Chapter 1
INTRODUCTION

Women constitute around half of the population and play a distinct role in the development of our nation. As mother she shapes the personality and character of her children and thereby the character of her nation. As housewife she maintains productivity of the human capital and her household through proper home management. Apart from this, a woman herself represents a unit of human capital and is therefore capable of contributing to the economy of nation. Thus, unless women are mobilized towards contributing to the national development and growth, the nation is only half way towards development. It is the fact that women can not contribute meaningfully in the process of development, until their own development is taken care of (Sandhyavani, 2008).

Recognizing the need for involving women in various developmental activities, the Government of India has initiated several affirmative measures by way of programmes and schemes to bring them into the mainstream of development. These affirmative actions have brought about perceptible changes in the socio-economic conditions of women. The literacy rate of females, which was 8.86% in 1951 rose to 54.16% in 2001. Women’s work participation rate, which was 19.7% in 1981, rose to 25.7% in 2001 (NIPCCD, 2007). Though women in India have progressed in all fields like political, social, economic etc. yet the basic amenities like health and education are less focused. Major developmental tasks, focusing on women’s health have been defined and emphasized with low efforts. Women have little access to productive resources and negligible control over health. This discrimination is the result of the gender bias which forms an inherent part of global society.
In the light of the above information, the present chapter of introduction discusses the concept of the study entitled “Assessment of Awareness and Impact Study of IEC Aids regarding Gender Health Inequity among Women of Jawan Block, Aligarh, U.P.” The chapter carried out in following sections:

1.1 Women’s health

1.2 Gender

1.3 Gender and women’s health

1.4 Information Education Communication

1.5 Rationale of study

1.6 Significance of study

1.7 Objectives of study

1.8 Hypothesis of study

1.1 Women’s Health

Health is wealth. According to the World Health Organization (WHO), health is a “state of complete physical, mental and social well being and not merely an absence of disease or infirmity” (Center for Health Education, Training and Nutrition Awareness, 2000).

Despite having an idealized tenet in this definition in providing terms for a state of complete physical, mental and social well-being, it is in fact a positive definition and can be structured with a set of health attainment indicators for minimal elements and a set of health attainment indicators for enrichment of elements. In other words, indicators for absence of infirmity and disease should be first considered in order to define the health status in a given location. A generally important factor in the consideration of the status
of health in relation to the overall developmental process is the health among women and children in the total population (Velkoff & Adlakha, 1998). Examination of available data for Indian women reveals very disturbing facts. It has been pointed out that India is one of the few countries in the world where women and men have nearly the same life expectancy at birth. The fact that the typical female advantage in life expectancy is not seen in India suggests there are systematic problems with women's health (Velkoff & Adlakha, 1998; National Human Development Report, 2001). There is a deficit of at least 35 million girls and women in this country and it largely stems from higher mortality in females than males for every age group up to age 30 (Velkoff & Adlakha, 1998; The World Bank, 1996). Sixty four women out of hundred can not cross a BMI of 18.5 kg/m$^2$ and more than 50% women suffer from anaemia (National Human Development Report, 2001). A large section (~90%) of all pregnant women in India suffers from anaemia, and that severe anaemia accounts for 20% of all maternal deaths in India. The maternal mortality rate being at least 450 per 100,000 live births among women in the age group 15 – 49 years (Velkoff & Adlakha, 1998; The World Bank, 1996). Severe anaemia increases the chance of dying from labour associated blood loss.

Health is multifactorial. The health of Indian women is intrinsically linked to a set of factors as biological determinants, behavioural and socio cultural conditions, socio economic conditions, environment and gender. However, all factors are responsible for shaping women's health but gender is more crucial. Gender is a powerful social determinant of health, which interacts, with other determinants such as age, family structure, income, education, social support and a variety of behavioural determinants. Gender differences help to shape the health of men and women by influencing their
exposure to various health risks, their access to health promoting resources and how they are treated by health services (Greaves, 2000). However gender can be conceptualized in various ways. Field et al., (1997), for example, suggested that the body is mapped through culturally specific gendered identity, from biological sex. In this way gender is not driven by biology, but discursively constructed and masculinity can be enacted or performed by either men or women (Payne S, 2006).

