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Assessment of Socio-Economic Profile and Reproductive Health Knowledge among Rural Women of Ayodhya District

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Abstract
Access to reproductive health information and services is severely hampered by socioeconomic and cultural factors for rural women in India, especially in areas like Uttar Pradesh's Ayodhya district. The purpose of this study was to evaluate the socioeconomic characteristics and reproductive health literacy of one hundred rural women in Shidhauna village, Milkipur block, who were between the ages of twenty and fifty. Structured interviews including sociodemographic information and a reproductive health knowledge scale were used to gather data using a cross-sectional descriptive approach and purposive sampling. The majority of participants, according to the results, had low incomes, little education, and little contact with healthcare professionals. Remarkably, just 10% showed strong awareness of reproductive health, whilst 60% showed inadequate knowledge. Reproductive health awareness was shown to be significantly correlated with factors like schooling ($p = 0.017$), use of prenatal care ($p = 0.001$), and interaction with ASHA/AWW workers ($p < 0.001$), according to chi-square analysis. There was a slight correlation between income and $p = 0.061$. These results highlight the necessity of focused interventions to improve reproductive health outcomes for rural women, with an emphasis on education, community-based outreach, and increased engagement of healthcare workers. In order to empower women and lessen disparities in reproductive health in rural India, the project provides evidence to inform the creation of local health policies and programs.

Key words: Reproductive health, Knowledge & Awareness

1. Introduction

In India, rural women frequently encounter several obstacles while trying to obtain reliable reproductive health information and services. In India, rural women represent the backbone of the household and agrarian economy, but they continue to be among the most marginalised groups when it comes to decision-making, healthcare, and education. Cultural norms, restricted access to information and services, and socioeconomic position all have a significant impact on their health, especially reproductive health. In many rural regions, gender-based violence, early marriage, high fertility rates, and poor maternity care are still major problems. Designing successful public health and social welfare initiatives requires an understanding of the socioeconomic position and reproductive health knowledge of rural women.

Rural women in India have many obstacles in the areas of economic involvement, education, and healthcare access, all of which have an immediate impact on the health of their reproductive systems. Ayodhya district, which is primarily rural and reflects many of the socioeconomic and cultural aspects seen in rural North India, is situated in the northern state of Uttar Pradesh. Poor reproductive health outcomes in regions like Ayodhya are caused by a number of reasons, including societal taboos, low poverty, and little education. Designing successful health interventions requires an understanding of their socioeconomic circumstances and degree of expertise. In order to identify important gaps and areas for intervention, this study intends to evaluate the socioeconomic circumstances and reproductive health awareness of rural women in this region. Women's socioeconomic profile, which includes things like income, education, work, and living conditions, has a significant influence on how they seek health care and make decisions. Women's access to reliable health information and services is hampered in many rural communities by early marriages, a lack of educational options, and gender conventions. A sizable portion of the female population in rural Ayodhya lacks sufficient understanding of reproductive health issues, including menstruation, contraception, maternal health, and STDs. Poor health outcomes like high maternal mortality, unintended pregnancies, and untreated illnesses are frequently caused by this disparity.

The National Family Health Survey (NFHS-5) shows that when it comes to measures like women's educational attainment, institutional deliveries, and the usage of contraceptives, rural areas fall well short of urban areas. Women's access to reproductive health treatments is further constrained by their lack of autonomy, lower literacy rates, and financial reliance on male family members. Numerous research have demonstrated the link between socioeconomic level and knowledge about reproductive health. Low-educated rural women were less likely to use family planning services, according to Singh et al. (2018). Reproductive health indices in rural areas are lower than those in urban areas, according to the National Family Health Survey (NFHS-5). Cultural stigma, limited access to healthcare, and low female autonomy are some of the obstacles (Kumar & Gupta, 2020).

