

**“A STUDY TO ASSESS THE EFFECT OF HEALTH EDUCATION
PROGRAMME ON KNOWLEDGE AND PRACTICES RELATED TO
COMMON SELECTED REPRODUCTIVE TRACT INFECTIONS AMONG
THE MARRIED WOMEN IN RURAL AREA OF PUNE DISTRICT.”**

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Under the

Board of Moral and Social Sciences

By

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Under the guidance of

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CERTIFICATE

This is to certify that the thesis entitled “**A STUDY TO ASSESS THE EFFECT OF HEALTH EDUCATION PROGRAMME ON KNOWLEDGE AND PRACTICES RELATED TO COMMON SELECTED REPRODUCTIVE TRACT INFECTIONS AMONG THE MARRIED WOMEN IN RURAL AREA OF PUNE DISTRICT.**” is a genuine and bonafide work prepared by Mrs. Madhuri S. Shelke under my guidance and direct supervision. The research report has been submitted to Tilak Maharashtra Vidyapeeth Pune in fulfillment of the award of the Degree of Doctor of Philosophy.

To the best of my knowledge and belief, the matter presented in this thesis has not been submitted earlier for the award of the degree of Doctor of Philosophy of Tilak Maharashtra Vidyapeeth, Pune.

Place: PUNE

Date: / /

DR. VISHAL G. JADHAV

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SUMMARY OF THE THESIS

BACKGROUND OF THE STUDY:

Health care of the women of child bearing age has been given due attention and importance, through various maternal and child health programs. Reproductive tract infections (RTI's) among women aged 15-45, is increasing in India. In rural areas, the lack of awareness and health facilities in turn lead to a high incidence of STDs/RTIs. Illiteracy, unhealthy lifestyle, burden of gynaecological and obstetrical conditions and procedures, strong traditional culture and practices put the Indian women at higher risk of acquiring reproductive tract infections (RTIs). In India mothers and children constitute 62% of the total population. Morbidity rate is high in women. Due to traditional beliefs and practices woman is conditioned to think about the family first and to suffer in silence for all personal matters, particularly related to health. She cannot speak openly on reproductive health matters so women seek medical consultation only when the problem is grave instead she practices home remedies or other means which leads into severe complications.

Reproductive health is one of major issues today because of, increasing spread of sexually transmitted infections causing a great threat of acquiring HIV and AIDS. Increasing number of adolescent pregnancies, the growing incidence of reproductive tract infections, maternal and child mortality and morbidity highlight the urgent need for appropriate and effective interventions of sex related matters and access to reproductive health services and information. Many studies have indicated association of factors like lack of education, early marriage, menstrual hygiene practice, contraceptive usage, knowledge about reproductive tract infections, treatment-seeking behaviour with the prevalence of reproductive tract infections. The fact that, creating awareness among this vulnerable group will clear various misconceptions about reproductive health issues including RTIs, and encourages preventive practices especially in Indian scenario.

Reproductive tract infections (RTIs) is a global health problem including both sexually transmitted infections (STIs) and non-sexually transmitted infections of the reproductive tract. World Health Organization estimates that each year there are over 340 million new cases of sexually transmitted infections in which 75-85% occur in developing countries. In India alone,

40 million new cases emerge each year. A majority of women continue to suffer from RTIs related complications like pelvic inflammatory disease, infertility, cervical cancer, chronic pelvic pain, post abortion and puerperial sepsis and ectopic pregnancy. One of the important component of the Reproductive and Child health Programme is to lead a healthy sexual life without any fear of contracting disease. RCH programmes gives a lot of importance to prevention of reproductive tract infections (RTIs) and sexually transmitted infections(STIs) also to promote and encourage healthy sexual behavior among couples through Information, Education and communication activities. In this context an effort has been made to create awareness among rural women .The purpose of the study was to assess the effect of health education programme on knowledge and practices related to common selected reproductive tract infections in rural area of Pune District. A community based cross-sectional study was undertaken among married women between 15 to 49 years in Pune District, Maharashtra.

Health Care Practices:

Health behaviour is a kind of a social behaviour and, as such, affects and gets affected by various socio-cultural parameters. For example, understanding of a disease is not a medical issue but is largely dependent on the shared knowledge of a particular community. Traditions, social practices and role relationships- all contribute to our dealings with health and illnesses. The sick role behaviour largely depends on how a community expects its sick members to behave. These social aspects of health form the basis for informal 'systems of health care.'¹⁸⁴ⁱⁱⁱ Medical anthropologist, Arthur Kleinman (1980), has classified health care practices into three sectors: popular, folk and professional. These three sectors not only differ in terms of their explanations of illness but also in the treatment regimen and the mode of social interaction. The popular sector refers to those informal health practices that primarily rely on familial and social network knowledge to deal with diseases. Home-made remedies, knowledgeable people who can be consulted, visiting spiritual centres are all part of the popular sector. These practices are outgrowth of shared experiences and transfer of knowledge from one generation to the other. According to Kleinman", 95 percent of the health problems in a society are taken care by this popular sector. The folk sector is rather a more organized with health and illness. These are the informal system which have evolved over a very long period of time, and are integrated within

the community life. The folk sector comprises herbal medicines, shamans and traditional healers and time / tested indigenous medicines. These folk treatments have survived for centuries because they share the belief systems of the community and are consistent with the social and religious practices. Kakar 1982 has evidenced that, what are considered as primitive and superstitious practices have their rationality rooted in a coherent world view and inefficacy in dealing, with a wide range of health problems. Even in this scientific age, the popularity of these folk practices has not declined. The third sector, i.e., professional sector refers to organized professional systems, like medical system, acupuncture and Ayurveda, which have a formal system of practicing. These systems are based on well-laid out theoretical basis, system of education and professional bodies and code of conduct. Such professional systems compete for public patronage and their coexistence is characterized by suspicion, "and underlying tension.

Investigator has considered sociological aspects in the study because health includes the social components. Most of the diseases include social causes and social consequences along with the medical problems. It helps nurses to know social life and understand the human society, it develops scientific attitude towards customs and traditions and culture.. To understand the epidemiology of diseases nurses should know that society is a complex network of human social relations. It helps to understand to find the health behaviour of the people. A study undertaken is related to reproductive tract infections to improve reproductive health is a genuine issue for the women which is common disease related to socio-demographic determinants .The disease can be prevented and treated if proper awareness methods by understanding socio-demographic determinants in women .

The scarcity of health care services, especially in rural areas, is a restraint for women to seek medical help. Also, health-care is often out of reach for common people. Since a majority of the women are not economically independent, they hesitate to spend money on their health.

Investigator correlates this theory and practice in context with the feminist theory did retain the critical Marxist stance that stressed theoretical knowledge must be generated and used for emancipatory practice. Feminist sociology is understood as a critical enterprise on three counts:

- It takes a woman-centered perspective.
- It interrogates the core concepts and assumptions of sociology from this perspective.

- It asks how social change can be effected to produce a more humane social world.

Feminist sociology theory strengthens the "critical emphasis in sociology" by its insistence that "sociological work be critical and change-oriented, not only towards society . . . but also towards sociology itself" (Lengermann and Niebrugge- Brantley, 1990:318).

Given the various forms of discrimination suffered by women, their low status in society and the consistent neglect of their health, there can be no two opinions on the fact that women urgently require special attention in health care. It is necessary that women's literacy level in rural areas should be enhanced, more employment opportunities to be given to them, and they should have a voice in decision-making. Women should not be treated as mere reproductive machines. They are a precious human resource and their contribution to the nation's socio-economic development is significant. It is very important that women's health is given top priority in our national agenda.

SOCIOLOGY IN COMMUNITY HEALTH:

Community health has been and remains a very applied field. It is also characterized by a population-based approach to health, and statistical methods are deemed the appropriate underlying method for the field. It is viewed as a science that seeks to intervene, control and prevent large-scale processes that negatively affect the community's health. By these criteria, there is a strong logical fit of sociological principles and practices within community health.

AIM AND OBJECTIVES OF THE STUDY:

Aim: A study "to assess the effect of health education programme on knowledge and practices related to common selected reproductive tract infections among the married women in rural area of Pune District.

Objectives of the study:

- To assess the knowledge of the married women related to common selected reproductive tract infections.
- To assess the practices of the married women related to common selected reproductive tract infections.

- To assess the effect of health education programme on knowledge and practices of the women related to common selected reproductive tract infections.
- To correlate the knowledge of the married women with their practices.
- To find the association between knowledge and practices regarding common selected reproductive tract infections with selected demographic variables.

HYPOTHESIS:

- H₁: - The post-test knowledge and practice score of the women in relation to the reproductive tract infections will be significantly higher than their pretest knowledge and practice score.
- H₂:- There will be significant co-relation between knowledge and practices of the women in relation to the reproductive tract infections.
- H₃:- There will be at least one demographic variable which has significant association with knowledge.
- H₄:- There will be at least one demographic variable which has significant association with practices.

STUDY VARIABLES:

- The independent variable was planned health education programme regarding reproductive tract infections.
- The dependent variables were knowledge and practice scores of the respondents.

CONCEPTUAL FRAMEWORK:

The study was based on the “General Systems Theory” for assessing the effect of health education programme. Accordingly, the study was organized around the conceptual framework based on the process of input, throughput and output.

- Input into the system includes subject characteristics such as age, age at marriage, education of self and husband, occupation of self and husband, family income, type of family, menstrual, sexual and gynecological data, place of delivery and partner participation.

- Throughput includes the entire process of developing and administering the health education programme and finally the output reveals the changes in knowledge and practice level in terms of scores.
- In the present study, output refers to gain in knowledge and practices assured by the women about reproductive tract infections.

MATERIALS AND METHODS:

- Quasi-experimental approach was used to evaluate the effect of health education program on knowledge and practices related to common selected reproductive tract infections among the married women in rural area of Pune District and its effectiveness was determined statistically.
- The study was conducted in the rural area of Pune district. Pune district includes 13 tehsils. Probability proportionate multistage sampling technique was used for sample selection. From each tehsil two villages were selected randomly (one for experimental and one for control group), from these two villages samples with sample size proportionate to tehsil population was taken for experimental and for control group. Random sampling technique was used to select samples from each village .Total 605 for control group and 605 samples for experimental group were selected for the study. Women who consented to participate in the study with age between 15 to 49 years were included in the study. Total sample size was 1210 (605 – control and 605 – experimental).

DATA COLLECTION TOOLS AND TECHNIQUES:

In order to meet the objectives, data collection tool was prepared to assess knowledge and practices (Self expressed practices were assessed which is defined in operational definition) of the respondents.

The tool consists of four sections.

Section A –Consist of socio-demographic characteristics of the respondents.

Section B – Comprised of knowledge questions to assess the knowledge related to reproductive tract infections.

Section C – Consist of 3 point Likert scale to assess the practices of the respondents divided into four categories (preventive and promotive, antenatal, intranatal, postnatal, abortion, family planning, curative and awareness) practices.

Section D –Structured Health education plan.

DATA ANALYSIS:

The following analysis was computed:

- The items in the demographic data variables were computed in terms of frequency and percentage.
- Item-wise increase in level of the knowledge of pre test & post-test between both the groups regarding reproductive tract infections
- Item wise increase in level of the practices of pre test & post-test between both groups regarding reproductive tract infections
- Paired t-test was applied to compare knowledge scores before and after health education programme.
- Paired t-test was applied to compare practice scores before and after health education programme to the respondents.
- Two sample z-test was applied to compare effect on knowledge scores of experimental and control groups.
- Two sample z-test was applied to compare effect on practice scores of experimental and control groups.
- Pearson's correlation coefficient followed by the t-test for significance of correlation coefficient was used for analysis of data related to find correlation between knowledge and practices regarding reproductive tract infections.
- Analysis of data to find association between knowledge and selected demographic variables was done using ANOVA (Analysis of variance).

MAJOR FINDINGS OF THE STUDY:

Section I - Findings related to demographic variables:

Majority of the respondents 23.6% and 23.3% of them were from age group 26-30 years in experimental and control group respectively. Majority of the women in both the groups were, married between 18-22 years of age, had primary education and were housewives from joint family with the family income between Rs. 5000-10,000. Majority 64.3% and 64.1% of them had irregular menstrual pattern in experimental group and control group respectively. Majority of them had normal and hospital deliveries. Regarding contraceptive use by husbands, very few 7.6% and 7.1% of the husbands were using nirodh and 3.5% and 2.8% of them had vasectomy in experimental and control group respectively. 35% and 35.4% of the women had gynecological problems in experimental group and in control group respectively. More than half 55.1% and 54% of the women were not using any contraceptive method in experimental and control group respectively, out of those who were using contraceptives, 24.7% of them were using Cu-T, 10.1% of them had oral pill and 10.1% of them had tubectomy.

Item analysis regarding knowledge:

Majority of them from both groups stated that, women are more vulnerable for reproductive tract infections because of lack of time. Majority of them from both groups opined in pretest that poor genital and menstrual hygiene is the possible cause of reproductive tract infections. Very few of them from both groups in pretest stated that poor general health/low immunity are the possible cause of RTIs.

In pretest very few of them in both groups opined that genital itching, swelling in the groin, fever, and pain & bleeding during sexual intercourse are common sign and symptoms of RTI. In pretest, more than half of them from both group responded that reproductive tract infection is spread by the use of unclean water for genital hygiene sharing clothes and sharing/use of public toilet. Very few of them opined that it happens through mother to child, and unsafe abortion and delivery. In pretest, more than half of them from both groups responded that when RTI symptoms are seen, it is treated by home and herbal remedies. None of them from either group responded in pretest that prenatal and neonatal infections are the complications

which are caused if reproductive infections are not treated, which changed to 71.4% in experimental group in posttest, Only 9.4% of them knew that the safer sex practices are the preventive and control measures for RTI, in posttest which remained at 10.1 for control group and for experimental group it changed to 68.9%.

Item analysis regarding practices:

33.8% of the control women and 33.2% of them from experimental group never used sanitary napkins. In pretest, in control as well as in experimental group, around half of the women never cleanse genital region before intercourse. 71.6% of the women in control and experimental group never followed safer sex practices in pretest, in Posttest control group percentage almost remained unchanged however in experimental group, 46.1% of them always followed safer sexual practices. In control and experimental group, in pretest, 46.3% and 45.1% of them would never prefer hospital delivery. Also for experimental group, there is significant improvement in the responses that always prefer deliveries conducted by trained personnel and always seek immediately medical advice if any problem arises during intranasal period. There is significant improvement in the number of women in experimental group in posttest who seek postnatal care. In control as well as in experimental group, almost half of them never followed awareness practices in pretest. For control group, the percentages remained almost same in posttest. However, experimental group percentage of following awareness practices raised significantly in posttest as compared to pretest.

Section II –

Analysis of data related to assess the knowledge of women related to the common selected reproductive tract infections:

a. Findings related to pre-test and post-test knowledge grades:

In pretest, majority of 70.9% of the women in experimental group had poor knowledge (score 0-24) regarding reproductive tract infections, 27.9% of them had average knowledge (score 25-48) and only 1.2% of them had good knowledge (score 49-72) regarding reproductive tract infections. Whereas in posttest, majority of 64.6% of the women had good knowledge (Score 49-72), 26.3% of them had average knowledge

(score 25-48) and only 9.1% of them had poor knowledge (score 0-24) regarding reproductive tract infections.

b. Paired t-test for effectiveness:

Paired t-test was applied to compare scores before and after health education to respondents. The knowledge scores of women improved significantly after receiving health education. Thus, the health education on reproductive tract infections is proved to be effective in delivering the knowledge and creating awareness.

c. Comparison of knowledge of experimental and control group:

Two sample z-test was applied to compare effect of health teaching on knowledge scores of experimental and control groups. The knowledge scores of women in experimental group improved significantly as compared to those in control group. Thus, the health education on reproductive tract infections is proved to be effective in improving the knowledge.

Section III-Analysis of data related to the effect of health education programme on the practices of the women related to the common selected reproductive tract infections.

a. Comparison of average pre-test and post-test practice grades:

In pretest, majority of 67.4% of the women in experimental group had good practices (score >82) regarding reproductive tract infections, 32.6% of them had average practices (score 41-82) and none of them had poor practices (score <41) regarding reproductive tract infections, whereas in posttest majority of 73.9% of the women in experimental group had good practices (score >82) regarding reproductive tract infections, 26.1% of them had average practices (score 41-82) and none of them had poor practices (Score <41) .

b. Paired t-test was applied to compare practice scores before and after health education programme . The practice scores of women improved significantly after receiving health education on reproductive tract infections. Thus, the health education on reproductive tract infections is proved to be effective in improving the practices.

c. Comparison of the effect on practice scores of experimental and control groups:

Two sample z-test was applied to compare effect on practice scores of experimental and control groups. Practice scores of women in experimental group improved significantly as compared to those in control group. Thus, the health education on reproductive tract infections is proved to be effective in improving the practices. Experimental group showed significant improvement in curative practices in posttest as compared to pretest

Section IV- An Analysis of data related to correlation between knowledge and practices regarding reproductive tract infections:

The correlation between knowledge and practices was assessed using Pearson's correlation coefficient. There was positive correlation between knowledge and practices of women regarding reproductive tract infections. More the knowledge of the women, better are their practices regarding reproductive tract infections.

Section V- An Analysis of data to find association between knowledge and selected demographic variable was done using ANOVA (Analysis of variance).

Since p-values corresponding to self occupation and husband's occupation are small (less than 0.05), null hypothesis is rejected. Self occupation and husband's occupation, women having business, the working husbands are the demographic variables which were found to have significant association with knowledge of the women regarding reproductive tract infections.

Section VI - An Analysis of data to find association between practices and selected demographic variables was done using ANOVA (Analysis of variance).

Since p-values corresponding to self occupation, monthly family income and place of delivery are small (less than 0.05), null hypothesis is rejected these demographic variables which were found to have significant association with practices of women regarding reproductive tract infections.

SCOPE OF STUDY FINDINGS :

Implications of the study in Nursing and in Sociology:

The findings of the present study have implications for nursing practice, education, administration, research and public education i.e. to society.

Results of the present study can be used to create awareness among women at grass root level which will improve their promotive, preventive, curative and awareness practices regarding reproductive tract infections to maintain their reproductive health.

Nursing education is a means through which nurses are prepared for sound scientific practice. Nursing education had shown tremendous changes in respect to curriculum. Health education is also one of the important aspects in promotion of health and prevention of illness.

Nursing administration: Evidence based care is an important function of an administrator. Findings of the study can be adopted as routine activity at different setting's, regular in service training can be organized for the nursing personnel.

Nursing research and public health :As per the changing health needs of the people health care setting today has become dynamic and more demanding which needs research based practice to render quality care. Results of the present study can encourage nurse professionals to utilize the intervention in different settings i.e. to the individual, family, community and the society. It will also help in programmes run by government in ministry of health and family welfare, NRHM (National Rural Health Mission), ICMR, prevention of RTI/STI and HIV/AIDS activities.

Implications to sociology:

1. Application of this study helps to educate the women by increasing their knowledge through health education programme which motivates their behaviour and habits to improve their practices regarding reproductive tract infections.
2. To identify the failure health measures of the women to utilize the health facilities and to analyze the reason for such resistance among them.

3. Its application delivers fruitful attention in the social system towards their attitudes, cultural practices related to health and illness. The distribution and the causal factors of health and disease are studied in relation to the social factors such as status, income, education, occupation and their practices.

The socio-economic progress of the nation depends upon the progress of the villages. Scientific method of investigations has to be conducted to find out the ways of dealing the health problems identifying the strategies will help to overcome the problems. Developing the right attitudes among the rural communities to prevent reproductive tract infections and to promote reproductive health, among the women residing in rural area. It will help the national programs under taken for the development and welfare of the society. Some of the rural development program in India are Rural health education, Community development program, National adult education program, integrated rural development program, Family welfare program and Development of women and children in rural areas. Rural development programs can be executed successfully only through the active involvement of local people, community participation and various functioning departmental agencies. The present study will help as remedial measure to overcome rural problem of the women in improving their reproductive health.

RECOMMENDATIONS:

On the basis of the findings of the study, it is recommended that:

- A similar study may be replicated on a large population; at state, national and international level; thereby findings can be generalized globally for a large population.
- A similar study may be conducted repeatedly in same area for reinforcement.
- A similar study may be conducted including the dimensions of people's beliefs ,attitude, health seeking behavior and actual practices towards prevention and control related to reproductive tract infections
- Similar kind of studies can be under taken in different settings and different target population.

- A comparative study can be carried to ascertain the knowledge regarding reproductive tract infections between urban and rural community.
- Qualitative and longitudinal studies can be undertaken to actually observe their practices.
- A study can be conducted to compare the effectiveness of health education with other teaching strategies.
- Teaching programmes may be designed for teachers and community leaders to disseminate knowledge regarding reproductive tract infections.
- More research-based legislation and programs aimed at preventing reproductive tract infections in collaboration with family welfare programmes which will be more creative and cost-effective intervention initiatives.

CONCLUSION:

The knowledge of human behaviour with an interdisciplinary approach to understand the human needs in the context of wider social problems. It is a total system approach to understand human behaviour views man as a product of socio-psychological and cultural factors. It helps to find solutions to problems which arise due to man's complex nature. Keeping in mind the importance of sociological aspects towards community especially women in rural area investigator thought of reproductive health problems and assessed their existing knowledge and practices regarding this problem and created awareness with the intervention i.e. health education programme so that through community participation we can adopt measures to prevent and control reproductive tract infections and promote and restore their reproductive health. So investigator has considered interdisciplinary approach .

Findings of the study reveals that health education programme is effective to improve the knowledge and practices regarding reproductive tract infections in rural area. There was positive correlation between knowledge and practices of women regarding reproductive tract infection. As the knowledge increases there is improvement in practices of the women. Self occupation and husband's occupation . Women having business, the working husbands are the demographic variables which were found to have significant association with knowledge of the women regarding reproductive tract infections. Self occupation, monthly family income and the place of

delivery are the demographic variables which were found to have significant association with practices of women regarding reproductive tract infections.

ABBREVIATIONS

1. A.N.M.-Auxillary Nurse Midwife.
2. DLHS - District Level Household Survey.
3. HIV/AIDS - Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome.
4. IUCD - Intrauterine Contraceptive Device.
5. NFHS –National Family Health Survey.
6. NRHM - National Rural Health Mission.
7. PHC - Primary Health Centre.
8. RTIs/STIs - Reproductive Tract Infections/Sexually Transmitted Infections.
9. WHO - World Health Organisation.

