

## Chapter VIII

### Summary, Conclusion and Policy Implications

#### 8.1. Introduction

This chapter provides summary, conclusion and policy implications based on the findings of the present research work. It highlights background of the study, research area and objectives, profile of the respondents, knowledge and practices related to reproductive and infant health, women's autonomy, decision-making power, gender role and domestic violence. In addition, it presents some of the policy implications on young women's reproductive and infant health, limitations of the study and scope for future research.

#### 8.2. Background of the study

The wellbeing of women's reproductive and infant health is often dependent on appropriate decisions and treatment of health problems. Since women bear children and are primary caregivers in households, they are crucial for all matters related to their reproductive and infant health. Though ideally it should be an equal responsibility of both men and women, society expects the accountabilities differently. Each society has a certain set of values and norms that not only facilitate its functioning but also shape the behaviour of its members. Gender norms, i.e., the socio-cultural definition of 'man' and 'woman', the way societies distinguish and assign them social roles are variable and change from time-to-time, culture-to-culture and even family-to-family within the same society.

Gender disparities and ambiguities associated with gender role have influence on the sexual and reproductive health of young people. Worldwide health care providers, policy makers and donors recognize the direct connection between young people's gender roles that translate into their reproductive and infant health care behaviour. The prevailing unequal power equation and traditional practices often make young women more vulnerable to adopt healthy reproductive and infant health behaviour. Again, inequitable gender norms and related behaviour induce violence. It is again a fact that young people in a society are frequently socialized around a constellation of traditional gender norms related to reproductive and infant health.

There are evidences which clearly outlined that a substantial proportion of young women in India are still getting married below the legal age of marriage and a significant percentage of them experience immediate motherhood too. Again, there is a lack of informed choice in contraception, and incidences of unwanted reproductive health outcomes among young women take place. Gender and social norms that govern relationships between men and women in their daily lives also govern decisions on whether and when to use services. If these norms are not altered concurrently with improvements in access and service delivery, health results will only be partially met.

Some of the studies in the past have primarily focused on youth (men and women) in the urban settings and few have attempted to study the same in rural setting. Few studies have an integrated approach of gender, reproductive and infant health behaviour. Moreover, studying reproductive and infant health behaviour from a gender perspective in a rural set-up is expected to unfold many un-addressed issues. In the above context, it was essential to explore reproductive and infant health behaviour among young married women with a gender perspective. This is expected to reveal some of the ways in which the society transmits and reinforces the ideological beliefs pertaining to young women in different socio-cultural settings. Furthermore, obtaining young people's view, especially from those who live in rural areas, will not only help in filling the gaps in knowledge in a more effective manner but will also help in incorporating them into programmes and policies that will be favourable towards them.

### **8.3. Study area and objectives**

The present study was undertaken in the selected villages of Gajapati district of Odisha State. The purpose was to understand young married women's space in determining their reproductive and infant health care behaviour with a gender perspective. The specific objectives are: (1) to understand the knowledge and practices regarding reproductive and infant health care among young married women; (2) to examine the gender responsiveness towards young married women's reproductive and infant health care practices; (3) to identify the factors determining young married women's decision-making on reproductive and infant health care seeking behaviour; and, (4) to study the association between socio-demographic factors including gender role and reproductive and infant health care among young married women.

The study hypothesized that (1) though women are better aware of reproductive and infant health care behaviour, they don't practice accordingly, (2) treatment seeking of the reproductive and infant health problem is more among women with higher autonomy, (3) men play an important, often dominant role in decisions crucial to women's reproductive and infant health, and (4) women of higher age and having more children are better care takers of their reproductive and infant health.

The study broadly conceptualized that reproductive and infant health care behaviour is subject to mainly four sets of factors, i.e., (i) individual level factors like women's age, education, occupation, caste, religion, exposure to mass media, number of children, experience of infant mortality, attitude towards gender roles and responsibilities, inter-spousal communication; (ii) household level factors such as type of family, income, standard of living, influence of elder members of family including husband; (iii) community level factors like availability of health care facilities, door step services provided by frontline health workers and availability of transportation facility; and, (iv) autonomy factors like mobility and decision-making power of women. These factors in combination directly or indirectly influence young women's knowledge and behaviour towards their reproductive and infant health.

