Chapter 9: Findings and Analysis of data on Respondents who are Adults (not adolescents) and Admitted for Causes other Pregnancy (Category C)

9.1: Socio Economic Profile:

From Chapter 3 we know that there are 62 adult (non adolescent ) women who have been admitted in the Obstetrics and Gynaecology Ward of the hospital for cases other than pregnancy during my field study. Out of them 48 are married and have husbands, 3 widows and 11 of them are unmarried.

9.1.1: Age of Respondents: The present age of the respondents have been described in the following figure

![Age of Respondents](image)

**Figure 34. Source: Computed from Survey Data**

The figure shows that 12 women are between 20-29 years of age, 11 between 30-39, 19 between 40-49, 17 between 50-59 and 3 persons between 60-69. Maximum number of women fall in the category of 30-39 that is the middle age where they face lots of gynaecological issues and they lead better lives in future if proper treatment is done. One interesting point is to be noted here. All unmarried women falls in the age group of 40-60 years. It means that all the
women who belong to the age group of 20-50 are all married (including widow). The unmarried women may feel shy or embarrassed to visit gynaecologist in the reproductive years whereas the married women do not have such inhibitions. That is why the gynaecological issues of unmarried adult women are not addressed in due time. This factor cannot be generalized but can further be analyzed with the help of case studies.

9.1.2: Religion: The religious background of the women can be explained with the help of Figure 29. It shows that 32 women (52%) are Hindus and 30 (48%) are Muslims. Among the unmarried 11 women, 8 of them are Hindus. If we compare the data with the pregnant women we can say that the number of Hindu unmarried women and Hindu women with gynaecological problems other than pregnancy are more than their Muslim counterparts. The reasons may be awareness, perception, social taboos, education, lifestyle etc but it can be further understood with the help of case studies since all the women have unique problems. The qualitative analysis with the help of case studies always provides complementary analytical structure to the quantitative analysis.

![Pie chart showing religious distribution of women, with 52% Hindu and 48% Muslim.]

Fig. 35. Source Computed from Survey Data
9.1.3; Marital Age: From Figure 20 the age of marriage of the respondents can be depicted. Most of the women in the sample were married very early. Out of the 48 married women 6 women were married below 18 years (2 Hindus, 4 Muslims). This is an evidence of child marriage. Maximum number of women (32) were married in the age group of 18-20 years. 6 of them were married between 21-23, 3 of them between 24-26, 2 between 27-29 and 2 after 30 years. It can be also stated that among the 6 women who were married below 6 years of age, 2 of them are Hindus, those who were married between 18-20 years of age, 15 of were Hindus and 17 were Muslims, those who were married between 21-23 years of age, 3 of them are Hindus and 3 are Muslims, those who were married between 24-26 years of age, 2 are Hindus and 1 is Muslim, those who were married between 27-29 of age, 1 is Hindu and 1 is Muslim and those who were married above the age of 30 and above 1 is Hindu and 1 is Muslim. The data does not reveal any significant conclusion with respect to the religious status of respondents but it can be very well understood that early marriage is the general practice in both the religions.

Figure 36. Source Computed from Survey Data
9.1.4. **Age at First Child Birth:** Out of the 48 married women 47 have children. The figure below presents a picture of their age when their first child was born. It has been found that the women became mothers at a very young age and most of them do not practice contraceptive methods. 6 women have children by 19 years, 29 women have their first child birth at 20-25 years age, 12 women have their first children between 26-31 years. There is no significant difference in the data between Hindu and Muslim women.

![Age at First Child Birth](figure37.png)

**Figure 37. Age at First Child Birth**

9.1.5. **Educational Status:** The educational status of respondents can be understood from Figure 32. 11 women cannot read and write, 28 women have studied till 8th class, 7 of them have studied till 9th class, 12 of them have studied till 10th class and 4 of them are graduates. Among the women who have studied till 10th class, 4 of them are Muslims and 3 Hindus. Among the women who have attended 10th class, 8 women are Hindu and 4 Muslim women.
9.1.6. Occupation: The occupational status of the respondents can be explained from Figure 23. Out of 62 women, 22 are homemakers, 8 do embroidery works, 10 domestic help and attendants, 5 agricultural workers, 2 of them are vendors, 6 work in micro credit organizations, 7 provide tuitions and 2 of them do Government jobs. It has been found that the 2 respondents doing Government jobs are unmarried. The women who are early married could not pursue higher studies and some of them are employed in unskilled or semiskilled jobs. From the JMP analysis and case studies, the relationship between their health status and occupational status can be explained.
9.2. Mental Health:

The mental health status of the women is quite poor. Depressions, sense of insecurity are very common features in respect of the unmarried women. The condition of the unmarried women is worse who are financially dependent on other family members. Many of the respondents are unaware and do not have proper perception regarding their mental health. 14 women said they didn’t know whether they had any mental illness or not. Out of the 14 women 7 are Muslims and 8 are Hindus. So there is no observed significant difference between the two groups. 12 of them said they had no problems. Out of the 12 women 8 are Muslims and 4 Hindus. It was concluded from the data that the Muslim women are less aware of their mental health in comparison to the Hindus. Although it was found in their oral narratives that they suffer from silent depression or they did not consider severe depression under the category of mental disorder. The reported cases of mental illness were anxiety (7 respondents), depression and fear (6), hypertension (11), mental torture (5) and acute depression (7). The number of Muslim women suffering from various mental illness are anxiety (3), depression and fear (2),
hypertension (6), mental torture (1) and acute depression (3). The number of Hindu and Muslim women in this case is quite similar Muslim (30) and Hindu (32). Within the given data it can be said that the problems faced by them are similar and Hindu women are a little more aware than Muslim women. The individual case studies can provide a better picture of their mental health situation.

![Mental Health](image)

**Fig. 40. Source: Computed from Survey Data**

**9.3: Findings Regarding Their Health Status:** It can be noticed that the primary health rights of non–mothers (both adolescent and non-adolescent) are violated more in comparison to pregnant women. Most of the complications of pregnant women are part of the process in pregnancy. The non adolescent or adult women (62) have been admitted to the hospital for treating several gynaecological issues. Majority of these issues are affecting their primary right to health. If they have not neglected their primary health, their health conditions could have improved. There are some issues like uterine fibroids and ovarian cysts which are not related to negligence. These can happen during any point of time and could not be prevented earlier. Thus most of the women who have been operated for ovarian cysts(7) and fibroids (21) have...
ensured their primary rights. The main diseases found are Endometriosis 2 cases, Cancer 4 cases (adenocarcinoma /female genital cancer, trophoblastic disease and tumour, two cervical cancer), Endometrial Hyperplasia 1, Endometriosis 3, UTI 4 cases, genital herpes 2 cases, AIDS 1. These diseases are preventable to many extent. Women’s negligence and lack of power in decision making and awareness prevent them from exercising their right to health. No of women who do not make their own decisions are 47. Hysterectomy is quite common (12), contraceptive use is moderate (19), primary rights have been neglected (38) and health awareness and perception is low (26).

9.4: Analysis: Negligence and lack of decision making are very important factors which affect the primary health rights of women. The women cannot exercise their freedom of choice and are not aware of their rights including right to health. These attributes are never questioned in policies including the MDGs. In some cases the women who have undergone different kinds of surgery can have other problems too like cardiac disease and pulmonary disease. These diseases can be prevented earlier in some cases, and if proper care is taken these diseases can be managed and controlled. Decision making problem and lack of awareness are also contributing factors for their ill health. It is found that the women who are unmarried and have economic independence are more empowered compared to the women who are married and have low economic status. The unmarried women who earn their own living can make their own decisions about their sexual and gynecological health compared to the dependent unmarried women. However both married and married respondents are found to be very embarrassed when they are asked about gynaecological and sexual diseases. Most of them are very shameful to have these diseases whether they are self sufficient or not. But overall the general trend is that the economically and socially empowered women have a better health condition compared to the women who are less empowered. (Bharat & Aggleton; Wang & Pillai) Thus we can conclude that the primary rights of those women have been violated who
9.5. Detailed Analysis:

A. Correlation of “Primary Rights Neglected” to input variables

A1. Description of Input variables:

– Age, Marital Status, Age at Marriage, Age at FCB, Occupation Education, Mental Health, Religion, Health Awareness and Perception, Decision Making Problem, Contraceptive Practice.

Top 3 input variables correlated to “Primary Rights Neglected”:

– Decision Making Problem (SS ~ 6.3)

– Age at FCB (SS ~ 2.8)

– Education (SS ~ 0.6)

Overall R Square of 3 Splits is medium at 0.64.