CHAPTER I

INTRODUCTION

Background of the study:

Health and wellbeing is a matter of concern which affects all aspects of human being. Health has wider implications for social, economic and political life of an individual. Especially health of the women has great association for the growth and welfare of a country. Women play many roles as wives, mothers, care taker in the family and in the present scenario as earners. (Dr. Naresh Yadav). Our culture, gender norms and values give rise to gender differences and inequalities, a woman cannot receive health services because of some community norms. Furthermore low status of women in most of the societies restricts them to avail the health care facilities. Marriage and childbearing brings out new health problems related to reproductive health. Studies also show that women are more vulnerable than men to reproductive health problems as they take most of the responsibilities related to bearing and rearing of child and household management (Moser 1987: Lee/Smith And Trujillo 1992 et. al. 2003). During pregnancy woman are more vulnerable to certain environmental hazards .Every year about half a million die of causes related to pregnancy and child birth (UNICEF 1991). As reported by WHO (1992), every step of reproduction may lead to increased risk of abortion, birth defects, foetal growth retardation and peri-natal deaths. In addition to all these a woman is exposed to reproductive health problems right from her adolescent period till her death. The magnitude of reproductive and sexual health problem is increasing at higher rate (Pachuri, 1998). Most of the problems are related to child birth, abortion, sexually transmitted diseases and gynaecological health (reproductive tract infection, infertility and menstrual irregularities) the future of human health in the 21st century depends a great deal on commitment to investing in woman health in the world today. Their health largely determines the health of the children, who are the adults of tomorrow (World Health report 1998).

Women are always under the domination of a multifaceted socio-cultural norms and values which conditions them to be silent and not complain regarding their health problems, also rigid societal inequalities have habituated them to suppress their needs. Thus women are the sufferers of the uneven socioeconomic categorization and also the subordination at home and in the society.

From the Fifth Five Year Plan (1974-78) (National Policy for the empowerment of women 2001), onwards, there are remarkable changes taken place in the approach to women's issues from welfare to progress. The National Commission for women was laid down up by an Act of Parliament in 1990 to safeguard the rights and legal entitlements of women still in the Indian context the female children before and after the birth have been ignored which give rise to higher infant mortalities, low proportion in the total population, female infanticide even foeticides and lower levels of nutrition. Besides hospitalized health care, female children are being neglected even in terms of feeding practices. In India half of the women get married before the age of 18 years which is a legal age by law, the proportion of married girls in age-group 15-19 is high. Though, the Child Marriage Restraint Act specifies the cut-off age for marriage as 18 years people in rural areas think that better to get their daughters married than giving them education. Illiteracy, superstitious beliefs and culture are still an existing in our country. The reasons for the gap might be deficiency of information, education and awareness, prevailing traditions, misconceptions, superstitions, etc. The cultural norms, beliefs, customs and faith do not permit the individual and groups to adopt new structure. Many research studies have shown that education of women has powerful association with the confidence to adopt new customs, the willingness to use health services, lowering of child mortality rates, improvement of family health and nutrition, use of family welfare services .According to National Family health Survey.

The rural women have significant contribution in agriculture and functioning in rural area. Compared to the role of rural women in the development of the nation their position in the society is lower than men. Women tolerate their health problems in a culture of silence and they do not receive treatment in time. (The Food and

Agriculture Organization of the United Nations) In India mothers and children comprise 62% of the total population. Morbidity rate is high in women. Traditional values and practice habituated woman to take care of her family first and suffer in silence particularly related to health matters. Women do not express openly on reproductive health issues instead of seeking medical help adopt home remedies or other resources which lead to severe complications. They seek health care when the problem is severe.

In context to the reproductive health problem among rural women of India which is closely related to their socio-cultural aspects investigator first would like to discuss the sociological concepts.

Indian society:

Indian society is an amalgamation of various ethnic groups, culture, religion, caste language and community. There is cultural heterogeneity, religious plurality, caste hierarchy in the society. But amidst this diversity Indian society shows unity in diversity. Rural, Tribal and urban communities exist within the society. Almost 74 percent of India's population lives in rural area, and having farming as a major occupation. Indian culture reflects these differences in socialization process and gender differences. The roles and responsibilities are quite different among men and women in rural as well as urban area. There are various castes in hierarchy levels having different habits, dietary patterns and lifestyle differences. Indian society is vibrant and subjected to social change time to time due to internal or external forces. These changes brought out social mobility and development. There are a number of things which are accountable for a continual and alter in Indian situation. Adaptation happens when current organizations adjust to fulfill new needs. Integration happens when a society assumes a new factor and makes it part of itself. Of the various aspects which have allowed society to adopt/integrate or don't succeed to adapt/integrate, the most important ones are governmental freedom and introduction of democratic values industrialisation, urbanisation, increase in education, legal actions, societal change in caste system, and social movements and social awareness like(feminism, globalisation and anti-casteism).Modernization and Social changes has led to three movements: feminism, globalisation and anti-casteism.(Ahuja R.2001)

Status of women in India: Women status in India was inferior to men. Women always suffered due to culture of silence which adversely affects their reproductive health and leads to complications of reproductive system. So the feminism i.e. political and social movements for women's rights started by feminists in India. Till the 1950s, women in our society were subjugated to men in all respects. They had secondary and subordinate position in the society. Today, women have become aware of their rights. They want opportunities for gender equality and identity of self still rate of violence against women is increasing. The feminist movements want women to be empowered and given opportunities to perform roles of their choice. The issue of patriarchy and priorities of women have become part of all socio-political discussions. The feminist movement has developed the sentiment that political and public life has become distant from the experience and values of the most.

Globalisation: Globalisation is a societal process in which the restrictions of location on societal and cultural arrangements diminish and in which people are more aware that they are moving back (Malcolm Waters, 1995:3). Thus, in the process of globalisation, physical distance and obstacle have become less important for interaction and exchange in social (which includes political and economic) and cultural matters. Fifty years ago, mobility was more from villages to cities, then it increased from cities to cities, from region to region, and now it has extended from country to country. Everybody now knows that people and objects are conveyed round the world more swiftly than in the past and that the words and messages can cross the world in minutes and seconds. Fifty years ago, a message pertaining to trade and commerce or a social, cultural and even a political message took several weeks and considerable physical effort to deliver, now it takes only minutes. Thus, global dimension to contemporary life in economics, politics and culture is apparent. With increase in the various levels of interaction, reactions and responses occur at all levels quickly. The interplay at local, state, national and international levels has affected action and identity. The consequences of globalisation among people in India are perceived now in economic, political and cultural fields. The economic effects are perceived in the development of trade routes, in the growth of trade, in economic independency.

Anticasteism: There have been movements of opposition to caste exploitation and casteism and in favour of caste equality and giving special privilege to depressed caste people.

Political Independence and Introduction of Democratic Values:

Political independence has provided opportunity to everyone to develop self awareness and subconscious alignment towards vital interest and principles including identification, status, dedication and needs. Today, people are more concerned with 'individuality'. The categories which were completely or mostly omitted from free public connections for years together, also now demand getting discriminatory rights to rise in public scale. The areas which had stayed economically in reverse because of British rulers' policies want a share in developing techniques. Some cultural categories want governmental independence to preserve their social identification. Spiritual categories want independence to educate certain principles and sub social standards to their associates. All these needs and demands have impacted the nature of change in society and the process of modernization in our country in the last five decades. The governmental independence has also led to major changes in public framework of community and its program of power by abolishing the program of Jamindari and princely states. Role of urbanisation in changing various public systems is significant. System of joint family is changing to nuclear pattern. Places provide increasing opportunities for new careers and occupational opportunities. Those who are away from traditional ways their progress is faster and change in their attitudes.

Industrialisation: In the Indian society Industrialization brought marked changes in financial and socio-cultural fields. Urbanisation and Industrialization moved in hand in hand giving rise to Migration to urban areas. The three most important effects of industrialisation on family organization: Firstly, family which was a principal element of production transformed to a consumption unit. This affected not only the traditional structure of the joint family but also the relations among its members. Secondly, factory employment has freed young adults from direct dependence upon their families. As they became financially dependent, the traditional authoritative head of the family's role weakened. In city many cases,

along with men and their wives started earning affecting intra-family relations to some extent. Finally, children have ceased to be economic assets and have become liabilities. Thus, work and home have become separated due to industrialisation.

Status of women in India:

Sociologists are often interested in the process of changing structure and status of women. Though there is documental evidence that in Vedic time's women enjoyed a high status in society, but gradually, down the ages, they came to be treated as second-class citizens, with almost no rights, no education and no say in most matters. They were neglected and inferior in position to the background in a male-dominated patriarchal society. Eminent social reformers like Raja Rammohan Roy, Swami Vivekananda and others, who tried to uplift the status of women in India. Mahatma Gandhi's progressive ideas on women and their contribution to the Indian Freedom Movement, gave a further impetus to their status. After India gained Independence, though our Constitution-makers granted equality of status to women, and also gave them the right to vote, in general, women still do not enjoy full equality of status in the society. Patriarchal system and kinship system has still strong hold in the rural community leading to a male dominated society. This is particularly true that the majority of women in the rural areas, who are illiterate, housebound and ignorant of their rights under the law. In the urban areas, with the spread of education and the increase in the number of women working outside their houses, the situation is, however better.

Several Indian women face discrimination throughout all stages of their life, starting at (or even before) birth, as child, adolescent and adult. Socialization process itself reflects discrimination from childhood. In total eleven million abortions happen annually and around twenty thousand women die once a year as a result of abortion connected complications. Female feticide, malnutrition and poor health care of females are common problem in Indian women. Male child is looked after in better way than female child in terms of care, schooling, and nutrition which results in deficiency disease. Deficiency disease affects women which leads to malnutrition and to anemia, leads to the risk factors in maternity, complicating childbearing and leading to maternal morbidity and mortality, gives rise to premature babies. It is

directly responsible for 20% of all maternal deaths and is a contributing factor for 20% more, according to available statistics. Out of an estimated 500,000 maternal deaths globally, only 1% occur in developed countries, with the highest number in South Asia. WHO has estimated that 61% of all women in the. Child-bearing (age 15-49 years) are anaemic. In India, over 80,000 mothers die per year, i.e. almost 10 per hour.

Regarding education in Indian scenario ,though primary education is made free for women , but due to patriarchy system parents are not willing to send girls for further education due to feeling of insecurity and for social customs Illiterate women become illiterate mothers that affects their quality of care ,poor quality care affects kid health leading to higher mortality , morbidity and deficiency disease in youngsters, mothers with very little education has poor health-promoting behaviors, . Regarding child marriage in India though the prohibition of child marriage act 2006 bans marriage below age eighteen years for women and age twenty one for boys, however in rural areas due to family customs and traditions girls get married before eighteen years of age areas Early marriages results in early pregnancies which increases the complications during antenatal, intranatal, and postnatal period and also affects infant mortality and morbidity. Also a low status of following elegance against Indian women can be linked to many social standards. Social forces of patriarchy, structure and multigenerational families play a role to gender positions. Men use greater rights and superior rights to create an unfair society that simply leaves females with little to no power. This societal structure is shown with female's low contribution within India's national parliament and the labor force. Also a low status in the society and have been treated as inferior to men. This has led to a low priority being accorded to their health needs. Women have been socially conditioned to think of their family first and of themselves later. So they often neglect their own health.

Feminist Concept is a way of looking at the public globe through the lens of sex inequality. The focus is on power of men and women .Feminist theory details the positions women have in community and the fights women face. Most significantly, this way of thinking about the public globe concentrates on the privileges of women, including: economic, sexual, reproduction, residence and voting privileges.

There are a number of key ideas in Feminist Concept. While public motions and demonstrations are often related with feminism, more central ideas, like: sex, state policies, energy, assault, and the department of work. Each of these is mentioned in turn below.

Concept of Gender:

Sociologist has made distinction between sex (biological differences between male and female) and gender (socially produced differences between being feminine and being masculine). Gender is more clearly defined as socially produced ways of acting in the society. Gender is shown in macho and female details. Cultures vary in what it indicates to be macho or elegant, showing that these details are culturally constructed and discovered. The characteristics are described in oppositional regards to each other. For example, men who show feelings are viewed as poor in the United States and are attributed elegant features. On the other hand, women who show dedication are viewed as to be macho. Feminist advocates the reactions when women cross the sex line with the men their responses are different that is if a women when accomplishes success, she is praised but men who enter in traditional women domains are often handled with doubt. It is always looked with suspicion if she tries to act or wear men's dress since they are recognized as being pursuing an unachievable desire. This means they are trying to move in another more respectable domain and vice versa that is if men act like women he is moving down. This implies that men standing rely intensely on negative women generalizations.

Politics:

A place where women are not completely missing but hardly ever discovered is in state policies. Women are underrepresented in governmental organizations in most nations, though women do seem to be increasing their rates of contribution in many of these nations. However, even when women do gain access into state policies they tend to be focused in positions with less energy and lower reputation. Studies show strong connection between rates of women in legal bodies and in ministerial positions that there is lesser representation at higher level. Women in those professions are typically available at the bottom of the structure, not the top. According to Lewis and Runyon, gender socializing, situational restrictions and architectural challenges communicate in discerning against women in governmental office.

Gendered Division of Labor:

Even though women now form a large portion of the workforce they continue to work in different jobs, under different conditions and generally less pay. Sociologists refer to the dividing up of workforce as men's job and those as women's jobs as sexual division of labour or in more recent term the gendered division of labour. Since women can have kids and do most of the daycare in most societies, it is believed that they are instantly more caring than are men. On the other hand, men are regarded as bread earners involved in productive work for women and kids only regarded to be working if they are involved in productive work. Nowadays women work together with men in many areas.

Religion:

Religion has been a significant cause of the oppression of women for thousands of years. For most faiths, particularly monotheistic faiths, God is portrayed as men and resolved as Father. In the Spiritual development tale, Eve is created from Adam's body, indicating men brilliance. Many of the prophets of Christianity, Judaism, and Islam are men, such as Moses and Muhammad. The majority of spiritual power numbers are men, and in some faiths, like Roman Catholicism, women are not allowed to become clergymen. Religious organizations and their specific camp have provided to patriarchal cultures around the globe. While some faiths are support away from such patriarch (e.g., Unitarian Universalists, many faiths are ongoing to hold back women. (Anjana Maitra Sinha;1993)

Reproductive health and Feminist struggle: An investigator has taken up a study on reproductive health of the women in rural area where male dominance and patriarchy system still exists. Sex related issues matters in preventing reproductive tract infections and creating awareness among women will help them to gain knowledge, so the investigator thought from feminist point of view especially radical feminism which discuss about reproductive and sexual health and rights of women. Females reproduction privileges may consist of some or all of the following: the right to legal and safe abortion; the right to birth control; freedom from forced cleanliness and contraception; the right to accessibility good-quality reproductive health care; and the right to knowledge and accessibility to help make free and informed reproduction choices. Reproductive privileges may also add the right to receive knowledge about

sexually transmitted infections and other aspects of sex, and protection from practices such as female genital mutilation (FGM).

Reproductive privileges developed as a part of individual privileges at the United Nation's 1968 International Conference on Human Rights. Feminism in Native Indian is a set of motions aimed at interpreting, establishing, and protecting equivalent governmental, economic and public privileges and equivalent opportunities for women in India. It is the pursuit of women's privileges within the Indian community. Like their feminist alternatives all over the world, Indian feminists seek gender equality: the right to operate for equivalent wages, the right to equivalent accessibility to health and knowledge, and equivalent governmental privileges. The feminists also have battled against culture-specific problems within India's patriarchal community, such as bequest laws and the practice of widow immolation known as Sati.

The history of feminism in India can be separated into three phases: the first stage, beginning in the mid-nineteenth century, started when male European settlers started to speak out against the public evils of Sati; the second stage, from 1915 to India's freedom, when Gandhi integrated women's motions into the Quit Indian movement and independent women's organizations started to emerge; and finally, the third stage, post-independence, which has focused on fair treatment of females at home after marriage, in the employees and right to governmental equal rights.(Anjana Maitra Sinha;1993)

Despite the progress produced by Indian feminist motions, females living in modern India still face many problems with elegance. India's patriarchal lifestyle has created the process of gaining land-ownership privileges and accessibility to knowledge challenging. In the past two decades, there has also appeared a distressing trend of sex-selective abortion. To Indian feminists, these are seen as injustices worth struggling against. Radical Feminism was a division that established during the second trend of feminism in the Sixties. Radical feminists believed that these were deliberate power plays by men and that the institutions and systems that supported this oppression were just the tools they used to maintain control. Radical feminism, considers that the main cause of women's subordination originates from power

relations based on sexual differences (mainly, the woman's ability to conceive, procreate, and give birth to children). On the basis of women's reproductive tasks that set women apart as mothers, an ideological system is constructed. Patriarchy defines men as superior to women and is defended and Maintained through an intricate web of values, norms and institutions. The key perpetuation of women's subordinate position comes from the strong resistance from family as the core unit of society. This perspective pinpoints to the core unit as family which acts as the main locus for the reproduction of the sexual division of labour. The role of the women in family is associated with identification of women as mothers and housekeepers, thus creating an artificial private realm for women and a public realm for men. Nowadays, women have acquired the right to vote and get elected outside the house. Additionally, the U.S. Declares had gone through the sex-related trend which had reduced stress for people to be totally monogamous and had given them more room for sex-related appearance. The sex-related trend had also introduced some independence to sex-related appearance. However, there was still an absence of reproduction privileges. Extreme feminists thought these were purposeful energy performs by men and that the organizations and techniques that reinforced this oppression were just the resources they used to sustain management.

The word sex is used by feminists to relate to the culturally designed personality and part objectives which community has described in a different way for men and women. Very often, though wrongly so, the conditions sex and sex are used interchangeably. Feminists, however, claim that there is a clear difference between the two. While sex is culturally artificial, sex represents the scientific or inherited features that distinguish men from women. Feminism also suggests that it is culturally designed sex variations that have most often been used to subordinate or oppress women. Generally, that is stereotypically used to explain a man is mostly considered as positive or fairly neutral, such as powerful, huge and competitive, while the woman is often considered as adverse – fearful, shy, poor, small, and so on. According to the feminist psychoanalytic viewpoint, our own feeling of difference or separateness from others, as well as our emotional and social encounters and presentation of sex or sex-related difference are manufactured through emotional, social and social procedures,

and they get verified through relational encounters. Specialists hold that we can only understand sex difference, human distinctness and separating, relationally and situationally (Thorne 1978). Judith Butler well known feminist theorist states that, typically, feminism (and the world at large) has thought about sex in a binary style. In other words, people are often divided into two unique categories: men and some women. Her statements against these binary categories, exposing that sex should be seen as a person function that changes and changes rather than remaining set. She indicates that women have been lumped together in an organization with allocated functions and interests, and these limitations outstanding to choose their own information. She shows how gender performances are tied to relations of ruling, in Smith's terms. On the other hand, however, like Foucault, Butler insists that regulatory norms and discourses are never wholly determining. One could argue that, in the end, Butler's work seems individualistic because she emphasizes that it is in interaction that subjectivities are formed. (Bert N.Adams,R.A Sydie 2002)

Sociology, Feminism and Reproductive Health:

Feminist health sociologist puts forth the argument that medicine and patriarchy control the women by enforcing passivity, dependence and submission as appropriate feminine traits. Women's life surrounding their reproductive capacity has many components which have been medicalized like menstruation, premenstrual syndrome, menopause, reproductive tract infection etc. In sociology studies have been conducted menstrual taboos against biological and psychological theories. In feminist analysis, medicine is shown to define women by their biology and their reproductive capacity: menses, pregnancy and menopause. .So it is important to understand Feminist theory to understand reproductive health. Feminist theory was a modern development of the movement.

For many young female sociologists, the impact of the movement was emancipating. Most of the young feminist sociologists were part of a relatively privileged group of women who had access to higher education, Revolutionaries come from groups who, although not absolutely deprived, nevertheless feel deprived in the light of what they have been promised or assume that they should obtain. The 1960s and 1970s were eye-opening decades for young women activists who found that, despite their

contributions to civil rights and the antiwar movement, they were still remained the victims of male sexism (Bernard, 1989:24). In examining gender inequality, the Beauvoir rejected explanations from biology, psychoanalysis, and Marx. Juliet Mitchell maintained that in all of these theoretical traditions, women were not presented as subjects in themselves but simply as objects for made men, and most especially as sexual objects: where in women is created only for sex (1974:xix). Generally male is regarded the subject of modernity both in political and economic sphere, whose rational and objective were very natural which justified the separate role at home and work . Epstein (1988:233) pointed that dichotomous thinking still prevails not only in the daily life but also in their reasoning when comparisons are made; the characteristics assigned to men are always ranked higher.

Marxism and Feminism:

Marxist analysis assumed that women's subordination to men was a result of their absence from the productive process. Consequently, women did not control property but were themselves property. It was assumed that the entry of women into paid labor would contribute to the eventual achievement of the workers revolution, so that after the revolution women's subordination men would be eliminated. This solution was problematic from the outset because the basis for social organization was supposedly found, according to Marx.

Foucault's feminist theory and women's health:

Knowledge, Truth, and Power (Foucault and Feminist Responses): Knowledge has always been linked to power, in the sense of having the power to have an effect on individuals or, more generally, on society. Michel Foucault's central concern was how knowledge related to power. He was especially concerned with charting how different regimes of knowledge shaped modern society. Foucault did not regard knowledge *as* power but as contributing in different ways, in different contexts, to the exercise of power. Foucault thus qualified Bacon's assertion that knowledge and power are like cause and effect. Knowledge itself does not provide any inevitable, predictable effects. Furthermore, power itself can produce knowledge. Foucault's concern is particularly timely given the way in which information about individuals is monitored, evaluated, and stored in modern society, effectively abolishing the classic Enlightenment distinction between a public and a private realm.

Foucault's analysis of discourses of power, truth, and sexuality is a masculine analysis. In *Discipline and Punish* (1977) Foucault charts the subject of Power, particularly disciplinary power. He sees power everywhere and at some level, as available to all, it can encourage to overlook women's systematic subordination of other women, as well as systematic domination by men (Ramazanoglu, 1993:10). Hartsock (1990:169) highlights that if energy is everywhere and not a single embodiment but, then it also seems that would seem that those groups which dominate the other get involved in the power domination and blame the one who suffers. But feminists need to separate affected and harmless types of energy, and a review the needs of energy different perspective and place. Martin (1988:17) points out that Foucault's ideas, if to be concluded logically, it is very important to be left as hypotheses and/or methodological provocation's, could make the question of women's oppression insignificant. According to Martin, feminists must refuse a political stance which brands on the basis of sex and should refuse to be content with fixed identities or to universalize ourselves as revolutionary subjects (1988:16).

