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To assess the knowledge attitude and practices regarding women empowerment and its impact on health status of women in rural and urban areas attached with Govt. Medical College, Patiala, Punjab

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Introduction: Women's empowerment, or autonomy, is a multifaceted concept. In a patriarchal society, as exists in large parts of India, men are placed in a more advantageous position than women. The state of male supremacy is reflected in the child rearing and caring practices, the Access to nutrition, child care and education all favour boys over girls. **Material and Methods:** In this cross-sectional study, all married females from 200 households were interviewed in rural (CHC Bhadson) and urban (MCH Center Tripuri) field practice areas attached with department of Community Medicine, Government Medical College, Patiala (100 households each from rural and urban). **Results:** After interviewing 110 women in rural and 103 in urban area, the data regarding socio demographic profile of the respondents and their knowledge, attitude and practices regarding various domains of empowerment and their health status was compiled and analysed statistically. Knowledge regarding legal age of marriage was higher in urban women (78.64%) as compared to rural women (43.64%).**Conclusion**: From the information it can be concluded that the attitudes or opinions of the women in a family are definitely influenced by the better empowerment status of the women. It is evident that if the empowerment (education, occupation and financial status) of the reproductive age group of women is enhanced it will lead to better health status. **Recommendations:** It is recommended that provision of education, employment and improving their socio economic status by the Government will lead to modification in the overall health scenario of the family, community, state as well as a country.

Keywords: Empowerment, Economic, Health, Discriminated, Compiled

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Introduction

Women's empowerment, or autonomy, is a multifaceted concept. In a patriarchal society, as exists in large parts of India, men are placed in a more advantageous position than women. The family lineage and living arrangements are centered on men, and inheritance and succession practices tend to neglect women as well.

The state of male supremacy is reflected in the child rearing and caring practices, the celebrations for the birth of a male child and the differential treatment meted out to boys. Access to nutrition, child care and education all favour boys over girls. From a very early age, a girl is socialized to give priority to the needs of the male members in the family.

The effect of these practices is a tilt in the power relations in favour of males. Women's empowerment is essentially an effort to rectify this imbalance and attain gender equity [1].

The most common indicators for measuring empowerment measure capabilities, education and health in particular, and control over economic and political resources and decision-making. Numerous factors environmental, socio-cultural, political and economic affect women's health outcomes. The excess health burden for women negatively impacts the health of families and communities [2].

The WHO concludes that there is significant greater impact on several health related outcomes, including mortality rates for children under five years of age, adult female and male mortality, adult female and male life expectancy at birth and total fertility rates when it is compared to income, women's educational level, particularly the aspects of generation and utilization of new knowledge [3].

Gains in women's health have been uneven and gaps continue to exist in accessing healthcare, which reflects class ethnic, and rural and urban inequalities among others. Lack of infrastructure, capacity building and financing continue to be the issues as does societal discrimination. Hence, WHO (2008) report focuses on primary healthcare as a means to address inequalities in access [4 5].

The health of Indian women is intrinsically linked to their status in society. Research on women's status has found that the contributions made by Indian women to families are often overlooked, and instead they are viewed as economic burdens.

Further, Indian women have low levels of both education and formal labour force participation. They typically have little autonomy, living under the control of firstly their fathers, then their husbands, and finally their sons. All of these factors exert a negative impact on the health status of Indian women.

Punjab has emerged as the most developed, but least gender sensitive State of India. On one hand, women are defied, put on a pedestal and worshipped but on the other, they are suppressed and subordinated, denied even the right to take birth. The first Guru of Sikhs Guru Nanak Dev Ji, emphasized the role and importance of women in the family and community.

He stated, *"So kyunmandaaakhiejitjamehrajan"* which is quoted in Shri Guru Granth Sahib Ji. At the same time, the population culture of Punjab legitimizes numerous practices derogatory to women. Women continue to be worshipped as kanya, devi yet they also continue to be subordinated, suppressed and discriminated against in everyday life.

Thus, it is recognized that empowerment is a multi-dimensional term. As a result, several efforts have been made to develop comprehensive framework to delineate the various dimensions along which women can be empowered. Also, the studies have shown that empowerment cannot be understood without understanding the socio-cultural as well as the political and economic context in which development takes place.

Then there are studies that show that women's empowerment reflects community norms, rather than women's individual traits. As very few studies have been done in this part of country so present study was planned to know the knowledge, attitude and practices regarding women empowerment and their health status.

