through adopting small family norm.

The relation between religion and type of contraception used showed that among the major religious groups, the percentage of PPS is highest among Christians, followed by Hindus while among the Muslims the percentage is very low. This shows the cultural differences in the attitude towards fertility control. It can be due to their early marriage and lower educational attainment lower preference given to a permanent solution for their fertility problems or that their husbands were against the use of permanent method.

The relation between income and the type of contraceptive method used to prevent pregnancy showed that higher income group had used PPS to prevent pregnancy than lower income group. As the level of the income increases the knowledge about contraceptive measures also increases.

Doctors were the main source of motivation for using contraceptive method for respondents having high education and high income. Hindus were found to have Doctors as the main source of inspiration for using contraceptive method. This shows the differential approachability of respondents to health care givers especially hospitals and doctors.

With regard to the awareness and utilization of family planning techniques it was found that socio-cultural variables like current age, age at marriage, education, occupation, religion and income have much influence on
reproductive health awareness, awareness on family planning, use of specific method of contraception for both spacing and for permanent pregnancy control. Doctors were found to be the major motivator for these behaviour and action. In the light of these positive relationships our third hypothesis that there is significant relationship between socio cultural background and attitude and behavior towards family planning stands proved.

These findings lead us to conclude that socio-cultural factors have direct effect on reproductive health of mothers. Rather than being a medical problem, reproductive health has to be considered as a combination of several underlying factors in which socio-cultural characteristics play a major role.

**Suggestions**

1. Our study shows that those who make plans and programmes in the field of reproductive health have not fully appreciated the tremendous importance that socio cultural factors play in the efficient execution of these plans and programmes. These factors affect all aspects of reproductive health behaviour – perception of morbidity, care and treatment taken, attitude towards different elements of reproductive health, measures taken by the Government to improve reproductive health and response of the target clients. It is high time that decision makers working on improving women’s reproductive health pay serious attention to these matters to get full results from their programmes.
2. A major thrust in health programmes for women, especially on fertility control is family planning. In spite of the fact that vasectomy is comparatively simple and could be performed within a short time and with small cost compared to PPS which takes longer time both for surgery and healing and costlier and more painful and in spite of the further fact that government has been using all its propaganda machine for promoting vasectomy, actual performance shows that vasectomy is very much on the decline and PPS has taken the lion’s share of the permanent method. Government should make a socio cultural study of this trend and find out whether the trend could be reversed.

3. There is a trend in the use of health care services, viz., even for the poor to go for private sector health service than for government sector services even when the former is very costly and the latter is free to the poor. Government should find out why health service seekers behave the way they do and how government service in this sector could be made user friendly.

4. The issue of reproductive morbidity among women is not addressed adequately. Steps should be taken to identify the problems and commit more medical facilities for the same. Women should be made more aware of the health consequences of reproductive morbidity conditions since most of the women still continue to treat it as ‘natural’.
5. Reproductive health care establishments in government hospitals are still dominated by male doctors and many women, especially from rural areas and Muslim communities hesitate to go to them for treatment related to their reproductive issues. There should be more female doctors in these establishments.

6. There is a comparative neglect of adolescent reproductive health. In spite of the minimum age of 18 years fixed by law for marriage of girls, our study found that many girls get married and become pregnant even before they reach the age of 18. This has several adverse implications all of which affect their reproductive health, some of them for their entire life span. Appropriate steps should be taken to prevent this trend.

7. In the context of Kerala, media can play a very meaningful role in this area (sex education) by providing basic information on sex. It should be done without sensationalizing the issues.

Limitations of the study

1. A major limitation in all studies about sexuality is the validity and reliability of the information collected through face to face interviews. This is more so when the subject is a Muslim woman in her late teens and early adulthood. In spite of all precautions taken by the researcher in establishing rapport, she found that some of the information especially about sex life and certain gynaecological diseases were not entirely reliable. We tried to make the responses as sincere and truthful
as possible by asking apparently harmless side questions and by interpolating form their answer. The only saving grace was that the researcher was a woman having two children and could establish some common wavelength in the conversation with her respondents and could happily answer many of their genuine inquisitive counter-questions on many personal sex and reproductive issues.

2. Though our study points to the underplay of the socio cultural dimension by the planners and programmers in the implementation of reproductive health care reforms in India this matter has not been pursued further in the present study as this has not been its focus. However, a separate study on this aspect will be desirable as it will throw much useful light on the causes of under-achievement of the programme.