

Effect of family type on birth practices and health problems of rural women

Vinod Kumari

CCS Haryana Agricultural University, Campus Kaul, Kaithal, Haryana

Women's health status affects their productivity and thereby their role in society and development. Their own health is influenced by various factors, which need to be investigated to improve their health status. Keeping this in view, the present study was undertaken to find out the impact of family type on marriage and birth practices and health problems of rural women. It was found that the type of family had a significant effect on birth practices. The results indicated that 26.4% respondents from nuclear family were married after 20 years of age, while it was only 4.5% in case of joint families. In all deliveries in 58.3% cases were performed at home while only 33.3% in hospitals. Nuclear families were more conscious about post partum hygiene. A shift towards health awareness was observed among rural women as 73.3% visited doctors for pregnancy and birth related checkups which was quite higher than that observed in earlier studies. More rural women from nuclear families (71.1%) reported work excessiveness as compared to joint families (36.4%). A significant impact of family type on occurrence of diseases among rural women was also observed. It was concluded that women from nuclear families were more health conscious and had better knowledge in adopting marriage and birth practices than those of joint families.

Keywords: rural women, birth practices and health problems

Women are key provider of health services to the family and the society. Women's health status affects their productivity and thereby their role in society and development particularly in the context of poverty where women's work is essential for family survival or for improved quality of life. Good health is state of complete physical, mental and social well-being and not merely the absence of disease. Healthy women can make more useful contribution to their families and society but the rural women have poor health status because of a variety of factors. Poor health in a community is a part of vicious circle which involves inability to work, low income and poverty, under-nourishment and anemia, spread of infections and fostering of anemic diseases.

Every human being has the right to live in an environment with minimum health risks and to have access to health facilities. Social attitudes and prejudices are unfavorable toward the female sex in the term of food, nutrition and health care. Singh and Dak (1993) revealed that in developing countries, women and children are neglected group in all spheres of life. Health of woman is now being received an ever-increasing recognition as a human right in the belief that healthy women can make more useful contribution to their families and society.

Social, cultural, economic and environmental factors influence the maternal health. The asses of woman to health services must be seen beyond their availability, as much depend on socio economic condition and cultural setting; and house hold responsibility and ignorance tend to neglect their illness until their health problem get aggravated and they become too sick to move around to perform the normal activity. All the more, they are dependent on others in the family to get them needed medical attention. Studies on the time attention of women and men among rural house hold in India though few, indicate that rural woman work for longer hours than men and as a consequence of this they are victim of several health problems. The area of marriage and childbirth is affected greatly by traditional practices and beliefs.

Social scientists have studied the problem of women's ill health and the factors associating with it. They have traced numerous factors associated with ill health in India and abroad, but such studies are lacking in Haryana, especially about women's health problems in the countryside.

It is all the more useful to assess the health status of rural women in the context of family structure. Therefore with this background in mind the present study was undertaken to find out the impact of family type on marriage and birth practices and health problems of rural women.

Method

Participants

The married women of reproductive age group of 15-49 years, visiting the community health centre, were the target group of the study. A total of 120 women were interviewed with the help of structured interview schedule on various social and health aspects.

Instruments

The interview schedule was constructed with a list of diseases. Before constructing the interview schedule, a comprehensive list of common diseases of rural women in Haryana was prepared from secondary sources while making a list of diseases. The schedule so prepared covered the respondent's socio-economic and personal attributes, personal and community hygiene, marriage and birth practices and various health problems.

Statistical analysis

Chi-square test was applied to find the significance of association between various variables.

Procedure

The data were coded and analyzed by SPSS statistical package. The cross tabulation was attempted to know the association of family type with marriage and birth practices as well as various health problems of rural women.

Results and discussion

Socio-economic attributes of respondents:

It is imperative to know the personal, social and economic background of the rural women before discussing their health aspects. More than three fifth respondents were belonging to upper caste followed by backward (31.7%) and a few to scheduled caste (6.7%). Sixty three per cent respondents were having nuclear families and rests were having joint families. Thirty per cent respondents' families were landless and small farmers while one fifth were marginal farmers (up to 2.5 acres), one third were having between 2.6-5 acres and 18.4% were having land between 6-10 acres. Age of the respondents play an important role in determining the health status. Half of the respondents were above 35 years of age followed by 26-35 years (31.7%) and up to 25 years (18.3%).