Not all feminists have seen Foucault's position on the issue of subjectivity and identity as problematic for feminist politics. Judith Butler (1991) argues about bodies are socially produced (made) by discourse, but always in the gendered terms. She argues that there is classificatory relationship between sex and gender producing our bodies. Therefore she believes bodies cannot be understood unless marked by sex/gender. Judith Butler suggests that the idea of the constructed subject does not preclude the possibility that the subject has agency. On the contrary, she believes construction is that the necessity to speak as and for women should be abandoned, but the phrase women should be recognized with their differences that cannot be decrease one's identification (1992:15). Actually, the very tension among females over the material of the term signify the theory of feminist concept.

Butler further notes the importance to feminist politics of the way in which the dualities of bodies and sex maintain the reproductive sexuality which is the most important (1992:17). What she means is we always make sense of people in terms of gender. If you come across a person whose gender is unclear, you do not know how to interact. The control over bodies and minds of individuals that is the mark of modern power/knowledge regimes is particularly invasive for women.

From understanding various theories including Foucauldian, feminist, gender, Marxist perception in the light of reproductive health of women I came across important determinants and dimensions of health and health delivery to women. There are some important dimensions of the following:-

Social dimensions of health and well-being:

Health and wellbeing is a matter of concern to all strata of the society. Health is much larger a domain, which affects all aspects of human existence. It has wider implications for social, economic and political life of an individual and indeed cannot be fully understood within the confines of medical model. It is widely accepted that health is a social well-being is still a more complex concept to be managed by medical professionals.

Social scientists have been actively engaged in empirically examining the social factors which contribute significantly in promoting good health and controlling diseases. Their persistent efforts to understand health from social perspective have firmly rooted social scientists in addressing larger issues related to causes and cures of health problems and controlling diseases. Four sectors that cover most of the areas and discipline of social sciences these four sectors are: socio economic concomitants of health, health services and systems, health care practices and health attitude and perceptions. There are number of socioeconomic and socio demographic constructs like ethnicity, gender, age, religion, caste and social class, which affect the exposure and vulnerability diseases, shapes the perception of and responses of health problems, actuates the effectiveness of health promotion efforts and creates an impact on an individual's life and well being.

The sector Health services and systems is concerned with developing the health of the people by delivering health care services which are acceptable and accessible to people. The sector of health care practices deals with health behaviour and practices of communities and the way sick people are treated by the society. It is an effort to understand health issues from the perspective of local communities, the informal health care practices and remedial measures taken by the communities. Kleinman (1978) has termed it as folk practices sector in which health care practices evolve and sustain because of their popular appeal in contrast to professional practices which are supported by institutional setup.

People's attitude and perception of health deals with people's own understanding of the cause of illness, their health behaviour and the ways they take care of themselves when they fall ill. The multisectoral approach defines health as a complex web of environmental, social, economic and individual factors which are interrelated with each other. The community should generate their own health needs, identify their solutions, mobilize their local resources and develop local organizations to meet those needs. This is essential to make health care programs accessible and acceptable to the community; it is a non-expert social approach to health care where people from the grass root level can take initiatives. Multi-sectoral approach and community involvement became the basis for the Alma Ata resolution of 1978 and of subsequent national and international policies and programs to provide primary health care to all by the year 2000.

Socio economic concomitants of health:

People low on socio-economic ladder are not only more vulnerable to infection but also have lower access to health services (WHO, 1998). In general, people below poverty line, children, women, aged and displaced ones suffer more from health problems than other strata of society.

Vulnerable groups: according to Chambers 1989, vulnerable means not only exposure to risk but also lack of means to overcome these risks. WHO (2002) adopted a gender policy where it acknowledges that sex—the biological facts of being male and female and gender—the cultural norms that determine masculinity and femininity have important impact on health. The policy considered the fact that there are factors determining health and burden of ill health for men and women. In a given culture, gender norms and values give rise to gender differences and inequalities; for eg. a woman cannot receive health services because her community norms do not allow her to travel alone to the medical clinic or there are societies which do not discourage males from practicing promiscuity that may lead to the infection of STD and HIV and at the same time wives of those males become vulnerable to those infections because the cultural norms bar them from using condoms. Moreover, low status of women in most of the societies restricts them to avail the health care facilities. Moreover, studies also show that women are more vulnerable than men to many of these health problems as they take most of the responsibilities related to bearing and rearing of child and

household management (Moser 1987; Lee/Smith and Trujillo 1992; Sapirr1990; Jordan and Wagner 1993; Crew 1995 and obrist et. al. 2003). Pregnant woman are more vulnerable to certain environmental hazards every year about half a million die of causes related to pregnancy and child birth (UNICEF 1991). As reported by WHO (1992),A woman is exposed to reproductive health problems right from her adolescent period till her death. The magnitude of reproductive and sexual health problem is donting (Pachuri, 1998). Most of the problems are related to child birth, abortion, sexually transmitted diseases and gynaecological health (reproductive tract infection, infertility and menstrual irregularities) the future of human health in the 21st century depends a great deal on commitment to investing in woman health in the world today. Their health largely determines the health of the children, who are the adults of tomorrow (World Health Report 1998).

Health systems and Services:

Health systems have existed ever since people made systematic attempts to protect their health and treat diseases. Throughout the world the traditional practices based on herbal cures and/or spiritual counselling and providing both curative and preventive care, have existed for thousands of years and even today have survived despite the dominance of modern medicine. The modern health systems, aiming to cater to the needs of a large mass of population, existed barely a century ago. Although in many countries the existence of hospitals has a longer history than the organized health system. With the onset of industrial revolution there occurred a transformation in the lives of the people, especially in relation to health and health systems.

Most of the information available on health system refers to the provision of investment in health services, i.e. health care, including curative, preventive and palliative interventions, whether directed to individuals or populations. People come into direct contact with the health system as patients attended by the health care providers. It matters very much how the system treats people's health needs ,meets their expectations, treats them with dignity, pays value to their time and anxiety and how it raises revenues from them. Including how much protection it offers them from financial risk.

Again, in order for an individual to utilize a service, they must believe that the service will benefit their health. Some studies that have focused on the perceptions and motivations to use health services reveal that care is often inadequate and in-sensitive (Thaddeus and Amine, 1994; WHO, 1991). Moreover, location of services and transportation problems in accessing services can be a barrier to the utilization of health facilities (Price, 1984; Greenwood, 1987; Sundari, 1992). Sometimes, corruption in public health services creates aversion among the care seekers. In a survey conducted in India, it was found that a quarter of all respondents had paid bribes for health services (Kumar, 2003). Health system includes all the activities whose primary purpose is to promote, restore or maintain health (World Health Report, 2000). Real progress in health depends vitally on strong health systems based on primary health care. Systems should integrate health promotion and disease prevention and treatment for acute illness and chronic care on the other. This should be done across all levels of health care system, with the aim of quality services equitably and efficiently to the whole population (World Health Report, 2003). Formal health services, including professional delivery of personal medical attention are clearly within this boundary. So are actions by traditional healers, and all use of medication, whether prescribed by the provider or not and home care for sick, which is somewhere between 70% and 90% of all sickness is managed (Kleinman, 1978). At present, enhancing interventions, like roads and environment safety, improvement in sanitation, educational level in general and of girls in particular - all come under the purview of health system. The World Health Report, 2000 states that the health systems not only have a responsibility to improve people's health but to protect them against the financial cost of illness and to treat them with dignity. Thus, it has identified three major objectives to develop the health systems:

- (1) Improving the health of the population they serve.
- (2) Responding to people's expectation.
- (3) Providing financial protection against the cost of ill-health.

Health system today represents one of the largest sectors in the world economy and the global spending on health care was about \$2,985 billion in 1997 or almost 8% of world gross domestic product (GDP) (World Health Report, 2000). India is one of the countries of the world which has lowest health budgets (commission for

Macroeconomics and Health, 2000). The much hyped health policy of India, adopted in 2002 giving priority to revive public health system, and received no budgetary allocation for 2002-03. The Government of India spends a mere 17.3% of its total health budget on the public health system as against England, which spends 96.9 percent, USA 44.1 percent, Srilanka 45.4 percent, China 24.9 percent (Gupta, 2003). The World Health Report (1995) identified 'poverty' as the greatest cause of suffering and showed widening gap in health status between the rich and the poor. One of the priorities given by this report is to develop Public Health policy with its emphasis on equity, i.e., equal access to health care. However, going by the report prepared by the WHO-appointed Commission of Macroeconomics for Health (2000), in India in general, it has been observed that though there has been a considerable development in the health status of the people and improvement in the health system and intervention, there exists wide differential between and within the states, between the rich and the poor and between the rural and urban populations.

Health Care Practices:

Health behaviour is a kind of a social behaviour and, as such, affects and gets affected by various socio-cultural parameters. For example, understanding of a disease is not a medical issue but is largely dependent on the shared knowledge of a particular community. Traditions, social practices and role relationships- all contribute to our dealings with health and illnesses. The sick role behavior largely depends on how a community expects its sick members to behave. These social aspects of health form the basis for informal 'systems of health care. Medical anthropologist, Arthur Kleinman (1980), has classified health care practices into three sectors: popular, folk and professional. These three sectors not only differ in terms of their explanations of illness but also in the treatment regimen and the mode of social interaction. The popular sector refers to those informal health practices that primarily rely on familial and social network knowledge to deal with diseases. Home-made remedies, knowledgeable people who can be consulted, visiting spiritual centres are all part of the popular sector. These practices are outgrowth of shared experiences and transfer of knowledge from one generation to the other. According to Kleinman, 95 percent of the health problems in a society are taken care by this popular sector. The folk sector

is rather a more organized with health and illness. These are the informal system which have evolved over a very long period of time, and are integrated within the community life. The folk sector comprises herbal medicines, shamans and traditional healers and time / tested indigenous medicines. These folk treatments have survived for centuries because they share the belief systems of the community and are consistent with the social and religious practices. Kakar 1982 has evidenced that, what are considered as primitive and superstitious practices have their rationality rooted in a coherent world view and inefficacy in dealing, with a wide range of health problems. Even in this scientific age, the popularity of these folk practices has not declined. The third sector, i.e., professional sector refers to organized professional systems, like medical system, acupuncture and ayurveda, which have a formal system of practicing. These systems are based on well-laidout theoretical basis, system of education and professional bodies and code of conduct. Such professional systems compete for public patronage and their coexistence is characterized by suspicion, and underlying tension.

Sick Role Behaviour:

Health and illness has been a major theme within sociology since the development of Parson's theory of The Social System). Parson in his functionalist approach, contends that a healthy population that could undertake various tasks is required to promote the smooth functioning of a society. Sick people cannot take up their normal social roles. According to Parson sick role behaviour is based on some, rights and obligations. Sick people are exempted from the normal social role expectations and also from the responsibility of their sickness. At the time it is obligatory for a sick person to seek out treatment and get well, as soon as possible.

As Parson posited, rights are contingent on obligations, and if a sick person fails to comply with treatment, he or she forfeits the privilege of the privilege of the sick role. Though Parson never conducted empirical research, his formulation of sick role behaviour has been the basis of the sociological work in this area. This sick role behaviour was considered universal, regardless of culture or social status. This approach, however, has certain limitations and cannot be applied in the case of a chronic illness. In later reformulation of sick role, Parson (1975) argued that although complete recovery was not possible for the chronically sick, it was medical practice to

manage their condition in such a way that they could establish a relatively normal social role. Parson's reformulation, however, fails in the case of physical disability where the issue of recovery is often not of much relevance. In fact, it may be argued that in such formulations of sick role, medicine becomes a mechanism of social control. Patients were conceived as powerless and at the mercy of the specialists who can dictate what a patient should do. Most of the further research on patient compliance is guided by this view of the patient. It was also presumed that once sick, a patient will always seek treatment. In traditional societies, there are pluralities of health care systems and patients have a freedom to choose anyone or more modes of treatment. Sick role, for example, has very different connotation in traditional healing.

Social construction of Health and Illness:

Health and illness are often defined in organic terms, referring to bodily conditions, as assessed by the medical professionals. This typical expert-oriented approach fails in delivering the services. In the first instance, the patient will approach health professional only when they find their symptoms threatening and realize that they need medical attention. It thus seems important to see health and illness from patient's perspective (Radely, 1994). It can be contended further that illness is a social illness and understanding of the symptom is a collective Endeavour.

Great deal of subjectivity in the interpretation of the symptoms and social beliefs, expectations and status provides the basis for symptom interpretation. People make sense of their illness in a social interactional process. 'It is a joint construction in which patients, their families and, social acquaintances all play a role. This social construction of the disease and its symptoms may not match with those of medical professional however patients and their families take important treatment-related decisions based on these understanding of the disease this understanding also becomes the basis to decide which mode of treatment to perceive to recover. Dalal (2000-2001) has found that Indian patients more frequently attribute their illness to god's will, fate and karma than to germs, pollutants and lifestyle found in most of the western countries .Accordingly whereas in the west people consult medical doctor for their health in India and other Asian countries they are equally likely to consult fate and spiritual pillars (Joshi, 2001).

Traditional healing practices:

All traditional societies in the world have evolved their own systems of curing and healing and most of these systems have sustained due to their patronage by common man. Traditional healers which comprise family priest, guru's, shamans, pirs, godmen, etc. are all involved in dealing with health and other personal crisis. When suffering an illness people frequently visit these healers for alternative remedies even while they are getting medical treatment these healers are presumed to have healing powers or are held as medium to connect to the super natural. Their treatment is realistic which may combine social, spiritual and medicinal aspects to bring relief to the suffering individuals. In India there are a large number of healing centres and their popularity has not declined even with the access to western medicine.

Kleinman (1978 and Kalkar 1982) have studied these healing systems as they are practiced in Asian countries. Thirdly, the most important aspect to be examined is patient-healer communication. The essence is not in what is communicated but how is it communicated, Fourthly, these healing practices are social activities in the sense that generally the whole family, including the extended social net, participates in the process of healing. People are supposed to openly share their problems, often in the presence of others and it is a collective venture, where the target is not the person but his or her own family. Thus, there is much sharing and social interaction involved in the healing process.

Health Perceptions and Attitudes:

In this sectoral approach health is understood from the people's perspective. It views a person as embedded in a socio-cultural context, in which he or she imbibes certain belief system. These socio-cultural beliefs would determine the way a patient evaluates and gives meaning to his/her sickness. Kleinman (1980) has made a distinction in his research between disease and illness. Whereas disease is an organic malfunctioning as diagnosed by a medical practitioner; illness is a subjective construction of the experience of disease by the patient. It is patient's own interpretation and perception of the disease, which is greatly influenced by the culture to which the patient belongs. This approach to health assumes a unity of the mind and body, and that these two in a complex interactional process determine the health status of a person. Mind is presumed to be both the cause of a disease and contributor to

recovery. According to the Health Belief Model, propounded Rosenstock (1966, 1974), knowledge of patients health related beliefs is crucial in, understanding the patients psychological state of readiness to take specific action. Rosenstock originally proposed his model to predict preventive health behaviour, which was later on extended by Kasl and Cobb (1966) to explain sick role behavior. Social support network plays a crucial role in deciding about the course of illness an individual is experiencing, as well as in maintaining good health and longevity. In a review of 50 recent studies, Uchino, Uno and Holtlunstad, (1999) discovered that individuals having high level of social support have lower blood pressure and higher immunity than those having low level of social support.

Health and well being:

The WHO definition of health emphasizing physical, mental and social well being has contributed shifting towards positive health and well being. Health thus connotes an efficient functioning of the body and the mind as well as capacity to participate in social activities and being able to discriminate and abide by the moral principles, it takes a holistic perspective in each nutritional status immunity from diseases, better quality of social and family life, peace and contentment are important. Studies on well being have focused both on mental and situational attributes and have consequently looked into both individual and cultural aspects of well being(Sharma 1999).in fact, greater interest in well being than in physical health has established the salient's of social science research in contributing for general well being of a person.

Health scenario in India:

Health policies, programs and practices mirror the culture, society and political scenario and India is a good case in this regard. In 2001 the government announced a new health policy with the main objective of achieving an acceptable standard of good health of general population the policy aim to strengthen the infrastructure decentralize health care facility through panchayati raj setting up national accounting services and to regulate private practice this rampant privatization in past two decades has indeed resulted in total collapse of public health services.

Anthropological perspective in health:

Health today is one particular area which has engaged the attention of not only the medical professionals but also of social scientist including anthropologist and sociologist, policy makers and administrators, development specialist and human welfare activist. The reason for this are two folds: i) change in concept and ii) change in emphasis. At the conceptual level sickness behaviour representing health behaviour is used as a concept to distinguish between diseases as a biological category and illness as a social category at another level human populations undergo a continuous process of adaptation to disease and illness. Concepts of health and disease are a part of every culture in one sense understanding of disease means understanding of its causes which concentrates more on its biology of health but there is a question of relation between biological and social phenomenon. Illness representing social forces acts upon biology of health. Studies in the field of health provide the necessary scope for transdisciplinary sciences to go for an integrated mode of investigation health is one of the focal center of integration of human, biological and social sciences. Dalal 2001 commented that social and family support has neglected variables and must be given due attention especially in the light of deteriorating health care services in our country. Instead of looking into the cost of distress now the focus is more on positive behavioral change in individual and community levels the preventive efforts are required to gear and activate the larger social machinery in order to invigorate social change. Today this is one of the most challenging social dimensions of public health. Therefore the investigator has taken up the preventive aspect of reproductive tract infections.

An important factor of sustained improvements in the health status is efficient and sustainable community participation. It is now the time to train people of the tribal communities to create self-help groups and sustainable health services system by utilising the locally available resources. As the community accepts their own people easily and ethnicity and belongingness. Factors definitely enhance the outreach of health services educate the community by providing training hence to create an awareness investigator implemented a health education program regarding Reproductive Tract Infections. Reproductive tract infections affect young men and women in their prime working ages it also has serious economic consequences this

diseases are closely related to social circumstances and human behaviour. Women consider these diseases as something unmentionable and consequently tried to hide them. In no other branch of medicine the quack both inside and outside the profession finds such fertile and profitable field of exploitation of the gullible people as in this area. The factors that contribute to higher rate of RTI/STI in woman are also related to gender inequalities. In many developing countries fact that men migrates to cities results in concentration of men away from their families with a demand for sexual services. Where culture expects women to be passive and subservient to men, women have little or no control over decision making related to sexuality nor do they have control over sexual behaviour of their male partners or over the use of condoms for prevention of sexually transmitted infections.

Significance of health in Sociology:

Scope of sociology- Calleberten describes, since sociology is an elastic science it is difficult to determine just where it's boundaries begin and ends. It is impossible to divide as it studies human interactions, interrelations, their conditions and consequences .Scope of sociology is very wide. It studies the various aspects of society, e.g. social processes, traditions morphology, social control and social pathology. In 1902, Emile Durkheim has classified sociology into various fields and sub-fields, one of them is medical/ health sociology.

Role of Social Factors in Health:

Social situations and social environment will have influence on the occurrence of disease, prevention of illness and health maintenance. Unhealthy life styles and high-risk behaviour predisposes sicknesses. For healthier life maintenance modification of life style is required. Societies have to organize their resources to cope with health hazards and deliver medical care to the population. Individual and societies tend to respond to health problems in a manner consistent with their culture, norms and values. Factors like social, cultural, political, and economic, etc. will have definite influence over health maintenance. It is the responsibility of health care professionals to arrange Information Education and Communication (IEC) campaigns through mass media activities emphasizing the public on healthy life style and individual responsibility for healthcare. The high-risk behaviour includes poor diet, lack of exercise, smoking, alcoholism, drug abuse, stress and exposure to STD.

Adverse social conditions like poverty reduces life expectancy and creates health problems. Public health in an applied technology resting on the joint pillars of natural science and social science until these pillars are strong, the arch of the public health will not be firm' The health care professionals use the knowledge of social sciences in implementation of medical and health care activities.

Role of Social Factors in Disease:

Deviation in the normal functioning of the body produces discomfort or adversely affects the individual's health status. Every society has certain norms, values, ideals in regard to health and disease, deviation from which is treated as an aberration or a disease. Diseases occurs due to various factors such as invasion by microbes or other pathogenic agents which disturbs the haemostatic balance and results in malfunctioning of organs, low standards of living, poor environmental sanitation, poor housing, bad habits like smoking and alcoholism, inadequate nutrition, low economy, poverty, contamination of food, water with industrial effluents, air pollution, poor urban planning, deprived of family relationships, inadequate physical activities, defective lifestyle, sexual harassment, unemployment, rapid economic growth, over population, job strain, occupational maladjustment, migration and healthy comparisons, illiteracy, discrimination, misunderstandings, stress, large gaps in income, inadequate access to healthy foods, isolation, etc. In the sociological context disease is associated with a particular way of life, vulnerability for diseases are common among the people who are facing certain problems like isolation, geographic or social mobility, inability to fulfill role expectations, hanging inconsistency in status, inadequate social support blocked aspirations, lack of consistency or uncertainty in outcome of vital events, value polymorphism and rapid social changes. Social factors affects diseases at three levels:

1. Physical level: The social class, environment, nutrition, housing, etc. are responsible for occurrence of disease.
2. Psycho-social level: Diseases occur due to prevalence of mental stress and strain resulting from specific environmental factors.
3. Cultural level: Social milieu, attitudes, beliefs psychosomatic factors, etc. affects the disease pattern and in implementation of preventive and therapeutic modalities.

Social environment affects different attitudes among various cultural groups about seeking medical and health care.

The multiplication of disease is related to social factors, community involvement is essential in organising health education campaigns to bring health awareness, social and cultural factors similarly affects our ability to stay well. Social support is essential and plays a crucial role in our physical and mental health, through its health sustaining and stress- buffering functions with social ties live longer and have better health. Rapid industrialisation, urbanisation and technological advancement made the social environment giving rise to stress and strain, which leads to chronic and degenerative disease.

Investigator planned for health education programme for women in rural area in Pune district to create an awareness regarding reproductive tract infections.

Sociological Investigation:

Critical examination into a situation to discover new facts about a particular or specified social phenomenon to discover intellectual and practical answers to problems through the application of scientific methods in the universe' is called social investigation. It is a careful, critical enquiry or examination in seeking facts or principles diligent investigation in order to ascertain something. It is a critical in the light of newly discovered facts. It is the study of activities undertaken to search a solution for the social problems. The society has to march on its present form with the help of constant research and investigation. Long march from Stone Age to computer age has been the result of research. Today society is facing sJrreal social problems of formidable in nature. They demand solutions and any attempt to solve the problems must be through scientific enquiry. It aims at increasing our knowledge about society and strategies involved solvation of social problems.

