Chapter 5
DISCUSSION

The present chapter on discussion follows the results that were drawn in previous chapter from the data collected in field. It is divided into the following sections:

5.1 Demographic characteristics of rural women
5.2 Gender health inequity and impact of IEC among rural women
5.3 Association between gender health inequity awareness among rural women and demographic characteristics
5.4 Rural women's health status and its association to gender health inequity practices

5.1 Demographic characteristics of rural women

Various demographic characteristics obtained from the results of the field information are discussed in the light of reviewed studies, under following heads –

5.1.1 Age
5.1.2 Education
5.1.3 Occupation
5.1.4 Type of family
5.1.5 Religion and caste
5.1.6 Socio economic status

5.1.1 Age

Age is considered as an important variable that has its influence on women's knowledge, perception about their health. Study indicates sufficient representation of all the age
groups among women. But, a vast majority of women were in their prime reproductive age where health issue is of great significance as most of the rural women (32.1%) in study were in age group of 18 to 24 years, 29.3% of women were of age 25 to 29 years; remaining rural women were at the age of 30 to 40 years. While, in the study by Al Olugbenga - Bello et al. (2011) more of the women were in the age range of 35 years and above followed by 20 to 29 years. Ye Yang et al. (2010)'s study also depicted that majority of women belonged to the 17–35 year old age group. Different situation was observed by Garg R et al. (2010) that majority of women were in the age group of 26 – 35 years. Earlier studies by Joshi N. et al. (2009) and Mustafa R. et al. (2008) also indicated that majority of women belonged to the age group of 21 – 30 years. Similarly, Bhandari G.P. et al. (2006) and Mao J (2007) indicated that most of the women were concentrated in ages of 20 – 29, 20 - 25 years respectively. On the basis of number of above mentioned supporting evidences, one can claim that age of a woman between ranges of 18 – 40 years is an important determinant to study gender health inequity among women.

5.1.2 Education

Education enhances the ability of individuals to achieve desired demographic and health goals (National Family health Survey -3, 2007). There is a wide gender disparity in the literacy rate in India according to census 2011. By confirming national scenario, present study reveals differentials in educational attainment of rural women and their husbands. It was found that more women (41.4%) were illiterate as compared to their husbands (10.4%). This information was a clear indication of the gender gap in education of the couples. There were several reasons behind it like lack of income resources, school
distance and cultural values of early marriages. Parents desire to wed their daughter over schooling. Bhandari G.P. et al. (2006) support these findings as they found that husbands of women were more literate as compared to them. Ye Yang et al. (2010) and Garg R (2010) also found that higher proportion of women had no schooling. Above findings also indicate the less access to education among rural women. This was because of strong stereotyping of female and male roles, males were thought of to be more useful and hence were educated. Females were pulled to help out on agricultural farms at home as they are increasingly replacing the males on such activities which require no formal education. But, in the study by Joshi N. et al. (2009) minimum numbers of women were illiterate and remaining had a minimum primary level of education. While in the present study, only 1.3% of women had their education less than five years of schooling. Similarly, Mustafa R. et al. (2008) reported that minimum number of women had primary education while most of rural women were completely illiterate. While, 24% of rural women were found illiterate by Mao J (2007) and minimum level of education was matric among women. Present study also indicated that women who attended school, majority of them (19.2%) had completed 12 or more years of education. Similar trend was also observed by Varma G.R. et al. (2007) and Bhandari G.P. et al. (2006). Whereas, Al Olugbenga-Bello et al. (2011) found that most of the total women had secondary school education.

5.1.3 Occupation

Present study reveals that majority of women (60.9%) were not involved in any kind of occupation, because of their family responsibilities and their family / husbands’ disapproval. This large scale detachment of women from productive sector was attributed
to cultural practices also. Majority of rural women were housewives as observed by Garg R (2010). While, Ye Yang et al. (2010) indicated in their study, that most of the women were farmers. Similar trend was also observed by Varma G.R. et al. (2007), Mao J (2007). Study indicates that, among women who were employed most of them (25.3%) were involved in agriculture. Agriculture is a part of the Indian economy and underlies most viable productive activity in the country but, it has been declining in current years. It is indicating from the findings related to husbands' occupation that only 17.2% of husbands were involved in agriculture work. According to them, income from agriculture did not satisfy their needs. Further, 4.0% of the husbands were unemployed and remaining husbands were involved in non agricultural occupation. All these statistics also indicated the clear division of labor between husband and wife, in which wife was considered as housekeeper and her husband was perceived as bread winners of the family. Hence in Indian rural society husband plays a fundamental role in household economy and wife depends completely upon her husband for her financial needs.

5.1.4 Type of family

Married women's attitude and behavior varies with respect to type of families (Ali and Sultan, 1999). Study depicts that most of the women (62.4%) belonged to nuclear family and remaining (37.6%) belonged to joint family. Reason behind this was 'quarrels', an everyday affair among women. Similar trend was observed by Rao K. et al. (2010) and found that the 63.5% of rural women were from nuclear family. This indicates that joint families are rapidly changing into nuclear families in rural areas also. Rural women, in the study, were also giving preference to live in nuclear family to address their socio -
economic needs properly. Thus, the joint family system was in the downward in the study area.

5.1.5 Religion and caste

Religious norms have a direct effect on women’s attitude and behaviour. Study indicates that majority of women (95.7%) belonged to Hindu community and remaining women (4.3%) belonged to Muslim community. Similar findings were observed by Bhandari G.P. et al. (2006) that majority of the study population were Hindu by religion and almost all the rest are Muslim. In contrary, Al Olugbenga-Bello et al. (2011) found in their study found that most of them were Muslims. Present study highlights that in study sample, majority of women (48.5%) were from schedule caste followed by 16.4 % of the women were from general caste, 35.1 % of the women were from backward caste. Varma G.R. et al. (2007) also observed similar trend in their research that most of the women belonged to schedule cast. Caste system was very strong in rural areas. It has been also observed that villages were divided according to their religion and caste; rural women did not prefer to go from one side to another side of the village.

5.1.6 Socio economic status

Income of the household is also one of the indicators of household status and affordability of resources. Present study reveals that majority of women (52.5%) belonged to poor class, 31.8 % of women belonged to lower middle class, only 8.8% of women were very poor. While remaining (6.8%) were from upper middle class. Whereas, Joshi N. et al. (2009) in their study indicated that majority of rural women belonged to the lower socioeconomic group. Above findings indicate lower socio-economic status of
women which means the lower accessibility, affordability, acceptability and actual utilization of various available resources among women.