Objectives

To study the knowledge, attitude and practices regarding women empowerment and its impact on the health status of women in rural and urban areas of district Patiala.

Material and Methods

Setting and Type of Study: The study was carried out in Rural (CHC Bhadson) and Urban MCH (Center Tripuri). It is cross-sectional study.

Sampling Method: Interview technique was used to fill the predesigned and pretested proforma.

Sample Collection: All married females from 200 households were interviewed in rural (CHC Bhadson) and urban (MCH Center Tripuri) field practice areas attached with department of Community Medicine, Government Medical College, Patiala (100 households each from rural and urban). And urban (MCH Center Tripuriatt) field practice area attached with department of community medicine, Government medical college Patiala.

Married females from age group of 18 – 49 years were included in this study. A pre-tested proforma was used to collect information of knowledge, attitude and practices (KAP) regarding women empowerment and their health status. Every 5th house was selected by systematic random sampling technique in both the areas.

In this way, 200 houses including 100 each in urban and rural areas were surveyed and every married women in the house in the age group of 18-49 years was interviewed. Total 110 married females from rural and 103 married females from urban area were included in the study.

Information was collected regarding their sociodemographic characteristics, their health status, their knowledge, attitude and practices regarding various domains under study. Every women was interviewed individually. On an average each women was interviewed for 45 minutes. The study was conducted between March 2011 to June 2012.

Inclusion Criteria: Those women who were married from age group 18-49 years and submitted written consent to participate in the study included.

Exclusion Criteria: those married females were excluded from the study who were not fulfilling the above criteria and refused to submit the written consent for the study.

Statistical Methods: were used to collect so and analysis the data.

Ethical Consideration and Permission: The permission was obtained from the Institutional Ethical Committee.

Results

The major findings of the study are as below:

Table-1: Knowledge of Respondents about Legal age of Marriage

Knowledge about Legal Age	Rural (n=110)	Urban (n=103)
Yes	48 (43.64)	81 (78.64)
No	62 (56.36)	22 (21.36)

Table 1 depicts that legal age of marriage is higher in Urban women where 78.64 % women knew about legal age of marriage but in Rural only 43.64 % women knew that legal age of marriage is 18 years notified by the Govt. of India.

The Mean age of marriage in rural and urban areas was 18.89 years and 21.71 years respectively. In both the areas majority were Hindus (53.64% rural and 77.67% in urban area respectively).

Table-2: Status of Respondents Regarding Treatment of Anaemia During Pregnancy.

Treatment of Anaemia	Rural (n=110)	Urban (n=103)
Yes	54 (49.09)	66 (64.08)
No	53 (48.18)	32 (31.07)
Never Conceived	03 (2.73)	05 (4.85)

Table 2 shows that 64.08% urban and 49.09% rural women received treatment for anaemia during pregnancy. In rural area 48.18% pregnant women revealed that they were not treated for anaemia.

Table- 3: Status of Causalities Regarding Respondent's Child

Status of Causality	Rural (n=110)	Urban (n=103)
Yes	12 (10.91)	06 (5.83)
No	98 (89.09)	97 (94.17)

Table 3 reveals that 10.91% rural and 5.83% urban women had lost their children due to some illness or accident. In the rural area 75% of children died were females whereas 66.67% children died in urban area were males.

Table-4: Working Status of Respondents

Working Status	Rural (n=110)	Urban (n=103)
Working	08 (07.27)	21 (20.39)
Not working	102 (92.73)	82 (79.61)

Table 4 reveals that there is slightly higher percentage of women working in urban areas as compared to rural areas.

Table-5: Attitude of Spouse towards Respondents

Attitude of Spouse	Rural (n=110)		Urban (n=103)	
	Yes	No	Yes	No
Helps in Household Work	53 (48.18)	54 (49.09)	65 (63.11)	37 (35.92)
Ever hit during arguments	67 (60.91)	40 (36.36)	53 (51.46)	49 (47.57)
Husbandnot alive	03 (2.73)	--	01 (0.97)	--

Table 5 depicts that majority (60.91% rural and 51.46% urban women) reported that they had experienced domestic violence.

The data also reveal that the attitude of husbands in urban is better (63.11%) to give helping hand in household work as compared to rural area husbands (49.09 %).

