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An Association between Socio - Economic Status and KAP of Reproductive Health of the Early Married Women

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Abstract: ***Background:*** *Previous researches show that the women who are married before legal age, living in poor communities, belonging to the age group 15 to 24 years, face more reproductive health problems due to lack of information on reproductive health.* ***Objective:*** *To knowthe association between the socio- economic status of the early married women who were living in the urban slums.* ***Method:*** *A cross sectional study was conducted among 253 early married women of theage 15- 24 years in the slums of Lucknow district.* ***Results:*** *Out of 253 majority of the respondents 119 (47%) were belonging to the III class of socio-economic status. Most of the respondents had low level of knowledge (91.7 %), negative attitude (79.1%) and poor practice (81.8%) regarding their reproductive health.In present study it was foundthatthere is an association between the score of practice and socio - economic status of the respondents.* ***Conclusion:****It can be concluded that there are an association between the socio-economic status of the respondents and their reproductive health practices but interestingly it is found that no association existed between the knowledge and attitude.*

Keyword: Early married women, Reproductive health, socio economic status, knowledge, attitude and practice**.**

Introduction:

UNICEF, 2016 reported that the child marriage is still widespread in India, which is home to a third of the world's child brides. About half of theIndian women were married before they turned 18 years.It was noticed in the report of Census, 2011 that the incidences of the child marriage are being declining nationally but the pace of change remains slow, in nearly all the states, especially in the age group of 15-18 years. Uttar Pradesh is one of the states that have an incidence of child marriage higher than the national average. Many researches showed that child marriage is associated with the adverse reproductive health outcome of women. (Santhya et al (2010), Raj A. et al (2010), Maharjan et al (2019). It was found that a women's reproductive health status is greatly influenced by the menarche during adolescence, beliefs and attitudes regarding menstruation and more importantly the behavior during the menstrual period (Fetohy et al, 2007) and the women, married before legal age are more prone to face the violence, exposure to RTI and become pregnant as adolescent that results increased risk of delivery complications, maternal mortality and child mortality.(UNICEF, 2016)Child marriage prevalence is the percentage of women 20-24 years old who were married or in union before they were 18 years old. (UNICEF State of the World's Children, 2017). It was revealed in NFHS, 2016 report that the prevalence of child marriage amongst 15-19 years old and 20-24 years old girls of India. Socio-economic status is an important factor affecting the health condition of an individual or a family and health behavior of an individual or a community is interdependent on their socio-economic status. (Sharma R, 2013). Therefore, the objective of the study is to access the association between the socio- economic status of the early married women who are living in the urban slums.

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Research Methodology:A cross sectional study was conducted among the early married women who were living in the urban slums of Lucknow. According to NFHS-4 the prevalence of child marriage amongst 15-19 years old and 20-24 years old girls were found. Thus, by considering the prevalence of early marriage, the respondents who were belonging to the age between 15-24 years and married before 18 years were recruited for the study.Modified BG Prasad scale, 2018was used for determining the socio-economic status of early married women, living in urban slums of Lucknow.

Sample size: For estimating the sample size following formula was used:

$$N = \frac{Z^2 pq}{d^2}$$

$$N = \frac{1.96^2 \times 0.80 \times 0.20}{(0.05)^2}$$

$$= 245 + 25\ (10\%)$$

$$= 270$$

Where N is the required sample size, Z is the reliability coefficient at 95 % confidence interval (1.96), p is equal to 1-p, and d is the acceptable error (0.05) (Barman A, 2015).
To the best of our work there was no previous data on the KAP regarding reproductive health of the early married women living in the slums of Lucknow. Hence for deciding the value of p the overall percentages of knowledge (79%), attitude (80%) and practice (78%) of reproductive health of early married women who were living in the urban slums that have been calculated from the pilot study and later applied to calculate the sample size of the present study. By observing the scores of knowledge (79%), attitude (80%) and practice (78%), it was noticed that the attitude score (80%) was the highest value. This procedure should be used when someone is unable to arrive at a better estimate of p. The value for p used in this study was 80%. (Wesson DW, 2006)The sample size obtained was 270 but only 253 participants were responded. Therefore, giving a respond rate of 93% only 253 questions were included in the present study. 17 (7%) questionnaires were not included in the study due to declination of the respondents and missing data.