Gajapati district of Odisha, which has been studied, borders Andhra Pradesh. Primary data was collected through a combination of quantitative and qualitative methods. Data collection through quantitative method included structured survey through a questionnaire and qualitative method included focus group discussion (FGD). Currently married women, aged between 15-24 years and who had a pregnancy outcome in the last one year preceding the survey, were interviewed. Similarly, to get insights into different aspects of reproductive and infant health care behaviour nine FGDs were conducted. All the eligible respondents for the study were selected through a multi-stage sampling design and a total of 324 women were interviewed at the household level. All necessary ethical principles including informed consent of the participants had been taken into consideration during the data collection process. Scientific software packages like SPSS and Atlas-ti were used for analysis.

#### **8.4. Profile of study population**

Young women covered in the study had a mean age of 21 years. About 35 per cent of women and 30 per cent of the husbands have no education, while only 24 per cent of women and 45 per cent of husbands have studied up to Class IX and above, which was reported by the women. More than three-fourths of the women were home-makers, while almost the same proportion of husbands was either working as daily wage labourers or were self-employed. More than half per cent of the study population (57 per cent) resided in *pucca* houses, while only 28 per cent had *kachha* houses. The study area was highly inhabited by scheduled castes (SCs) and other backward classes (OBCs). Data showed that about 40 per cent of the women are of SCs and 30 per cent OBCs, while 15 per cent each belong to scheduled tribes (STs) and general castes. Similarly, Hinduism and Christianity are two major religions which have following of about 53 per cent and 45 per cent respectively, with very few per cent women belong to Muslim category (2 per cent). The major source of drinking water for people in the villages was open well followed by bore or tube well. About 75 per cent women reported that there was no toilet facility in the house and they used open spaces of the village for this. Data revealed very few women (8 per cent) belonged to high standard of living, while more than 60 per cent were in medium standard of living category. There were about 31 per cent women who had low standard of living. Twelve per cent women and 32 per cent of their husbands had high exposure to different types of mass media. A majority of the women (62 per cent) and their husbands (46 per cent) had medium exposure to mass media. About one fourth of the young women and their husbands had low exposure to mass media.

#### **8.5. Marriage and fertility**

The study found that a high proportion of young women (92 per cent) were consulted by their family members prior to deciding about their marriage, but 8 per cent of them were deprived of consensual marriage. Qualitative findings highlighted that most of the young women were married to the person primarily chosen by their parents or relatives. About 64 per cent of them had married before completing the legal age of marriage, the mean age at marriage being 17 years. Though there are few women whose husbands were more than 10 years older than them, the mean age difference between the husband and wife was six years. It was found that 25 per cent of the women were within one year of their marriage, while about 38 per cent each had spent 2 to 4 years and above 5 years of their marital life. Among all the young women, 90 per cent had live births, 3 per cent had still births and 7

per cent had abortions within the year preceding the survey. At the time of survey, 49 per cent of the women had no or one child, 36 per cent had 2 children and 15 per cent had 3 or more children. About 19 per cent of the women had experienced at least one infant mortality since they were married.

### **8.6. Knowledge and practice about antenatal care**

The study revealed that most of young women (93 per cent) were aware that they should receive at least three ANC's during pregnancy, but only 77 per cent received three ANC's during pregnancy. When they were asked about the timing of ANC, more than 95 per cent of them said that the first one should be received during initial three months of pregnancy. But 71 per cent of them received it in the first trimester. Though it is essential to get the first ANC during first trimester, 24 per cent of the women received it in the second trimester and 6 per cent in the third trimester. Women received ANC services mostly at government hospital and anganwadi centre. Provision of ANC services by ANM in every village in every month seems to be a major contributor for receiving such services in a non-medico platform like an anganwadi centre.