The relationship between women's health outcomes and socioeconomic level has been highlighted in a number of research. According to studies by Jejeebhoy (1998) and Kishor (2005), women who are more financially independent and have greater levels of education are more likely to use family planning techniques, give birth in a medical facility, and obtain prenatal care. According to a 2016 survey by the International Institute for Population Sciences (IIPS), just 58% of Indian rural women utilise any kind of contemporary contraception, and only 53% receive complete prenatal care. Financial limitations, unavailability of female healthcare practitioners, sociocultural restrictions, and travel time to medical facilities are some of the obstacles. According to Singh et al. (2017), women's reproductive decisions are greatly influenced by their decision-making authority. Many women in rural Uttar Pradesh, where patriarchal values are prevalent, rely on their spouses or in-laws to make decisions about their health, which frequently results in care being delayed or refused. Misconceptions and understanding gaps around contraception continue despite awareness campaigns. A study by Bansal & Meena (2019) found that low contraceptive use in rural India is a result of cultural stigma and false knowledge regarding adverse effects.
By concentrating on the Ayodhya district, which has received less attention in previous studies, this study expands on previous research.

Objectives:

- To assess the socio-economic profile (including age, education, occupation, income, and family structure) of rural women in selected villages of Ayodhya district.

- To evaluate the level of reproductive health knowledge related to menstrual hygiene, antenatal care and family planning.

4. Methodology

The socioeconomic profile and reproductive health knowledge of rural women in the Ayodhya district of Uttar Pradesh, India, are being evaluated in this study using a descriptive cross-sectional approach. The study, which focused on a sample of 100 women between the ages of 20 and 50, was carried out in the village of Shidhauna block in Milkipur. In order to especially include women from low-income and low-education households—who are frequently the most vulnerable and neglected in terms of reproductive health services—a purposive sampling strategy was used. A systematic interview schedule was used to gather data, and its two main components were a 20-item reproductive health knowledge measure and a sociodemographic questionnaire. With the use of Microsoft Excel or SPSS, the gathered data was examined using descriptive statistical techniques, such as frequencies and percentages, in order to interpret the results and uncover trends in the participants' understanding of reproductive health.

5. Results & Discussion

Variables	Category	Frequency	Percentage
Age	**Young (20-30)**	45	45%
	Middle (31-40)	35	35%
	Old (41-50)	20	20%
Education	**No formal education**	33	33%
	Primary School	27	27%
	Middle School	15	15%
	High School	10	10%
	Intermediate	10	10%
	Graduation & above	05	05%
Monthly household income	**Below Rs. 5000**	40	40%
	Rs. 5001-10,000	35	35%
	More than 10,000	25	25%
Family type	**Nuclear**	67	67%
	Joint	43	43%
	Extended	-	-
No. of Children	**One-two**	17	17%
	Three-five	59	59%
	More than five	24	24%
Age of first pregnancy	**Less than 18 years**	08	08%
	18-25 years	63	63%
	After 25 years	29	29%
Place of last delivery	**Home**	57	57%
	Government hospitals	38	38%

	Private clinics	05	05%
Anenatal Care (ANC)	**4+ ANC visits**	27	27%
	1–3 visits	43	43%
	No ANC	30	30%
Contraceptive Use	**No contraception**	51	51%
	Sterilization	19	19%
	Temporary methods (condoms, pills)	30	30%
Interaction with ASHA/AWW workers	**Regular**	20	20%
	Occasionally	37	37%
	Never	43	43%
Reproductive Health Knowledge Level			
Knowledge Level	Poor (0–7 correct answers)	60	60%
	Moderate (8–14 correct answers)	30	30%
	Good (15–20 correct answers)	10	10%

The study's rural women's socioeconomic and reproductive profile shows notable differences in age, income, education, understanding of reproductive health, and use of healthcare. Twenty percent were older (41–50 years), thirty-five percent were middle-aged (31–40 years), and forty-five percent were youthful (45 percent). The importance of focused reproductive health interventions is shown by the demographic distribution, which shows a preponderance of women in their reproductive years. The respondents' level of education was noticeably poor. Only 5% had completed graduation or beyond, and one-third (33%) had no formal education. Women's access to reproductive health knowledge and services may be significantly hampered by such limited educational exposure, which can prolong cycles of poor health and limited autonomy.

Only 25% of homes made more than Rs. 10,000 per month, while 40% of households made less than Rs. 5000. This low-income profile points to economic fragility, which is frequently linked to limited access to family planning and high-quality healthcare. Nuclear families accounted for 67% of the respondents' households, which may lessen the impact of extended family dynamics on reproductive choices but may also lead to a lack of social support for maternal care.