Exactly one third respondents were illiterate while 23.3% were educated up to plus two level and 8.3% were post-graduate. The results indicated an increase in education level of rural women over times as Mehta (1986) reported 83% illiterate rural women in her study. Families of more than half of the respondents were having one earning member and 36.7% were having two and only 5.0% were

having 3 earning members in their respective families.

Association of family type with marriage and birth practices

The role played by rural women in socio-economic development of a society is really praise worthy but not given any significant attention even. They generally suffer more because of poverty, hesitation, illiteracy and nutritional deficiencies. Many of the health problems of rural women pertain to marriage and birth practices; hence it was essential to know these practices in a sociological context.

The type of family and the relationship among its members play a powerful role in the pathogenesis of physiological and appetite disorders (Snafner et al., 2004). Mitan (2002) also observed that multidisciplinary team approach and family involvement is required for treatment of chronic illness among adolescent girls. The number of family members affect their lifestyle, availability of quality food and access to better health facilities which ultimately influence the health attributes of its members specially the women and children. The association of family type with marriage and birth practices of rural women is cited in Table 1.

Table 1. Association of family type with marriage and birth practices

Practices/ Family Type	Nuclear	%	Joint	%	Total	%
Age at marriage						
Below 18 years	22	28.9	16	36.4	38	31.7
18 to 20 years	34	44.7	26	59.1	60	50.0
Above 20 years	20	26.4	2	04.5	22	18.3
						$\chi^2=28.5^{**}$
Place of birth of first child						
Not application	2	02.6	8	18.2	10	08.3
Home	44	57.9	26	59.1	70	58.3
Hospital	30	39.5	10	22.7	40	33.3
						$\chi^2=10.4^*$
Cutting method of placenta						
NA	4	05.3	8	18.2	12	10.0
Scissor	6	07.9	8	18.2	14	11.7
Sterilized knife	2	02.6	2	04.5	4	03.3
Sterilized scissor	48	63.2	10	22.7	58	48.3
Blade	16	21.1	16	36.4	32	26.7
						$\chi^2=19.3^*$
Medical checkup during pregnancy						
NA	2	02.6	8	18.2	10	08.3
Yes	64	84.2	24	54.5	88	73.3
No	10	13.2	12	27.3	22	18.3
						$\chi^2=14.4^*$
Work excessiveness						
Yes	54	71.1	16	36.4	70	58.3
No	22	28.9	28	63.6	50	41.7
						$\chi^2=13.8^*$

Age at marriage

The results showed 50.0% respondents were married between 18 to 20 years of age while 31.7% married below the age of 18 years. Similarly the birth of first child was below 20 years of age in 43.3%

cases and it was 20-25 years in 45% cases. Although the results indicated about one third cases of marriage below 18 years yet the trend observed was favorable over time as Mehta (1986) reported age at marriage up to 17 years in 78% cases. This might be due to the increase in literacy rate among women over times as also reported by

Vani (2000) that women need to be educated about their health and men need much greater awareness about health problems of women.

Early marriage and pregnancy had adverse effect on women health as also reported by Srinivasan and Durgaprasad (2000) that adolescent girls burdened with child bearing before they were biologically as well as sociologically mature suffered most that declined the health of women. Ene-Obong et. al. (2001) also reported that age at marriage had a positive correlation with body mass index and all nutritional variables. The marriage age across family types revealed that 26.4% respondents from nuclear families were married after 20 years of age, while it was only 4.5% in case of joint families. A significant 2 value indicated the influence of family type on marriage age and it was comparatively higher in nuclear families than in joint families.

Place of birth of first child

The type of family also had a significant influence on place of birth of first child. In joint families, birth of first child was performed in hospital in 22.7% cases while in nuclear families it was done in 39.5% cases. In all deliveries in 58.3% cases were performed at home while only 33.3% in hospitals. Local dai helped during delivery in 43.3% cases. Islam et. al. (2006) also reported that only a small proportion of deliveries took place in hospitals in Bangladesh. They found that education, economic status, breathing problems, liver disease and palpitation during pregnancy appeared to have significant association with place of delivery in rural women.