5.2 Gender health inequity and impact of IEC among rural women

Findings related to awareness and practices of gender health inequity among rural women has been discussed under following headings –

5.2.1 Menstruation
5.2.2 Marriage
5.2.3 Reproduction
5.2.4 Contraception
5.2.5 Abortion

5.2.1 Menstruation

The occurrence of menstruation indicates the non-pregnant status of women. A missed period indicates the pregnancy. Menstruation becomes a central issue in a woman’s life, as it has been indicated by previous studies. Many scholars also pointed out that the low social status of women in Indian society ‘the culture of shame and silence’ associated with their reproductive health matters make public discussion on these topics a taboo. Present study reflects incomplete knowledge and unscientific notions pertaining to practices and procedures of menstrual process among rural women of Jawan Block before intervention. In rural area, women did not like to talk about menstrual issues. For improving knowledge regarding menstruation, IEC, a flip book “Masiddharm – Sharirik par chooachoot nahi”; (Menstruation - Physiological but not untouchability), string game, puzzle and Color TV...
were used in group sessions and personal meetings. These IEC aids covered physiological aspect of menstruation and maintenance of hygiene during menstruation like bathing, use of absorbent material, change of absorbent and restrictions (Annexure IV).

Study indicates that before IEC, most of the rural women (66.4%) were not aware about physiological aspect of menstruation, only minimum number (7.6 %) of rural women were aware about its physiological aspect and relates it with reproduction. Remaining had misconceptions like it just happens, result of a disease, curse upon them, ‘natural process’, untouchable process. Similar misconceptions were also observed by Anjum F., et al. (2010) where, women regarded menstruation as a natural process; perceived it as a disease and curse from God. In the study by Umeora et al. (2008), women considered themselves dirty or were just indifferent to menstruation. Study by Dhingra R (2007) and Singh A. J. (2006) also supports these findings and concluded in his study that rural women considered it as a ‘curse upon them’, which prevents them from performing any religious duties and rituals. It indicates the rural women’s unawareness regarding scientifically logical understanding of menstrual process. After implementing IEC, present study depicted that majority of rural women (76.8 %) became aware with menstruation as physiological process and relate it with reproduction, while other remained unaware about it and had misconceptions. These improvements were found statistically significant (p < 0.01).

In the present study, with the help of IEC aids in personal meetings and group sessions, women were informed about the importance of hygiene with bathing during menstruation. Findings indicate the significant improvements (p < 0.01) in bathing practices among rural women after implementation of IEC. Most of the women started to
bath daily after implementing IEC (92.9%) as compared to before IEC (80.1%) as they thought that if they bathed daily during menstruation it would result swelling on abdomen and gynecological problems may occur. Similarly, Anjum F., et al. (2010) found that rural women avoided bath during menstruation.

Significant impact of similar IEC aids was also observed in use of absorbent material during monthly menstrual cycle (p < 0.01). Rural women (81.3%) who were using rejected old cloth without washing as an absorbent before IEC, after IEC sessions (73.5%) most of them women started to wash rejected old cloth before using and dry in sun thoroughly. Before implementing IEC, use of rejected cloth without washing was widely prevalent among rural women. The reason behind it was that they did not have access to contemporary treatment material such as sanitary napkin, tissue or clean cloth. They were unable to buy costly readymade sanitary napkins or lack of availability in rural areas (Dhingra R., et al., 2007). In rural Bangladesh, Akhter S., (2007) reported that majority of rural women used old cloths during menstruation and moreover they reused them without washing them properly and drying thoroughly. Very few women used sanitary napkins (Singh A.J 2006). In the present study, as an impact of IEC aids this unhygienic practice was changed.

The significant impact of IEC aids flip book, string game, puzzle game and colour TV was not found in the practice of changing daily menstrual absorbents. As the practice of changing menstrual absorbents was satisfactory before IEC, significant number of women (90.9%) changed daily absorbents, but after IEC, more of rural (98.7%) started to change menstrual absorbent daily or two times in a day and they did not reuse it, remaining women continued to change it according to the condition. Due to lack of
resources, more improvements could not be expected. As women had limited amount of absorbent material so they could be expected to change it after every six hours.

During menstruation women were considered impure or contaminated or dirty. So, all kinds of restrictions were imposed on them like not to cook anything in kitchen, not to go to the place of worship or light the holy lamps etc (Singh A. J. 2006). In the present study, before IEC, rural women had restriction on eating (35.9%) as they were not allowed to eat pickle, curd, rice and other cold eatables and another restriction was in performing daily household chores (15.9%), however religious rituals were not taken into consideration in the present investigation. Study by Akhter S. (2007), also supports the findings as study observed eating restrictions in rural Bangladesh however items were different and women were not allowed to touch anything which is holy and sacred. Similarly, Anjum F. et al. (2010) reported that rural women avoided meat, eggs, pickle, fish, milk, yogurt, lady finger and cold drinks during menstruation. Similar findings were also observed by Umeora et al. (2008) in rural Nigeria. Singh A J (2006) also found similar restrictions on eating cold things like rice, curd, milk. Women had misconception that consumption of such things leads to pain during menses hence they believed in taking some hot things (dry ginger powder, spices, chilies, and jaggery) every month so that the period comes on early and on time. For removing these misconceptions, during IEC sessions, except physiology of menstruation, women were also told the importance of those eatable items for their health that were prohibited during menstruation and physical activity. IEC aids in personal meetings and group sessions had significant impact (p < 0.01) in reducing number of women who faced restrictions during menstruation. Number of women, who faced restrictions, was found to be decreased,
most of women (79.3%) stated that there was no restriction among them, while remaining had restrictions on either on own eating or to do daily household chores.