Table- 6: Health Status of Respondent

Health Status	Rural (n=110)	Urban (n=103)
Osteoarthritis	02 (1.8)	01 (0.97)
Rheumatoid arthritis	–	01(0.97)
Cardiovascular disease	01(0.9)	–
Diabetes mellitus	03 (2.7)	05 (4.85)
Hypertension	08 (7.27)	13 (12.62)
Fibroid Uterus	02 (1.8)	01 (0.97)
Epilepsy	02 (1.8)	–
Dysfunctional Uterine Bleeding (DUB)	01 (0.9)	–
Piles	01 (0.9)	–
Migraine	–	02 (1.94)
Renal colic	–	01 (0.97)
Depression	–	01 (0.97)
Hypothyroidism	–	01 (0.97)
Left paraplegia	–	01 (0.97)
Chronic Cervical pain	–	01 (0.97)
Cataract	–	01 (0.97)
Total	20 (18.18)	29 (28.15)

Table 6 depicts that the overall health status of the respondents in rural areas is better as compared to urban areas (18.2% and 28.15% health problems respectively.

Table-7: Comparison of the Empowerment Status of the Respondents

Status of Empowerment	Rural (110)		Urban (103)	
	Employed (n=08)	Unemployed (n=102)	Employed (n=21)	Unemployed (n=82)
Participate in Decision Making	04 (50)	22 (21.57)	20 (95.24)	49 (59.77)
Have Bank/ Postal Account	04 (50)	30 (29.41)	18 (85.71)	39 (47.56)
Have Freedom to Spend Money	03 (37.5)	21 (20.59)	19 (90.48)	38 (52.78)

Table 7 reveals that status of empowerment in the rural as well as urban women is better among those who are employed.

Table-8: Socioeconomic Status of Respondents Versus Attitude Regarding Different Domestic Issues

Attitude	SES Class-I	SES Class–II	SES Class–III	SES Class–IV	SES Class–V
Rural					
Desire of Male Child	00 (00)	08 (7.27)	17 (15.45)	47 (42.73)	17 (15.45)
Sex Determination be Permissible	01 (0.9)	05 (4.54)	09 (8.1)	38 (34.54)	16 (14.54)
Justify Honour Killings	00 (00)	03 (2.7)	20 (18.81)	22 (20)	07 (6.36)
Justify Domestic Violence	00 (00)	01 (0.9)	03 (2.7)	07 (6.36)	01 (0.9)
Only Men Should Earn	00 (00)	03 (2.7)	13 (11.81)	35 (31.82)	09 (8.1)
Urban					
Desire of Male Child	00 (00)	22 (21.36)	10 (9.71)	11 (10.68)	–
Sex Determination be Permissible	00 (00)	12 (11.61)	02 (1.94)	07 (6.79)	–
Justify Honour Killings	00 (00)	00 (00)	00 (00)	03 (2.9)	–
Justify Domestic Violence	00 (00)	00 (00)	00 (00)	01 (0.97)	–
Only Men Should Earn	00 (00)	00 (00)	00 (00)	02 (1.94)	–

Table 8 depicts that in rural area the attitude regarding domestic issues (Desire of male child, sex determination be permissible, Justify Honour Killings, Justify Domestic Violence and Only Men should earn) is more in SES Class – IV as compared to the attitude of urban women where it is more prevalent in SES Class – II (regarding Desire of Male Child and Permission for Sex Determination) and other issues in urban settings are on the increasing side in SES Class – IV.

Discussion

The present study was carried out from March 2011 to June 2012 in rural and urban field practice area attached with department of Community Medicine, Government Medical College, Patiala.

After interviewing 110 women in rural and 103 in urban area, the data regarding socio demographic profile of the respondents and their knowledge, attitude and practices regarding various domains of empowerment and their health status was compiled, analyzed statistically. The observations of the study are discussed with the previous studies carried out by different authors.

In this study, total 110 women in rural and 103 women in urban field practice area were interviewed. Majority of the women (24.54% rural and 32.04% urban) were from the age group 28-32 years.

Percentage of Sikh population in this study was less (43.64% rural and 22.33% urban) as compared to that of Punjab where Sikh population is 53%.

Literacy rate of urban women was 96.12% which was higher than rural women where literacy rate was 80%. Female literacy rate has increased from 53% in 2001 to 65.46% in 2011 in India [6].

Literacy rate in Punjab of women in rural as well as in urban areas is much better than the figures at National Level i.e. NFHS-3 Survey 69% [7]. According to National Family Welfare Statistics (NFWS) in 2011 it is 71.34%. [8].