1.2 Gender

Biologically, human societies are stratified into men and women dichotomies. All the known societies are unequally distributed (Pathy, 1987). There is some sort of identified division of labour between male and female in every kind of society. The biological division of humans into male and female is the basis of the most elementary social stratification everywhere (Mair, 1999). However, they represent only a part of the complex set of criteria by which it can be learn to distinguish femaleness from maleness. Equally important are the socially defined characteristics that different cultures assign to individuals defined as female and male i.e. gender. These apparent differences are sometimes justified with reference to biology, for example, women are given certain sorts of jobs for instance, because their biological capacity for motherhood is said to make them more 'caring'. In reality however, gender differences are social constructions that can potentially be changed in ways that most biological characteristics cannot (World Health Organization, 1998). The term gender describes those differences between men and women which stem from social causes; a social construct regarding culture bound conventions, roles and behaviours for, as well as relations between women and men and
boys and girls’ (Krieger, Zierler, 1995). In 1978, Kessler and McKenna defined gender as the “psychological, social and cultural aspects of maleness and femaleness” in other words; it represents the characteristics taken on by males and females as they encounter social life and culture through socialization (Wharton, 2005). According to WHO “gender refers to women’s and men’s roles and responsibilities, which are socially determined”. Gender is related to how we are perceived and expected to think and act as women and men because of the way society is organized, not because of our biological differences (World Health Organization, 1998).

1.2.1 Gender Roles of Women

Every society around the world assigns gender roles which direct activities and govern behaviour for women and men, girls and boys. Mediated by factors such as socio-economic level and other status differences between women and men in a given society, these gender roles exert various degrees of constraints. In general, the more rigid the gender role in a society, the sharper the gender division of labour and the lower the status accorded to women. The roles are rooted in rational responses to a lifestyle, no longer adapted to the forces of social change sweeping the world. The roles expected of women to behave and respond in a particular way according to Moser C., 1993 are categorized as:

- Productive roles
- Reproductive roles
- Community roles

*Productive Roles*: The productive role comprises work done by both women and men for payment in cash or kind. It includes both market production with an exchange value and
subsistence / home production with an actual use value and also of a potential exchange
value. For women in agriculture production this includes work as independent farmers,
peasants’ wives and wage workers. Whereas the ideology of patriarchy has served to
reinforce the popular stereotype the male breadwinner, reality does not bear this out.
Throughout the third world most low income women have an important productive role.
Nevertheless, the rigidity gender divisions of labour have ensured that although this is the
one area in which both men and women work, they do so unequally. Ideologically
masked asymmetrical gender relations in productive work, whether it is in the formal or
informal sector, rural and urban production means that again women as a category are
subordinated to men.

Reproductive Roles: The reproductive role comprises the child bearing/rearing
responsibilities and domestic tasks undertaken by women, required to guarantee the
maintenance and reproduction of labour force. It includes not only biological
reproduction but also the care and maintenance of the workforce (husband and working
children) and the future workforce (school – going children). The reproductive role is
naturally considered women’s work because women bear children and that connects
naturally to the reproduction of all human life. There is no reason why this should extend
to the nurturing and caring, not only of children but also for adults, if they are sick or
aged, through the daily provision of range of domestic services. This contradiction
reflects the diversity of definitions and meanings of reproductive work.

Community Management Roles: The community managing role comprises activities
undertaken primarily by women at the community level, as an extension of their
reproductive role. This is to ensure the provision and maintenance of scarce resources of
collective consumption, such as water, health care and education. It is voluntary unpaid work, undertaken in 'free time'. The community politics role in contrast comprises activities undertaken by men at the community level organizing at the formal political level. It is usually paid work, either directly or indirectly, through wages or increase in status and power.

1.3 Gender and women's health

The distinct roles and behaviors of men and women in a given culture, dictated by that culture's gender norms and values, give rise to gender differences in access to health among women. Both gender differences and gender inequalities can give rise to inequities between men and women in health status and access to health care. Gender inequities determine much about the health risks a woman faces in her life, her knowledge, her vulnerability, personal resilience, capacity, self-confidence and access to social support systems which help her to deal with health problems as they arise. Many of these practices are, as can be seen, in the area of sexuality, biological reproduction and the life cycle. Brief introduction of these practices has been given below:

1.3.1 Access to food

Girl child are deprived of adequate nutrition. Girl infants are breastfed less frequently, for shorter durations and over shorter periods than are boys (Das et al. 1982; Khan et al. 1983). Weaned earlier, young girls may not get the required quantities of supplementary food, as described by Levinson (1974). Male children receive larger quantities of cereals, fats, milk and sugar than females. Further, even in households that theoretically have enough food, the way it is distributed may leave women inadequately nourished.
Typically adult man and male children are fed first, women eat only after the men have finished and young wife must allow her mother in law to eat first, whatever is left is divided among young mother and her female children.