5.2.2 Marriage

Marriage at a young age often in the absence of physical and emotional maturity undermines the ability of young women to make informed decisions about their lives. Early marriage is still a major social problem in Indian societies especially in rural areas. Present study indicates that marriages occurred very early among rural female. In the study area it was observed that majority of women (42.9%) got married between ages 15 to 17, followed by 30.6% of the women who got married at 18 to 20 years, 16.9% of women got married when they were less than 15 years and minimum number (9.6%) of women got married at the age of 21 to 24 years. These findings are supported by Akhter S, (2007), observed that the age at marriage for girls among rural women in Bangladesh was thirteen to sixteen years. In rural area 54% of women got married in this age group. Earlier, study conducted by Sidramshettar, S.C., (2004) in Rural Karnataka found that nearly half (58%) were married before reaching the legal minimum age at marriage ie between 10 to 14 years. Sivaram M. et al. (1995) also reported similar observations. Though, among those who thought that they married too early, most of them of rural females reported that they were married early because their parents wanted them to (Choe. M. K et al., 2004). Above findings indicate that early marriage still at its high time while this prevalent traditional practice of the rural India is abolished. However this is only possible when there is sufficient awareness and education of its drastic consequences. Present study indicates ignorance, lack of adequate information and proper awareness among rural women about the issue of marriage for girls at right age and
adverse effects of early marriage. To build awareness regarding ill effects of early marriage on women, marriage at right age and to change the favoring attitude towards early marriage, IEC was conducted. IEC aids *flash cards on Chhoti si dulhan* (The Little Bride), *puppet show on Ramsakhi ki shadi* (Marriage of Ramsakhi) was conducted in group sessions. Personal meetings with the help of *flow chart on Atharah ke bad shadi, shadi me na kare jaldwaji* (Marriage after eighteen, not be early) were also conducted (Annexure IV). These IEC aids covered the issue of legal age of the marriage (18 yrs for the girls and 21 yrs for the boys), problems of early marriage, severe health problems like anemia, early pregnancy affecting the health of newborn and increased risks of mortality and skill development of girls (Annexure IV). Because the major reason for marrying girls early was dowry and social insecurity therefore attention was given on skill development of girls. These IEC aids had significant impact on women regarding issue of marriage.

Before IEC 20.2% of women did not know about the right age of marriage and according to 8.6% of women right age of marriage was before eighteen, according to 35.6% of women, right age of marriage was eighteen. Women who were married at right age of marriage were aware about it. While, according to 32.8% of women right age of marriage for girls was after eighteen. However, 2.5% of women gave other answers; according to them there was no criterion of right age of marriage as whenever it becomes possible after starting menses or when elders of the family take decision, girl should marry. Further, after implementing IEC, majority of women (88.6%) became aware about right age of marriage ‘eighteen’, while 6.3% of women said that right age marriage was after eighteen, others remain unaware. Above findings indicates highly significant
improvement (p < 0.01) in awareness regarding right age of marriage among women after implementation of IEC.

IEC aids flash cards, puppet show and flow chart also had significant impact in changing attitude of rural women towards early marriage. In the present investigation, before intervention, 13.9% of women gave opinion in its favor that 'early marriage is right'. According to them if parents marry their daughters early they become free from their responsibility. Other reasons for supporting early marriage were social standing, insecurity of girls and dowry. This indicates the effect of tradition norms in the opinion regarding early marriage among women. Remaining (9.3%) of women gave other answers, according to them early marriage was wrong but due to harassment of women like rape and teasing it was right and 28% of women were not aware about it and they did not give any opinion. After intervention opinion on early marriage among rural women became improved. In the opinion of majority of women (90.2%) it was wrong, comparatively high from before intervention, however others remained unaware. These improvements were found to be statistically significant (p < 0.01) also.

IEC aids flash cards, puppets and flow chart also had significant impact on awareness regarding ill effects of early marriage on health of women. Present study indicates that majority of rural women (69.9%) were not aware regarding the effect of early marriage on their health and 2.3% of women said that there was no effect of early marriage on health of women. Most of the women, who were aware about the ill effect of early marriage on women's health, had already experienced these problems. They argued that the health of girls who married early was at risk, including complications such as low birth-weight babies or, in extreme cases, leading to the death of the mother after delivery.
After implementing IEC, awareness regarding effect of early marriage among rural women was found to be increased. Most of women were aware about effects of early marriage on women's health. Among them 20.2% of women were aware about 'stop physical development of girls', 13.9% of women were aware about 'weakness', 29.8% were aware about 'early pregnancy death and disability', 1.3% of women were aware about RTI/STD, 16.9% of women were aware about all and others remain unaware. These findings indicate significant improvement (p < 0.01) in women's awareness regarding health consequences of early marriage after implementation of IEC.

5.2.3 Reproduction

It is a common phenomena that pregnancy and childbirth are special events in women’s lives, and, indeed, in the lives of their families. This can be a time of great hope and joyful anticipation, only when it happens safely. It can become possible when women become aware regarding issues of pregnancy and child birth. In the present study, considerable proportions of women were not aware regarding these issues. Women thought that pregnancy and child birth was natural therefore there was no need to pay attention on it. IEC was implemented for changing attitude about reproduction and related issues. IEC aids, *flip book on Swasth ma swasth shishu* (Healthy mother healthy baby), poster *Garbabastha me rakho dhyan – Pao ek swasth pran* (Take care of women in pregnancy – get a healthy life), *Bhrun vikas* (Foetal development) and *card game* on antenatal care were implemented on the issue of reproduction (Annexure IV). These IEC aids covered the issue of number and gender composition of children, age of pregnancy, birth interval, antenatal care, delivery and nearby facilities that women can access during pregnancy. Initially, women were explained that how their baby develop in their womb
with the help of a poster on *Bhrun Vikas* (*foetal development*). As, better understanding of foetal growth and development and its relationship to the mother's health can result in increased attention to the potential care to improve both maternal and newborn health. Other issues were taken into consideration subsequently.

Above IEC aids indicate significant impact on **awareness regarding number of children** among women. Present study observes that before IEC, higher proportion (37.9%) of women considered two to be the ideal number of children. Similarly, Dey Indira *et al.* (2009) and Varma G.R. *et al.* (2007) observed that a majority of women considered two to be the ideal number of children. Present study observes that three or more to be the ideal number of children was considered by 37.9% of women. Study by Puri S. *et al.* (2007) supports the finding as in their study substantially higher proportions of women responded that the desirable number of children was three and for a few women it was recorded as more than three. After implementing IEC in present study, number of women (86.6%) was increase who favours two children, as the ideal number of children. While, remaining women were in favour of one child and three or more children as the ideal number of children. These findings indicate that IEC aids *flip book on Swasth ma swasth shishu* (*Healthy mother healthy baby*) brought significant improvement in women's awareness regarding number of children ($p < 0.01$). Further, in the present study, regarding the number of children women had, observes that majority of women (36.1%) had more than three children followed by higher proportion (32.1%) of women had one child, 18.4% of children had two children, 13.4% of women had three children. Similarly, Mustafa R. *et al.* (2008) reported that the majority of women had
more than five children. While, Sharma S. et al. (2009) found that majority of women had three children.