Importance of Sociology in Nursing:

1. Sociology directs the nursing globe to understand the socio-economic status of the patient that bears an adverse effect on health.
2. Sociology enhances Role-behavior, which refers to the way in which a certain individual fulfills the expectations of his/ her role. For example, the patient expects the nurse to possess scientific knowledge and the ability to apply it in

numerous techniques. He/she expects her help to conserve and restore strength and also expects them to keep comfortable and safe to relieve their pain.

3. Sociology highlights that needs of an individual are met only through the process of social interaction which is the very essence of social life. The medium of interaction is said to be effective when there is a flow of communication from higher level to lower level and vice versa.
4. The contribution of sociology is more significant, because the nurses deliver due attention, care, be kind hearted to improve the health and finally save the life of the people, where lies the sustenance of society.
5. Sociology has a marked importance in nursing as it nourishes co-operative spirit. It has made human life possible and livable.
6. Sociology facilitates the nursing field to identify the hidden social factors that influences health.
7. Sociology feeds the knowledge of diverse population in a society. Knowledge about diversity has gained importance in nursing, as they are subjected to administer care with irrespective of race, religion, caste, class, etc.

SIGNIFICANCE AND NEED FOR THE STUDY:

The knowledge of human behaviour with an interdisciplinary approach to understand the human needs in the context of wider social problems. It is a total system approach to understand human behaviour views man as a product of socio-psychological and cultural factors. It helps to find solutions to problems which arise due to man's complex nature. Keeping in mind the importance of sociological aspects towards community especially women in rural area investigator thought of reproductive health problems and assessed their existing knowledge and practices regarding this problem and created awareness with the intervention i.e. health education programme so that through community participation we can adopt measures to prevent and control reproductive tract infections and promote and restore their reproductive health.

Today reproductive health among women is a major issue due to the reasons like population control policies which are imposed on women for population control and secondly because of increasing problem of HIV and AIDS. Serious problems such as increasing spread of reproductive tract infections and sexually transmitted infections,

rising number of adolescent mothers, maternal and infant morbidity and mortality necessitates for proper and efficient interventions of reproductive health issues and access to reproductive health services.

In developing countries reproductive tract morbidity is high among women which results in severe consequences on maternal health and social well being. Majority of the Indian women persist to suffer from reproductive tract infections gives rise to pelvic inflammatory diseases, salpingitis, pelvic adhesion, infertility, cervical cancer and chronic pelvic pain. Even though early detection and treatment of reproductive tract infections can prevent and minimise the severity of long term consequences, these infections are overlooked. There is often low frequency in utilisation of specialised services for the management of reproductive tract infections, because these infections are commonly asymptomatic and do not show indistinct, non-specific symptoms, as 50% chlamydial and gonorrhoeal infections among women remain asymptomatic. Low female literacy and a lesser amount of awareness lead to reduced understanding of reproductive and sexual healthiness. The socio-cultural taboos, values and norms also restrain the women for seeking treatment related to reproductive tract infections. (Monica Rathore, S.S.Swami)

Public awareness is essential for preventing the transmission of reproductive tract infections (RTIs) and sexually transmitted diseases (UNFPA 2004). Most of the serious health problems caused by these diseases are preventable. It has been shown that communities with good access to effective prevention and treatment services have lower reproductive tract infection and sexually transmitted disease rates and complications than communities where services are poor and not used by people because of unawareness. (W.H.O. 2005) Thus awareness regarding reproductive tract infections is of vital importance in the community.

In a developing country like India, health and nutritional status is linked with social, cultural, and economic factors. These factors influence all aspects of the lives of poor people and have consequences not only on their own health but also for the well-being of their children. This is particularly true in the case of females, as women's health issues are still not taken seriously, even by themselves.

Women, especially the younger age group, silently suffer from reproductive tract infections and its longer-term complications like pelvic inflammatory disease (PID), cervical cancer, infertility, spontaneous abortion and ectopic pregnancy. Reproductive Tract Infections (RTIs) is a broad definition that refers to three general types of infections that affect the reproductive system. In women either the upper reproductive tract organs or the lower reproductive tract organs (vagina, cervix and vulva); for males these infections are at the penis, testicles, urethra or the sperm tube (Dixon-Mueller & Wasserheit 2001). The infections include sexually transmitted infections (STI), infections of the reproductive system that are not caused by sexual contact, and infections that result from inadequate prevention practices by healthcare providers (Population Council 2001). Generally seen as a 'quiet' epidemic problem causing a significant proportion of morbidity and mortality among women in developing countries (Dixon-Mueller & Wasserheit 2001). WHO in 2001, has estimated 340 million people infected with a curable STI. Studies in developing countries have found reproductive tract infections prevalence rates ranging from 52 to 92 per cent (National Academy Press 1997). Studies conducted in India indicate high prevalence of reproductive tract infections (Bang et al. 1989) revealing a prevalence varying from 19 to 71 per cent (Latha et al. 1997) which can be attributed to different socio-cultural practices and taboos prevailing in different communities. The research studies in the rural areas of Maharashtra have indicated an increasing rate of reproductive tract infections.

As per the survey conducted (1999) Government of India, the prevalence rate of reproductive tract infections in India was 28.8 per cent (Chellan 2004). It is slightly more common among rural women (30 per cent) compared to urban (26 per cent); also the prevalence rate is lower for educated women—31 per cent among the illiterate compared to 22% among women who passed 10th standard of schooling (IIPS 1998–99). The annual incidence of Sexually Transmitted Diseases (STD) in India is estimated at 5 per cent or approximately 40 million new infections occur every year (Luthra et al. 1992). The consequences of reproductive tract infections vary from none to severe which include social stigma, reproductive system complications, spousal abuse, male dominance and abandonment pregnancy-related complications, as well as congenital infections, pelvic inflammatory Disease (PID) can develop, leading to

infertility, ectopic pregnancy and chronic pain (UNFPA 2004). Further, impact of RTI on the transmission of HIV infection.

Untreated reproductive tract infection is responsible for 10–15 per cent of foetal wastage and 30–50 per cent of prenatal infection (Ranjan & Sharma 2002). While none of them are curable, they are all preventable. The fact that 30–50 per cent of women with infections (up to 70–75 per cent in the case of chlamydia), and a smaller but significant proportion of men, do not have any symptoms so the treatment of these infections and prevention of their relapse is complex (National Academy Press 1997). Studies have indicated association of social factors like illiteracy, early marriages, menstrual hygiene practice, contraceptive usage, knowledge about this, treatment-seeking behaviour with the prevalence of reproductive tract infections. The fact that attainment of education clears various misconceptions about many illnesses, including reproductive tract infections, and encourages preventive practices, have been authenticated in various studies conducted in India (Piot & Holmes 1984; WHO 1999). Nandan et al. (2002) reported a high prevalence among illiterate women. Age at first marriage has a profound impact on childbearing. Early marriage extends a woman's reproductive span, thereby contributing to large family size, especially in the absence of contraception (Adlakha et al. 1991). Mothers below 19 years of age contribute to 8.3 per cent of fertility in India, and this is also closely linked with pregnancy wastages like pre-mature death, still birth, neonatal deaths, low birth weight babies and maternal mortality (National Resource Center for Women 2007). Government of India launched a comprehensive reproductive and child health programme in 1997 with special emphasis on management of reproductive tract infections (Srivastava 2008). India has a vast network for public health delivery; a three tier system of healthcare sub-centres, Primary Health Centres (PHC) and Community Health Centres (CHC) to provide services in rural areas. The National Rural Health Mission (NRHM) was launched in 2005 to improve the availability and accessibility to quality healthcare services, especially for those residing in rural areas, the poor, women and children (MOHFW 2005).

The presence of STI increases the risk of acquiring and transmitting HIV infection ,in addition married women are reluctant to seek medical help because of lack of privacy, lack of access to female doctors at the health facilities, the cost of treatment, embarrassing symptoms , their subordinate social status and women often bear these symptoms, thinking it is normal.

There is a serious need for the National Rural Health Mission to address the issue of reproductive tract infections in rural women. Therefore following recommendations are made:

In this context investigator thought, prevention, detection and management of reproductive tract infections which has been overlooked in India. Several studies have pointed out that women in India often bear the symptoms of these infections silently without seeking health care most of the reproductive tract infections which can be preventable by creating awareness and their participation in the society. One of the major factor which affects health of the women especially reproductive health is a socio-demographic variables and so the investigator felt the need to conduct an interdisciplinary research in this area that is sociology and nursing considering both the aspects of health and the socio demographic variables affecting women's health that is social aspect in rural area of Pune district. On the other hand, several determinants such as socio-demographic, economic, sexual, medical, behavioral practices and dynamics of health seeking related to reproductive tract infections including other gynecological morbidities have not been adequately explored in India. In view of these the investigator makes an attempt in this direction and aims to assess the effect of health education programme on knowledge and practices related to common selected reproductive tract infections among the married women in rural area of Pune district.

Statement of the problem:

A study to assess the effect of health education programme on knowledge and practices related to common selected reproductive tract infections among the married women in rural area of Pune District.

Purpose of the study:

The purpose of the study is to develop health education programme on reproductive tract infections and determine the effectiveness among married women residing in rural area of Pune district to create an awareness which will help in prevention and control of reproductive tract infections and to improve reproductive health of the women.

Objectives of the study:

- To assess the knowledge of the married women related to common selected reproductive tract infections.
- To assess the practices of the married women related to common selected reproductive tract infections.
- To assess the effect of health education programme on knowledge and practices of the women related to common selected reproductive tract infections.
- To correlate the knowledge of the married women with their practices.
- To find the association between knowledge and practices regarding common selected reproductive tract infections with selected demographic variables.

Operational definitions of key terms used in the study:

- **Effect:** According to Oxford Dictionary, effect means, a change which is a result or consequence of an action or other cause.

In this study effect means outcome of administration of health education in terms of women's knowledge and self expressed practices regarding common selected reproductive tract infections.

- **Knowledge:** According to Oxford Dictionary, knowledge means a state of being aware of or informed.

In this study knowledge is considered as awareness of women regarding reproductive tract infections in common selected reproductive tract infections as per their perception.

- **Practices:** According to Webster's dictionary, practice means repeating an activity /actions to improve ability.

In this study, it refers to the actions of the women regarding reproductive health related to reproductive tract infections as per their own traditions and beliefs which are expressed by them i.e. self expressed.

- **Health education:**

1. Beneson defines it as it is the process by which individuals and groups of people learn to behave in a manner conducive to the promotion, maintenance or restoration of health. Education for health begins with people as they are, with whatever interests they may have in improving their living conditions. Its aim is to develop in them a sense of responsibility for health conditions, as individuals and as members of families and communities.

2. The definition adopted by the National Conference on Preventive Medicine in USA is Health education is a process that informs motivates and helps people to adopt and maintain healthy practices and lifestyles, advocates environmental changes as needed to facilitate this goal and conducts professional training and research to the same end.

Definition according to the investigator:- Health education is a process of change in knowledge and improve practices related to reproductive tract infections among the rural women. In the present study the structured health education plan is prepared by the researcher on reproductive tract infections based on understanding level of rural women.

- **Reproductive Tract Infections (RTI) :**It is defined as an infection of the reproductive system of a man or a woman, refer to three different types of infection: (i) sexually transmitted infections (STIs) – also known as sexually transmitted

diseases (STDs), caused by viruses, bacteria, or parasitic organisms that are passed through sexual activity with an infected partner. (ii) Endogenous infections, which appear an overgrowth in the vagina. (iii) Iatrogenic infections, which are introduced into the reproductive tract by a medical procedure, such as menstrual regulation, induced abortion, IUD insertion, or childbirth. All these three types of reproductive tract infections (RTIs) overlap and are considered together. Both are the gateway to HIV& AIDs. In the present study researcher has considered mainly syndromic approach since health education is for rural women than specific disease conditions of selected common reproductive tract infections

Meaning according to investigator- Reproductive tract infections include a variety of bacterial, viral, and protozoal infections of the lower and upper reproductive tract. Syndromic approach has been considered for common selected reproductive tract infections such as gonorrhea, chlamydia, syphilis, bacterial vaginosis (BV), lymphogranulomavenereum (LGV), trichomoniasis, and chancroid. Viral infections most common include human papillomavirus (HPV), hepatitis B virus (HBV), herpes genitalis (herpes simplex virus [HSV], primarily type HSV-2), trichomoniasis, cervical infections, Chlamydia, gonorrhea, HPV.

Hypothesis:

- H₁: - The post-test knowledge and practice score of the women in relation to the reproductive tract infections will be significantly higher than their pretest knowledge and practice score.
- H₂: - There will be significant co-relation between knowledge and practices of the women in relation to the reproductive tract infections.
- H₃: - There will be at least one demographic variable which has significant association with knowledge.
- H₄: - There will be at least one demographic variable which has significant association with practices.

Limitations:

- The study is limited to only the women who are married between the age group of 15-49 years.
- The study is limited to only the married women who are residing in rural area of Pune District.
- The practices assessed are self expressed practices of the married women.
- Effectiveness was assessed once after administering health education programme.

Assumptions:

- Married women residing in rural area have inadequate knowledge and practices related to common selected reproductive tract infections.
- Adequate knowledge and experience may promote reproductive health of the women and improve their practices related to common selected reproductive tract infections.

Conceptual framework:

According to Polit and Hungler conceptual framework represents a less formal attempt at organizing phenomena. It deals with concept that is assembled by virtue of their relevance to a common theme.

The authors also state that, conceptual framework is a cohesive supporting linkage of selected inter-related concepts. It is the device for organizing ideas and in turn bringing order to related object, events to be observed and experience. The conceptual framework serves as a guide to research and also a springboard of the generation for research hypothesis. A variety of conceptual models can be used to guide nursing actions. The value of models of nursing to provide direction for professional practice, education and research is valued in the literature and is useful for professional accountability. By delineating the boundaries of nursing, they serve as a construction for the growth of professional knowledge.

The present study aims at developing and evaluating the effectiveness of health

education programme for women. The framework of the present study is based on the systems model for development of health education program for creating awareness and improving practices regarding reproductive tract infections.

A systems theory can be used to describe and explain the behaviors of individuals, groups, and communities. It emphasizes how each isolated part affects the whole and how the whole affects each part.

These system conceptual models are particularly useful in community and public health nursing. Communities, made up of various subsystems and groups and influence each other, can be analyzed, interpreted, and understood from a systems theory perspective.

Systems models are based on general systems theory as (Von Bertalanffy), Every creature represents a system, which is a complex of elements in mutual interaction. Using systems theory concepts, any community can be considered a whole made of many parts. The parts are organized to function as a whole for a good of the community.

Assumption from System's Theory:

1. A system is related or connected as to form a unity.
2. A system is a whole that functions as a whole by virtue of the interdependence of its parts.
3. Systems have inputs, outputs, control and feedback processes.
4. Input, in the form of feedback, is referred to as information.
5. Living systems are more complex than mechanical systems and have values and response to direct their functioning as a whole.

A community is an open system that exchanges materials such as energy, goods, and services, values and ideals with the environment inside and outside the community. The community as a system has boundaries, the most obvious being geographic lines such as mountains or rivers. The imaginary boundary is one that encompasses all the subsystems in the community and identifies what is inside and outside the subsystem.

All systems function through four processes: input, Process(throughput), output, and feedback. These processes are continued through communication within the community so that subsystems relate to each other to provide effective functioning.

Each community is a social system made up of interrelated and interdependent subsystems. The subsystems are economics, education, religion, health care politics, welfare, law enforcement, energy, and recreation. When any one of the subsystems is affected, the community as a whole is affected.

Input:

Along with the stimuli, the adaptation level of the person, act as input to that person as a system. Significant stimuli that comprise the focal, contextual and residual stimuli include the factors such as the degree of change, past experiences, knowledge level, strengths and limitations.

One kind of input is the energy & raw material that transformed by the system such as Information, money, energy, time, individual effort, & raw material of some kind. In the present study, refers to the learner group with their characteristics, level of competence and learning needs input include existing knowledge and practices of the women.

The target group is married women in the age group between 15-49 years old in rural area of Pune .Investigator used a semi- structured knowledge questionnaire to assess their level of knowledge and 3 point Likert scale to assess their self expressed practices.

Process:

The processes used by the system to convert raw materials or energy from the environment into products that are usable by either the system itself or the environment. Thinking, planning, decision-making, constructing, sorting, sharing information, meeting in groups, discussing, melting, shaping, hammering, etc are the examples of process.

Green L., et.al. (1980) describe health education is designed to encourage people to adapt their behaviour so that they practice healthy habits, they have devised a model called 'Precede which helps in teaching learning process Two basic propositions underscore the outcome oriented Precede Model—

1. Wellbeing and individual health behaviour are caused by multiple factors.
2. Health education designed to influence behaviour must be multidimensional.

This model focuses primarily on planning and evaluating community health education programmed. It involves client in a problem solving approach to provide health education for an identified area of need. The precede-proceed model focuses on helping communities to change the behaviour. It begins by assessing the environment in which the group lives and consider^ the social factors that influence health behaviours. Next the model examines both the internal and environmental factors of the group that predispose it (PRECEDE) to certain behaviours or health problems. The model then calls the identification of factors that will help the group in adopting healthy actions, priorities are set. The programme developed, implemented and finally evaluated (PROCEED).

Process refers to four different operational procedures in implementing the program. The operational procedure includes:

1) Planning:

- Search for material
- Review of literatures
- Preparation of proposal
- Preparation of criteria for development and evaluation of the health education plan.
- Preparation of blue print for development of data collection tool.

2) Organising:

- Collection of materials

- Development of health education plan
- Search and select areas
- Time planning for pre and post-test

3) **Implementation:**

- Giving pre-test
- Administration of health education plan.(accepting the health education, discussing with the peers)
- Giving post-test on 15th day
- Data collection

4) **Evaluation:**

- Data analysis
- Coming to conclusion

Output:

An output of the person as a system is the responses of the person. Output responses can be both external and internal. Thus these responses are the person's behaviors. They can be observed, intuitively perceived by the nurse, measured and subjectively reported by person. Output responses become feedback.

The product or service which results from the system's throughput or processing is output.

Refer to the performance of the target group trained in the program. Evaluation of their performance after the training is aimed at determining evidence of the desired behavioral changes in relation to the program. In the present study, output refers to gain in knowledge and practices assured by the women about reproductive tract infections.

Feedback:

Information about some aspect of data that can be used to evaluate & monitor the system & to guide it to more effective performance. Feedback to the system is discussed in the form of implications of findings.

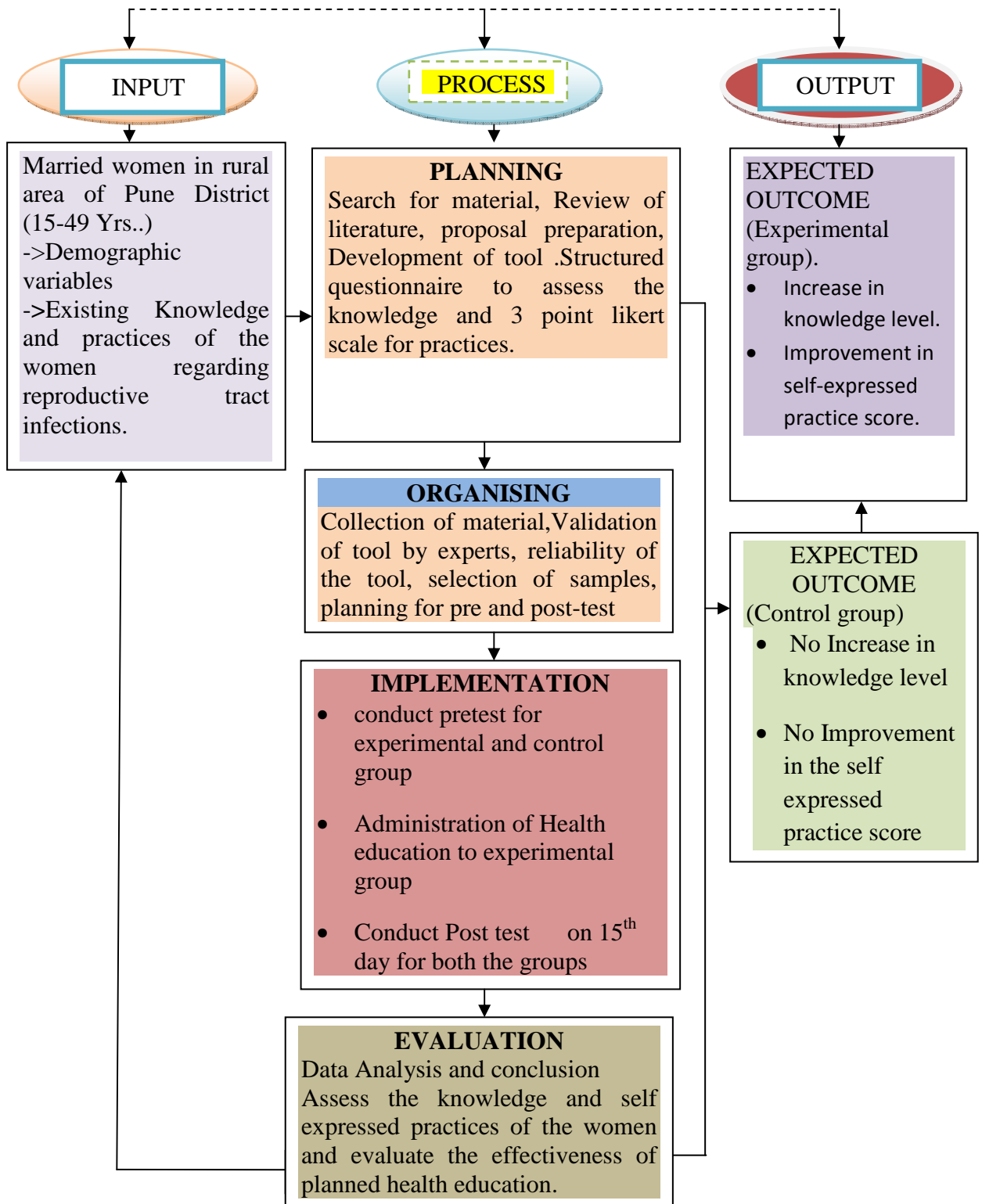
Summary:

This chapter deals with the background of the study related with sociological aspects and health aspects in nursing, need for the study, problem statement, objectives, operational definitions, scope of the study, limitations, assumptions and conceptual framework.