Awareness and receiving of three ANC's were found better with higher education of a woman and her husband. Data revealed that a majority of young women (90 per cent) with no education were aware that at least three ANC's are required. But only 61 per cent of similar women received three ANC's for their last pregnancy. More than 88 per cent women who studied higher than Class IX received at least three ANC services for their last pregnancy. Older young women had slightly better knowledge about ANC services. It was found that 78 per cent of the women with whom someone like front line health service providers or household members discussed about the need for ANC received three ANC services, whereas this was low (65 per cent) for women who did not have any discussion about the need for it. Women with more autonomy were better aware (97 per cent) as well as accepters (91 per cent) of three ANC's compared with women of moderate and low autonomy. Antenatal check-ups like BP, Hb, protein urea and abdomen examination are essential to identify high risk pregnancy. In the present study it was found that about 77 per cent of young women were aware of TT and IFA, and 89 per cent of them received them, although only about 7 per cent of them were aware and received the essential antenatal check-ups. Logistic regression results highlighted that the likelihood of receiving three ANC's was 2.5 times significantly high for women with education and 2.3 times high

for women belonged to general and other backward classes compared with their respective other groups. Women who had higher standard of living, had discussion with a health service provider or family members about the need for ANC, and had high to moderate autonomy and decision-making power had significant impact on accepting three ANC services. The study reveals that more than 54 per cent of the young women experienced some or the other health problem during their last pregnancy and of those about 20 per cent had not sought any treatment mainly because they did not feel the need for it

### **8.7. Knowledge and practice about delivery care**

Regarding the place of delivery, a majority of young women (97 per cent) said that a woman should deliver in a government or private health facility. Still 27 per cent women did not deliver their last baby in a health facility and delivered at home. Though most of the women think that a woman should deliver in a health facility, only a small number actually went there. This phenomena cuts across their socio-demographic characteristics. Education does not seem to much influence institutional delivery as women with lower education were aware and delivered their last baby in an institution. However, all the women in the younger age group (15-19 years) were aware and 84 per cent of them delivered their last baby in an institution, while this was 69 per cent for women aged 20-24 years. Seventy-five per cent women who had a discussion with health service providers/household members regarding the place of delivery delivered their last baby in an institution, while this was 62 per cent for women who did not do so. Exposure to mass media had a positive impact on institutional delivery. Among the women who delivered at home, 90 per cent arranged a new blade to cut the umbilical cord, and 83 per cent arranged clean cloth to wipe and wrap the baby. Only 55 per cent women arranged new thread to tie the umbilical cord which is critical to prevent the baby from cord infection. Not even a single woman identified a vehicle to go to an institution in emergency. The logistic regression models highlighted that there is a significant association between caste and institutional delivery, where women in the general and other backward classes were 4.1 to 4.7 times more likely to delivery their last child compared with the SC and ST women. Likewise, women who had a discussion about the place of delivery with the health service provider or household member were 1.6 to 2 times more likely to deliver their last child in a health facility. Women with high to moderate autonomy were 2.8 times significantly high in delivering the last child in an institution compared with women of low autonomy. The study also highlights that more than 87 per cent young married women were aware

that a woman can suffer some health problem during delivery. Most of them were aware of obstructed labour (71 per cent) and excessive bleeding (44 per cent). Nearly 35 per cent women experienced a problem during delivery and of those about 79 per cent sought treatment. Those who had not sought treatment mostly delivered their last baby at home.

### **8.8. Knowledge and practice about postnatal care**

Nearly 80 per cent women were aware that post-natal check-up should be done within one day (24 hours) of delivery, but about 14 per cent did not know when to do it. Among those women who delivered at home, about 79 per cent had not done any post-natal check-up, whereas of those who delivered their last baby in an institution, more than 90 per cent received first post-natal check-up within one day of delivery. This is because women who delivered in a health facility had to stay there for 48 hours after delivery and by default they were visited by doctors and ANMs, whereas this does not happen in the case of home deliveries. This was also evident from the qualitative findings. In the post-natal period about 83 per cent women were aware of some problem and nearly 42 per cent of them suffered from one or the other. Analysis of awareness and treatment seeking behaviour for post-natal health problems by different background characteristics showed that 85 per cent women in the older age group (20-24 years) and 77 per cent women in the younger age group (15-19) were aware that a woman can suffer from them during post-natal period. Among the 15-19 years old women who suffered from any health problem, 87 per cent sought treatment, while the corresponding figure was 59 per cent for women aged 20-24 years. All the women having a high standard of living, 77 per cent women of medium standard of living and 46 per cent women of low standard of living sought treatment for their post-natal health complications. Seventy-three per cent women who had discussion about the need for post-natal care and 64 per cent who did not have it sought treatment for their post-natal health complications. The logistic regression results also depicted that women of 15-19 years were more likely to seek treatment for their post-natal problems compared with women of 20-24 years. Women of general and other backward classes were up to four times more likely to seek treatment for their post-natal health problems compared with SC-ST women. Similarly, women having high to moderate gender equitable attitude were almost 3.8 times more likely to seek treatment for their post-natal health problems compared with those of low equitable gender attitude.