Similarly, effect of IEC was also found in awareness regarding the gender composition of the children among rural women. Present research indicates that before IEC, majority of women (46.2%) considered one boy and one girl as ideal gender composition of their children. However higher proportion of women (27.8%) desired more sons than daughters, while minimum number of (2.3%) women wanted more daughters than sons. A desire for only son was noted among 19.2% of women compared to 0.8% who wanted only daughters. Similarly, Dey Indira et al. (2009) also observed these findings as ideal gender composition of the children was one son and one daughter as considered majority of the mothers. In the study by Varma G.R. et al. (2007), Puri S. et al. (2007) most of the women opted for son. These findings indicate higher male preference among rural women. The reason behind it was economic dependency of female on male and marriage of a girl leads to extra financial burden on their family. During IEC sessions, attention was also given on skill development of girls. After implementing IEC aids more rural women became in the favour (60.9%) of one boy and one girl both as ideal gender composition of their children. Higher proportion of women (34.8%), considered that sex of child does not matter for them. Remaining women's views were not influenced by IEC aids regarding gender composition of child. These findings indicate the significant impact of IEC aids in changing women's gender preferences of children (p < 0.01).

Regarding age of pregnancy in the present study, before IEC, it was found that the awareness regarding age of pregnancy among rural women was low as majority of
women did not know about the right age of pregnancy. Only 8.8% of women were aware about the right age of pregnancy (< 22). After implementing IEC aids, it was observed that majority of women (83.6%) became aware about right age of pregnancy (20 years or < 22) whereas 10.4% of women considered 24 years or after as the right age of pregnancy, < 24 years age of pregnancy were considered by 2.3% of women and remaining women remained unaware. These findings indicate improvements in women's awareness regarding age of pregnancy after implementation of IEC (p < 0.01). Women's perception reflect in their practice, it was found with age of first pregnancy of these rural women, as majority of women first pregnancies occurred before the right age of pregnancy. Akhter S. (2007) endorsed these findings that majority of first pregnancies occur at sixteen to seventeen years for rural women, the teenage mother neither have sufficient knowledge about the process of pregnancy nor are they ready psychologically and physically for childbirth. Further, analysis of number of pregnancies indicates that majority of women (31.3%) had one pregnancy, 14.6% of women had two pregnancies and 10.4% of women had three pregnancies. While, 18.9% of women had four pregnancies and 16.2% of women had five pregnancies. Remaining 16.7% of women had six or more pregnancies. Different trend was also observed by Ye Yang et al. (2010) that majority of women had ≥ 3 pregnancies.

Present study indicates that before IEC, majority of women were not aware regarding the interval between births of two children. This reflects from the interval between their children as among 7.8% of women birth of their children occurred after 36 months of a previous birth and among majority of women (51.8%) birth of their children occurred within less than 18 months. Moreover, only 22.7% of women considered >36 months as
correct interval. After implementing IEC aids *flip book on swastha maa swastha shishu* (Healthy mother healthy baby), majority of women (66.4%) became aware about > 36 months of birth interval. However, 1.5% of women considered <18 months as right birth interval, 22.5 % of women considered 18 – 35 months as right birth interval. Remaining women remained unaware about it. These findings indicate significant improvements (p < 0.01) in women's awareness regarding birth interval after implementation of IEC.

Regarding the consent of last pregnancy among rural women, study depicted that 53.8% women reported that their last pregnancy was wanted, 42.2% stated their last child was not wanted while the remaining 4% said that they did not think about it. Similar trend was also observed by Dibaba Yohannes (2010) that about 39% of women reported that their recent pregnancy was unintended. It reveals that higher proportion of pregnancies were either accidental or decision of other family member. However decisions regarding number of children to have and time to have another child are all controlled by the men (Odimegwu C. and Okemgbo C N. 2003) in rural areas.

Present research reveals that majority of women (53.8%) were aware about at least one bad consequence of closed birth interval between two children as compared to 45.5% of women who were not aware about it. Findings indicate that rural women were not completely aware about the consequences of birth interval between two children. While, after implementing IEC aids, data indicated that most of women (79.8%) were aware regarding bad consequences of closed birth interval as compared to 20.2% of women were not aware about it. Improvements in women's awareness regarding consequences of birth interval between two children after implementation of IEC were significant (p < 0.01).
Present study highlights the significant impact of IEC aids *flip book, poster and card game* on awareness regarding antenatal care among rural women. Card game was specifically prepared for antenatal care among rural women. After implementing these IEC aids, it was found that *most of the women (28.8%)* had complete information regarding antenatal care as compared to before IEC that, only *2.8% of women had complete information about antenatal care including full package of antenatal care and number of visits*. While, other *66.9% of women also had information about ANC after IEC as compared to 56.6% of women*, before IEC but it was incomplete. Ye Yang *et al.* (2010) also endorsed the findings and found that most of the women lacked sufficient knowledge about antenatal care. These findings indicate significant (*p < 0.01*) improvement in women's awareness regarding access to antenatal care after implementation of IEC. Akhund S *et al.* (2011) also revealed positive impact of intervention among women regarding awareness about ANC. Majority of women (90%) of the women understood the messages with the help of sketches on ANC.

Regarding, *women's access to antenatal care*, Matthews Zoe *et al.* (2001) in her research revealed that at first glance, the situation with regard to antenatal care utilization was encouraging among rural women. Present study also observes similar situation but majority of women (75.5%) got incomplete antenatal care, minimum number of women (6.8%) got complete antenatal care, whereas remaining 17.7% of women did not get antenatal care. The main reason was that they believed that pregnancy being a natural phenomenon did not need any special care (Metgud C. S. *et al.*, 2009). Similarly, Pradhan A. (2005) observed that majority of women (78%) were benefited by antenatal care services. Earlier, a study by Kalita D.K. (2001) concluded that about 96% mothers had
registered their names ANC. Above findings indicate the effect of lack of information and proper awareness about ANC on accessing it.

Study reveals that most of the women's deliveries (56.6%) were done at home and local birth attendant of the village performed this task. It was customary, to keep a woman in 'isolation' after the delivery in her natal home (Ram F. et al. 2006). Similar observations were observed by Garg R. (2010) that majority (66.1%) of women's deliveries were found to have taken place at home. In the current study rest of the deliveries were performed at health facilities i.e. government hospital (16.7%), Community health center of the Jawan block (11.1%), private hospital (15.7%). In contrary, Pradhan A. (2005) studied that most of the deliveries were hospital deliveries assisted by the doctors. Earlier a study by Kalita D.K. (2001) endorsed the findings of present study and stated that most of women's deliveries took place at home and normal deliveries were higher among those that took place at home.