1.3.2 Physical Mobility

Women’s mobility and activities are curbed and they are expected to learn to become submissive and dependent. They are also expected to become self-sacrificing in relation to other family members, especially husbands and children. Traditions and sociocultural norms can encourage women’s seclusion or result in restricted mobility. Reasons for restrictions on women’s mobility lie in the tradition of male guardianship or in the male perception of the necessity of protecting women. A survey conducted in Punjab, Pakistan, revealed that only 35% of women were allowed to go unescorted to a market in their village, 28% were allowed to attend health centers unescorted and only 12% were allowed to visit neighbouring villages unescorted. On a mobility index with a maximum value of 5, the women of Punjab were assigned 1.4 value (World Health Organization, 2007)

1.3.3 Menstruation

Monthly menstruation has been socialized and mythologized into being the unquestioned natural, normal and beneficial state for women. It is therefore no wonder that throughout history, menstruation has been assigned roles that ranged from defining a woman’s status and social role to being seen as a curse that womankind had to endure. No aspect of female physiology seems to be as a shrouded in mystique as is that of a women’s menstrual cycle. In many societies, ironically, practices surrounding notions of purity and
hygiene are often harmful to the health of girls and women including the management of menstrual hygiene.

1.3.4 Marriage

Significant numbers of girls in the developing world are married before they reach adulthood. Marriage too early can prevent them from accessing health services or attaining educational, economic, or social opportunities. Historically, early marriages have been used to secure critical social, economic and political alliances for families or clans (McIntyre, 2006; ICRW, 2005). The Universal Declaration of Human Rights recognizes the right to “free and full” consent to a marriage, acknowledging that consent cannot be “free and full” when one of the individuals involved is not sufficiently mature to make an informed decision about a life partner (UNICEF, 2005). Hence, early marriage is considered a human rights issue. Nonetheless, in many developing countries, particularly in poorer rural areas, girls are often betrothed or committed to an arranged marriage without their knowledge or consent. Such an arrangement can occur as early as infancy. Parents see marriage as a cultural rite that provides protection for their daughter from sexual assault and offers the care of a male guardian (McIntyre, 2006). Many parents often feel that a young girl is an economic burden and therefore wish to (Levine, Lloyd, Greene, & Grown, 2009) marry off their young daughters before they become an economic liability (McIntyre, 2006).

1.3.5 Reproduction

Women have been born with unique but a complex phenomenon to take the progeny ahead. But unsafe reproductive behaviour like early pregnancy can have harmful
consequences for both young mothers and their babies. According to UNICEF (2005), no girl should become pregnant before the age of 18 because she is not yet physically ready to bear children. In many parts of the developing world, especially in rural areas, girls marry shortly after puberty and are expected to start having children immediately. Although the situation has improved since the early 1980s, in many areas the majority of girls under 20 years of age are already married and having children. Those who start having children early generally have more children, at shorter intervals, than those who embark on parenthood later. Generally throughout the developing world, the average food intake of pregnant and lactating mothers is far below that of the average male. Cultural practices, including nutritional taboos, ensure that pregnant women are deprived of essential nutrients and as a result they tend to suffer from iron and protein deficiencies. Most rural areas throughout the developing world have disproportionately fewer health centers and clinics, trained midwives, nurses and doctors than urban areas. For most rural dwellers, health treatment obtained from traditional birth attendants. Most traditional birth attendants have no formal training in health practices but acquire their skills via apprenticeship. According to the World Health Organization (WHO), more than half the births in developing nations are attended by traditional birth attendants and relatives. Although these women have every good intention to assist their patients, mortality rates are higher in the rural areas where they operate.