### **8.9. Knowledge and practice about family planning**

It was found that most of the young women (98 per cent) were aware of a family planning method and about 64 per cent used one such method. Though awareness regarding a modern family planning method was the same, only 28 per cent women used a modern method. Further analysis illustrated that about 10 per cent women used a modern spacing method and 19 per cent a limiting method of family planning. Still, a significant proportion of young women (36 per cent) used traditional methods to prevent pregnancy. Nearly 84 per cent women knew that modern contraceptives are available in the government hospitals. Similarly, 48 to 49 per cent women said they are available in medical stores and anganwadi centres. Often women considered anganwadi centre and medical store as a place to obtain condoms and oral pills.

Awareness of family planning methods is high among women with all socio- demographic characteristics. However, there are variations in the use of contraceptives by some socio-demographic characteristics. Thirty per cent women in the age group of 20-24 years used a modern family planning method. It was 24 per cent for women aged 15-19 years. Similarly, 37 per cent women who completed more than five years of marital life and 45 per cent of them who had more than three children were found to be using a modern contraceptive method. The corresponding figures were about 11 per cent and 15 per cent for women in the initial one year of marital life and having no or one child respectively. Contraceptive use increased with longer marital duration and a larger number of children. Despite a high level of contraceptive awareness, only half of the young women who never had a discussion with husbands about the number and timing of having children were aware of any modern contraceptive and none of such women also used a modern method. Regression analysis showed that SC and ST women were more likely to use a modern method compared with general and other backward class women. The likelihood of modern contraceptive use is significantly high among women who had two or more children. Similarly, women having high to moderate equitable gender attitude were almost twice more likely to use a modern contraception compared with women having low equitable attitude.

### **8.10. Knowledge about RTI/STI and treatment seeking behaviour**

Nearly 16 per cent women reported that they were aware of one or the other symptom of RTI-STI. About 14 per cent women experienced at least one symptom in the past six

months. About 28 per cent women knew the use of condom and that abstaining from husband could prevent RTIs. The most critical thing is that nearly 18 per cent young women did not know how to prevent it. Similarly, 33 per cent women said that STI could be prevented by using condom and 31 per cent women said by abstaining from husbands. There were about 22 per cent women who did not know how to prevent STI. However, of the 44 women who experienced at least one symptom of RTI/STI in the past six months, only 20 women (46 per cent) sought treatment either in a government or private hospital. Further analysis revealed that 27 per cent of the women who completed more than Class IX were aware of RTI/STI problems and 75 per cent of them sought treatment. A similar pattern is observed for women whose husbands completed Class IX and above. Women in the age group of 20-24 years who experienced any RTI/STI symptom sought treatment, while only 18 per cent of them were aware about RTI/STI problems.

### **8.11. Knowledge and practice about infant care**

It was found that 93 per cent women were aware of at least one essential care (*cut cord with a new blade, tie cord with new thread, wipe and wrap with clean cloth, no bath for a week, breast feeding within one hour and minimal handling of the baby*) to be taken to prevent infection to a newborn baby, but there was only one woman (0.3 per cent) who was aware of all of them. However, 77 per cent young women were aware that breast feeding has to be initiated within one hour of delivery and 81 per cent knew that exclusive breast feeding has to be continued till six months. In actual practice only 58 per cent women breastfed their children within one hour of birth which is almost 19 per cent points less than the percentage of women aware of it. Similarly, 55 per cent women exclusively breastfed for six months which is 26 per cent points less than the percentage of women aware of it. Similarly, though 77 per cent of the young women were aware of correct age of initiating breastfeeding, only 27 per cent initiated it at that age. Most of the women (69 per cent) initiated complementary feeding before the baby completed six months. This finding clearly compliments the obtained result of low rate of exclusive breast feeding till six months.