Present study indicates the women's awareness regarding place of delivery that according to majority of women (46.7%) home was suitable place for delivery, as it was economic and accessing hospital facility for delivery was costly or difficult due to unavailability of transportation. Present study indicates that 21.2% of women were aware to go to hospital for delivery, 18.9% of women were aware to go private hospital, 10.6% of women gave other answers. according to them if pregnant woman have any problem in delivery, she must go to hospital either private or government if she does not have any problem in delivery, home was best place for it and remaining 2.5% of women were aware of CHC for delivery. Whereas, after IEC, majority of women became aware about safe place for delivery as during investigation they were informed about health risk of
unsafe deliveries for them and their babies. Most of the women agreed to access hospital for delivery specifically government hospital (56.7%) because cost was one of a factor for not accessing hospital for delivery among women and their family also. During IEC sessions, they were also informed about facilities under Janani Suraksha Yojana and support of ASHA (Accredited Social Health Activist), they became in favour of it. However, only 4% of women were aware of CHC for delivery because apathy of CHC staff. While, 10.4% of women were aware of private hospital. Only 4% of women said that home was suitable place for delivery and 25.3% of women gave other answers but responses were different from before intervention. According to them, women must access hospital facility at the time of delivery either government or private. Above findings indicate significant (p < 0.01) improvements in women's awareness regarding place of delivery after implementation of IEC aids.

5.2.4 Contraception

Earlier studies indicated that despite the availability of highly effective methods of contraception, many pregnancies are unplanned and unwanted. The utilization of the contraceptives affected with lack of proper information and awareness about the method among the users. In the present investigation, IEC was implemented to raise the awareness of rural women regarding contraceptives. IEC aids story cards Chhota pariwar swastha pariwar (Small family healthy family), Posters on Parivar Niyojan ke sadhan (Contraceptives), Beti ho ya beta parivar rakhe chhota (Either girl or boy but family must be small), Doosre bachhe me antar laye – Swasth pariwar payen (Interval between two children – Get a healthy family) were based on various contraceptives for women and their husbands, need of these contraceptive for their healthy family.
These IEC aids had significant impact \( p < 0.01 \) on women regarding their awareness on various contraceptives. Present investigation, depicts that after implementing IEC aids in group sessions and personal meetings, more rural women (97.5%) became aware about contraception as compared to 63.1% of women before IEC. It was also found by Al Olugbenga-Bello \textit{et al.} (2011) and Tuladhar H \textit{et al.} (2008) that majority of the women had good knowledge about contraception. Similar trend was observed in the study by Mao J. (2007). Majority of women knew about birth control measures. Majority of the women were aware about the mechanical method of family planning i.e. loop and condoms (65.3%) followed by chemical method i.e. oral pills (58.6%). Awareness about the natural method was low (42.6%) (Sharma B. \textit{et al.}, 2005). Though rural women were aware about various contraceptives before IEC but they were not aware about its need. It was reflected in use of contraceptives. Present study observed that before IEC majority of women (59.3%) were not using any contraceptive. Tuladhar H \textit{et al.} (2008) found similar situation but methods were different. The main reasons were found that they did not have need to use it, followed by not have information about it and husbands’ disapproval, fear of side effect and non availability. Husbands’ disapproval for using contraceptives was also observed by Shah N. A. \textit{et al.} (2008) and Kaushik S. \textit{et al.} (2003). Other similar reasons were also observed by Kaushik S. \textit{et al.} (2003) as women were not using contraception due to the fear of side effects, they belief they did not need due to infrequent sexual relation and they were “too old”. Non availability of contraceptives was also observed by ARTH (2000). Some women also felt that using pills might adversely affect subsequent childbearing. During IEC sessions these reasons were discussed with help of story cards. With the help of these aids they were told to reduce
sexually transmitted disease also and were counseled to talk to their husbands. After IEC, study reveals that higher proportion of rural women started to use contraceptives. Female and male sterilization were reported to use by 13.6% and 2.8% of women respectively. Further, 6.3% of women were using contraceptive pills, 4.0% of women were using IUD, 2.0% of women were using injectable, 27.3% were using condom and 1.8% were using Rhythm. These findings indicate the significant (p < 0.01) improvements in women's use of contraception after implementation of IEC. Similarly, Bertrand J.T. et al. (1982) found a strong association between family planning communications and the adoption of a contraceptive method. Majority of women showed marked improvement in knowledge regarding family planning after IEC intervention.

However, in rural area, the use of contraceptives regarded as the wife’s responsibility (Sharma B. et al. 2005). But they do not have power of taking decision regarding contraception. Present research depicts the similar situation as use of contraception was the decision of only 3.8% of women, while, 29.3% of women’s husbands alone took decision regarding use of contraceptives and 41.7% of women and their husbands both took decision regarding use of contraceptives. Al Olugbenga-Bello et al. (2011) also had similar observation, they reported that 37.4% women’s husband solely decided on family planning, among 21.4% of women it was their decision but among 41.2% women, it was a joint responsibility of husband and wife. Further, study indicates that after IEC 12.9% of women stated that to use contraceptives was their decision, while 18.2% of women stated that their husbands alone took decision regarding use of contraceptives. Further, most of the women (65.9%) stated to take decision with their husbands regarding use of
contraceptives. Findings indicate significant improvements (p < 0.01) in women's decision making regarding contraception after implementation of IEC.

Present investigation describes the side effects of contraceptives among women. Regarding the side effects of contraception 10.9% of women reported irregular menstruation followed by 2.8% allergy, 1% of women reported amenorrhea, 1% of women reported lower abdomen pain, 0.8% of women reported weakness, while 24.7% of women did not experience any side effect. Amenorrhea, irregular bleeding, weakness, lower abdominal pain as side effect of different contraceptives were also observed by Shah N. A. et al. (2008). Present study also reveals that if women had any problem while using contraceptive, whether they shared it with their husband or not. It has been observed that 11.4% of women were not sharing problems because using contraception was their decision and husband would not understand their problems. Further, 27% of women did not have any problem to share it. During IEC session women were counseled to share their problems with their husbands because husband and wife both had to bear the responsibility of using contraceptives. After implementing IEC, data indicates that more women (15.9%) started to share their problems related to contraception as compared to before IEC. These findings indicate significant improvements (p < 0.01) in women's sharing problems regarding contraception after implementation of IEC.

5.2.5 Abortion

Earlier studies have pointed out that the issue of abortion affects many women in the world; it is 'poor, adolescent, rural women who suffer the most. Present study considered the issue of abortion, either safe or unsafe affects the health of women. In the study IEC
was conducted to bring change in the **attitude of women towards aborting their child**.