1.3.6 Access to health care among women

Adult women and female children are at a disadvantage with respect to health care. One reason for the relatively high mortality rates among women is that women receive less medical care than men. A high proportion of women receive no treatment at all for their
illnesses and that among who do, self care home remedies and traditional medical care are most common method used. In contrast, men are more likely to receive modern medical treatment including high quality institutional care. Compared with the men, women also tend to receive care at later stages of an illness, even in case of life threatening conditions. Additionally, households tend to spend less on women’s health than on men’s health (Center for Health Education, Training and Nutrition Awareness, 2000).

1.3.7 Contraception

In many cases, it is the woman who has to deal with the consequences of being sexually active with regards to contraception, child bearing and caring. Although women are often held responsible for unplanned pregnancies, young women are often stigmatized for using contraception. This double standard can put women at risk and discourage them from protecting themselves. Because most methods of contraception are controlled primarily by the woman, men often feel left out of the responsibility of contraceptive use. They feel uncomfortable discussing and participating in contraceptive decisions. Women, on the other hand, assume that their male partner is reluctant to use contraception without discussing it with him (Center for Health Education, Training and Nutrition Awareness, 2000).

1.3.8 Abortion

In India, abortion has been legal for decades but access to competent care remains restricted because of many barriers. But, unsafe abortion is an urgent public - health and human - rights imperative. As with other more visible global-health issues, this scourge
threatens women throughout the developing world. Every year, about 19 – 20 million abortions are done by individuals without the requisite skills or in environment below minimum medical standards or both. Nearly all unsafe abortions (97%) are in developing countries. An estimated 68,000 women die as a result and millions more have complications, many permanent. Important causes of death include haemorrhage, infection and poisoning (Grimes, et al., 2006).

### 1.3.9 HIV / AIDS

Almost as many women as men are now dying of AIDS. However, there are important differences between women and men in the underlying mechanisms of HIV /AIDS infection and in the social and economic consequences of HIV / AIDS. These stem from biology, sexual behaviour and socially constructed ‘gender’ differences between women and men in roles and responsibilities, access to resources and decision-making power. A number of studies have examined the role of gender on women’s risk and vulnerability to HIV / AIDS (WHO, 2003).

In each of these cases (menstruation, marriage, reproduction, contraception, abortion etc.), gender norms and values and resulting behaviours, are negatively affecting health of women. Therefore, above practices can be considered as **Gender health inequity** as all of the practices are responsible for making women vulnerable to health concerns. Gender health inequities are not fixed. They evolve over time, vary substantially from place to place and are subject to change. They can be changed. Health communication strategies help to foster these practices individually and institutionally and can contribute to sustainable change toward healthy behaviour. Largely concerned with individual behaviour
change or reinforcement and/or changes in social or community norms, public health education and communication seek to empower people vis-à-vis their health actions and to garner social and political support for those actions (WHO, 2001).

1.4 Information Education Communication

Information Education Communication in health programmes aims to increase awareness, changes attitudes and bring about a change in specific behaviour. IEC means sharing information and ideas in a way that is culturally sensitive and acceptable to the community, using appropriate channels, messages and methods. It is therefore broader than developing health education materials because it includes the process of communication and building social networks for communicating information. IEC is an important tool in health promotion for creating supportive environments and strengthening community action, additionally, to play an important role in changing behaviour. These initiatives are grounded in the concepts of prevention and primary health care. IEC can be defined as an approach which attempts to change or reinforce a set of behaviours in a “target audience” regarding a specific problem in a predefined period of time. It is multidisciplinary and client-centered in its approach, drawing from the fields of diffusion theory, social marketing, behaviour analysis, anthropology and instructive design. IEC strategies involve planning, implementation, monitoring and evaluation (WHO, 2001).

1.4.1 Channels in use for IEC

Information Education Communication (IEC) combines strategies, approaches and
methods that enable individuals, families, groups, organizations and communities to play active roles in achieving, protecting and sustaining their own health. Health information can be communicated through many channels to increase awareness and assess the knowledge of different populations about various issues, products and behaviours. It can be broadly discussed as:

a) IEC Methods

b) IEC materials

a) IEC Methods: According to the National Health Education, Information and Communication Centre, 2003, IEC methods has been described as follows:

- Interpersonal communication
- Group communication
- Mass communication

Interpersonal communication, sometimes called face to face communication, is one of the most effective methods of communication. Interpersonal communication can be done on one to one basis or with small groups and can promote sharing of information, encourage dialogue and help people to make their own decisions. The communication channels are in use to reach our target audience with predetermined formats at each service delivery. Interpersonal network is significantly effective in each stages of behavioral change. In the initial step to make the target audience aware of their health needs and impart knowledge to them, there are important messages. This approach is meaningful at the most secondary stage when the target audience to be motivated to go to practice healthy behavior.
Group communication such as seminars, workshops, coordinating meetings and social gatherings are more appropriate to advocate decision-makers and encourage supporting organization to come forward in sharing partnership. Moreover, there has been substantial use of all forms of methods and media in the health services delivery, for example:

- Personal- self-learning and personnel letters
- Person to person – discussion, counseling, office calls, tutorials, home visits
- Group (person to group, group to group and intra-group) – Lecture, meeting, study tours, discussion, tutorials, home visits, demonstrations, play/drama etc.

Mass Communication usually involves a much wider audience and employs mass media methods to reach out to large number of people at one time rather than personal interaction. Similarly, news, drama, serials, jingles and talk shows are radio programs that are used for IEC programme. Indigenous and folk performances are most effective means of influencing people's knowledge, attitude and behavior if developed, managed and performed effectively in an appropriate formats i.e. folk singing, folk drama, folk dances, street drama and local cultural events etc.

Interpersonal and mass communications play different but complementary roles in IEC. Conventionally, the IEC approach is used in the field of health for creating awareness, increasing knowledge, changing attitudes and moving people to change their behaviour or adapt an innovation.

b) IEC materials: IEC materials bring together all of the tools and techniques for communication and group work used to promote and assist behaviour changes.
According to AMC Cancer Research Center, 1994, IEC material is categorized into four categories:

- Visual Materials
- Action - Oriented Exercises
- Audio Materials
- Audio Visual Materials

**Visual Materials**: Visual materials help people learn by seeing. Visuals can, but do not always, contain words, pictures and/or numbers, but if words are displayed, they are not the emphasis of the medium. Different visual materials include posters, flip charts and display boards have been described in table 1.1.

<table>
<thead>
<tr>
<th>Type</th>
<th>Benefits</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poster</td>
<td>Stands-alone. May be distributed and posted in a variety of settings.</td>
<td>Typically informational and does not generally influence behavior change.</td>
</tr>
<tr>
<td>Flip Chart</td>
<td>Tells a story or teaches skills in a step-by-step manner. May be used as a guide for presentations by trained facilitators.</td>
<td>Requires a trained facilitator. Not appropriate for larger audiences.</td>
</tr>
<tr>
<td>Talk Board</td>
<td>Enables learners to share experiences through the telling of a story.</td>
<td>Requires a trained facilitator. Can be time-intensive because of the experiential-based interaction that use creates.</td>
</tr>
<tr>
<td>Display Board</td>
<td>Involves the learner</td>
<td>Involves the learner</td>
</tr>
</tbody>
</table>

Source: AMC Cancer Research Center, 1994
Visual materials are particularly useful for people with limited literacy skills and people from oral cultures. For low-literate individuals, even the simplest text sometimes cannot be understood. Low-literate individuals, therefore, tend to be more dependent on graphic or visual information than on information provided through print media.

Table 1.2 Action Oriented Exercises

<table>
<thead>
<tr>
<th>Type</th>
<th>Benefits</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role play</td>
<td>Can bring learning close to real life. Requires few props or special objects.</td>
<td>Used exclusively in a group session. More than one person takes part in the role play itself.</td>
</tr>
<tr>
<td></td>
<td>Learners can represent objects through pantomime. Useful for developing practical and social skills.</td>
<td>Requires audience participation in a group activity.</td>
</tr>
<tr>
<td>Song</td>
<td>Easy for most people to remember songs and rhymes and effective for reaching communities.</td>
<td>Requires someone skilled in song-writing to write lyrics and music.</td>
</tr>
<tr>
<td></td>
<td>Does not require reading or writing skills. Requires few resources to develop.</td>
<td>Requires someone willing and able to lead a group in song.</td>
</tr>
<tr>
<td>Story-telling</td>
<td>May take less preparation time. Learners can tell their own stories that are related to the topic of discussion.</td>
<td>Requires a group setting and a trained facilitator and can be time-consuming.</td>
</tr>
<tr>
<td></td>
<td>Can teach lessons through the use of parables.</td>
<td>Requires a storyteller who is aware of community patterns, customs, beliefs, and traditions.</td>
</tr>
<tr>
<td>Games</td>
<td>Provides entertainment. Encourages interaction among the learners, providing peer support. Can involve a group of participants of different ages.</td>
<td>Use of symbols must be handled carefully as symbols often have specific meanings in different cultures. Requires audience participation.</td>
</tr>
</tbody>
</table>

Source: AMC Cancer Research Center, 1994

Action-Oriented Exercises: Table 1.2 described different action oriented exercises.