Sampling design: When it is difficult to access subjects with the target characteristics, the snow ball sampling is applied. In this method, the existing study subjects recruit future subjects among their acquaintances. Sampling continues until data saturation. (Burns N & Grove SK 1993). Early married women of the age 15-24 years were a hard-to-reach population.Hence a well-recognized NGO which focus on the all sexual and reproductive health issues of the women of reproductive age and also run outreach teams and are in regular contact with a number of early married women living in slum throughout the city, was contacted for the collection of data. The potential participants were recruited with the support of the volunteers of that NGO who were working in the different communities of the city. Snowball sampling techniques were used to recruit the participants for the study.

Study instruments:
An interview schedule was used to collect the quantitative data for the study.B. G Prasad scale was used to determine the socio-economic status of the study subjects. It was developed at the Institute with the assistance from the faculty members and other experts of women's reproductive health. The pilot study was conducted among early married women who were living in the urban slum and the questions were modified accordingly. The reliability of the questionnaire was checked by calculating the Cronbach alpha (α) test. The respondents were asked about their knowledge, attitude and practice regarding the reproductive health of women.

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To get the score of knowledge, attitude and practice of total reproductive health the questions in the scheduled questionnaire addressed four main areas; menstruation, family planning, RTI and reproductive right. Schedule questionnaire used in the study was translated to Hindi for better understanding of the participants of the study and back translated in English.

Focus Group Discussion: At the end of research, an FGD was organized with the main target group was to verify, disprove, modify or differentiate the study's provisional finding.

Operational definitions to find out the KAP score of women's reproductive health:

Knowledge: There were 63 questions in this part and the respondents were asked regarding their knowledge of reproductive health of women. Each question has two choices; Yes and No. A correct answer was given 1 score where as a 0 score was given for a wrong answer. The overall knowledge of the study participants was accessed using the sum score of each outcome based on bloom's cut off point. The scores were classified into 3 level as follow Bloom's cut off point, high level knowledge if the score was above 51 points (80%), moderate if the knowledge score was 38-50 points (60% - 79%) and low if the score was less than 37 points (< 59%).

Attitude: Overall attitude included 63 itemsto access the perception or outlook regarding reproductive health problems, causative factors and preventive measures ofreproductive health issues. All individual answers were summed up for total scores and calculated for means percent. The scores were classified into 3 levels (positive attitude, neutral attitude and negative attitude) according to Bloom's cut off pointthe positive attitude score that fell above 50 points (80%), neutral attitude score that fell between 38-50 points (60% - 79%) and negative attitude score that fell below37 points (less than 59%).

Practice: It is the overt behavior, habit or custom that a person does, follow up or carry out in her daily life in prevention of reproductive health issues. 55questions were used to access the experience and action of the respondent. Each question contains 1 point for positive practice and 0 for negative practices. The total response score was 55 point and classified in to 3 according to Bloom's cut off point as practice score that fell above 43 points (80%) is good practice,practice score that fell between 33- 43 points (60% - 79%) is fair practice and practice score that fell below 32 points (less than 59%) is poor practice.

Data collection procedure:
Informed consent was taken from each of the study subject prior to the initiation of the study. The participants were explained about the purpose of conducting the study individually prior to the initiation of the recruitment process.

Inclusion criteria: Early married women aged 15 – 24 years who were living in urban slums from more than six months were included in the study.

Exclusion criteria: The women who have not given consent for being the participant of the study and the women who were non-co-operative were not recruited.