In a study conducted in South India in 2007 to assess reproductive health awareness 79.5% of women aged 13-49 years of age knew that legal age of marriage and reported that child bearing before the age of 20 years is unsafe and endanger life [9].

The mean age of marriage and mean age at first pregnancy was higher in urban area women as compared to the women from rural area. According to NFHS-3 the median age at first marriage in Punjab is 19.8 years among the women.

One-fifth of women age 20-24 years got married before the legal minimum age of 18 years [7] in a study carried out in Kabul by International Centre For Reproductive Health, University of Ghent, Belgium in 2002 the mean age at marriage was 17.2 years .16.2 percent of the participating women are were married at the age of 14 years or younger, [10].

A study carried out by Aggarwal et al (2004), 84% pregnant and 92.2 % lactating women were with severe anaemia in 9.2 and 7.3 per cent respectively [13]. thirty eight percent of Punjab women have anaemia, 26 percent with mild, 10 percent moderate and 1 percent with severe anaemia [11].

Status of anaemia according to National Family Welfare Statistics, NFWS (2011) is that 20.8% in India and 48.05% in Punjab are anaemic [8].

Amartya Sen analyzed that 100 million women are missing from this planet due to worsening gender ratio in India, China, South and West Asia et. United Nations Children Fund estimated that upto 50 million women and girls are missing from India only because of female foeticide or high mortality rate of girl child due to lack of proper care in home and at health facilities, son preference and sex ratio in India (940) and in Punjab (893) continues to be unfavourable to females.

Discriminating care of a girl child leads to malnutrition and impaired physical, mental and social development of a female child leading to lot of social and health problems in the family and community [10] [14].

The current employment status of women as per survey of NFHS-3 (2005- 06) shows that currently 23% of married women in Punjab are working or employed [11] [15].

The percentage of all types of violence was higher in the present study carried out in Punjab as compared to women of Punjab reporting domestic violence only 30% in national family health survey (NFHS – 3, 2005-6).[11].

The reason for better health status in rural women may be due to their better life styles, pollution free environment and less psycho social problems as compared to urban areas. So it is evident that if the empowerment of the reproductive women group is enhanced, it will lead to better health status. These attitudes or opinions of the respondents are definitely influenced by the better empowerment status of the women [16].

Conclusion

From the above information it can be concluded that rural women had a more rigid attitude towards gender issues and urban women on the other hand were more aware of various aspects of empowerment.

The attitudes or opinions of the women in a family are definitely influenced by the better empowerment status of the women. It is also concluded that the reasons for better health status in rural women may be due to their better life style, pollution free environment and less psychosocial problems as compared to the urban area.

It is evident that if the empowerment (education, occupation and financial status) of the reproductive age group women is enhanced it will lead to better health status and modification in the overall health scenario of the family, community, state as well as a country. It will further lead to curb the tendency of honour killings in the society and will create a cordial and peaceful atmosphere.

Contribution by co-Authors

Dr. Sukhwinder Kaur with the help of **Dr. Gurmeet Singh** and **Dr. Rajinder Singh Balgir**

Contributed to guide, collect and analyse the data. **Dr. Yash Mitra** along with author and co-authors contributed to construct the tables and helped in corresponding various activities to complete the original article. All the authors read and approved the final manuscript.

What this study adds to the Existing Knowledge

There are problems of knowledge, attitude and practices regarding existing education system, legal age of marriage, partial family welfare services, MMR, IMR, infanticide and foeticide, Honour killings.

Therefore following steps by the health department in particular and in general the Govt. and community must share the responsibility to empower the women by implementing and enforcing following steps to change the worst scenario existing in rural areas of Punjab and even the slums of urban areas of Punjab:

- Literacy rate is to be enhanced.
- The health and family welfare department should start a campaign in the sub-urban, urban and rural areas to educate the population regarding legal age of marriage, to provide family welfare services in addition to the health services.
- The activities of health and family welfare department will lead to decrease in various morbidity and mortality (MMR, IMR, infanticide, foeticide) rates. It is further recommended that the campaign by the health and family welfare department should be a continuous process to sustain and enhance the health status of the women in the family.
- The community leaders as well as the Government authorities should have a vigorous campaign of education and counseling against honour killings in the community.
- The attitudes or opinions of the women in a family are definitely influenced by the better empowerment status of the women so it is recommended that provision of education, employment and improving their socio economic status by the Government and responsibilities of families will lead to better health status and modification in the overall health scenario of the family, community, state as well as the country.

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