Action-oriented exercises or strategies can be defined as educational materials and
methods that require the learners to be actively involved. These exercises include role play, theater, songs, storytelling, and games. Action-oriented strategies are particularly useful with low-literate audiences because they engage the audience in the simulation of real-life situations. The learner is relating, interacting and formulating relationships with others while acting out a situation.

Audio Materials: Audio materials rely upon hearing. They are useful when an audience has limited reading and/or visual capabilities. Different audio materials have been described in table 1.3.

<table>
<thead>
<tr>
<th>Type</th>
<th>Benefits</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiotapes</td>
<td>Does not rely on the printed word or visuals which can be misinterpreted by the intended audience. Can use sound effects to enhance the message and can use local language, and references which enhance the listener’s ability to identify with the message contained on the tape. Accessible to a large audience.</td>
<td>Language used on the tape and the language skills of the audience. May be “tuned out” by the intended audience if there are no visuals to watch. Requires equipment for production.</td>
</tr>
<tr>
<td>Radio</td>
<td>Very entertaining. Does not rely on the printed word or visuals to relay a message. Can use local language and slang which help listeners to identify with the message and can use music to attract attention.</td>
<td>Requires commitment on the part of a local radio station to play the docudrama during times that the intended audience is listening. Requires good sound equipment for production.</td>
</tr>
</tbody>
</table>

Source: AMC Cancer Research Center, 1994
Audiovisual Materials: Audiovisual materials involve both hearing and sight. Since most people learn through visual communication, audiovisual materials effectively increase knowledge. In addition, by visually representing a desired behavior, audiovisual material can teach a learner how to perform a behavior. The audio portion can add several dimensions, including motivating the viewer to watch the presentation, increasing identification with the characters or message, and helping the viewer retain the information. Different audio visual materials have been described in table 1.4.

Table 1.4 Audio Visual Materials

<table>
<thead>
<tr>
<th>Type</th>
<th>Benefits</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Videotapes</td>
<td>Can include issues and topics that are culturally acceptable to the intended audience. The language, dialect, characters, and scenery used in a videotape can help the viewer to identify with the message or story being conveyed. Can be used in group settings when appropriate equipment is available. Can be used as “triggers” for group discussion.</td>
<td>Are expensive to produce. Many learners are exposed to high quality video media which places a demand for high quality videotapes. Requires production equipment, VCR and monitor to use and trained facilitator.</td>
</tr>
<tr>
<td>Slide-tape Programs</td>
<td>Appeals to both hearing and visual senses and does not rely on the printed word to get message across. Use of visuals can be specific to the intended audience. Can be used in a group setting or as a stand-alone.</td>
<td>Are less sophisticated than videotapes, so that audiences may be less satisfied with them. Requires an automatic advance slide-projector and screen.</td>
</tr>
<tr>
<td>Interactive</td>
<td>Can be fun to use.</td>
<td>Requires self-motivated learners to approach and use the program and some computer literacy on the user’s part.</td>
</tr>
<tr>
<td>Multimedia Programs</td>
<td>Provides learner opportunity to choose topics or receive responses to questions which enhance thought processing and motivation to continue with the lesson.</td>
<td></td>
</tr>
</tbody>
</table>

Source: AMC Cancer Research Center, 1994
1.4.2 IEC in health programmes in reference to gender and health

Health education and promotion has been an integral component of all national health and family welfare programmes. Information Education and Communication (IEC) efforts in health go back to mid twentieth century after the independence of the country. Government of India has been using electronic media like television, radio, and folk media to promote family planning and a number special health care programmes like leprosy eradication, control of blindness, tuberculosis, malaria, filaria, iodine disorders/ deficiencies and most recently HIV/ AIDS. National Family Health Survey (2005 - 2006) reported that among the different types of media, television and radio have the broadest reach across all categories of women. Overall 55 percent of ever-married women watch television at least once a week. However, among women, the next most common media source is the radio (International Institute of Population Sciences, 2007).