Statistical analysis used: The data was entered into SPSS, version 20 sheets and analyzed. Data was presented in the form of tables. Frequency, mean, Standard deviation and chi square test was used for the analysis of data.

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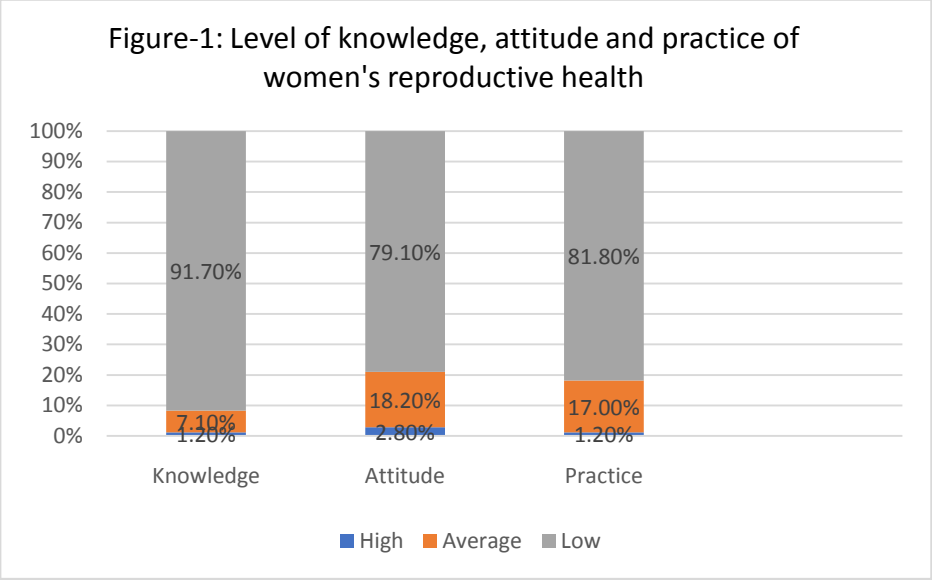
Results:

Socio- economic status of the respondents:

Table-1: Socio- economic status of the respondents		
Socio-economic class	**Frequency**	**Percentage**
I	4	1.6
II	45	17.8
III	119	47.0
IV	82	32.4
V	3	1.2
Total	**253**	**100.0**

Socio-economic status has been defined as "The position that an individual or family occupies with reference to the prevailing average standards of cultural and material possessions, income and participation in group activity of the community". (Park K., 2015). The socio-economic status of the respondents was determined by using the BG prasad socio-economic scale, 2018. Table-1, depicts that the majority of the respondents 119 (47%) were belonging to the III class followed by IV class 82 (32.4) and less than one fifth sample population 45 (17.8%) was belonging to II class followed by I class 4 (1.6%).



Level of knowledge, attitude and practice score of reproductive health:

Knowledge possessed by a community refers to their understanding of any given topic reproductive health in this case. Attitude refers to their feelings towards this subject, as well as any preconceived ideas that they may have towards it. Practice refers to the ways in which they demonstrate their knowledge and attitude through their actions. (K. Kaliyaperumal, 2004). Figure-1expresses the level ofknowledge, attitude and practice of the early married women who live in the slums of Lucknow city. The knowledge Score of total reproductive

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health (mean = 25.06; SD=8.017; n =253) 91.7 (n=232) of the respondents scored in the low knowledge, followed by average Knowledge 7.1% (n=18). High level of knowledge was very low 1.2% (n=3). The attitude Score of total reproductive health (mean = 30.38; SD= 9.032; n =253). 79.1% (n=200) of the respondents scored in the negative attitude, followed neutral 18.2% (n=46). Positive attitude was very low 2.8% (n=7). The practice score of total reproductive health (mean=24.35; SD= 8.221; n= 253), 81.8 % (n=207) of the respondents scored in the poor practice range while 17% (n=43) followed fair practice. Only 1.2 % (n=3) fell in the category of good practice.