IEC aids flash cards 'Ladka hi hoga' (Will Be Son), poster Garbhat – Sehat par asar (Abortion – effect on health), *Paper folding* game were based on ill effects of abortion on women's health (Annexure IV). IEC was also focused to use contraceptive rather than practicing abortion. These IEC aids had significant impact (*p* < 0.01) in changing rural women's opinion on abortion. Present study reveals that 11.1% of women favoured abortion while 35.1% of women reported it as wrong. On the other hand 7.1% of women gave other answers. According to them abortion is right if family have one or more daughter without any son or if the woman and her family did not want more child otherwise it is wrong. After implementing IEC, majority of women (75.3%) became against it while remaining women remained unaware.

Further, study depicts the **number of abortions** experienced by rural women that 13.4% of women of all interviewed women had experienced one abortion over their lifetime, while, 7.8% of women had experienced two abortions. Remaining women experienced none of the abortion. These finding are sustained by Jejeebhoy S. J. (2011) as in her study, 11% of all women interviewed had experienced one or more abortions over their lifetime. Similarly, Getahun H. (2000) also found a lifetime history of abortion as 20.8% of the women but the mean number of abortions per woman was higher. Present investigation highlights the reasons of practicing abortions among women, reasons for seeking abortion among rural women were 'don't need any more daughter' (10.6%) and 'don't need any more child' (9.8%), doctor's advice (0.8%). Supporting these findings, Dhillon B. S. *et al.* (2004) also observed similar reasons as 'don't need any more children' and 'don't need any more daughters' for seeking abortion among rural women.
Aborting the birth of a girl child and limiting family size as the reason for the abortion were also observed by Ganatra B. et al. (2001).

Regarding place of abortion, present research reveals that considerable proportion of women had sought pregnancy termination form private hospitals where successful abortions had been performed by doctors and had gone surgical abortions. Successful surgical abortions by doctor among majority of women were also observed by Jejeebhoy S. J. (2011). Further study points out that only 1% of women accessed government hospitals followed by CHC/ PHC (0.8%). Self introduced of hard material in vagina was used for inducing abortion by 4% of women. Pregnancy termination by unqualified providers was reported by 0.8% of women. Dhillon B. S. et al. (2004) supports the findings as in their study it was found that majority of women accessed abortion services from private clinics as compared to government hospital and PHC/CHC. Similarly, self-introduction of hard material in the vagina and chloroquine over-dosage for inducing abortion was also found by Getahun H. (2000). The decision to terminate the pregnancy and place of abortion was made by the husband. Further present study indicates the health problem faced by women after abortion. Women who practiced abortion over a life time, among them 9.1% of women did not face any problem after abortion, 7.1% of women reported incomplete abortion followed by severe bleeding (2.5%), chronic pain (2.0%), infertility (0.5%). Similar observations were also found by Ganatra B. et al. (2001) as in their study three quarters of the women reported one or more problems like severe bleeding, menstrual irregularities and weakness after abortion.

During IEC sessions with the help of IEC aids, reasons for practicing abortion and post abortion morbidity were discussed and they were counseled to not to practice abortion in
any case except doctor’s advice as, abortion affects women’s health. Study depicts the significant impact ($p < 0.01$) of these IEC aids on awareness regarding health consequences of abortion among rural women where before IEC, majority of women were not aware about consequences of abortions on women’s health. After implementing IEC aids flash cards, poster and paper folding games, most of the women became aware regarding consequences of abortion on health. About 29.3% of women reported RTI/STD followed by infertility (23%), weakness (14.1%), all above (15.7%). ‘Nothing’ was stated by 2.3% of women.

Above findings indicate significant impact of various IEC aids like flash cards, flip book, story card, puppets, posters and games on issues of menstruation, marriage, reproduction, contraception and abortion. Similarly, Mishra B.N. et al. (2008) observed significant improvement in the knowledge and practice of women after implementing printed health educational material. These statistics indicates that IEC and women’s awareness regarding gender health inequity were significantly associated i.e. IEC aids are effective tools to bring behavioural changes among rural women regarding gender health inequity.

5.3 Association between awareness regarding gender health inequity among rural women and demographic characteristics

Study shows the association between socio demographic characteristics and menstruation among rural women before and after IEC. It is common perception that women gain more experience and knowledge about social issues, as they get older. This experience gives them better understanding to make decision about their life. In contrast, women of younger age have less experience and are less knowledgeable. This indicates association

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between age of women and knowledge of social issues. Similarly, present study indicates significant association between pre IEC awareness about menstruation and age of women, occupation of women (p < 0.05), religion, socio economic status and education (p < 0.01). Further, post IEC awareness regarding menstruation was found to be insignificant with demographic characteristics of women. Study also indicates significant association between before IEC bathing at the time of menstruation and socio economic status at (p < 0.05) and religion (p < 0.01), further, between post intervention bathing at the time menstruation and rural women's education (p < 0.05) and religion (p < 0.01). Study observes significant association of use of absorbent material during menstruation among women with education, occupation, religion, age and socio economic status (p < 0.01) before IEC and education, occupation, religion, socio economic status age (p < 0.01) after IEC. Similarly, statistically significant and strong relationship of education of the women and socio economic status with their menstrual hygiene practices in terms of using material either as ‘Used cloth’, ‘Fresh cloth’, ‘Sanitary pads’ or ‘Home-made pads’ was also found by Singh S. et al. (2011). While, change of absorbent material during menstruation was significantly correlated with rural women’s education and socio economic status of women (p < 0.01) before IEC and post IEC with age (p < 0.01), education (p < 0.05) in the present study. Whereas, restrictions during menstruation among rural women was significantly correlated with age, religion (p < 0.01), education (p < 0.05) before IEC while post IEC with age (p < .001), religion and occupation (p < 0.05). Above findings indicates that demographic characteristics are significantly associated with overall awareness regarding menstruation before and after IEC. In contrast, Parmar V, (2010) revealed that the demographic characteristics as age and
literacy level of the participants had no significant effect on the knowledge level related to menses.

Present research depicts significant association between awareness regarding age of marriage among women and age of women (p < 0.05), occupation, socio economic status of women, education (p < 0.01) before IEC and between post IEC and religion (p < 0.01) only. Further, significant association was found between opinion on early marriage among women and education, socio economic status of women (p < 0.01) before IEC. On the other hand, post IEC opinion on early marriage was significantly correlated with age (p < 0.01) only. While, before IEC awareness regarding effect of early marriage among women was significantly associated with education, religion and socio economic status of women (p < 0.01). Whereas, post IEC awareness regarding effect of early marriage on health was significantly correlated with education, occupation and religion of rural women and socio economic status (p < 0.01). Above findings indicates significant association between demographic characteristics and marriage before and after intervention among rural women conforming the findings of earlier studies. For example Parveen S (2007) that women’s education was positively correlated with their level of gender awareness i.e. timing of marriage.