National health programmes are supported with health education and promotion strategies and activities specifically designed to suit programme needs. Such national programmes include those for leprosy eradication, tuberculosis control, malaria eradication and HIV/AIDS control, as well as the national iodine deficiency disorder programme and the environmental health and sanitation programme. Interministerial committees at central and state levels meet periodically to review the progress of health education activities. NGOs and other professional organizations have joined with government agencies all around the country to improve health education. The media division of the CHEB has been strengthened to support media promotion activities as well as materials production.
Information Education Communication in different health programme has been given below:

The IEC approach uses a community-based strategy. In India, interpersonal communication at grass roots level is being strengthened by establishing women’s health organizations (Mahila Swasthya Sangh - MSS) in villages existing national health policy (NHP), 1983. By 1995-96, 74,000 MSSs had been established. Funds were earmarked for setting up IEC bureaus in eight states in 1995-96. Training of frontline workers and field functionaries in various departments is being strengthened. The sensitization of local leaders is implemented through orientation training camps.

The National AIDS Control Programme in India has been advocating behaviour change with various innovative approaches and strategies that target audience-specific messages to identified subpopulations. HIV/AIDS prevention programmes focus their efforts and messages on promoting three prevention behaviours: delaying sexual debut among young persons (abstinence), limiting the number of sex partners/staying faithful to one partner (being faithful) and use of condoms (the ABC message). Overall, approximately 4 in 10 women know each of the three ABC methods. Forty five percent of women who have regular media exposure know about avoiding HIV by using condoms and limiting sexual intercourse to one uninfected partner, compared with only 10 percent of women who are not regularly exposed to media (International Institute of Population Sciences, 2007).

The Information, Education and Communication (IEC) strategy under the NRHM, aimed to spread awareness on the preventive aspect of healthcare and disseminate information regarding availability of and access to quality healthcare for the poor, women and
children in rural areas. The Ministry had been implementing a comprehensive IEC package for publicity through extensive use of television, radio and other media with the help of the Song and Drama Division, Directorate of Advertising and Visual Publicity and Directorate of Field Publicity of the Ministry of Information and Broadcasting. In addition, hoardings in rural areas, advertisements in print media and printed material in regional languages by the States were also being utilized for IEC activities. But, awareness about the Janani Suraksha Yojana is low in some states particularly among rural women. Communication is not focused on emphasizing on importance of institutional delivery.

The communications media have played an important role in promoting the family welfare programme in India. In 1968-69, the Mass Education Media (MEM) division was created in the Department of Family Welfare. Channels of communication such as the Television, Radio, Song and Drama Division, Directorate of Field Publicity, and the print media promote reproductive health and population issues. Slightly more than three in five women reported that they heard or saw a family planning message in the past few months. Nearly half of women saw a family planning message on television; one-third heard a family planning message on the radio; about one-quarter saw a family planning message on a wall painting or hoarding; and percent saw a family planning message in a newspaper or magazine. The substantial gender exposure to family planning messages is seen with widening of the horizon of understanding on issues related to contraceptive use and helping to achieve desired family size (International Institute of Population Sciences, 2007).
Many of the existing IEC (Information, Education, and Communication) materials are not sensitive to women’s needs. Listen to what women have to say about health and what they would like to know about it, rather than simply transferring information to them. Develop culturally appropriate women sensitive and specific IEC material, which would take into account on issues regarding women’s health (Choudhary & Shelley, 2000).

1.5 Rationale of the study

Present research particularly focuses on awareness and practices of gender health inequity and impact of IEC on rural women. India’s National Health Policy 2002 acknowledges the importance of women’s health as a major determinant of the health of entire communities. Indeed, on their health rests the well being of the future generations. In terms of resources for socio-economic development, nothing can be considered of higher significance than the health of women. Additionally, women’s health particularly sexual and reproductive health is also a fundamental aspect to reach gender equity the third millennium development goal. Though, India was signatory of Alma Ata Declaration in 1978 recommending “Health for All by A.D. 2000”. The 20- point programmes also pin points special thrust on improving the women’s health but significant gains in health status of women have not been achieved. Further, the gender stigmas such as abortions, early marriage, dowry, low educational attainment among female are increasing day by day in U.P. especially in rural areas. All of them lead to lower participation of women in economic activities and restricted physical mobility which affects the women’s health. The third Goal of Millennium Development urges the achievement of gender equity. Therefore, in order to fulfill the global commitment,
gender equity is essential. Furthermore, gender equity is also needed for rapid achievement of other Millennium Development Goals (MDG) such as: reducing child mortality, improving maternal health, achieving universal primary education, combating HIV/AIDS and reducing poverty. In the Gender Development Index (GDI), India ranks 114 out of 155 countries (Times of India, 2010). Keeping in the view, gender and women’s health as major indicators of nation’s development, present study focuses on assessment of awareness regarding gender health inequity among women.