Regarding child immunization, it was found that 83 per cent of the young women were aware of some or the other immunization given to a child within one year. On the contrary, 92 per cent women said that receiving at least one immunization for their last born child was more than they were aware. This seems possible due to the universal immunization

flagship programme of the Government which was evident from focus group discussions. Subsequent analysis was carried out to understand the knowledge regarding each vaccine/immunization. Results illustrated that though 81 women were aware that BCG had to be given to a child, 66 per cent knew the appropriate month of administering it. Similarly, 66 per cent women were aware of DPT-1, 55 per cent of DPT-2, 43 per cent of DPT-3 vaccine. But the appropriate time of giving this vaccine was known only to 37 per cent, 30 per cent and 20 per cent women respectively. Same is the case for measles, where 31 per cent women were aware of it, but 24 per cent knew when it had to be given. On the other hand, though 91 per cent of the infants received BCG, only 76 per cent received it in time. Similarly, 79 per cent infants received DPT-1, 68 per cent DPT-2 and about half of them DPT-3 vaccine. But the percentage of infants receiving these vaccines in appropriate time was much lower. This accounts for 54 per cent for DPT-1, 40 per cent for DPT-2 and 30 per cent for DPT-3. Same is the case for measles, where 19 per cent children received the vaccine at any time, but 13 per cent children received it in time.

About 78 per cent of young women were aware of the health problem of an infant. The most common problem known to women was fever (91 per cent), followed by watery stool/diarrhoea (58 per cent) and vomiting (40 per cent). Nearly 51 per cent infants had a health problem and of those almost 93 per cent sought treatment. The common problems reported are fever, watery stool (diarrhoea), vomiting, cold and cough. Women preferred treatment in a government facility (58 per cent) for their infant health problems. About one third of them were found to be treated in a private facility. Subsequent analysis revealed that women of 20-24 years were slightly better aware of infant health problems and also seeking treatment, compared with women of 15-19 years. More specifically, a considerable proportion of women with no and low education were aware of infant health problems and sought treatment for them. About 82 per cent of women who had three or more children were aware of some or the other infant health problems, but only 63 per cent of them sought treatment for them. However, 98 per cent women who had two children and 94 per cent women who had no or one child sought treatment for the health problems faced by their children. Eighty-four per cent women who had discussion with front line health service providers like ASHA, ANM, anganwadi worker or an elder member of the family about infant care were aware of the infant health problems, while this figure was only 22 per cent for women who did not do so.. Similarly, 94 per cent women who had discussion about infant care and 82 per cent women who did not have it sought treatment

for their infant health problems. Though awareness about an infant health problem was found to be better (94 per cent) among women having low equitable gender attitude, treatment seeking for infant health problem was universal (100 per cent) for women with high equitable gender attitude as compared with other women. Ninety-three per cent women of high standard of living and 78 per cent women of low standard of living were aware of infant health problems, whereas all the women having high standard of living and 85 per cent of women having low standard of living sought treatment for the problems experienced by their infants. Logistic regression analysis illustrates that women in 20-24 years of age were eight to nine times more likely to seek treatment for their infant health problems compared with women of 15-19 years. The likelihood of treatment seeking behaviour for infant health problems among general and other backward class women was more than four times higher compared with SC and ST women. After controlling all the socio-demographic variables including women's autonomy and decision-making power, it was found that women with high to medium standard of living were about ten times more likely to seek treatment for their infant health problems compared with women with low standard of living. Again the odds of treatment seeking of infant health problem were 8.7 to 8.8 times significantly higher for women who had discussion with health service providers or household members about infant care. Women in the high to moderate autonomy and decision- making power were 6.4 and 1.5 times more likely to seek treatment respectively for their infant health problems compared with other women.