It was interesting to note that 68.3 per cent were taking special food like sandha, goond, halwa, pinni, etc. during deliveries but rest were deprived of special food during pregnancy and lactation. Nagda (1996) also reported that the number of people eat less food than they need, the worst sufferers being the pregnant women and the lactating mothers.

Cutting method of placenta

Nearly half of the respondents were using sterilized scissors for cutting of placenta after the birth of baby (Table 1) while 26.7% women were using blade for this purpose. Mehta (1986) reported that more women (31.0%) were using ordinary knife for cutting placenta. The awareness among women towards hygienic birth practices is essential to check congenital infections. Stegmann and Carey (2002) also reported that prenatal infections accounted for 2 to 3 per cent of all congenital anomalies. The knowledge of these diseases will help the clinicians appropriately counsel mothers in preventive measures to avoid these infections.

The type of family also had a significant effect on post partum care as sterilized scissor was used in 63.2% cases in nuclear families while in joint families ordinary blade was used in maximum cases (36.4%).

It was found that nuclear families were more conscious about post natal hygiene which was a cause of infection in infants and mothers. Stephensen and Tsui (2003) also observed that household and community had a strong contextual influence on reproductive wellness of women.

Medical checkup during pregnancy

A shift towards health awareness was observed among rural women as 73.3% visited doctors for pregnancy and birth related checkups whereas Mehta (1986) reported that only 11.0% visited for medical

checkups and Singh and Bhan (1996) reported that during illness daughters were given home treatment or no treatment while sons had medical treatment. The data of medical checkup across family types revealed that more than 80% women from nuclear families got routine medical checkups during pregnancy whereas about 55% from joint families went for medical examination during pregnancy and this difference was found significant. Kaur and Narwal (1988) observed low level of adoption of immunization practice by the rural women and found significant association of family type with the adoption of immunization.

More visits of women from nuclear families might be due to the reason that they had to visit health centre even for minor problems of pregnancy while older women in joint families took care of such problems to some extent.

It was found that 51.7% women were taking rest of 31-45 days after delivery while 38.3% rested only up to 30 days and others were taking rest of more than 60 days. The rest taken for more than 60 days was mostly in case of caesarian deliveries. It was interesting to note that rest of less than 30 days was mostly in case of birth of girl child.

Work excessiveness

The women of rural sector are burdened with their multifaceted duties of farm and home. Bagchi and Kapil (1984) revealed that women undertook an extremely strenuous load of agricultural work in addition to the workload at home, without any significant improvement in their dietary intake. This was also revealed in present study as 58.3% women told work excessiveness in daily routine chores. Mehta (1986) observed that 52.0% women worked daily for 7-10 hours where as 29.0% worked for more than 11 hours daily.

The data of work excessiveness across family types revealed that more rural women from nuclear families (71.1%) reported work excessiveness as compared to joint families (36.4%). This might be due to the reason that they did it as their own home and tried to complete each and every task in time while those from joint family may not be thinking so because of presence of other women in the family. The work excessiveness may affect their health status as also reported by Aydin et. al. (2005) that there existed a significant relationship between social factors and depression.

Association of family type with health problems of rural women

Various health problems of rural women for which they were visiting health centre were also investigated (Table 2). It was found that majority were suffering from common diseases (30.0%) followed by chronic ones (21.7%). Sex organ related infections were also reported in 8.3% women. Mehta (1986) also reported that 26.7% women had noticed sex related diseases but only 18.75% of them visited hospital for treatment.

Few of them were suffering from deficiency diseases and pregnancy related problems (1.7% each) which were mainly due to inadequate diet. Mitan (2002) also reported that eating disorders represents a significant source of chronic illness in adolescent girls. He observed that multidisciplinary team approach and family involvement was required for treatment of adolescents. Bove and Olson (2006) also observed that eating pattern is one of the factors contributing to obesity in rural low income women in United States.