Split sequence:

1. Decision Making Problem (SS ~ 6.3)

2. Age at FCB (SS ~ 2.8)

3. Education (SS ~ 0.6)
A2. Analysis of the Figures:

Fig. 41. Partition for Primary Rights Neglected

![Partition for Primary Rights Neglected](image)

Source: Computed from Survey Data

Fig. 42. Split History:

![Split History](image)
Source: Computed from Survey Data

Fig. 43. Column Contributions:

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<th>Term</th>
<th>Number of Splits</th>
<th>S$^*$</th>
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<tr>
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</tr>
<tr>
<td>Age at Marriage</td>
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<td>Occupation</td>
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<tr>
<td>Mental Health</td>
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<tr>
<td>Religion</td>
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</tr>
<tr>
<td>Health Awareness and Perception</td>
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</tr>
<tr>
<td>Contraceptive Practice</td>
<td>0</td>
<td>0.0000000</td>
</tr>
</tbody>
</table>

Fig. 44. Split details:
A3. Explanation: From the above split history, column contributions, partition analysis and split details it can well be understood that decision making (SS~6.3) is the most important input variable which is influencing primary health rights of women. From the study it can be found that women who can make their own decisions enjoy a better health status compared to the women who cannot make independent decisions. Moreover, it is found that out of 22 women who stay at home, 2 are unmarried and rest are married. The number of working unmarried women are 9 and number of married working women is 28 and most of them can take independent decisions. But there is also other dimension. The decision making situation sometimes depend on their marital status. Since they are not married and do not have children they enjoy a low social status compared to the women who are married and have children.

A4. Discussion: From the literature also we can see that women’s subordinate status in household affect their decision making ability (Hartmann,1998). There exists a growing inequality in health status (Crenshaw & Ameen, 1993). Thus we found that decision making role of women is a very important determinant of women’s health. If we do the perception analysis it can be found that women who can make their own decisions generally have better perception. Women can make independent choices regarding their health care and thus they have a good health status. Since the study is based on a feminist perspective this role is very crucial as effective decision making leads to women empowerment.

A5. Explanation: The second and third most important variables are age at first child birth (SS~ 2.8) and education (SS ~0.6) of respondents. Age at first child birth also have an impact on the health status of women. Very early child bearing brings with it increasedrisks
for both mothers and their infants (MDG, 2014). The decision to have children has physical and emotional implications for women. Indifference to the emotional and social aspects of fertility has contributed to the violation of women’s rights (Hartmann, 1998). In this study there are 47 women who have children and 6 women have their first child birth by nineteen years.

A6. Discussion: It is found that women who are married early become pregnant also at an early age. They could not exert their reproductive rights and decision making. This have a huge impact on their sexual and gynaecological health. Women should have a control on their own bodies. They should decide when to have children. But this factor is missing in most of the case studies. The third factor is education. Women lag behind men in terms of social and economic power (Wang & Pillai, 2001). So their educational status is lower compared to their male counterparts. Studies also show that women have a subordinate position in the households which means that men typically have greater wealth, better jobs, more education, greater political clout and fewer restrictions on behaviour (Sen, 1994, 1997). In this particular study we find that the women who have attended higher studies have a better perception and understanding regarding their health status. They have better awareness. If they can decide freely about their health issues their right to health is ensured. In some cases where they cannot make their own decisions inspite of having better awareness and perception. There we found that their right to health is not ensured. Here the third most influencing factor is education which suggests that women who are more educated have a better perception and understanding of their health conditions and thus their right to health is ensured compared to the women who are not well educated.

B. Correlation of “Health Awareness and Perception” to input variables
B1. Description of Input Variables:

Input variables:

– Age, Marital Status, Age at Marriage, Age at FCB, Occupation Education, Mental Health, Religion, Primary Rights Neglected, Decision Making Problem, Contraceptive Practice.

Top 3 input variables correlated to “Health Awareness and Perception”:

– Age at Marriage (SS ~ 4.2)
– Mental Health (SS ~ 3.8)
– Religion (SS ~ 1.2)

Overall RSquare of 3 Splits is medium at 0.60.

Split sequence:

1. Age at Marriage (SS ~ 4.2)
2. Mental Health (SS ~ 3.8)
3. Religion (SS ~ 1.2)

B2. Analysis of Figures:

Fig. 45. Partition for Health Awareness and Perception:
**Fig. 46. Split History**

Source: Computed from Survey Data
Fig. 47: Column Contributions:

```
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<th>SS</th>
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</thead>
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<td>Religion</td>
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<tr>
<td>Marital Status</td>
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<tr>
<td>Age at FCB</td>
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<td>0.0000000</td>
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<td>Occupation</td>
<td>0</td>
<td>0.0000000</td>
</tr>
<tr>
<td>Education</td>
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</tr>
<tr>
<td>Decision Making Problem</td>
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<tr>
<td>Contraceptive Practice</td>
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</tr>
<tr>
<td>Primary Rights Neglected</td>
<td>0</td>
<td>0.0000000</td>
</tr>
</tbody>
</table>
```

Source: Computed from Survey Data

Fig. 48. Split Details
**Source: Computed from Survey Data**

**B3. Explanation:** From the above split history, column contributions, partition analysis and split details it can well be understood that age at marriage (SS~4.2) is the most important input variable which is influencing health awareness and perception of women. The second and third most important variables are mental health (SS~3.8) and religion (SS 1.2) of respondents. Most of the respondents are married very early. 6 women are married under 18 years and 32 women are married between 18-20 years.