### **8.12. Source of knowledge regarding reproductive and infant health care**

Education, exposure to mass media, interaction with mother, mother-in-law and especially the frontline health service providers like ANM, ASHA and anganwadi worker have come out as important sources for obtaining knowledge about different reproductive and infant health care for young women. Data revealed that most of the women (73 per cent) got information related to ANC services from the health service providers like ASHA, ANM, anganwadi worker, etc. While about 22 per cent women said that they came to know about this information from mother, mother-in-law, TV and radio programmes, some women (19 per cent) also got ANC related information from friends and relatives. Similarly, more than 80 per cent of the young women said that they received information about delivery and post-natal care including newborn care from the health service providers like ANM, ASHA, anganwadi worker, etc. These sources of information were common across all reproductive and infant health matters with little variations.

### **8.13. Decision-making power and gender role**

The study elucidated that in addition to the biological difference between the sexes, there are other socio-cultural factors that play vital roles in defining the decision-making power of men and women. If a woman took the decision either by herself or jointly with her husband, she was considered as involved in decision-making. In most of the domestic issues women's involvement was poorly reflected. About 40 per cent women were involved in deciding daily menu in the household, while another 60 per cent women said that it was decided by either husband or any other member of the household. In all other cases like daily shopping, purchasing household items, spending family earnings (where money was involved), only 18 to 25 per cent woman were a part of decision-making. These decisions were mostly taken by either husband or other household members.

Similarly, on decisions related to specific reproductive and infant health issues show a favourable situation for young women since at least half or more were a part of decision-making. Specifically, 93 per cent women reported that they were involved in deciding when to get pregnant, 85 per cent in the number and timing of having children, 84 per cent in using a family planning method and 70 per cent in going for ANC during the last pregnancy. In decisions related to the treatment of health problems during pregnancy, delivery, post-natal period and infant health problems, about 50 to 55 per cent women were involved. The overall decision-making power index depicted that a low proportion of women (8 per cent) had high and more than 60 per cent had low decision-making power. On contrary, a majority of the women reported needing permission of husband or other members of the household for going to health facility, shopping, meeting friends, etc. About two-thirds of young women had little autonomy, 23 per cent had moderate and few (11 per cent) had high autonomy. This shows the extent of restrictions placed on women in performing many of the social activities in personal life.

The logistic regression results for women's involvement in deciding about going for ANC highlighted that those aged 20-24 years were significantly 2.4 times more likely to involve in the decision on going for ANC compared with 15-19 year old women. Similarly, the likelihood of women's involvement in taking decision on going for ANC services was 1.6 times higher for those who stayed within five kilometers from a health facility compared those who were staying more than five kilometers. Women who had discussion with a health service provider or any household member about the need for ANC were almost 1.4

times more likely to involve in the decision on going for antenatal care. The odds of women's involvement in taking decisions on going for antenatal care were 1.3 times more for women with high to moderate autonomy and 1.6 times more for women having high to moderate equitable gender attitude compared with their opposite group of women.

The likelihood of women's decision on seeking treatment of infant health problems was 2 to 2.3 times higher for women of 20-24 years compared with women of 15-19 years. Young women who had discussion with a frontline health service provider or any household member about the need for infant care were 1.1 to 1.8 times more likely to involve in taking decision on treatment of infant health problems compared with those who did not have it. Odds of women's involvement in taking decisions on treatment seeking of the infant health problems was almost four times higher for those who had high to moderate autonomy and gender equitable attitude compared with women of low autonomy and gender equitable attitude respectively.

Analysis of women's involvement in deciding about the number and timing of having children depicted that women aged 20-24 years were significantly better in taking decisions about it compared with 15-19 year old women. Similarly, compared with SC-ST women, general and other backward class women were almost four times more likely to involve in the decision-making of number and timing of having children. The odds of women's involvement in deciding about number and timing of having children were 2.1 to 2.4 times significantly high for those who had discussions with their husband regarding the issue. After controlling all the variables, it was found that women with high to moderate autonomy were 1.3 times more likely to involve in the decisions on having number and timing of children compared with those having low autonomy.