Table-2: Association between Socio-economic status and the level of KAP of respondents' reproductive health

	Socio-economic status					Total	Chi Square Sig
	I	II	III	IV	V		
Knowledge category							
High level	0	2	1	0	0	3	χ^2 =10.752 Df=8 P=.216
	0.0%	66.7%	33.3%	0.0%	0.0%	100.0%	
Moderate level	1	3	5	9	0	18	
	5.6%	16.7%	27.8%	50.0%	0.0%	100.0%	
Low level	3	40	113	73	3	232	
	1.3%	17.2%	48.7%	31.5%	1.3%	100.0%	
Total	4	45	119	82	3	253	
	1.6%	17.8%	47.0%	32.4%	1.2%	100.0%	
Attitude category							
Positive	0	4	2	1	0	7	χ^2 =9.558 Df=8 P=.297
	0.0%	57.1%	28.6%	14.3%	0.0%	100.0%	
Neutral	1	10	20	15	0	46	
	2.2%	21.7%	43.5%	32.6%	0.0%	100.0%	
Negative	3	31	97	66	3	200	
	1.5%	15.5%	48.5%	33.0%	1.5%	100.0%	
Total	4	45	119	82	3	253	
	1.6%	17.8%	47.0%	32.4%	1.2%	100.0%	
Practice category							
Good	1	0	1	0	1	3	χ^2 =49.410*** Df=8 P=.000
	33.3%	0.0%	33.3%	0.0%	33.3%	100.0%	
Fair	0	10	18	15	0	43	
	0.0%	23.3%	41.9%	34.9%	0.0%	100.0%	
Poor	3	35	100	67	2	207	
	1.4%	16.9%	48.3%	32.4%	1.0%	100.0%	
Total	4	45	119	82	3	253	
	1.6%	17.8%	47.0%	32.4%	1.2%	100.0%	

$***P< 0.001$.

Association between Socio-economic status and KAP scores of reproductive health:
Table-2 revealed that there is no association between Socio-economic status and knowledge and attitude level of the respondents. There is a statistical association was found between Socio-economic status of the respondents and practice score of reproductive health (χ^2 =49.410, df=8, p=<.001) of respondents.

Discussion:

In our study it was found that the early married women living in the slums majority of them belong to the lower socio-economic class and having low level of knowledge, negative attitude and poor practices regarding their reproductive health. It is supported by the NFHS (2016), UNICEF (2017), Maharjan et al (2019) as stated that the child marriage is associated with the poor socio-economic status and poor reproductive health outcomes due to lack of information regarding their reproductive health. There is an association found between the poor reproductive health practices of the respondents and their low socio- economic status. The same findings were reported in the research done by Jose M J et al, 2019. It was also showed in previous researches that the low level of knowledge regarding reproductive health and the socio- economic status of the women is also associated. (Jose M J et al, 2019). But our study rejected the findings of the previous researches as it is expressed no association between the respondents' knowledge level of reproductive health and socio-economic status of the respondents.This difference occurs because the data collected from the slum community by the help of NGO workers where the volunteers of NGO were already providing the knowledge to have safe and healthy reproductive health. But it was noticed that the respondents have not much information about the government's financial servicesthat are provided to the women,for improving their reproductive health.

Conclusion: In conclusion the present study estimated that the low level of knowledge is associated with the early marriage. Whether there is an association between the poor reproductive health practices and socio-economic status but there was no relation between the knowledge and socio- economic status of the respondents. It is why that the NGO's were already working to promote the knowledge of reproductive health among the respondents. It is noticeable that the respondents have very little information and lack of awareness about the Government's financial supports regarding their reproductive health. Thus,it can be suggested that if the NGO's or local reproductive health providers do work to improve the knowledge regarding financial services of women reproductive health, the improvement in the reproductive health of the women can be seen.

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