FIGURE - 1

Conceptual framework of the study based on Systems model

CONCEPTUAL FRAME WORK



CHAPTER II

REVIEW OF LITERATURE

Review of literature is an essential step in the development of a research project. It enable researcher to develop insight into the study and plan the methodology. Further, it provides the basis for future investigation, justifies the need for replication, throws light on the feasibility of the study, and indicates constrains of data collection. It helps to relate the finding from one study to another with a view to establish a comprehensive body of scientific knowledge in a professional discipline, from which valid and pertinent theories may be developed.

The reviewed literature for the present study is organised under the following headings:

- I. Literature related to Sociology.
- II. Literature related to Reproductive tract infections in abroad
 - a) Studies related to reproductive tract infections.
 - b) Interventional studies.
- III. Literature related to Reproductive tract infections in India
 - a) Studies related to reproductive tract infections.
 - b) Studies related to women's health and practices.
 - c) Interventional studies.
- IV. Literature related to Reproductive tract infections in Maharashtra

I. Literature related to sociology:

Kana MA, Doctor HV et.al (2014), study findings revealed that community-based involvement aid in reducing maternal and child mortality rates and enhance care-related outcomes especially in low- and middle-income countries. Sabarwal S¹, Santhya KG. (2014) performed a study on women's independence and to understand the physical violence among women in rural India. Post-analysis result shows the self-protective effect of fiscal autonomy and freedom of movement in reducing the risk of marital violence. T. Fitzgeraad ,T. Laura Cohen (2014), conducted a study on health improvement of the women .Massachusetts women have the highest rates of wellness insurance policy in the nation and women accessibility to good care has enhanced across all market groups. However, essential challenges persist. This

clearly indicates that inspite of various Government guidelines, plans, and programmes on females medical concerns, experiments on females wellness, still there is absence of females empowerment in the self-wellness matters, though she plays a vital role in a society. Yasukawa K1, Nomura K,(2014) performed a study which reveals that a Japanese women often experienced gender inequality in addition to gender based career obstacles as compared to men. Yount KM1, Dijkerman S ,et.al. (2014), states that research findings shows that if the women is highly qualified, a good earner, does marriage at later age and the most important component - family support had significant association with lesser stress. Shahabuddin AS1, Delvaux T et.al. (2013), performed a research on maternal health-related programs that should be established especially focusing on young women who are often ignored in Bangladesh and hence, the study concludes that these strategies could positively work on women to enhance health-seeking behaviour. Nomura K1, Gohchi K. (2012), conducted a study that indicates strong awareness of gender-based impediments was associated with part-time practitioners in their working place during practice. Stone J1, Moskowitz GB. (2011), performed a study which states the importance of training on cultural proficiencies for medical professionals. The study indicates on non-conscious stereotyping and prejudice that contribute to racial and cultural inequalities in health care. Existing training in cultural competence is found to be inadequate to reduce these problems. However, study states that these problems can be reduced by arranging workshops or other learning modules that benefit medical professionals. Mobaraki AE1, Söderfeldt B. (2010), conducted a researchers in which women's roles and rights in Saudi society were examined crucially, that consist of women's education, marriage, polygamy, fertility, and job opportunities. S. M Tavish, S. Moore, et.al. (2010), performed a study on National women literacy, individual socio-economic status, and maternal health care use in sub-Saharan Africa which mainly focus on the importance of women literacy on maternal health. The Researcher found several aspects within countries which can directly affect the maternal health such as personal age, education and learning, city residence and family. Thus, the study specifies that if there is growth in women literacy, income-related inequalities may decrease including women increased labour and greater position in society. Mobaraki AE1, Söderfeldt B. (2010), conducted a researcher in which women's roles and rights in Saudi society were examined crucially, that consist of women's education, marriage, polygamy, fertility, and job opportunities. Seeleman C1, Suurmond J.

(2009), performed a study on cultural proficiency in which the study specifies main reasons in looking after a culturally different individual population and indicates that there are more magnitudes to provide high-quality care than merely the social. Moreover, the researcher believes that it plays a significant role in the further development of social proficiency in medical curricula. Van Balen F, et.al.(2009), gave emphasis on perspectives of reproductive health specially focussed on sterility which can be achieved by women's education and counselling. In this study the researcher focus on three adverse maternity encounter: first maternity encounter indicates about healthcare advancement which give couples a good opportunity to conceive and have kids, though it has seen that adequate therapy is only manageable for the upper classes, whereas the other middle class to lower class keep going to traditional healers. Second adverse encounter regarding maternity is elderly foetal wastage, however it may also result in permanent sterility. The last adverse maternity encounters are recurrent induced abortions. Ogburn T, et.al.(2009),performed a research on barriers to women's health .According to this study the researcher state that women health needs are different than men has and to provide a proper coverage of health facilities in women, number of well trained and licensed physician needs to be expanded so as to see how the women respond to illness and therapy. Koblinsky M¹, Anwar I, et.al.(2008), performed research on reducing maternal mortality and improving maternal health so as to build up the right quality of emergency obstetric care in rural areas that include education of women, menstrual regulation, family planning and delayed first birth, which plays a significant role to achieve their goal. Cuellar NG, Brennan AM. (2008), conducted a study on cultural proficiency in the undergraduate medical program in which researcher states that more requirements are put into existence on medical staff to integrate material related to social proficiency which has become challenging to medical staff such as to understand the women's lifestyle and social ability as they correspond with education, introducing educational requirements, and introducing goals for learning social qualified information. R. A. Levine, et.al.(2008), pays attention to improve the women literacy rate worldwide which could be a great role changer of women in society and thus, the investigator made a model that would assess effectively the changes in socio-demographic factors due to education. The researcher put forward the benefit of women's education especially regarding reproduction, child-rearing, and wellness actions. According to the researchers, if women are educated they can explain their health problems in a

more elaborative form which in turn will be easier for the physician to provide adequate treatment without any delay. Cuellar NG, Brennan AM. (2008), conducted a study on cultural proficiency in the undergraduate medical program in which researcher states that more requirements are put into existence on medical staff to integrate material related to social proficiency which has become challenging to medical staff such as to understand the women's lifestyle and social ability as they correspond with education, introducing educational requirements, and introducing goals for learning social qualified information. Koblinsky M¹, Anwar I, et.al.(2008), performed research on reducing maternal mortality and improving maternal health so as to build up the right quality of emergency obstetric care in rural areas that include education of women, menstrual regulation, family planning and delayed first birth, which plays a significant role to achieve their goal. Kawaguchi L, Fouad NA, Chiang C. (2007), performed a study on scope of women's empowerment and their utilization of maternal health services with the objective of to determine the association between both the concept respectively in Egypt in which the researcher extracted five dimensions from the gathered data such as decision-making in daily life, freedom of movement, support by family and freedom from domination, economic security and stability, and relationship with the society. In this study the researcher indicates that out of above five mentioned dimensions, support by family and freedom from domination was the only factor was positively associated with maternal health service utilization. Qureshi N, Shaikh B.T. (2007), in this study the researchers focus on women's right to health but there are community and cultural hurdles such as women's low position, lack of training and learning contributes to hamper women's power as a result it may have a harmful effect on their families. Hence, the study concludes that there should be gender equality and powers the women's strength to increase women health position. Feinberg E¹, et.al.(2006), performed analysis on Improving women's health during post-partum period that describes, the part of child care takers can play a vital role to enrich female health post-natally. Researcher's current evidence indicated that child care taker can successfully identify postpartum females with depressive disorders, monitor symptoms, therapy adherence, and even communicate outcomes in women healthcare provider. A. Glasier, A. M. Gülmezoglu.et.al (2006), in this study the researchers states that in spite of universal accessibility to women, sex-related and women health especially in terms of unsafe sex remains neglected and disempowered almost everywhere, whereas on the other

side progress made in community wellness is seen through the great impact on conservative political, religious, and social forces around the entire globe. International Institute performed a research in India for Population Sciences (2005), which states about sterility. According to this study the researcher found that high sterility is seen in child marriages and found higher in slums than in towns. The study states that girls who marry in their young age, often come up with domestic assault in their relationships; it was supported by International Centre which clearly indicates that girls who got married at their young age are three times more prone for sex related assault whereas, in Indian scenario, women's reproduction is based on their lifestyles. Women's position and power as a person plays a significant role in their reproductive health. P. Brown (2004), in this study the researcher emphasises on social movements in women's health in which the researcher gave his best to study the health problems. The study worked on various components of community activity to provide the best way of wellness strategies which can be categorized into three: wellness should be accessible, unbiased ease of access to women's health care, and improved supply of health care services. Mac Arthur C, et.al (2003), focussed on reformulating the postpartum care priority wise so as to provide quality care on women's physical and psychological health needs. In this study the participants were availing care only when they fall sick and midwives actively participated in delivering care to them, since the treatment provided to the postpartum group was worth it was proved to be highly cost-effective, which in turn resulted in improvement in women's psychological health. Wickrama, K.A.S., Lorenz, F.O.(2002), performed a study on women's health in developing countries and what can be the influence of social status on women's health. After analysis the researcher discloses that a women's health is directly affected with their socioeconomic status and hence, concluded with, if the women's social economic status gets better and it will play a vital role to improve the health status of the women. N.E.Moss (2002), gave emphasis on gender equality. The researcher discovers the impact of women's wellness at the macro and micro level. The geopolitical ambience of women's wellness consists of country- legal rights, guidelines and solutions, and structures that shape sex and economic inequality whereas discrimination of women between and within households direct to the patterning of females wellness. Thus the study came to a conclusion and suggests several ways of advancing information, implementation of the plan, to better understand the impact of sex and socioeconomic inequality on women's wellness.

Lindbohm M.L. (2002), performed analysis on women's reproduction health and thus decided to do epidemiological research on work-related hazards and reproductive health which is the most significant and exploring area. An effect of job pressure and personal susceptibility to reproduction toxicants is also gaining in importance. K.E.Picketta, M Pearl (2001), focussed on women's socioeconomic perception and wellness outcomes. This study conclude that by drawing public health attention to all those risk factors which can contribute to make women ill can bring a huge transformation in women wellness outcomes. Andrist L.C.et.al.(2001), in this study the researcher states about women's health. Every health professional have their own thought and have a belief that in the developmental stage of menopause, there is need to do some positive amendments in the women's standard of living as it is the normal physiological changes that occur in developmental stage. The researchers examined and found that women believe the menopausal conversion is a normal and part of developmental stage. K. Pillai et al.(2000) gave emphasis on maternal mortality in which the researcher did the comparison between women literacy and expectant mother's death rate percentages. After crucial scrutiny the researcher found that stable rates of increase in women literacy were associated with declining expectant mother's death rate percentages. Hence the study proves that women literacy plays a major role in reducing antenatal death rate percentages in under developed countries. J.E. Mill ,J.K. Anarfi, (1999) gave emphasis on HIV risk environment for women and Challenges faced by them for prevention of HIV transmission, in this study the researcher made a close observation to find out the experience of women with HIV sero-positive. Sample taken in this study was thirty one women who were interviewed to discover the broad perspective of HIV transmission and to identify various aspects that arbitrate women's ability to prevent from infection. Women faced many teething troubles like many women experienced poverty during their childhood, societal belief that preferred the training and learning of men. With limited education, learning and few professional abilities, a woman has to be dependent on men as a tactic for endurance. Hence, the women are not capable to guide decision-making in this field. Jejeebhoy SJ1, (1998) performed a study on household assault and foetal mortality in the primary or reproductive health that claim for the integration of services to identify, relate, and avoid household assault. The researcher states that there is a need for incorporated services so as to prevent and avoid women from physical assault.

Reutter L et.al (1998), in this study the researcher gave emphasis on women with stumpy wages keeping the objective as to explicate the opportunity of unrestricted healthcare on the women's wellbeing. In this study the Researcher used William's conceptual framework to evaluate, psychosocial and health factors which consist of three chief components: Medical Care, Psychosocial Factors, and Wellness Outcomes. In this study the Researcher found that the Psychosocial Factors, particularly health seeking behaviour was the most common component. Thus this design was proved to be an effective configuration to organize women's healthcare. Weisman CS. (1997), in this study, the researcher pays attention to the feelings of women healthcare and their health. The study found some challenges and opportunities for modifications in women health care programmes and stressed on the limitations of health plan and programmes solutions and thus the program pinpointed the methods for integrated, constant high-quality care. Lenore Manderson (1997), in this study the researcher explored about the women empowerment. Thus to determine the needs and priorities of women, Researcher exemplify the importance of participatory techniques, and the importance of the sustained involvement of women in assessment, execution and appraisal and hence, the study improved the women positions and roles. Leipert B¹, Reutter L. (1997), in this study the researcher assessed the women's health and community health nursing practice in geographically separated configurations. Several discussions carried out and eventually summarized as the concept of physical isolation. The criticisms acknowledged major gaps in the legendary works and public health care practice for which several methods came into consideration for developing strategy to increase women health and public health practice in physically separated configurations in Canada. Campbell JC, Lewandowski LA., (1997), in this study the researcher focused psychological and wellness among women and children as well as their kids which explore the need for screening, intervention, research, and changes in the medical care system. Catrin Evans (1997), in this study the researcher pinpoint on health-seeking behaviour in regards to reproductive health among a group of sex workers. Maladaptive ways of health seeking behaviour was found after analysis which forced on to arise several questions like the first choice of therapy or assume the procedure of health seeking to be persistent mainly by societal beliefs about ill health. On the basis of analysis several recommendations and plans were formulated for the production of effective reproduction wellness solutions, and for the prospect of treatment and management that openly enhances reproductive health of a women.

Bennett T. (1997), in this study the researcher focused on women and child health with the aim of to define various actions or events that would promote women health in maternal and child health and thus women health should be integrated more into the MCH arena. Mbizvo MT¹, Bassett MT (1996), in this study the researcher pays attention to the reproductive health of women and prevention from life threatening disease AIDS, in which the researcher states that reproduction is the equal responsibility of both men and women but in most of the cases it is seen as completely women are responsible alone. Involvement of men in reproductive health care is very less as a result women has to bear the burden not only of being expectant and giving birth but also the pressure of unwanted child, accountability for contraception, sterility and often undiagnosed reproductive tract infections ,STDs such as AIDS. Therefore, the researcher says that there is a need of some factors which effectively work on reproductive health outcomes that should be followed up by positive reproduction health promoting behaviours which focus on both men and women liabilities ,for example; interpersonal support towards protection from STD's, unwanted pregnancies and expectant mother death. Thus the responsibilities should be equally distributed from the women alone to both sexes. Curlin P, Tinker A. (1996), in this study the researchers have focussed on women's health, as women often tend to neglect their reproductive health and because of their poor health seeking behaviour, straight away affects their health and develop complications which in turn lead to maternal mortality. Campero-Cuenca L. (1996), in this study the Researcher focussed on women health by means of gender perspective which help to specify various social factors which can directly affect women's health in regards to their age, education, patriarchy, economic condition, their status in the family and most noteworthy their reproductive health which often remains neglected by women and use home remedies to overcome social stigma whereas health professionals have to cautiously watch it for health promotion and disease preventive measures. Santow G (1995), in this study the researcher pays attention to the role and physical health of women in their family as it could impair her health through biological and behavioural relationships .According to researcher, awareness and health education to women should be delivered regarding wellbeing, physical health and counselling to reunite the familial relationships, so that women's position in the family will be improved and eventually it will affect their position, progress in health and receiving health care attention. to fulfil it. Family members, especially husband's plays a vital

role to improve the health status of the women. S. Thaddeus and D. Maine. (1994), in this study the researcher focuses on maternal health programme, the goal of which is to spread out information to those concerned with expected mother from sufferings. The researcher pays attention to the interval between obstetric complications and its result, as there are several impediments to seek health care facilities in regards to distance, transport facilities, cost of care, shortage of qualified staff, essential drugs and supplies, administrative delays and clinical management whereas the satisfactory result will only be possible with quick and adequate treatment so as to fulfil the goal of maternal health programme. Raikes A1, Shoo R, Brabin L. (1992), in this study the researcher states that the men and women play different position in society and have different health needs. To increase women's health insurance policy and to achieve position in society one should avail National services, which is especially designed for women. Researchers also stressed in changing men's attitude to transform community norm discriminating against women. Leslie LA, Swider SM. (1986) conducted a study on women's health care in regards to their changing needs & factors. In this study, the researcher state that, women are less liable to have the benefits of insurance policy especially in those places where they work as a part-time, run a small business and other small manufacturing industries. In today's field of women, their health is getting higher and receives more emphasis in terms of information, which should be comprised of physiologic, psychosocial, and financial factors that together affect the place of women, which has to be gathered and examined constantly for the large group of women and later on these information can be used to funnel health plan making decisions and to put forward the base, for prevention from illness, treatment of disease and health promotion.

II. Literature related to Reproductive tract infections in abroad:

a) Studies related to reproductive tract infections:

AshikurS. M. Elahee (2013), gave importance to Reproduction tract infections among women in Slums of Khulna Town, Bangladesh so that they could break their silence. The main reason behind RTIs was found to be linked to great occurrence of uneducated, getting married at young age, illness methods and lack of knowledge about RTIs/STIs. Shao M.F, et.al. (2012) perform research regarding risk factors in women who are homosexual. Rate of RTIs were found to be high in female sex workers. Xiao Fang Wang, Jessie L. Norris, (2012), performed research on risk

behaviours for reproductive tract infection. After scrutinization Researcher discovered that homosexual women carry hazard of sexually transmitted infections whereas for prevention from such type of infections intervention should be done to create awareness among women. Zhi-fang Li (2010), performed study on Cervical and Breast Tumour and Reproduction System infections in Non-urban China. Moreover 99.7% of women indicated curiosity about a mixed screening project. Hence, the study concludes combined screening program would be more effective and popular as compared to single disease screening projects. Sami Ramia, et al (2012), performed a research on RTIs among married women aged between 18 to 49 years residing in a low-income , with the aim to explore the relationship between market and socioeconomic aspects which showed a somewhat great incidence of RTIs. Johnson LF, Coetzee D.J, et.al (2011), focussed on monitoring of sexually transmitted infections in Africa and after critical analysis incidence of gonorrhoea and syphilis is found to be highest in "high risk" groups such as sex workers and attenders of STI treatment centres. Balsara, Z P (2010) performed a research on reproductive system disorders among women participating in health treatment centres in Haripur, Pakistan. In this study the Researcher discovered the great incidence of RTIs among women's participating the units for reproductive health concerns. Sihavong A, Lundborg CS, et.al(2011),conducted a research on treatment-seeking behavior regarding RTIs. The Researcher found that both men and women had a number of confusions about the causes and symptoms of RTI/STI and their cure, and eventually end up with a desire not to pursue medical care. One of the most common treatment-seeking behaviour was self-medication, following advice mostly given by friends and drug suppliers. Though the significant reasons for not going to wellness features were worry of social elegance or shyness for investigations related to reproductive system. Moreover, both men and women have a prior knowledge about the condom use so as to prevent RTI/STI which they came to know through TV. and radio. Hence, the result of this study indicates that building up wellness knowledge and through treatments at the community level is recommended to increase quality of RTI/STI management. Kristin N.et.al. (2010) performed a research on STI treatment-seeking behaviours among youngsters in Nigeria: are there sex differences. Study results said a greater percentage of men than of women had desired strategy to their STIs. Rehan N., Bokhari Asma (2009) performed a research to calculate the incidence of RTIs among the Female Sex Workers in Lahore and Karachi. After scrutiny it was found that out

of all RTIs the occurrence of syphilis is very high among all high-risk groups; particularly in those who take drugs in injectable forms. Tang Yongjun, Julia Samuelson et.al. (2009), conducted a study in women belongs to rural area on the incidence of reproductive tract and sexually transmitted infections, study indicates that wellness promotion messages is important such as safe sexual and medical care seeking behaviour. Lan Pham Thi, et. al. (2008), in this study the Researcher focus on perceptions and behaviour regarding reproductive and sexually transmitted infections in rural residents of Vietnam, the Researcher suggested to develop wellness education strategies so as to provide widespread RTI/STI information to the community, moreover to improve the contact between RTI/STI victims. Akinrinola Bankole, Ann Biddlecom (2007), focussed on knowledge and information sources on sexual behaviour in Adolescents. The study indicates that adolescents are prone for HIV yet their knowledge regarding HIV prevention is poor. Thus, the study concludes that younger adolescents need to pay attention to improve the sources so that they can take a preventive measures for HIV. Biddlecom A .E. (2004), focussed on trends in sex-related behaviours and sexually transmitted infections among teenagers in the United States so as to explain sex-related behaviour such as use of condom. The Researcher states that condom use guidance not only decreases the risk behaviours but also improves in safety behaviours. Sevgi O Aral, et.al. (2004). Researcher states that women are often pressurized to find a spouse or get money and if they failed to do they drag themselves into sex work which they find the easiest way to earn money, whereas they remain unaware from all the life-threatening situations. In addition to effective protection from STDs and HIV, women need to build up their wellness knowledge which help to keep them aware from all the health hazard. Hawkes S. (2003) gave emphasis on companion notification for the control of sexually transmitted infections in which the study outcome reveals that partner or companion notification is a well-established public health activity to control various sexually transmitted infection. Deeb M. E. Awwad et.al. (2003), performed a research on incidence of reproductive tract infections, genital prolapse and being overweight in Lebanon. Study indicated unexpected high incidence of genital prolapse and obesity. To determine the incidence of without symptoms and unknown genital system infections, the department of human health and family planning services, performed a research among women participating in family planning medical center at Hlabisa Hospital. Moreover, women undergone gynaecologic examination during which a

genital swab was taken and the analytic testing swabs showed, 119 (63%) of the 189 females had at least one infection and 49 (26%) had multiple infections. Durr-e-Nayab (2002) emphasised on reproductive Tract Infections among Women in Pakistan that comprises of certain policy effects, for enhancing the women reproduction health. The policy concentrate on improved use of media, loyalty and awareness strategies that not only aid in prevention of RTIs but also benefits in notifying women against harmful risks. Fariyal F. Fikree (2002) performed a research to discover the factors influencing health-seeking behaviour of women in Karachi regarding reproductive tract infections. The Researcher reveals in this study that Pakistani women seek care for reproductive tract infections, but causes and treatments delivered to them are usually not related to sexually transmitted diseases, the Researcher therefore suggest proper training of healthcare providers for appropriate counselling and for promotion of treatment management. Sallam S.A.et.al. (2001), the study indicated a great need to work on women's understanding in regards to reproductive tract infections. Kaufman, Joan; Liqin, Yan (1999), the Researchers strongly emphasised on field-based methods to diagnose reproductive tract infections such as trichomonas, candida, bacterial vaginosis, gonorrhea, and chlamydia so as to suggest practicable approach to differential diagnosis and treatment for these infections. Lemeki M, et.al(1996), performed a research on women's understanding of STDs which indicates that intercourse, as accepted by women, is the prominent mode of illness. Thus, informants who had excellent understanding of AIDS are said to known as AIDS individual. Wesserheit J. N. et.al. focussed on RTIs that often attacks in child bearing age in rural area of Bangladesh and the study results indicates that tubectomised as well as IUD users are 7 times more likely to have confirmed RTI than nonusers.

b. Interventional studies:

Soheila Rabieipoor, et.al. (2011), performed research on reproductive health to empower women learners of Oromieh School through professional knowledge technique as a result it increased the knowledge level and empowered the university women learners. Based on these finding, women were educated and counselled in sex-related and reproductive health matters. Bahram A.et.al. (2009). In this study the researchers focused on incidence rate of bacterial vaginosis (BV) which found to be relatively high and the main cause of it was thought to be hygiene behaviors for which the researcher scheduled the programs of healthcare educations, and thus, targeted at

reducing BV occurrence. Ajuwon A J et.al. (2007), performed research on sex education program in secondary schools learners at Nigeria in which the researcher compared the effectiveness of teacher instructions alone, professional knowledge alone, and a combination of these two on reproductive health knowledge, attitude, perceived self-efficacy and sex-related practices among school learners and thus the research indicates that multiple intervention strategies have greater potential in improving their knowledge. Rahman M.S, Rahman M L (2007), performed a study on media and statistics among married people in Bangladesh, which play a crucial role in increasing the attention of AIDS, after analysis the results of both technique shows that knowledge, occupation, socioeconomic status, position in family, food consumption, area of residence and press exposure such as T.V and video add contribution in determining HIV/AIDS attention level. Ancheta R, Hynes C, Shrier LA. (2005). in this study the researcher recommended that if early sex knowledge and information from both parental and formal sources is given to high-risk adolescent girls, it would greatly aid in reduction of sex-related threat. Zhang T, Wu YQ (2004) concludes that the education and training of expectant mothers and child guidance clinics had a significant effect on improving their service skills and quality; consequently, the women covered by their service could receive better expectant mothers and child health-related care. Zhang T, et.al. (2003) concludes that extensive wellness information involvement programs had significant effect on information about RTIs/STDs among reproductive age group. Mounir G.M, et.al. (2003) the study concludes that wellness information system is the most suitable tactic for promoting young adolescents reproductive wellness. Speizer IS et al. (2001), The research finding indicates that STD/HIV can be successfully prevented from transmission when there is a contact with a peer educator who will provide all possible and related information about STD/HIV. O'Donnell, et al (1995) performed a study on the effectiveness of video-based treatments in promotion of condom purchase among men and women the study concluded that the adopted method of video-based treatment is effectively enhance condom use, improvement of information, enhance positive behaviour about contraceptives, among individuals who are at risk of acquiring and transferring HIV infection and other STDs and AIDS.