Present investigation shows significant relationship between pre IEC awareness regarding number of children among women and their age, socio economic status of women, education (p < 0.01), occupation (p < 0.05). While, post IEC awareness regarding number of children was significant with age, socio economic status of women, education and occupation (p < 0.01). Further, study indicates that pre IEC gender preference of children among rural women had significant relationship with education, occupation (p < 0.01)
and religion of women (p < 0.05). Except it, post IEC gender preference was positive and significantly correlated with education, occupation of rural women, age and socio economic status of women (p < 0.01). Further, present investigation depicts significant association between pre IEC awareness regarding age of first pregnancy and socio economic status of women, education of rural women (p < 0.01). Post IEC awareness regarding age of first pregnancy had significant relationship with religion (p < 0.01) and socio economic status of women (p < 0.05). Study shows relationship between demographic characteristics and awareness regarding birth interval between two children among women. Pre IEC awareness regarding birth interval between two children among women was found to be positive and significantly correlated with age of women and socio economic status of women, education, occupation, religion (p < 0.01). Whereas post IEC awareness regarding birth interval between two children was found to be positively significant with occupation of rural women, socio economic status of women (p < 0.01). Further, post IEC awareness regarding birth interval between two children was found to be insignificant with age, education and religion (p > 0.05). Study shows significant correlation between pre IEC awareness regarding consequences of closed birth interval among women and socio economic status of women (p < 0.05), religion, education (p < 0.01). Further, post IEC awareness regarding consequences of closed birth interval on health among women was found to be positively significant correlation with age of women, education (p < 0.01). Present investigation highlights significant relationship between pre IEC awareness regarding antenatal care among women age of women, socio economic status of women, education (p < 0.01). Study indicates, significant correlation between pre IEC awareness regarding place of delivery among
women education, socio economic status of women (p < 0.01), occupation, age (p < 0.05). On the other hand post IEC awareness regarding place of delivery was significantly correlated with education and religion (p < 0.05). Above findings indicates significant association between demographic characteristics and reproduction before and after intervention among rural women. Supporting the above findings, Hadi A, (2001) found that education appeared to play a significantly positive role in raising women’s perceptions regarding timing of childbearing.

Study shows significant correlations between pre IEC awareness regarding contraception socio economic status of women (p < 0.05), age (p < 0.01). On the other hand, post IEC awareness regarding contraception was found to be significant with socio economic status (p < 0.01). Further, study found significant correlation between pre IEC use of contraception and occupation of rural women, age (p < 0.01). Post IEC use of contraception was found to be significantly correlated with rural women’s education, occupation, religion, age, socio economic status of women (p < 0.01). Further, study pointed out significant relationship between post IEC decision making regarding contraception among women and occupation of rural women (p < 0.05), socio economic status of women (p < 0.01). Study indicates a significant correlation between pre IEC problem sharing regarding contraception among women and rural women’s occupation, socio economic status, education (p < 0.05), age (p < 0.01). On the other hand, post IEC problem sharing regarding contraception among women was found to be significant with religion, socio economic status of women (p < 0.05), education, age (p < 0.01). Above findings indicates significant association between demographic characteristics and awareness regarding contraception before and after intervention among rural women.
Supporting the above findings, Hadi A, (2001) also found that significant relationship between education and women’s perceptions regarding contraception. Similar findings were also observed by Okezie C. A. et al. (2010). Usage of contraceptives was higher among literate as compared to illiterate women (Ladusingh L. et al. 2006). In contrast, no significant association of contraceptive usages was observed with literacy while statistically significant association of contraceptive usage was seen with religion and the age of female by Hussain N 2011. Except it, religion played an important role in determining the attitudes of the people in limiting the family. Non-acceptors of family planning methods were higher among the Muslims (Mohanan P. et al. 2003). Similarly, Bertrand J.T. et al. (1982) concluded that education, working status of women and SES play a vital role in success of IEC interventions on family planning.

Study indicates significant relationship between pre IEC opinion on abortion and age (p < 0.05) and education (p < 0.01). On the other hand, post IEC opinion on abortion was significantly associated with religion, education (p < 0.05). Further, study shows significant correlation between pre IEC awareness regarding consequences of abortions among women socio economic status, education (p < 0.01). Above findings indicates significant association between demographic characteristics and awareness regarding abortion among women before and after IEC.

5.4 Rural women’s health status and its association to gender health inequities practices

In this section, association between rural women’s health and gender health inequity has been discussed under following sections –
5.4.1 Rural women’s health

Present study depicts that majority of rural women (67.2%) possessed normal BMI (18.5 – 24.99 kg/m²), 25% of rural women possessed low BMI (< 18.50 kg/m²) and 7.8% of rural women possessed BMI above > 25 kg/m². Rout N R (2009) sustained these finding as study evidenced that majority of rural women were having normal BMI. As far as anaemia was concerned, present investigation highlights that majority of women (56.3%) had moderate anaemia, 23.5% of women had mild anaemia, 7.8% of women had severe anaemia, remaining were normal. While, Gupta S K. et al. (2010) also found that among the study group majority of women were anemic. Whereas in rural Delhi Gautam V. et al. (2002) high prevalence of anaemia among rural women as compare to findings of present study. Above findings indicates that however most of rural women were having normal BMI but anaemia was widely prevalent among them. In the present study, majority of women were suffering from pain in joints and back ach followed by constipation, diarrhoea, fever, tuberculosis. Sharma R.K. (1986) also found that rural women were suffering from constipation, diarrhea. While coming to the menstrual problem among rural women, in present research, majority of rural women had no menstrual problem (55.3%), followed by Oligomenorrhoea, menorrhagia, delayed cycle, polymenorrhoea and genital infection. Rathore Monika et al. (2003) in rural area of Rajasthan found lower prevalence of menstrual problem. Whereas, Singh S. K. et al. (2001) observed in rural Maharashtra that few rural women were having at least one menstrual problem.
Painful period (dysmenorrhea) and scanty bleeding (hypomenorrhea) were the two leading problems.