Although 8% reported early pregnancies under the age of 18, raising concerns about adolescent reproductive health and associated risks, 57% of last deliveries occurred at home, indicating low institutional delivery rates, which are crucial for safe maternal and neonatal outcomes; utilisation of antenatal care (ANC) was suboptimal, with only 27% receiving the recommended four or more visits; and 30% reported no ANC visits at all. The relatively high number of children per woman—59% having three to five children and 24% having more than five—was a reflection of high fertility rates and limited use of family planning.

Negative health effects for mothers and children may result from this neglect. Only 30% of people utilised temporary methods of contraception, and more than half (51%) did not use any kind of contraception at all. This points to a need for better access to and knowledge of family planning choices as well as limited reproductive autonomy. Only 20% of respondents had regular contact with frontline health professionals, such as ASHA or AWW, and 43% had never interacted with them. The distribution of crucial information about reproductive health is hampered by this disconnect. Lastly, just 10% of women showed strong understanding of reproductive health, while the majority (60%) had poor knowledge. This research emphasises how urgently comprehensive, community-based health education initiatives that are adapted to the unique circumstances of rural women are needed.

Relationship between reproductive health knowledge and different socioeconomic and healthcare-related variables:

Chi-square tests were used to evaluate the relationship between reproductive health knowledge and different socioeconomic and healthcare-related variables. A significant threshold of $p < 0.05$ was established.

Variable	**Chi-square Test (p-value)**
Education vs Knowledge	0.0175
Income vs Knowledge	0.0607
ANC vs Knowledge	0.0013
ASHA Interaction vs Knowledge	0.000052

1. **Education and Reproductive Health Knowledge:** Knowledge of reproductive health and educational achievement were shown to be statistically significantly correlated ($p = 0.017$). Women who had more education showed greater knowledge. This bolsters the body of research demonstrating that education plays a crucial role in determining reproductive awareness and health literacy.
2. **Monthly Household Income and Knowledge:** Although the finding was not statistically significant, the relationship between income and reproductive health knowledge neared significance ($p = 0.061$), indicating that women from higher-income households tended to have superior knowledge. More research is necessary since economic empowerment probably improves access to health information and services.
3. **Antenatal Care (ANC) Utilization and Knowledge:** ANC visits and reproductive health awareness were significantly correlated ($p = 0.001$). The likelihood of having adequate knowledge was significantly higher for women who attended four or more ANC appointments. This emphasises how crucial maternal health services are as a means of disseminating health education.
4. **Interaction with ASHA/AWW Workers and Knowledge:** The strongest correlation ($p < 0.001$) was found between knowledge levels and interactions with frontline health workers. Better understanding of reproductive health was significantly correlated with regular interaction with ASHA/AWW workers, highlighting the critical role that community health workers play in rural health education.

6. Conclusion

Due in significant part to socioeconomic issues like low income and education, rural women in the Ayodhya district have inadequate awareness of reproductive health. These results highlight how education, participation in prenatal care, and interactions with healthcare professionals all have a substantial impact on rural women's reproductive health knowledge. Enhancing frontline worker outreach, promoting frequent maternal healthcare utilisation, and providing educational support should be the top priorities of interventions meant to increase health awareness. Although income is important, it seems to have a less direct impact than access to healthcare and education. The results highlight the critical need for outreach and health education initiatives that are specifically designed to meet the requirements of rural women. The study aims to identify trends, inequalities, and crucial areas for policy attention by gathering data directly from rural women of all ages and socioeconomic backgrounds. The results are intended to encourage stakeholders in developing initiatives that empower women and enhance reproductive health indicators in rural Ayodhya, as well as to promote awareness campaigns and local health programs.

7. Recommendations

1. **Community-Based Education Programs:** Provide women with regular reproductive health education workshops through Anganwadi centres and ASHA employees.
2.
3. **Mobile Health Clinics:** Set up mobile clinics for basic examinations and counselling in outlying locations.

4. **Encourage Participation:** Provide rewards for participating in initiatives that raise awareness of reproductive health.

5. **Involve Men and Families:** Encourage family support and male participation in conversations about reproductive health.

6. **Use Local Media:** To increase awareness in culturally appropriate methods, make use of street plays, posters, and local radio.

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