III. Literature related to Reproductive tract infections in India:

a) Studies related to reproductive tract infections:

Shailendra K.B.,et.al. (2013) study result indicates that knowledge regarding RTI was insufficient while the occurrence of RTI was high (26.8%) and the treatment-seeking behaviour was insufficient. Komal P Thekadi (2013) conducted study on reproductive tract infections among women the study findings indicates that women who used to maintain hygiene during menstruation had lower occurrence, whereas women with problems of dyspareunia, blood loss during and or after sex-related activity had highest possible incidence of reproductive tract infections. Berad A.S.(2012), The study finding indicates that there is a significant association between RTIs symptoms and age, age at menarche, age at wedding, age at first perception. Samanta A., Ghosh S.(2011) performed a research on health-seeking behaviour in regards to RTIs/STDs in which the researcher states that building up of actions of the current program all over the country among women is needed to build a positive health-seeking actions that will ensure success rate in control of RTI / STI. Srivastava Lalima (2010) conducted a study on reproductive tract infections among women of Non-urban Group in Mewat, India. According to the researcher wellness solutions should be made available to all so that women will feel safe to accept the therapy. Kosambiya, J.K Desai, V.K. et.al (2009), conducted a study occurrence of RTI/STI among women rural area of Surat findings revealed the impact of socioeconomic, socio-demographic determinants are related to occurrence of RTI/STI. Shagun Sabarwal and K. G. Santhya (2008) study finding reveals about two-fifths of married women and one-third of single women have undergone therapy from health care providers. Vinitha C.T., et.al. (2007) performed a research on sexual health attention and aspects impacting it in a rural community of southern India. The researcher states that in India Improving wellness attention among females is a complex process. Age, age at marriage, position and place of property were significantly associated with attention. Hence, this research reveals that women who are illiterate or educated less than 10th standard and residing away from primary medical care solutions with a low quality of life are less aware of sexual health. Patel, V et.al (2006), the study indicates that most of the women with RTIs is linked to endogenous attacks. Low - socioeconomic status and gender inequality are associated with brought up threat for BV, while the risks for STIs indicated that deprived females were likely to be contaminated by their spouses. Hemanta M, Latashori K et.al. (2005) states that only

in 11 and 9 districts respectively out of the total of 34 districts in the north-eastern States of had a higher level of awareness of RTI among men and in women, in addition to it the research indicates strong policy implication on awareness programmes to propagate the messages on RTIs and it's associated risks in the region.

Balamurugan S .and Bendigeri N.D .(2004) The study concluded that women with low educational status and illiterate women are prone to develop due to their poor menstrual and perineal hygiene and their own wellness behaviour is low as compared to well educated women. Rathore Monika, Bhardwaj A.K (2002) the study indicates that the occurrence of RTI was significantly associated with age, individual cleanliness, material used during period, worker giving birth, obtrusive birth control methods, gynaecological surgery. Aggarwal A.K, et.al performed a research on RTIs among married women of reproduction age in Haryana, India. Study showed increased incidence of reproductive tract infection and low utilisation of rehab facility.

b) Studies related to women's health and practices:

Health is a balanced state of well being for everyone resulting from harmonious interaction of body, mind and spirit. The health needs of women includes prevention of health disruption, promotion of a state of high level wellness, care and or cure services for illness states, and rehabilitation for chronic or disabling conditions. An Indian women's health is no longer considered merely a state of physical well being, but an expression of many roles that she performs as wife, mother, health care provider, and earner.

Banerjee B. (2009) conducted research on MCH in which the study states that there is a need to provide a comprehensive treatment in antenatal and intranatal period through individual and group approach. In this study desirable changes were found in wellness methods resulting in healthy mother and child. Dasgupta S. et .al (2006), conducted a study to find intra-natal care methods in a district of West Bengal where large number of deliveries are assisted by untrained persons which requires immediate and appropriate interventions along with its implementations to enhance the quality of care and to prevent complications. Coyaji (2002) states in the annual report of KEM Hospital, Pune that the root of the problem lies in the non-utilisation of available skills and information for the welfare of the group. Women and men have different

attitudes toward wellness and wellness seeking. There are several reasons for it such as social set up, culture, economic position, values and beliefs.

c) Interventional studies related to reproductive tract infections:

Geetha M. (2013) conducted a study on prevalence of reproductive tract infections in which the researcher suggests that health education will help in preventing reproductive tract infections among women which are thought to contribute in developing infections such as use of contraceptives and, personal and menstrual hygiene aspects. Dongre, A.R. , Deshmukh P.R et.al, (2007), performed a study on community-based wellness information in which involvement technique could bring a major changes in the attention and behaviour of non-urban teenage ladies regarding control over their menstruation hygiene.

Parwej Saroj, Kumar Rajeshet. et.al. (2005), focused on reproductive wellness information involvement trial to measure the effectiveness of a sex related information package in improving the information of younger women. Analysis reveals that peer information and conventional information strategies were effective in improving the sexual health information of women. Aggarwal A.K. and Duggal Mona (2000) conducted study on knowledge of individuals about RTIs and AIDS in Northern India. The result of the study suggest that health-education technique through home visits, RTI case control and guidance, and organizing a weekly hospital and occasional camps and health-education talks can increase the awareness and prevention form RTIs/STIs among men and women.

IV. Literature related to Reproductive tract infections in Maharashtra :

Bobhate P.S. et.al (2011), performed a research on RTIs among young women in a metropolitan slum of Mumbai. Study indicates that young women should be given appropriate information regarding puberty and reproduction wellness to help them to deal with their reproduction and reproduction wellness issues .Dongre, A.R. , Deshmukh P.R et.al (2007), The study indicates that health and fitness information contribution technique could bring significant changes in actions of non-urban younger women in growth of women's health. Parwej Saroj, Kumar Rajesh et.al.(2005), Crucial analysis reveals that professional information and conventional information strategies were effective in enhancing the duplication health and fitness

and health information among younger women. Singh S. (2002-2003) conducted research and states that reproduction deaths is itself a neglected area in the field of research and exploration. Moreover, the reproductive health of women in the developing country, like Indian citizen, needs and requires a lot of attention. This study has shown that incidence of reproduction deaths, including menstruation problem and RTI/STD, is very common among the non-urban women in Maharashtra. Bang R. and Hit A. (1986), conducted a study on gynaecological disease in Maharashtra Rural area to share the experiences of the researchers who performed a community-based study on gynaecological mortality. The researcher states that wellness seeking behaviour in women found to be poor as 92 per cent of women were found to have gynaecological problems whereas only 7 % of women had approached proper health care. Dr. K. Anil Kumar conducted study on reproductive health of younger women in Maharashtra in which the researcher covered the several aspects which comprises of antenatal, intranatal and postnatal, contraception and recent sex-related habits. Post -analysis results revealed that about 7 % of married young women are either pregnant or have already experienced giving birth. Hence, these 7 % of younger women had already commenced the process of childbirth before they could reach their appropriate age.

Summary:

Above overview of literature had given the insight to the investigator, to prepare for the existing study and to identify the reality of valid knowledge among women globally. This clearly indicates that in spite of various Government guidelines, plans, and programmes on medical concerns, experiments on women wellness, still there is absence of women empowerment in the self wellness matters, though she plays a vital role in a society. Sociological research shows that culture, norms, beliefs and practices, impact females productive and reproduction positions in family and workplace. The reviewed literature for the present study is organised under the following headings: the review of literature related to sociology, reproductive tract infections in abroad this includes, studies related to reproductive tract infections in various countries i.e. China, Bangladesh, Vietnam, other countries and interventional studies abroad, literature related to reproductive tract infections in India, studies related to women's health and practices in India related to reproductive tract

infections ,interventional studies, literature related to reproductive tract infections in Maharashtra.

Review of literature shows that lot of quantitative studies are conducted on reproductive health issues of the women, still there is need to conduct more qualitative and interventional studies for women's significant and active participation in gaining knowledge to create awareness and develop sound reproductive health practices.

CHAPTER -III

RESEARCH METHODOLOGY

Research methodology is the common pattern for organising the procedures for the empirical study together with the method of collecting valid and consistent data for the problems under an investigation. It deals with the methodology adopted for development and evaluating effectiveness of health education programme on knowledge and practices related to common selected reproductive tract infections among the married women in rural area of Pune District .It includes the description of research approach, research designs, variables under study, setting, population, sample and sampling technique, development of data collection instruments, development of health education plan, data collection and plan for data analysis to determine the effectiveness of the health education program.

Research approach:

Research approach is a systematic, objective method of discovery with empirical evidence and rigorous control. The control is achieved by holding conditions constant and varying only the phenomenon under study.

The research approach adopted for the study was experimental with pre-test post-test control group design to evaluate the effect of health education programme related to reproductive tract infections among the married women in rural area of Pune District and determining its effectiveness statistically.

This will help the researcher to evaluate the effect of the intervention that is the “health education program” on the variable that is “knowledge and practice” of married women related to reproductive tract infections.

Research design:

It is the plan, construction and strategy of investigations of answering the research question .It is the overall plan or blue- print the researchers select to carry out their study.

In the present study, the investigator selected pre test, post test, control group design (O1 X O2). In this design, the investigator introduced a base measure before and after a planned exposure, which is depicted as O1 and O2 respectively. The subjects were randomly assigned to two groups .Using comparative groups, several threats to

internal validity can be minimized. Keeping in view the objectives of the study, the investigator observed experimental and control groups prior to the treatment (pre-test). Experimental group received the treatment (administration of health education) and Experimental and Control groups were again observed (post-test).

In the present study, the base measure is the knowledge and practices and the experimental variable is the structured health education programme depicted as 'X'.

Thus the research design can be represented as:

Group	Pre-test	Treatment	Post-test
R-Experimental	01	X	02
R - -Control	01	-----	02

Figure No. 2: Pre-test – posttest control group design.

The interpretation of the symbols are as follows:

R- Randomisation

01 - pre-test score experimental group

02 - post-test score experimental group

X - Treatment variable (health education program)

01 - pre-test score Control group

02 - post-test score Control group

Setting of the study:

Setting of the study refers to the physical location and conditions in which data collection takes place in a study. Selection of an appropriate setting is important as it influence the way people behave or feel and how they respond.

According to Polit D.F. and Hungler B.P.(1990) the researcher needs to decide where the intervention will be implemented and where data will be collected.

The study was conducted in rural area of Pune District. Pune district includes 13 tehsils, from each tehsil two villages were selected randomly, from these two villages samples for experimental and control group were selected for the study.

Name of the villages selected for data collection:

1. .Ambegaon Taluka -Kanase, Chinchwali
2. Baramati Taluka -Jalochi, Songaon
3. Bhor Taluka -Sangamner, Khanapur
4. Daund Taluka -Lingali, Khopodi
5. Haveli Taluka -Kondhanpur, Walti
6. Indapur Taluka -Kalewadi, Lumewadi
7. Junner Taluka -Kolwadi, Bhorwadi
8. Khed Taluka -Markal, Shirol
9. Mawal Taluka –Dewale,Kadadhe
10. Mulshi Taluka -Urawade, Nande
11. Purander Taluka - Bhiwadi, Pimpale
12. Shirur Taluka Karandi, Kuruli
13. Velhe Taluka - Mohri, Niwi

Population:

According to Talbot, “A population is a group whose members possess specific attributes that the researcher is interested in studying.” The population of the present study comprises of the married women in rural area of Pune District.

Sample and sampling technique:

A sample is used in research when it is not feasible to study the whole population from which it is drawn. The process sampling makes it possible to accept a generalization to the intended population based on careful observation of variables, within a relatively small proportion of population. According to Polit and Hungler a sample consist of a subset of the units that compose the population.

Sampling technique:

The process of selecting a portion of the population to represent the entire population is referred to as sampling technique (Polit D.F.and HunglerB.P.1999)

In the present study, sampling technique is by probability proportionate multistage sampling.

Criteria for sample selection:**Inclusion criteria:**

- Women who are married
- Women between age group 15-49 years.

- Women residing at rural area at Pune district.

Exclusion criteria:

- Women who are below 15 years and above 49 years of age.
- Women who are not ready to participate in the study.

Sample size:

Pune district includes 13 tehsils Probability proportionate multistage sampling technique was done for sample selection. From each tehsil two villages were selected randomly(one for experimental and one for control group), from these two villages samples with sample size proportionate to tehsil population was taken for experimental and for control group . Random sampling technique was used to select samples from each village. Total 605 for control group and 605 samples for experimental group were selected for the study.



Figure No. 3: Map of Pune District with sample size from each tehsil

Using the proportionate sampling the sample size was calculated using the below formula:

$$n = [(z^2 * p * q) + ME^2] / [ME^2 + z^2 * p * q / N]$$

Data collection techniques and tool:

The most important and crucial aspect of any investigation is the collection of appropriate information, which would provide necessary data to answer the questions

raised in the study. Treece and Treece state that the instrument selected in a research should be as far as possible the vehicle that would best obtain data for drawing conclusions pertinent to the study.

The study aimed at evaluating effectiveness of health education program related to the reproductive tract infections in terms of knowledge and practices. Hence the instrument for data collection was pre-tested questionnaire for knowledge and 3 point Likert scale for self expressed practices after the validity by 25 experts. After explaining the purpose of the study to the women, those who consented for the study, questionnaire and 3 point Likert scale was administered. The first part is solicited for socio-demographic characteristics of the respondents; the second part assessed their knowledge regarding reproductive tract infections, while the third part 3 point Likert scale to assess self expressed practices regarding reproductive tract infections.

Schematic representations of steps of the research design:

Sample: Experimental and control group
Dependent Variable: Knowledge and self expressed practices, Pre-test :Structured questionnaire to assess knowledge 3 point Likert scale to assess self expressed practices Pre-test conducted for experimental and control groups.
Independent Variable: Planned health education programme Administration of health education to experimental group
Post –test: Conducted using the same tool for pre-test to experimental and control groups
Plan for data analysis: Distribution of demographic variables in frequency and percentage. Assess pretest knowledge and practices of the respondents. Assess the effectiveness of health education program, Correlate the knowledge of the respondents with their self expressed practices. Association between knowledge and self expressed practices with selected demographic variables.

Figure No.4: Schematic representations of steps of the research design.

Development of the tool:

An assessment tool was prepared to collect the data. For the development of the tool following steps were taken:

- Review of research and non- research literature used in the area related to reproductive tract infections.
- Opinions of suggestions were taken from experts, which helped in determining the important areas to be included.
- The investigator's own exposure to clinical field helped in the development of the instrument.
- The health education plan related to reproductive tract infections was prepared. Factors taken into consideration while preparing the health education plan were simple to understand for rural women , explanatory i.e. use of language which the women in rural area understand, communicative participatory learning, interest building, and attractive to create interest, keeping in mind attention span of subjects. Option and suggestions of experts in the field and the exposure of investigator in the area of research were considered.

Description of data collection tool:

The investigator used data collection tool consists of following sections:

Section A:

Deals with demographic characteristics of the respondents i.e. Age, age at marriage, religion, marital status, education of self and husband, occupation of self and husband, husband's stay, monthly family income, type of family, menstrual data, gynecological and obstetrical data, contraceptive methods adopted by wife and husband, perception about use of contraceptives, medical history and partner participation.

Section B:

Assessment tool for knowledge comprised of knowledge questionnaire to assess the knowledge regarding reproductive tract infections. In the knowledge questionnaire correct responses of the women were scored as one and incorrect response as zero. It mainly includes meaning of reproductive tract infections, organs of female reproductive system, common sites of infection, types, names, modes of transmission, causes, signs and symptoms, diagnosis and treatment, complications, preventive and control measures of reproductive tract infections.

Section C:

Assessment tool for self expressed practices consist of 3 point Likert scale to assess the self expressed practices of the married women. Practices comprised of positive and negative items each with 3 point Likert scale as always, sometimes and never for positive practice items always was scored as two, sometimes as one and never as zero whereas for negative practice items never was scored as two sometimes as one and always as zero. It consists of preventive practices i.e. hygienic, menstrual hygienic, sexual, antenatal, intra-natal, postnatal, contraceptive and abortion practices, curative and awareness practices.

Section D:

Preparation of health education plan.

Preparation of the health education plan:

The health education plan was prepared based on research literature and non-research literature on reproductive tract infections. A draft of structured health education Programme was developed, keeping in mind the objectives, criteria checklist, literature reviewed and expert's opinion. The main factors that were kept in mind while preparing the health education plan, literacy level of the subjects, method of teaching to be adopted, simplicity of language, relevance of teaching aids and attention span of women. The structured health education programme was first drafted in English.

Description of Structured Health Education Programme:

The health education programme is titled as "Health education program on reproductive tract infections".

The content selected is organized under the following headings:

The areas covered in health education plan:

- Introduction
- Organs of female reproductive tract, sites of reproductive tract infections.
- Meaning of reproductive tract infections
- Types of Reproductive tract infections
- Modes of transmission
- Factors causing reproductive tract infections
- Signs and symptoms
- Diagnosis and Treatment
- Complications of reproductive tract infections

- Preventive and control measures, safer sex practices
- Preventive, (hygienic, menstrual hygienic), sexual, antenatal, intranatal, postnatal, abortion contraceptive, curative and awareness practices.

To create an interest among the women different audiovisual aids were prepared which were in Marathi language and simple to understand. Models were shown to explain organs of female reproductive system and sites of reproductive tract infections, Charts, posters, flip charts, flash cards, roller, slide show, puppet show were used for health education.

Development of the criteria checklist for data collection tool and health education plan:

Validation of the tool for expert opinion was prepared .The draft of criteria checklist was constructed under the headings for demographic data, knowledge questionnaire and practice questionnaire in the column given in the criterion table against each question i.e. section, content ,relevant (agree, disagree), organised (agree, disagree), appropriately measurable (agree, disagree), remark.

The draft of criteria checklist for health education plan was constructed under the headings selection of content, organization of content, presentation, language, illustrations/ pictures, practicability and feasibility. Three response columns were developed i.e.

I) “Meets criteria” II) “partially meets criteria” III) “does not meet criteria.”

A remark column too was developed for suggestion of the evaluator.

The validity of the criteria checklist was determined by submitting to 25 experts from the field of Gynecology and obstetrics, Community Medicine and Nursing ,sociology and from statistical field. There was 100 percent agreement among the experts with the criteria statements. The suggestions given by experts incorporated and the final checklist was prepared with three responses column and a column for remarks.

Content Validity of the Health education Programme:

To determine the content validity, the initial draft of health education plan along with the tool was submitted to twenty one experts from the field, four doctors from the Gynecology and Obstetrics department and six from Public health i.e. Medical officers from Primary Health Centres and Department of Public Health. The remaining experts were nurse professionals specialized in Community Health Nursing and Gynecology and Obstetrics Nursing, sociology and the statistician. The

suggestions were accepted and incorporated in the study. The final draft of health education plan was prepared after incorporating suggestions given by the experts and the health education plan was translated to Marathi.

Content validity of the tool:

To ensure content validity of the tool it was submitted to 25 experts along with the blue print. The four experts were doctors from the Gynecology and Obstetrics Department and six from Public health i.e. Medical officers from Primary Health Centres and Dept. of Public Health, four experts from Dept. of sociology The remaining experts were nurse professionals specialized in Community Health Nursing and Gynecology and Obstetrics Nursing, sociology and the statistician. The suggestions were accepted and incorporated in the study. After incorporating valuable suggestions from experts, tool was administered.

Reliability:

Tool reliability reflects the degree of consistency with which an instrument measures what it intends to measure. (Polit D.T. & Hunler B.P.1990) The reliability co- efficient for the knowledge and 3 point Likert scale was calculated using split-half technique. The split half method was used for reliability and Chronbach's alpha was found to be 0.96 and 0.94 respectively for the two sections-knowledge and practices respectively. The tool was translated in Marathi.