Regarding prevalence of reproductive tract infection among rural women present investigation indicates that 43.7% of women were suffering from lower reproductive Tract Infection and only 0.5% of women were suffering from upper reproductive tract infection. Similarly, Pant B. et al. (2008) observed that women reported symptoms suggestive of reproductive tract infection. Rathore Monika et al. (2003) also observed similar situation in rural Rajasthan, women were suffering from RTI. Women were suffering from ‘Vaginal discharge’ , ‘Itching’, ‘Boils’, ‘Pain abdomen’ , ’Pain during sexual intercourse’, ‘Backache’, ‘Lymph node enlargement’ (Singh Sadhana et al., 2011, Sharma S et al., 2009, Kanitkar et al., 2004).

5.4.2 Association between rural women’s health status and gender health inequity practices

Study indicates significant relationship between body mass index and bathing at the time of menstruation, use of absorbents among women (p < 0.01). While, insignificant relationship was found between body mass index of women and change of absorbents used in menstruation and restriction during menstruation (p > 0.05). Further, study highlights that there was an insignificant relationship between anaemia among women and bathing during menstruation, use of absorbents, restrictions during menstruation (p > 0.05). Anaemia was significant with change of absorbents during menstruation (p < 0.05). Study also points out a significant relationship between change of absorbents (p < 0.05) and common illnesses among women. While, bathing during menstruation, use of
absorbent material, restrictions during menstruation (p > 0.05) were insignificant with common illnesses. Further, study indicates an insignificant association between bathing during menstruation, use of absorbent material, change of absorbents during menstruation (p > 0.05) and menstrual problems among women. Significant relationship was observed between common illnesses and restriction among women (p < 0.01). Study indicates a significant correlation between RTI among women and bathing at the time of menstruation (p < 0.05), use of absorbent material (p < 0.01). Singh S. et al. (2011) observed that RTI symptoms were strongly associated with menstrual hygiene practices of re-using 'cloth'. Women who were using ‘Used cloth’ during menstruation, most of them reported RTI symptoms as compared to women who were using ‘fresh cloth’, ‘sanitary pad’, ‘Home made pads’. Pant B (2008) also reveals that prevalence of RTI was significantly higher in women who used unworked clothes during menstruation as compared to women who used either washed clothes or sanitary pads. While, present study reveals that RTI was insignificant with number of absorbents during menstruation and restriction during menstruation among women (p > 0.05).

Present study highlights a significant association of body mass index, anaemia, reproductive tract infection with women’s age of marriage (p < 0.01). Women who married before the age of 18 years majority of them reported RTI (Pant B. et al. 2008). Kanitkar et al. (2004) also observed similar situation that RTI prevalence rate was highest among women who married at age 15 years and lowest for women married at 19 years or above. Further, study also reveals an insignificant relationship of common illnesses and menstrual problems among them with women’s age of marriage (p > 0.05).
Study indicates an insignificant relationship between body mass index of women and number of children among women (p > 0.05). With other reproduction practices, body mass index was positive and significantly associated with age of pregnancy, number of pregnancies, interval between births of two children, received antenatal care and place of delivery (p < 0.01). Further, study also indicates the significant relationship between anemia and number of children, age of pregnancy, interval between births of two pregnancies, place of delivery, number of children, received antenatal care (p < 0.01). Gautam V. et al. (2002) depicts that when, first pregnancy was delayed up to 18 years or later, the pregnant women were more often normal or had mild anaemia, however, these trends were statistically not significant. Moreover, study indicates different observation from above findings, regarding prevalence of anaemia and birth interval and found an insignificant relationship between them. Further, study also indicates the significant relationship between common illnesses and number of children, number of pregnancies, received antenatal care, interval between birth of two children, place of delivery (p < 0.01) while common illnesses was found insignificant with age of pregnancy (p > 0.05). Further, study also indicates a significant relationship between menstrual problems and number of children, number of pregnancies, birth interval (p < 0.01), place of delivery (p < 0.05) while menstrual problems were insignificant with age of pregnancy and received antenatal care (p > 0.05). Study observes a significant correlation between RTI and number of children, women’s age of first pregnancy, number of pregnancies, received antenatal care (p < 0.01). Similarly, association between higher fertility with higher incidence of RTIs/STIs was also observed by Gulati S.C., (2003). On the other hand, woman having no children also had the highest prevalence rate of RTIs (Kanitkar et al.
2004). While, RTI was insignificant with birth interval, place of delivery (p > 0.05). In contrast, indicating a significant association between place of delivery and RTI, study by Kanitkar et al. 2004 observed that home delivery was the greatest risk factor associated with RTI symptoms and delivery in private hospitals had minimum risk. Another study by Gulati S.C. and Sharma S. (2003) also revealed that institutional deliveries had significant and inhibitive effect on the incidence of RTIs.

Present investigation reveals significant association between body mass index and use of contraception, sharing problem regarding contraception (p < 0.01). Significant association was also found between anaemia and use of contraception, sharing problem regarding contraception (p < 0.01) among women. Common illnesses were insignificant with use of contraception, sharing problem regarding contraception (p > 0.05). Menstrual problems were also insignificantly associated with use of contraception, sharing problem regarding contraception (p > 0.05) among women. Reproductive tract infection was insignificantly associated with use of contraception, sharing problem regarding contraception (p > 0.05) among women. In contrary, Rathore M et al. (2003) indicated significant relationship between reproductive morbidities and use of contraception. But the prevalence of reproductive tract infection among women using oral contraceptives and condoms was less as compared to those who were using an intrauterine device and tubectomies. Women who were not using any contraceptive, most of them were suffering from RTI (Sharma S. Gupta B. P. 2009).

Study also indicates significant relationship between BMI and practice of abortions, number of abortions (p < 0.01), place of abortion (p < 0.05) while anaemia and common illnesses were insignificantly associated with practice of abortions, number of abortions,
place of abortion (p > 0.05). Significant relationship was found between menstrual problems and practice of abortions (p < 0.01) while menstrual problems were insignificant with number of abortions, place of abortion (p > 0.05). Further, RTI was significantly associated with practice of abortions, number of abortions, place of abortion (p < 0.05). Kanitkar et al. (2004) also observed that induced abortions were significantly associated with RTI prevalence.

Above discussion reveals that rural women in Jawan Block have incomplete knowledge regarding gender health inequity. Unhygienic practices during menstruation, early marriage, unsafe reproductive practices, no use contraception and unsafe abortion are still practicing due to misconception and traditional norms. These practices are affecting women's health as anemia, common illnesses and menstrual problems and RTI prevalent among these women. IEC have a significant impact to improve practices among rural women of Jawan Block.