Table 2: Association between family type and health problems of rural women

Health problems / F.Type	Nuclear	%	Joint	%	Total	%
Common diseases	26	34.2	10	22.7	36	30.0
Infectious	6	07.9	8	18.2	14	11.7
Chronic	12	15.8	14	31.8	26	21.7
Psychiatric	6	07.9	2	04.5	8	06.7
Sex organ	10	13.2	0	--	10	08.3
Skin	8	10.5	6	13.6	14	11.7
Eye/hair and mouth	4	05.3	4	09.0	8	06.7
Deficiency diseases	2	02.6	0	--	2	01.7
Pregnancy problems	2	02.6	0	--	2	01.7

$\chi^2=16.4^*$

A significant impact of family type on occurrence of diseases among rural women was observed (Table 2). The women from nuclear families were having more common diseases (34.2%) followed by chronic (15.8%) and sex related problems (13.2%). The women from joint families were suffering more with chronic diseases (31.8%) followed by common diseases (22.7%) and general infections (18.2%). Kaur and Narwal (1988), Singh and Dak (1993) and Bimla (1995) also reported significant effect of family on health attributes of women. Emami and Tishelman (2004) also reported that health maintenance and disease prevention in emigrant women of Iran of various ages were found to be related to perception of self and continual construction of social attitude in family atmosphere throughout the life span.

It was concluded that type of family had a significant effect on birth practices and health problems of rural women and women from nuclear families were more health conscious and had better knowledge in adopting marriage and birth practices than those of joint families.

References

- Aydin, N., Inandi, T., & Karabulut, N. (2005). Depression and associated factors among women within their first postnatal year in Ergurum province in eastern Turkey. *Women and Health*, 41(2), 1-12.
- Bagchi & Kapil. (1984). National consequences of rural development project. *Kurukshetra*. 33(1), 8-11.
- Bimla (1995). How healthy are village women? *Social Welfare*, 42(3), 16-17.
- Bove, C.F., & Olson, C.M. (2006). Obesity in low income rural women-qualitative insights about physical activity and eating patterns. *Women and Health*, 44(1), 57-78.
- Emami, A., & Tishelman, C. (2004). Reflections on cancer in the context of women's health- group discussions with Iranian immigrant women in Sweden. *Women and Health*, 39(4), 75-96.
- Ene-Obong, H.N., Enugu, G.I., & Uwaegbute, A.C. (2001). Determinants of health and nutritional status of rural Nigerian women. *J. Health Popul. Nutr.* 19(4), 320-30.
- Islam, M. A., Chowdhury, R. I., & Akhter, H. H. (2006). Complications during pregnancy, delivery and postnatal stages and place of delivery in rural Bangladesh. *Health Care for Women International*, 27(9), 807-21.
- Kaur, G., & Narwal, R.S. (1988). An immunization- a last adopted practice. *Indian Journal of Public Health*, 32(4), 199-202.
- Mehta, N. (1986). *Socio-economic factors affecting health in a village community*. M.Sc. Thesis, HAU, Hisar.
- Mitan, L.A.P. (2002). Eating disorders in adolescent girls. *Current Women Health Reports*, 2(6), 464-67.
- Nagda, B.C. (1996). Good nutrition for healthy mothers. *Social Welfare*, 43(4), 32-33.
- Singh, S., & Bhan, C. (1996). Food and health care of rural girls of Haryana. A sociological study. *HAU J of Research*, 26, 287-293.
- Singh, S., & Dak, T.M. (1993). Food beliefs in rural women in Haryana. *HAU Journal of Research*, 23, 202-205.
- Snafner, J.L., Tantillo, M., & Seidlitz, L. (2004). A pilot investigation of relation of perceived mutuality to eating disorders in women. *Women and Health*, 39(1), 85-100.
- Srinivasan, S., & Durgaparsad, P. (2000). RCH programme and women's health problem and prospects. *Social Welfare*, 47 (1), 3-7.
- Stegmann, B. J., & Carey, J. C. (2002). TORCH infections. *Current Women Health Reports*, 2(4), 253-58.
- Stephenson, R., & Tsui, A.O. (2003). Contextual influence on reproductive wellness in northern India. *American Journal of Public Health*, 93(11), 1820-29.
- Vani, C. (2000). Health communication and women. *Social Welfare*, 47(1), 26-27.