Pilot study:

Pilot study is a small preliminary investigation of the same general characters as the major study, which is designed to acquaint the researchers with the problem that can be corrected in preparation for a larger project. A pilot study was conducted to assess the feasibility of the study and present the health education plan to decode on a plan for a statistical analysis.

The objectives of the pilot study:

1. To know proper place available for the study.
2. To find out how much time is needed for respondents to answer the questionnaire.
3. To identify whether the respondents understood the wordings of questionnaire.
4. To refine the instruments.

After having obtained formal administrative approval, the study was conducted on 120 subjects, 60 in experimental group and 60 in control group by probability sampling technique.

A pilot study was conducted in rural settings from 10th April to 6th June 2011 in Haveli tehsil, Pune district, to assess the feasibility of the study and administer health education and to decide on a plan for a statistical analysis.

The study was conducted on 60 respondents from control and 60 from experimental group who were selected by random sampling technique. Data was collected through the structured questionnaire. On the first day purpose of the study was explained to women. After pre-test on the same day health education was administered to the women in experimental group for one to one and half hour. Post- test was done on 15th day using the same tool. Data was analyzed with the help of descriptive and inferential statistics. Findings indicated that health teaching was effective for women in rural area in increasing their knowledge and practices regarding reproductive tract infections.

Analysis and interpretation of data was done with descriptive and inferential statistics. Based on pilot study actual study was done.

Procedure for data collection:

Data collection technique used to assess knowledge related to reproductive tract infections was structured questionnaire and to assess self expressed practices 3 point Likert scale was used. After obtaining the prior permission from the District Health Officer to conduct the study the investigator conducted the study on 1210 subjects. 605 in experimental group and 605 in Control group by proportionate multistage sampling technique .Data was collected from 1st September 2011to 17th January 2013. On the first day, the purpose of the study was explained to each subject and confidentiality of her responses was assured, written consent was taken from each sample before giving the pre test. Pretesting took 45 minutes to 1 hour. After pre-test, on the same day health education was administered to the subjects of experimental group. Post-test was conducted on 15th day after pretest from both the groups and data was collected from women.

Plan for data analysis:

According to Kothari C.R (1985) Analysis means the computation of certain indices or measures along with searching for patterns of relationship that exists among the data groups. It involves estimating the values of unknown parameters of the population and testing of hypothesis for drawing inferences.

- Demographic characteristics of the samples in terms of frequency and percentage.

- Item analysis of knowledge and practices.
- Analysis of pre-test and post-test scores regarding knowledge and self expressed practices related to common selected reproductive tract infections.
- Paired t-test was applied to compare knowledge scores before and after health teaching to respondents. Two sample z-test was applied to compare effect of health teaching on knowledge scores of experimental and control groups.
- Paired t-test was applied to compare practice scores before and after health teaching to respondents. Two sample z-test was applied to compare effect of health teaching on practice scores of experimental and control groups.
- Pearson's correlation coefficient followed by the t-test for significance of correlation coefficient was used for analysis of data related to correlation between knowledge and practices regarding reproductive tract infections.
- Analysis of data to find relationship between knowledge and selected demographic variables was done using ANOVA (Analysis of variance).

Summary:

This chapter dealt with the research methodology adopted for the study. It includes description of the research approach, design, setting of the study, sample, sampling technique, data collection tool and technique and plan for data analysis.

CHAPTER IV

CASE STUDIES, NARRATIVES, LIFE EXPERIENCES

Impact of Social determinants and status of Indian women:

A community consists of many organizations and most important of them are the system of culture, family perspectives, marriage, social norms and customs. They provide the viewpoint and ethical basis for men and women about their privileges and responsibilities and their status and roles. Females form about 50% of individuals of the country, but their status is not equal to men due to patriarchy system and gender bias. Indian scenario, though women empowerment movements are taking place, government is developing policies for the women empowerment still in rural areas a low status in the society and have been treated as inferior to men. They are having less priority for education, lack of nutrition, female feticide, they are not self sufficient and though they are efficient they don't have decision making power, there are cultural beliefs and practices, norms and values which they have to follow so Women often have to bear the triple burden of a job, housework and children. This causes a lot of strain for her. This has led to a low priority being accorded to their health needs. Women have been socially conditioned to think of their family first, and of themselves later. So they often neglect their own health. There is a serious need for the National Rural Health Mission to address the issue of reproductive tract infections in rural women. Therefore NRHM recommends information on the prevalence of reproductive tract infections in rural women in India and the impact. Strategies to address the present gaps in reproductive tract infections, awareness and service provision for rural women.

Present study is related to educate women regarding reproductive tract infections which has vital role in maintenance of their reproductive health. In rural community women are ignorant about their reproductive health rights so in context to radical feminist theory, health education regarding reproductive tract infections is given to the women in experimental group and knowledge and practices are assessed.

In relation with the socio-demographic context an Investigator has narrated some case studies which reflects the situation in rural area of Pune district.

CASE STUDIES:

Dependency and lack of decision making power:

Case 1: Mrs Vanita is 40 years old living at Mohri village in Velhe. There are 18 members in her house. 2 brother in laws, with their wives and each family has 3 children, Vanita's family has four children, three daughters and one son. They live in Kaccha house and there are only two rooms for the whole family, there is no water and toilet facilities. Women have to go far to get the water and villagers have open air defecation practice. Place is very small and crowded for the family. Hygiene and cleanliness is not maintained. Father in law was working as a labourer. Their family income is between 15 to 20,000 per annum. All family members depend on the decision of eldest brother in law who is the only working male personnel and works as driver. Her husband is an illiterate person, do not earn so she has to go for work as labourer. Husband has habit of drinking alcohol and smoking. He never gives attention to his family sometimes he do abuse her physically and verbally. Mrs. Vanita has studied till 2nd standard. She wanted to take further education but her father did not allow her to study. He used to say that girls are burden and should get married as early as possible. She got married when she was 17 years old. Her mother in law used to say that Vanita should conceive immediately after marriage. She is 4th para and had undergone abortion 4 times since then she feels weak and tired. She is always worried. She expressed feelings of insecurity, always feel anxious about her children because she feels if anything happens to her who will look after her children. When asked whether she goes to doctor she says, money which I get has to be handed over to my brother in law for the family expenditure, no one will spend money for my health to doctor she cannot take decision to go to doctor though she is sick.

Education is landmark of women empowerment because it enables them to respond to the challenges, to tackle their traditional role and change their life. So that we can't neglect the importance of education in reference to women empowerment in recent years. Education of women is the most powerful tool to change the position in society. Women education in India has been a need of the hour, as education is a foundation stone for the empowerment of woman. Education also brings a reduction in inequalities and functions as a means of improving their status within the family and develops the concept of participation.

Child marriage in India has been practiced for centuries, with children married off before their physical and mental maturity. The problem of child marriage in India remains rooted in a complex milieu of religious traditions, social practices, economic factors and deeply rooted prejudices. Regardless of its roots, child marriage constitutes a gross violation of human rights, leaving physical, psychological and emotional stress in life. Sexual activity starts soon after marriage, and pregnancy and childbirth at an early age can lead to maternal as well as infant mortality.

In this case investigator has observed, women are usually not included in decision making and are socially and economically dependent on men and head of the family. This affect their emotional life and decision making in the family. The younger women, besides all these, have to carry the burden of early pregnancy, childbirth and breast-feeding. In terms of help offered to people for their various functions women seem to receive the least attention from the society. Limited opportunities to obtain education and information for women is a hurdle to affect their ability to participate and well-versed role in the family and in the society.

Cultural beliefs and practices related to treatment:

Culture affects the group's norms of family life, birth, childrearing, aging, as well as their recognition of illness and care-seeking practices related to health or medical conditions. Sometimes these beliefs and practices can facilitate or act as barriers to accessing health care services

Case 2: Mrs. Bhagirathi 28 years old staying at Kolwadi village in Junner tehsil .She got married at 20 years of age. She studied up to 10th standard . Her husband studied up to 5thstandard due to poor economic condition. His father died when he was 3 years old, so mother was only earning member to bring up her children. He also started earning when he was 14 years old. When he got married with Bhagirathi , he was 30 years old. They had 10 years of age difference. He used to always listen to his mother. After 5 years of their married life, they got separated. Bhagirathi told “I have poor financial condition as my husband is separated from me. I am helpless about my present life due to separation. I have to work hard to support my family as we are need money and can't afford anything in life. If we do not have money how I can go to doctor if doctor is far away and I need money for transport so though I am sick and feel like going to doctor and get treated ,I cannot not take treatment, I try home remedies or go to “Vaidu” who is nearby to my house” .She told after her 2nd delivery which was conducted by her neighbour that time she suffered a lot .She had

severe pain in abdomen and also white discharge .When she told this to her husband and mother in law they said to go to nearby “Vaidu” and get treated. She had high fever after Vaidu’s treatment , she was sick and was in bed for longer time. When her condition got worsened they sent her to parents home. She got treatment in primary health centre and became alright.

Case 3: Mrs.Radha from Chinchawali, tehsil Ambegaon, She had taken primary education studied up to 4th standard. She told “because of unemployment of my husband, I cannot take my children to doctor though they are sick. If I face any health problem till I can work I do not go to doctor , all my deliveries were at home nothing happened to me .After my second delivery I had severe menstrual bleeding still I did not pay attention since this is common to all women. Many a times I do not get sleep at night. I often get backache; headaches, body aches, abdominal pains and giddiness. I am fed up with everything. I feel weak”. Investigator discussed the problem and severity of it, if treatment is not taken in time there can be complications. Though women consider menstrual problems very common and natural but they should be made aware of its complications if not treated in time.

In rural area due to lack of transport facility, ignorance related to health matters ,common practice of home remedies and going for illegal practices like taking treatment from Vaidu or quacks are very common. Since they have these kind of practices when their health status deviate from normal and they try wrong remedial measures, complications arise which increases the morbidity rate and mortality of the women.

Female foeticide and gender inequality:

Case 4: Mrs. Kanta living at Dewale village, tehsil Mawal .She is staying in joint family with her in laws , husband, 3 children and one brother in law. Her husband is a farmer. They have poultry as side business. Income is around 60-70,000/- per annum. She also helps in poultry farm. Mrs. Kanta gave birth to 3 female babies. Her mother in law and husband wanted a baby boy. She told about the unhappiness expressed by her in-laws and husband after giving birth to a girl child, said ,“my mother-in-law is not happy with me and baby, as they wanted a son so they harassed, insulted, scolded and hurt me. They were unhappy with my three daughters and did not treat us well.” The review of the status of women in India tells the a fall in the status of women to an awfully low position from a relatively high status and dignity of the Vedic times. The fall in status has led to a socio-economic and religio-cultural deprivation of women.

From the womb to tomb women are victims of violence and deprivations. The vulnerability of women in rural India is worse. In India, girls are discriminated against because they are seen as a financial burden. Because men often work outside the home and make more than women, male children are more highly valued. Despite the illegality of dowry practices – gifts from the bride's family given to the groom's family at the time of marriage – the cultural practice continues. This increases gender bias. Infant mortality rates are higher among girls due to discriminatory childcare practices. Gender preferred abortions, while illegal, are widely practiced to prevent the birth of female babies. Feticide otherwise known as female infanticide is, "the illegal termination of a female form when it is detected to be growing inside the womb, (which) results in declining sex ratio." India's 2001 census revealed an imbalanced sex ratio among children in India. Similar practices are common in China for the same reasons.

Mrs. Asha, expressed inability to make personal, family or household decisions due to spouse dominance, superiority and power exerted to control wife's mobility, behaviors and contraceptive choices. She also expressed fear, anxiety, depression and nervousness of becoming a mother due to the pressure of a son and non-acceptance of a girl child. She experienced strained relationship and stress with the husband and mother-in-law. She also said, "I do not get support from my husband." Gender is one of many social determinants of health which include social, economic, and political factors that play a major role in the health outcomes of women in India. Therefore, the high level of gender inequality in India negatively impacts the health of women. Gender divisions within society also affect health through less visible biosocial processes, whereby girls' and women's lower social status and lack of control over resources exposes them to health risks.

The feminist studies and studies of reproductive health are necessary to view the social world from women's perspective as reproductive health problems have risen to become a public health problem. There is a need to focus on the health aspects of women with special reference to reproductive health in stressed communities and examine a cycle of revolving factors. Hence it is necessary to gain insights into women's perceptions regarding their reproductive health and well-being in the context of their present situation and circumstances. Sociological Views of Reproductive Well-being among Women The increasing burden placed on healthcare resources in developing countries by rapidly growing populations and poor reproductive health

was officially recognized at the Cairo International Conference on Population and Development in 1994. Since then the concept of reproductive health has taken a central place in the women's developmental studies (Hutter, Ramesh and Willekens 2000: 34-56).

Culture of silence:

Case 5: Mrs.Shanta from Kalewadi, tehsil Indapur. They are from a large joint family 24 members in her house. Father and mother in law , 3 brother in laws, with their wives and two of them have 4 children each and one has 3 children, Shanta's family have four children ,three daughters and one son They live in a 4 rooms , there is water and toilet facilities . Hygiene and cleanliness is well maintained. Her mother in-law is very fond of cleanliness. they do a farming and cattle rearing .Father in law was working as a labourer .but his two sons are very much hard workers and they bought the farm and started cattle rearing. Their wives are also helping them in their farm. Their family income is between 60,000 to 11lac per annum. All family members depend on the decision of mother in law. Her husband has taken primary education and she is an illiterate .Husband has habit smoking. All the male members in her family dominate their wives, women in the family have no freedom to go out or talk with the neighbours they are very much reserved, her mother in law does not allow them to mix with anyone. Mrs.Shanta told , "I got married when I was 16years old. Immediately I had my first pregnancy .During this period I never went for checkup since there was no female doctor . I was feeling shy to go to male doctor. I had to work in the house as well as in farm . Meanwhile I had three abortions and felt very weak. My sister told me to use contraceptives because she faced the same problem. But my family members wanted "Vansshacha Diva" so I did not use contraceptives .I was feeling giddy most of the time ,once I fell down while working in the farm ,that time my neighbor took me to doctor, that was the first time I went to doctor when I had problem. Doctor said my Haemoglobin level is less due to repeated abortions and also immunity is less, need to take treatment before next pregnancy. Then I realized that I should take care of my own self still my mother in law told me to take some herbal medicine which she used to take when she suffered from reproductive health and told this is common to all women we cannot do anything .It is in our destiny that all women are born with the sufferings and we should face them.

In India women always have "Culture of silence". They feel shy to go to male doctors. They prefer female doctors for their reproductive health problems. Unless

severity of the problem increases and complications arise. Women don't consider the reproductive health as problem they think it is normal and we have to suffer since we are born as females.

Treatment seeking behaviour:

Case 6: Mrs.Dewaki from Kuruli, tehsil Shirur .She says, “If I have any problem other than reproductive health problem I go to doctor .Once I was suffering from fever with chills, backache and was having yellowish vaginal discharge. I tolerated till I can , but I was feeling shy to tell this problem and was thinking how to tell this to doctor .When condition was worsened, I went to female doctor .She advised me that my husband also should come for checkup and both of us should get investigated and start medications at the same time. When I told to my husband, he got angry and said “I don't have problem, I will not come for checkup. If you feel you go alone, problem is not with me but with you. Though I took treatment repeatedly I was getting such type of illness ”.When the condition was explained by an investigator to her husband and importance of treatment at a time for both of them together is must her husband started treatment and both of them got cured. So counselling to both the partners in treating reproductive tract infections is of vital importance.

Indian women have low levels of both education and formal labor-force participation. They typically have little autonomy, living first under the control of their fathers, then their husbands, and finally their sons. These factors have a negative impact on the health status of Indian women. Poor health has repercussions not only for women, but also their families. Women in poor health are more likely to give birth to low weight infants. They are less likely to be able to provide food and adequate care for their children. Finally, a woman's health affects the household's economic wellbeing because a woman in poor health will be less productive in the labor force. In rural areas where women are less educated and economically deprived, their health condition is worse. In the context of health as defined by WHO – “A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” One must think how this can be achieved for Indian women.

If we observe the cases discussed above, investigator felt that women's health issues should be discussed and women should be made aware of their own health especially reproductive health matters where social determinants play an important role. Keeping this interdisciplinary context into consideration investigator used the interdisciplinary approach in the present study.

CHAPTER V

ANALYSIS AND INTERPRETATION OF DATA

This chapter presents the analysis and interpretation of data collected “To assess the effect of health education programme on knowledge and practices related to common selected reproductive tract infections among the married women in rural area of Pune district.” The data was analyzed according to the objectives of study, which were:

- To assess the knowledge of the married women related to common selected reproductive tract infections.
- To assess the practices of the married women related to common selected reproductive tract infections.
- To assess the effect of health education programme on knowledge and practices of the women related to common selected reproductive tract infections.
- To correlate the knowledge of the married women with their practices.
- To find the association between knowledge and practices regarding common selected reproductive tract infections with selected demographic variables.

Kerlinger defined analysis as the “categories ordering, manipulating and summarizing of data to obtain answers to research questions”. The purpose of analysis is to reduce data to intelligible and interpretable form so that the relation of research problem can be studied and tested.

The analysis is described in following sections:

SECTION I - Demographic characteristics of the married women residing at rural area of Pune district

SECTION II - Analysis of data in detail among the control and experimental groups regarding reproductive tract infections (Item-wise increase in level of the knowledge of pre test & post-test between both groups regarding reproductive tract infections)

SECTION III - Analysis of data to assess the effect of health education on knowledge scores of the women related to the common selected reproductive tract infections.

- Knowledge grades in pre-test and post-test scores.
- Comparison of average pre-test and post-test knowledge scores(Paired t -test for effectiveness)
- Comparison of knowledge of experimental and control group:(Two sample

z-test)

SECTION IV – An analysis of data related to the effect of health education on the practice scores.

- Practice grades in pre-test and post-test scores.
- Comparison of average pre-test and post-test practice scores (Paired t -test effectiveness).
- Comparison of practices of experimental and control group: (Two sample z-test).

SECTION V - An analysis of data related to correlation between knowledge and practices regarding reproductive tract infections (Pearson correlation coefficient test)

SECTION VI - An analysis of data to find association between knowledge and selected demographic variables i.e. age, age at marriage, education of self and husband, occupation of self and husband, monthly family income, type of family, place of delivery and participation of the partner.(ANOVA test)

SECTION VII - An Analysis of data to find association between practices with selected demographic variables i.e. age, age at marriage, education of self and husband, occupation of self and husband, monthly family income, type of family ,place of delivery and participation of the partner. (ANOVA test)

SECTION I: Description of sample characteristics along with demographic data

The sample was drawn from married women between 15 to 49 years who are residing at rural area of Pune District, selected by multistage proportionate sampling technique. The demographic data obtained was their age, age at marriage, education of self and husband, occupation of self and husband, monthly family income, menstrual data, gynecological and obstetrical data, contraceptive, sexual data, past medical history and partner participation.

Frequency and percentage distribution of the women by their demographic characteristics are presented in Table 1A.

SECTION I

TABLE 1A: Demographic description of the women by frequency and percentage

N=605, 605.

Demographic variable	Experimental		Control	
	Freq.	%	Freq.	%
Age				
15-20 yrs	11	1.8%	25	4.1%
21-25 yrs	103	17.0%	116	19.2%
26-30 yrs	143	23.6%	141	23.3%
31-35 yrs	133	22.0%	125	20.7%
36-40 yrs	104	17.2%	85	14.0%
41-45 yrs	70	11.6%	71	11.7%
46-49 yrs	41	6.8%	42	6.9%
Age at marriage				
less than 18 yrs	125	20.7%	120	19.8%
18-22 yrs	469	77.5%	477	78.8%
23-27 yrs	6	1.0%	5	0.8%
28-32 yrs	5	0.8%	3	0.5%
Religion				
Christian	6	1.0%	10	1.7%
Hindu	545	90.2%	546	90.2%
Muslim	54	8.9%	49	8.1%
Marital status				
Divorced	12	2.0%	12	2.0%
Married	578	95.5%	566	93.6%
Separated	4	0.7%	10	1.7%
Widow	11	1.8%	17	2.8%

In experimental group, maximum 23.6% of them were from age group 26-30 years, 22% of them were from age group 31-35 years, 17.2% of them were from age group 36-40 years, 17.0% of them were from group 21-25 years, 11.6% of them were from age group 41-45 years, 6.8% of them were from age group 46-49 years and remaining 1.8% of the women were from age group 15-20 years. In control group also maximum 23.3% of them were from age group 26-30 years, 20.7% of them were from age group 31-35 years, 19.2% of them were from group 21-25 years, 14% of them were from age group 36-40 years, 11.7% of them were from age group 41-45 years and remaining 6.9% of them were from age group 46-49 years, only 4.1% of the women were from age group 15-20 years,

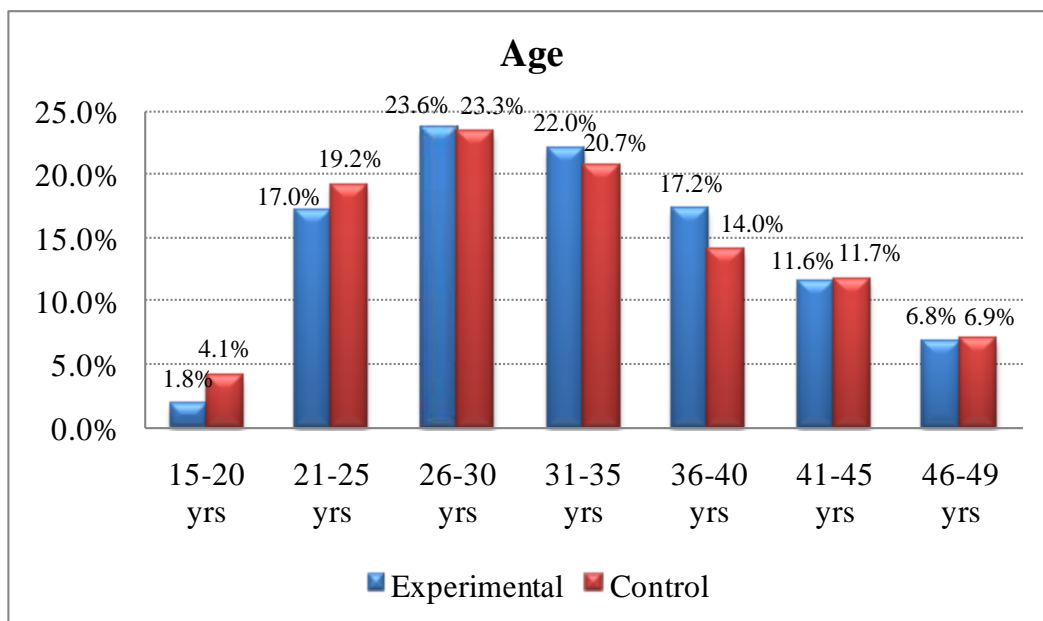


Figure No. 5: Distribution of women in both the groups according to age.