Logistic regression results of women's involvement in deciding a family planning method illustrated that women in the age group of 20-24 years were 4.5 to 5 times significantly more likely to involve in the decision-making compared with women of 15-19 years. Similarly, women in high to medium standard of living were almost 2.8 times higher in using a modern family planning method compared with women of low standard of living. Women staying within five kilometre distance from a health facility were more than twice better involved in deciding about a family planning method compared with those who stayed longer. The odds of taking decision about using modern family planning method

were 2.7 to 3.9 times significantly high among women who had inter-spousal communication about number and timing of having children compared with those who did not have it. After controlling all the variables, it was found that women with high to moderate autonomy were 1.9 times and women in high to moderate equitable attitude were 2.7 times more likely to involve in the decisions on using a modern family planning method compared with their respective counter group of women.

Eighty-six per cent of the young women reported receiving help in routine household work during last pregnancy from different people. Specifically, most of the help was provided by mother-in-law (55 per cent), followed by husband (31 per cent). Women also received accompanying support from different family members and frontline workers while going for the treatment of health problems which occurred during pregnancy, delivery, post-natal period as well as for RTI/STI and infant health problems. Among all, the husband provided major accompanying support to women while going for the treatment of health problems occurred during pregnancy (73 per cent), after delivery (42 per cent), RTI/STI problems (65 per cent) and infant health problems (51 per cent). However for the treatment of health problems which occurred during delivery, about 70 per cent women reported that frontline workers like ASHA, anganwadi worker, dai, ANM, etc., accompanied them. Additionally, more than 80 per cent of the women said that the frontline health service providers like ASHA, ANM, anganwadi worker and dai discussed about the health care needs with them.

Similarly the study has explored the young women's attitude towards gender norms and sexuality. There was an unequal gender role of young women in the decisions related to domestic issues, and reproductive and infant health care. Overall, a low proportion of women (16 per cent) had high equitable gender attitude and a high proportion (69 per cent) had low equitable gender attitude. Subsequent analysis revealed that 31 per cent women had high equitable gender attitude towards gender norms, 57 per cent had moderate equitable gender attitude and 13 per cent had low equitable gender attitude. Gender attitude towards sex and sexuality highlighted that about 10 per cent of women were in high equitable category and 57 per cent had low equitable attitude. Similarly, 38 per cent women had low equitable attitude towards domestic violence.

#### **8.14. Experience of domestic violence**

Some young women (14 per cent) reported experiencing some kind of violence in the past six months. Among them, mostly the husband was the perpetrator, followed by mother-in-law, which accounted for 60 per cent and 36 per cent respectively. Women experienced different types of violence, i.e., 42 per cent were scolded, 22 per cent slapped, 11 per cent insulted in front of others and 9 per cent pushed. Qualitative findings showed that scolding was very common and the triggers of violence included refusal for anything said by husband or mother-in-law, domestic quarrels, complaints by family members and overstaying the allotted time in the natal home. Gender attitude of women towards violence shows that 74 per cent women had low equitable attitude. This means that most of the women had accepted violence as a part of life. More specifically, 96 per cent women agreed that women were responsible for domestic violence and sensible women never let it take place. Similarly, 79 per cent women agreed that it was okay for a husband to hit his wife if she cheated him.

#### **8.15. Policy implications**

Young people are crucial for any population. Thus, any intervention targeting them has a sustained future implication. They are considered as the key to bring social changes and improve life style. In view of the findings of current study, a number of policy implications are suggested below:

- A majority of young women were partially aware of reproductive and infant health care behaviour. But a substantial proportion of them are not aware of all the good practices. Similarly, though women were aware of health problem they may face during pregnancy, delivery and post-natal period, a majority of them had no knowledge about the critical health problems that can increase their health risk. It was the same for infants. Thus, the behaviour change communication programmes need to focus more on the critical health components of reproductive and infant health emphasising on the young women. They also need to be provided print materials in pictorial form in local language for a ready reference. This will help in knowing good health practices and also identifying critical health problems to seek treatment in time.
- The common suggestion which also arises that, the ongoing RCH programs should focus more on adolescent girls to educate them in and out of school about health and nutrition. As they are the potential mothers, grooming up from the beginning is

essential to prevent and manage many reproductive and infant health problems in future.