Women’s health depends not only on range of gender based factors but it is affected by women’s consciousness that enables one to overcome external barriers for accessing resources or changing traditional ideology to attain better health. Both of them are essential ‘first steps’ for being healthy women because no amount of outsiders’ help can really achieve the desired results unless women themselves realize the importance of these issues for them. So there is urgent need for a ‘behavioral change’ among them by increasing awareness or consciousness regarding gender health inequity. In the light of the above information, a procedural assessment criterion has been involved in the study wherein IEC were used for creation of awareness. In recent years, the need for such kind of studies is very important.

Although there is a range of material available, which offer general assistance in considering gender issues in developmental practice and few refer specifically to the issues, which are most relevant to health issues such as the impact of gender health inequity on women’s health or the impact of IEC have yet received little attention. Secondly, most of them were based on secondary data on national surveys. Therefore, in
present study the primary data was used by designing own interview schedule rather than depending on the specific questionnaire.

The above premises were major considerations for the researcher to assess awareness and practice regarding gender health inequity among women before and after implementation of IEC. These considerations make the study relevant in both the current and past contexts of the need to improve women’s life in present and future.

1.6 Significance of Study

Present study will be helpful for gaining an understanding on women’s knowledge on gender health inequity. Appraisal of the progress of a region in the field of gender studies can be made time to time with the help of such studies. In the study, consideration of health lead to a better understanding of many areas of women’s health and wellbeing including policy approaches to planning and provision of health services. This would be helpful in the local level planning suitable to the health needs of women. Studies of this kind ultimately lead to remedial interventions. They help to evolve short term and long term policies. The study will be useful to policy makers and development specialists in national institutions, NGOs and donor agencies engaged in gender, health issues among women especially in rural areas.

As an impact study of IEC aids, this approach will be concerned with changes or reinforcement in women’s knowledge towards gender practices seek to empower women vis-à-vis their health actions and to garner social and political support for those actions. In this way, it is an effort to make valuable contribution to the community.
Planning and implementation of IEC will be helpful for the media planner and organizers to plan and implement the future IEC strategies and to incorporate the different concepts and themes in strategy to meet the information needs of the rural community. Further, evaluation of various IEC aids would be useful for various local, regional, national and international organizations engaged in community need assessment programmes. In view of these beneficial outcomes and because of the fact that no such awareness approach has ever been conducted in this region, the study was conducted in Jawan block of Aligarh District.

The present study is not an end in itself; rather it is an attempt to observe health problems faced by rural women due to gender health inequity in their lives and to introduce various IEC aids to rural women so that they can understand their health needs, that can be used as guide line for future researches of this field and contribute to the vision contained strategic direction towards health for all.

1.7 Objectives of the study

General Objectives

1. To assess the awareness regarding gender health inequity among women.

2. To ascertain the impact of IEC (Information Education Communication) aids on women.

Specific objectives

1. To study the demographic characteristics of women in study area.
2. To have an insight into the women’s awareness and practices regarding five gender health inequities - menstruation, marriage, reproduction, contraception and abortion.

3. To evaluate the impact of identified and implemented IEC aids on gender health inequity among women.

4. To establish association between awareness regarding gender health inequity (Pre and post IEC) among women and demographic characteristics.

5. To establish association between practices of gender health inequity and health of women.

1.8 Hypothesis of study

1. Impact of IEC (Information Education Communication) aids regarding gender health inequity on women is not significant.

2. There is no association between pre IEC awareness regarding gender health inequity among women and demographic characteristics.

3. There is no association between post IEC awareness regarding gender health inequity among women and demographic characteristics.

4. There is no association between practices of gender health inequity and health of women.