**B4. Discussion:** It has been found that the women who are married early do not have better perception of health compared to the women who are married later. It means that early marriage hampers their education and their perception regarding health. Their independent economic status is also very poor. They have children at very young age and their time and energy is consumed nurturing and rearing their children. Age at first child birth also have an...
impact on the health status of women. Very early child bearing brings with it heightened risks for both mothers and their infants (MDG, 2014). They do not have a broader outlook and does not have a peer group. So their awareness and perception is very poor.

**B5. Explanation:** The second factor which affects health awareness and perception is mental health. It means that the women whose perception is poor have a poor mental health status. Women have special emotional needs which are different from men. Health includes both physical and mental health. It has been found that the Hindu population has better awareness, perception compared to Muslim population. However the sample size is very small and the value of SS is 1.2 which is negligible to conclude anything based on their religious status.

**B6. Discussion:** (Whitty, 1996) posits that women’s right to the enjoyment of the highest standard of health must be secured throughout the whole life cycle in equality with men. Women experience differently than men with regard to different health conditions both physically and emotionally. It has been found that most the women are not aware of their mental health. They do not consider it to be a health issue. Religion is the third factor which implies that women belonging to a particular religion have better awareness and perception than others. Women’s health is an outcome of social existence. (Soman, 2005). Their existence depends on society, culture, economic and political factors. The extent of control over women and their reproductive choices is determined by social structural factors (Ramirez & Mc. Eneaney, 1997).

**C. Conclusion:** From the perception analysis we can also conclude that the decision making factor is the most important factor influencing women’s health. All other factors like awareness and perception, economic independence and education are important no doubt but the most important criteria for determining women’s health status is decision making. It has
been found that women who have good perception and awareness are not having good health status since their decision making status is very low. Women’s subordinate position in household affect their decision making and nutritional status which is reflected in their health status.

The final conclusion can be drawn by highlighting the power relationship in our society and patriarchy which play an important role determining the health status of women. In our society women’s sexual and reproductive health has been made equivalent to her pregnancy and motherhood. Does it mean that only the women who are pregnant have sexual and reproductive problems? Women can be married adolescents, unmarried adolescents and non–mothers who have sexual and reproductive health rights. They have different sexually transmitted diseases, unintended pregnancies, abortions and other consequences affecting the future of them and their communities. But their right to sexual and reproductive health are mostly ignored. Studies should be based on feminist perspectives to understand the gender discrimination and inequality of health status between men and women. There is a "politics of female sexuality” in the issues of adolescent health which should be addressed separately. Social constructionist approach can be used here which involves a move away from questions of difference and toward the "politics of female sexuality". Social constructionist research is typified by investigations of the cultural and personal meanings of girls' race and ethnicity, socioeconomic status, and sexual orientation in understanding their sexuality"(Snitow, Stansell, & Thompson, 1983). The dominant cultural conceptions of female sexuality as passive, devoid of desire and intelligence, and subordinate to male needs and desires make it difficult for women to negotiate safe sex and leave them with very little options. (Holland, Ramazanoglu, Scott, Sharpe, & Thomson, 1992; Thomson & Holland, 1994). Their right to health is violated from the very beginning from female foeticide to forceful sex and reproduction.
End Notes:

1 The data of the three categories of respondents have been analysed and findings has been derived.

Data analysis of the three categories of respondents has been done using Microsoft Excel and JMP statistical software. Tables, graphs and partition scattered diagrams are developed from the analysis.

2 Here spontaneous abortion and forceful abortion have also been included. It means that some of the women who are pregnant for second or third time may have spontaneous abortion or forceful abortion earlier.

3 The details of the occupation of husbands are not studied or analysed. Their occupations mostly include factory workers, rickshaw puller, auto driver, vendor, tea stall worker, care taker, embroidery worker.

4 It may be mentioned that the results present from the religion category of all the respondents do not tend to generalize anything within this small data. It does not have any bias over any religion or it is not intended to hurt anybody’s religious sentiments. The observations have been made in course of the field survey and the figures have been derived. More light can be drawn from the case studies. But they are unique and independent in nature and do not generalize or make any conclusions based on their religious status.

5 The perception level regarding mental health is poor in both the groups. It is only after asking several questions we can understand their level of mental distress. An adolescent woman (both married and unmarried) may give rely that he does not have any mental health problem or she does not know about mental health issues. But after asking questions it can be understood that she suffers from depression which she never realized consciously.