- There is a need for strengthening the existing platform of providing health services at the rural door step including village health nutrition days (VHND). In addition, the frontline health service providers like ASHA, ANM and Anganwadi workers need to make prioritized home contacts, where the neediest beneficiaries are served first. As most of the women were deprived of receiving antenatal check-ups (BP, Hb, urine protein, abdomen examination, etc.), VHNDs should compulsorily provide these services. Here ASHA and ANM should properly screen all pregnant women and infants for health problems and provide treatment and referral services.
- Despite financial schemes of the government to zero down home deliveries, a considerable proportion of births still take place at home. There is a need for finding strategies to convert each home delivery into an institutional delivery to save life of the mother and child. Otherwise, in the extreme condition where institutional delivery is not possible, trained birth attendants (ANM) should conduct the delivery at home to reduce health risk of mother and child. Such cases should also be given priority by the frontline health service providers during the post-natal period.
- Since the beginning of family welfare programme, modern contraceptive use has remained the core focus. Over a period of time, family welfare programmes have adopted different strategies to increase modern contraception and even provided free contraceptives at rural doorstep. In the current study it was found that a high percentage of young women still used traditional methods to control fertility. Hence there is a need for family focused counselling to the traditional method users by the front line health service providers and offer them other methods of choice. Also women who intent to use a modern family planning method have to be followed up continuously before and after the acceptance of desired method.
- Unequal gender role of young married women in decisions related to reproductive and infant health care behaviour; inequitable attitude towards different gender norms and sexuality, acceptance of domestic violence strongly urges focused efforts to intensify information education and communication (IEC) programmes in promoting gender equality for the development of society in general and young people in particular. Gender sensitive programmes at the community level such as puppet shows, street plays and community video shows creating awareness on the importance of the rights of the young women are suggested for a more democratic society.

- Women have little say in the decisions where money was involved. Even during focus group discussions women highlighted financial dependence as a major barrier of their empowerment. Young women were often compelled to be submissive and many times surrender to the demands of the spouse or in-laws. Thus, to enhance economic status and autonomy of young women, formation of self-help groups and establishment of household level income generation platforms for women is important. Additionally they need to be linked with banks and markets for easy financial and product transactions.

### **8.16. Limitations of the study**

The study has come out with important findings on how women are spaced in reproductive and infant health care decisions. It also explores the gender role, gaps in knowledge, practice and its association in different background characteristics of women. While interpreting the results, one should be aware of the methodological as well as other limitations of the study. They are given below.

- The cross sectional design of the study does not allow to draw conclusions regarding young women's change in reproductive and infant health care behaviour over a period of time. Similarly, it restricts understanding of the transformation of gender roles.
- The small sample size and narrow study group cautions to interpret and generalize the results for a larger population.
- Socially acceptable response bias cannot be totally ignored for the personalized and sensitive information collected in the study.
- The present study lacks men's perspective on different gender, reproductive and infant health issues.
- In addition to the variables collected and included in the present analysis, a number of other programmatic variables influence the reproductive and infant health care behaviour of young women. These variables include mostly the interventions carried out from time to time by different development organizations which were not a part of the current study.

### **8.17. Scope for future research**

Though the study has explored many important issues on reproductive and infant health, it identifies some scope for further research to get an in-depth understanding of reproductive and infant health care behaviour of young married women. They are:

- Many young women in the present study reported having infant mortality. Further research to understand its clinical reasons will provide a better picture to design strategies to save lives of infants.
- The present research did not study explicitly the background and consequences of abortion among young married women. This suggests further research to understand the issues.
- This study presents self-reported RTIs/STIs among the young women. Further research based on clinical testing of RTIs/STIs would give a better picture of its intensity and proactive treatment seeking behaviour.
- Covering a larger sample size and exploring men's perspective on similar gender, reproductive and infant health issues will give a more realistic and balanced perspective.
- The present study has limited scope of understanding various contextual determinants of reproductive and infant health. Therefore, it is essential to investigate further the context of reproductive and infant health behaviour with an emphasis on the ongoing intervention programmes for a better understanding.
- Young women who experienced domestic violence might have undergone psychological stress. The present study did not explore this issue and its negative health outcomes. Future research should focus on exploring the mental health conditions and coping mechanism of young women who are victims of domestic violence.