CHAPTER 3: Methodology

3.1: Area Selection:

To understand the above issues in an in-depth manner data was collected from the patients admitted in the National Medical College, Kolkata, West Bengal in 2010-11. The National Medical College is located in central part of Kolkata near Park Circus. This particular medical college has been selected keeping the following few factors in mind:

- It is an authorized and reputed Government hospital of Kolkata
- It is located at the heart of the city. People from different corners of Kolkata as well as outskirts come to the hospital
- Varied nature of communities come for treatment.
- People from different income groups prefer this hospital

3.1.1 Location of the Area:

Map 1. Kolkata, West Bengal (Source Google Map)
Map  2. National Medical College, Kolkata (Source Google Map)

Table 1: Distribution of cases in Two Years:

<table>
<thead>
<tr>
<th>Year</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2010</td>
<td>150 cases</td>
</tr>
<tr>
<td>Year 2011</td>
<td>158 Cases</td>
</tr>
</tbody>
</table>

Source: Primary Survey Data

3.2: Description of the Table: From the table it can be seen that in year 2010, 150 interviews were taken and 158 interviews were taken in year 2011. Therefore altogether 308 cases were studied in this time period.

3.3: Research Method: Both qualitative and quantitative methods have been followed in the research. The reasons for using both the methods is explained below.

3.3.1: Qualitative Method: Varied nature of data has been collected since people from different social, religious and economic backgrounds come to the hospital for better treatment.
Therefore variations in healthcare practices and behaviours are noticed in the women who come for treatment. The age group of the respondents, social and economic status and reasons for admission in the hospital are also different. There are three categories of respondents and the nature and degree of problems are different in each category. Individual experiences of the respondent are different. Their perceptions and actions are different. There was so much variety and uniqueness in each of the cases. So there was a need of qualitative analysis since the respondents has unique problems and health status which is different from one another. For effective and flawless primary data collection, survey, interview and case study methods were extensively used. These methods have been used to extract the most relevant information and analysing the data. Two rounds of interview have been conducted for data collection in 2010 and 2011. In order to use the survey method efficiently a questionnaire was developed. A semi structured questionnaire was used for interviewing the respondents. Informed oral consent was received from the study participants. The interviews were both focused and personal. Case studies were developed on the basis of interviewing the respondents. Both open ended and close ended questions were asked to the respondents. A perception analysis has been done to understand the women’s perception regarding health care, health and other human rights, contraception, spacing, sexual health and reproductive health. The voices and perceptions of the women respondents have been given importance in the perception analysis. Their individual experience and conditions are accounted for in this analysis.

3.4: Data Description: Total number of respondents for the purpose of thesis is 308. Out of them 249 are non-adolescent women and 59 are adolescent girls. Out of this non-adolescent group of women, 187 women were admitted with pregnancy cases and 62 women were admitted with gynaecological issues other than pregnancy. Out of this non adolescent women with gynaecological problems, 48 of them are married, 11 of them are unmarried and 3 of them are widow. Out of the 59 adolescent girls, 47 are married and 12 are unmarried.
Fig. 1. Respondents Profile

Respondents Profile N=308

- Pregnancy Cases (non-adolescent) - 61%
- Gynecological Problems (non-adolescent) - 19%
- Adolescent Girls - 20%

Fig 1. shows that out of the total 308 respondents, 61% (non-adolescents) are admitted for pregnancy related cases, 19% are adolescents admitted for pregnancy and other case and 20% are non-adolescents admitted for gynaecological issues other than pregnancy.

Fig.2. Distribution of Married and Unmarried Adolescent Girls:

Adolescent Girls

- Adolescent girls Married - 20%
- Adolescent girls Unmarried - 80%
Fig 2 shows that out of 59 adolescent girls 80% are adolescent married girls and 20% are unmarried adolescent girls

**Fig 3. Percentage of Non Adolescent Women with Gynaecological Problems**

<table>
<thead>
<tr>
<th>Women with Gynecological Problems (non-adolescent)</th>
<th>Married</th>
<th>Unmarried</th>
<th>Widow</th>
</tr>
</thead>
<tbody>
<tr>
<td>77%</td>
<td></td>
<td></td>
<td>5%</td>
</tr>
<tr>
<td>18%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fig 3 shows that out the 62 non-adolescent women, 77% are married, 5% are widow and 18% are unmarried

**3.5: Perspective:** The analysis of the case studies has been done from a feminist perspective to understand the issue of adolescent and reproductive health of women. My research focuses on the ignorance of women’s life situation and of male dominance which is the fundamental part of feminist research (Flick, 2009). A psychosocial approach has been made which implies that women’s biology has been looked through a psychosocial lens. This is an important part of feminist methodology which breaks the androgyny and focus on feminine attributes that are psychosocial in nature. Quantitative research often ignores the voices of women, turns them into objects, and they are often studied in a value-neutral way rather than researched specifically on women. Qualitative research allows women’s voices to be heard and goals realized (Mies, 1983). In my study the voices and perceptions of the women respondents have been taken into consideration. The cultural feminist theory has been applied here which deals with the “female essence” and “female nature” that is generally undervalued.
Here the women’s nature, their opinions and perceptions have been given due importance. Here the female qualities and nature have been regarded in an affirmative sense which is a source of personal strength and pride and a fount of public generation (Donavan, 1989).

3.6: Use of Mixed Method i.e. both qualitative and quantitative: However, only qualitative analysis is not sufficient for deriving the required results from the primary data. The questionnaire was structured to empirically achieve the study aim along with the qualitative analysis. The sample size of respondents is 308 which can be quantitatively analysed using statistical methods and software. Three category of respondents were there. The individual analysis can be made by using quantitative techniques. The derived tables and figures can give important findings. Some observations can be made and some trends can be developed if we quantify the data after analysis. Correlations can be measured to understand the relationships between different variables. Partition analysis can be developed to understand which variable is most important determining a women health status for example education, occupation, awareness and perception or decision making ability. The relationships between two variables is very important to understand the health status of respondents and the most influential variables can be derived from the perception analysis. Different health determinants can also be studied after careful analysis. The present research is based on both qualitative and quantitative research methods. This implies that a mixed method has been applied in this research for obtaining a holistic picture of the situation. Both qualitative and quantitative methods have been used to prove complete validity and reliability of the results Quantitative data analysis has been done by using JMP software for developing a partition analysis and finding the relationships between variables and how they are influencing the health status of women. Further analysis and interpretations have been made by using simple statistical tools from Windows Excel. Figures and diagrams are derived by using Excel which gives useful data for data analysis.
The secondary data needed were sourced from journal articles, reports, internet and other relevant publications. The different Human Development reports and MDG reports have been analyzed for this purpose.

Note:

The adolescent age group is between 13 to 19 years as mentioned by the World Health Organisation (WHO). Here the respondent’s present age is considered for determining her adolescent and non-adolescent status. For example, the respondent who is 21 years now is non-adolescent but she may be married or get pregnant when she was adolescent.

Pregnancy cases include cases of abortion and other pregnancy related complications like removal of ectopic pregnancy etc.

Spacing between two children has been assumed to be two years. If the spacing is less than two years it has been considered as low spacing.

All the pregnant women has at least 3 ante natal visits in the studied hospital or any other health centre]