In experimental group majority, 77.5% of them were 18-22 years at marriage, 20.7% of them were less than 18 years, 1% of them were 23-27 years and only 0.8% of them were 28-32 years at marriage. In control group, 78.8% of them were 18-22 years, 19.8% of them were less than 18 years at marriage, 0.8% of them were 23-27 years and only 0.5% of them were 28-32 years at marriage.

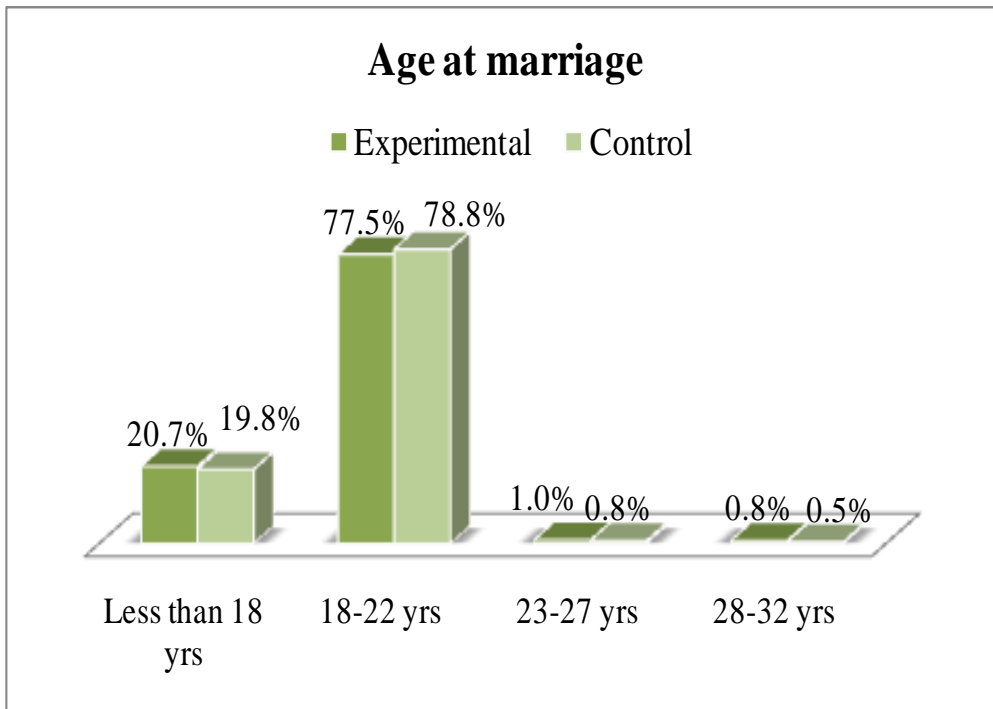


Figure No. 6: Distribution of women in both the groups according to age at marriage.

In experimental group, majority of 90.2% of them were Hindu, 8.9% of them were Muslim and 1% of them were Christian. In control group, majority of 90.2% of them were Hindu, 8.1% of them were Muslim and 1.7% of them were Christian.

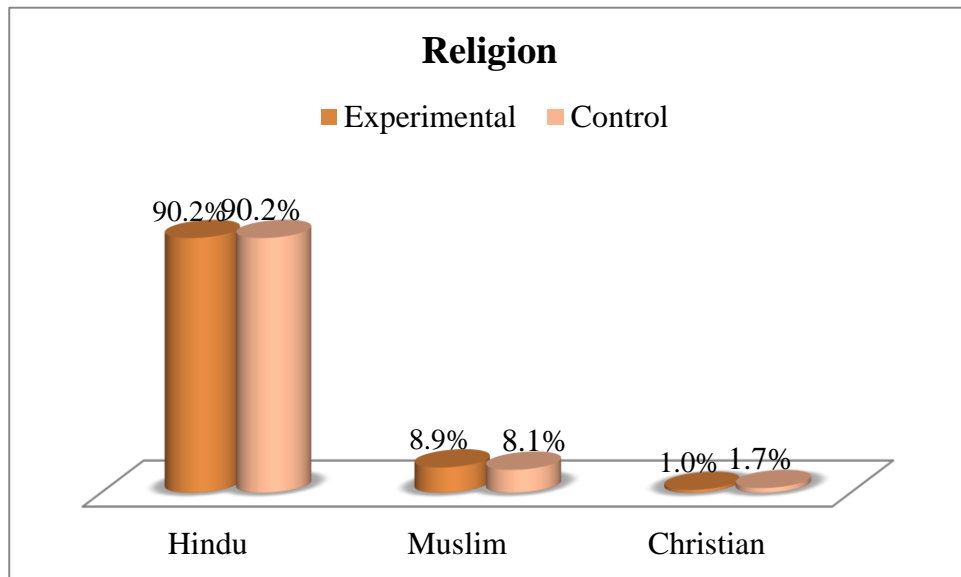


Figure No. 7: Distribution of women in both the groups according to religion.

In experimental group, majority of 95.5% of them were married, 2% of them were divorced, 1.8% of them were widow and 0.7% of them were separated. In control group, majority of 93.6% of them were married, 2.8% of them were widow, 2% of them were divorced, and 1.7% of were separated.

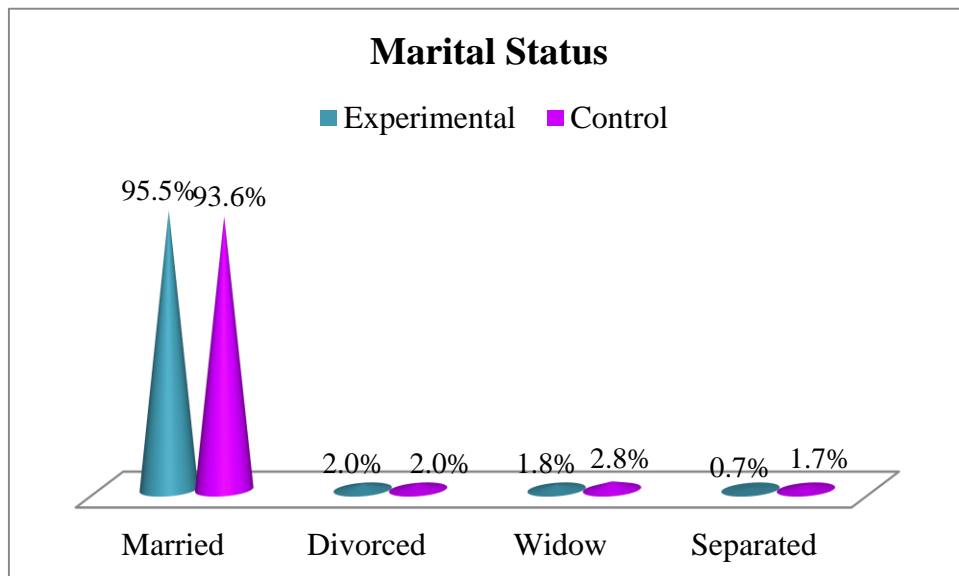


Figure No. 8: Distribution of women in both the groups according to marital status

TABLE 1B: Demographic description of the women by frequency and percentage

N=605, 605.

Demographic variable	Experimental		Control	
	Freq	%	Freq	%
Self education				
Illiterate	170	28.1%	151	25.0%
Primary	271	44.8%	267	44.1%
Secondary	101	16.7%	101	16.7%
Higher secondary	33	5.5%	44	7.3%
Graduate	22	3.6%	28	4.6%
Other	8	1.3%	14	2.3%
Husband education				
Illiterate	79	13.1%	73	12.1%
Primary	185	30.6%	159	26.3%
Secondary	207	34.2%	207	34.2%
Higher secondary	73	12.1%	85	14.0%
Graduation	47	7.8%	55	9.1%
Postgraduate	6	1.0%	8	1.3%
Other	8	1.3%	18	3.0%
Self occupation				
Business	33	5.5%	15	2.5%
Cattle rearing	53	8.8%	56	9.3%
Farming	111	18.3%	115	19.0%
Housewife	278	46.0%	266	44.0%
Labourer	57	9.4%	50	8.3%
Poultry	50	8.3%	39	6.4%
Service	23	3.8%	64	10.6%
Husband occupation				
Business	64	10.6%	38	6.3%
Cattle rearing	55	9.1%	49	8.1%
Company	44	7.3%	43	7.1%
Farmer	233	38.5%	222	36.7%
Labourer	62	10.2%	56	9.3%
Others	26	4.3%	19	3.1%
Poultry	19	3.1%	27	4.5%
Service	102	16.9%	151	25.0%
Stay Outstation				
No	499	82.5%	491	81.2%
Yes	106	17.5%	114	18.8%

In experimental group, majority 44.8% of them had primary education, 28.1% of them were illiterate, 16.7% of them had secondary education, 5.5% of them had higher secondary education, 3.6% of them were graduates and 1.3% of them had some other education. In control group also majority 44.1% of them had primary education, 25% of them were illiterate, 16.7% of them had secondary education, 7.3% of them had higher secondary education, 4.6% of them were graduates and 2.3% of them had some other education.

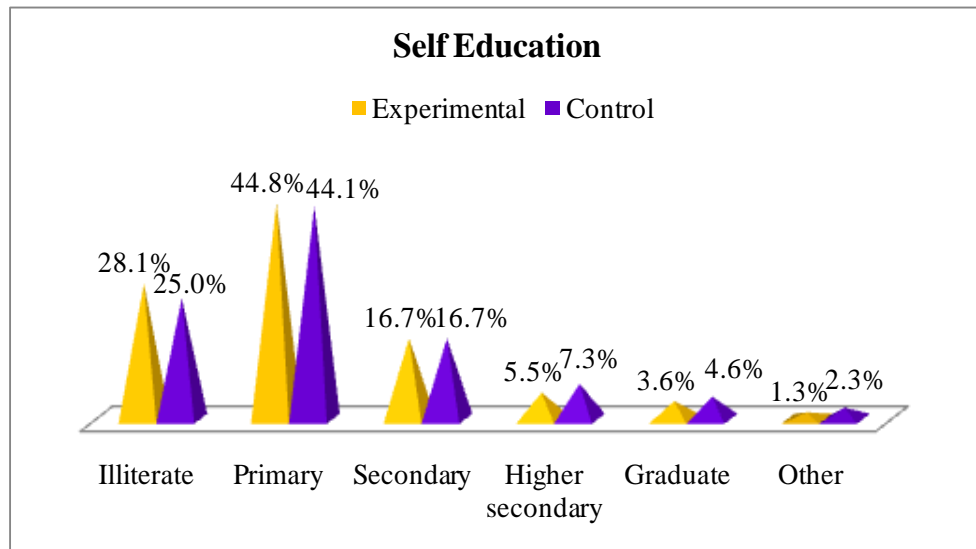


Figure No. 9: Distribution of women in both the groups according to the self education

In experimental group, majority 34.2% of their husbands had secondary education, 30.6% of their husbands had primary education, 13.1% of the women had illiterate husbands, 12.1% of them had higher secondary education, 7.8% of them had graduation, 1.3% of them had some other education and 1% of them had post graduation. In control group also majority 34.2% of them had secondary education, 26.3% of their husbands had primary education, 14% of them had higher secondary education 12.1% of the women had illiterate husbands, 9.1% of them had graduation, 3% of them had some other education and 1.3% of them had post graduation .

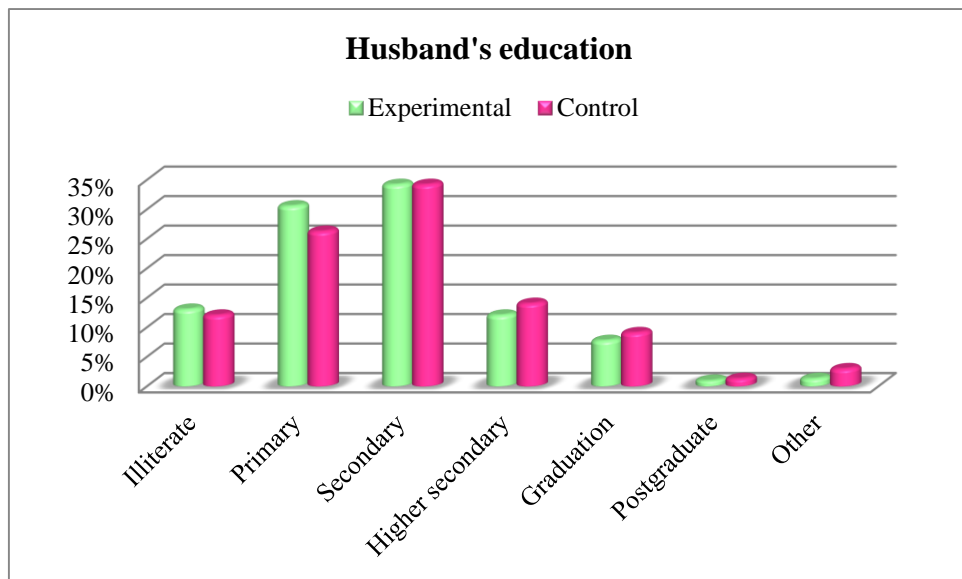


Figure No. 10: Distribution of women in both the groups according to their husband's education.

In experimental group, majority 46% of them were housewives, 18.3% of them were farming, 9.4% of them were labourers, 8.8% of them were rearing cattle , 8.3% had poultry ,5.5% of them had business, and 3.8% of them were doing service. In control group also, 44% of them were housewives, 19% of them were farming, 10.6% of them were doing service, 9.3% of them were rearing cattle, 8.3% of them were labourers, 6.4% had poultry and 2.5% of them had business.

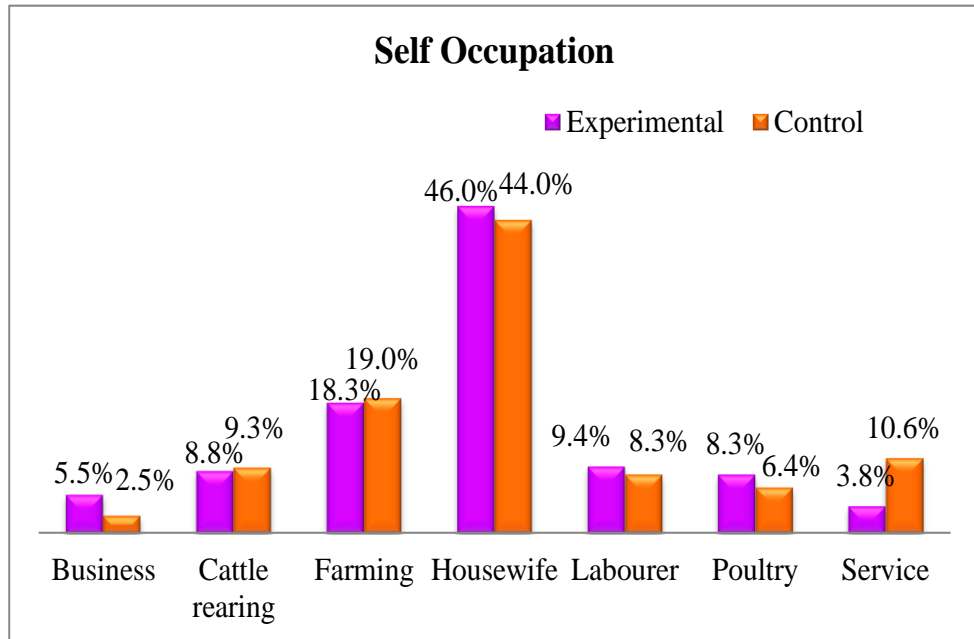


Figure No. 11: Distribution of women in both the groups according to their occupation

In experimental group, majority 38.5% of them were farmers, 16.9% of them were doing service ,10.6% of them had their husbnads doing business, 10.2% of them were labourers 9.1% of their husbands were rearing cattle, 7.3% of them were working in company, 4.3% of them had some other occupation and 3.1% of them had poultry. In control group majority 36.7% of them were farmers , 25% of them were doing service, 9.3% of them were labourers, 8.1% of their husbands were rearing cattle, 7.1% of them were working in company,6.3% of them had their husbnads doing business, 4.5% of them had poultry and 3.1% of them had some other occupation.

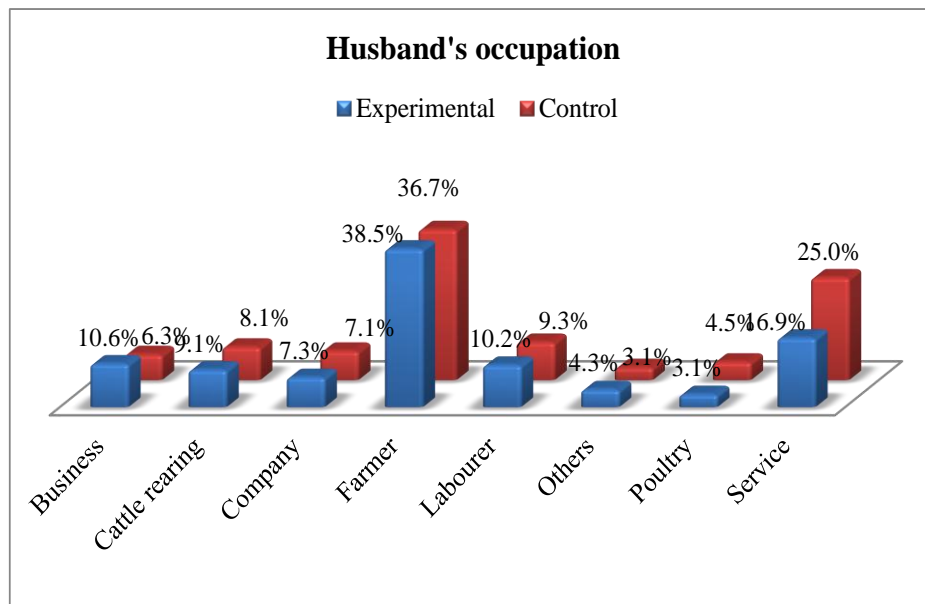


Figure No. 12: Distribution of women in both the groups according to their husband's occupation

In experimental group, only 17.5% of the women had their husbands staying outstation and in control group 18.8% of them had their husbands staying outstation.

TABLE 1C: Demographic description of the women by frequency and percentage

N=605, 605.

Demographic variable	Experimental		Control	
	Freq	%	Freq	%
Monthly family income				
Less than Rs. 5000	77	12.7%	84	13.9%
Rs. 5001-10,000	263	43.5%	241	39.8%
Rs. 10,001-15,000	182	30.1%	161	26.6%
Rs. 15,001-20,000	42	6.9%	64	10.6%
Above Rs. 20,000	41	6.8%	55	9.1%
Type of family				
Joint	463	76.5%	473	78.2%
Nuclear	121	20.0%	106	17.5%
Separated	21	3.5%	26	4.3%
Menstrual pattern				
Irregular	389	64.3%	388	64.1%
Regular	216	35.7%	217	35.9%
Duration of bleeding				
<4 days	41	6.8%	57	9.4%
4-6 days	524	86.6%	477	78.8%
> 6 days	40	6.6%	71	11.7%

In experimental group, majority 43.5% of them had income Rs. 5,001-10,000, 30.1% of them had family income Rs. 10,001-15,000, 12.7% of them had family income less than Rs. 5,000, 6.9% of them had income Rs. 15,001-20,000 and 6.8% of them had income above Rs. 20,000. In control group also majority, 39.8% of them had income Rs. 5001-10,000, 26.6% of them had family income Rs. 10,001-15,000, 13.9% of them had family income less than Rs. 5000, 10.6% of them had income Rs. 15,001-20,000 and 9.1% of them had income above Rs. 20,000.

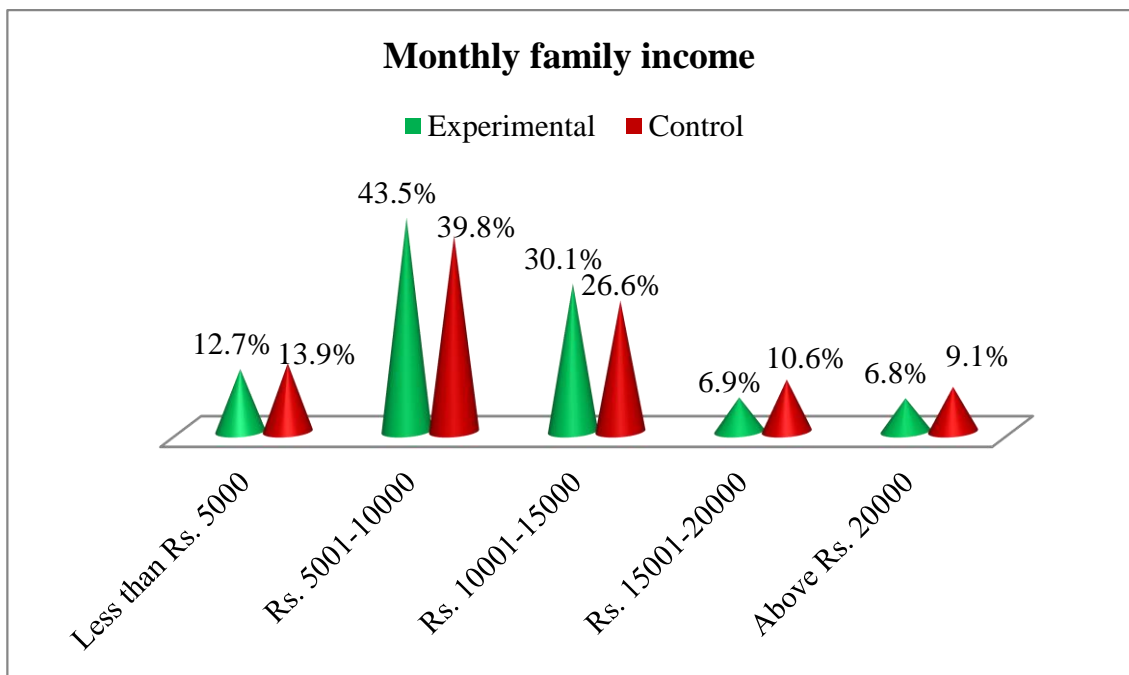


Figure No. 13: Distribution of women in both the groups according to monthly family income.

In experimental group, 76.5% of them had joint family, 20% of them had nuclear family and 3.5% of them were separated. In control group, 78.2% of them had joint family, 17.5% of them had nuclear family and 4.3% of them were separated.

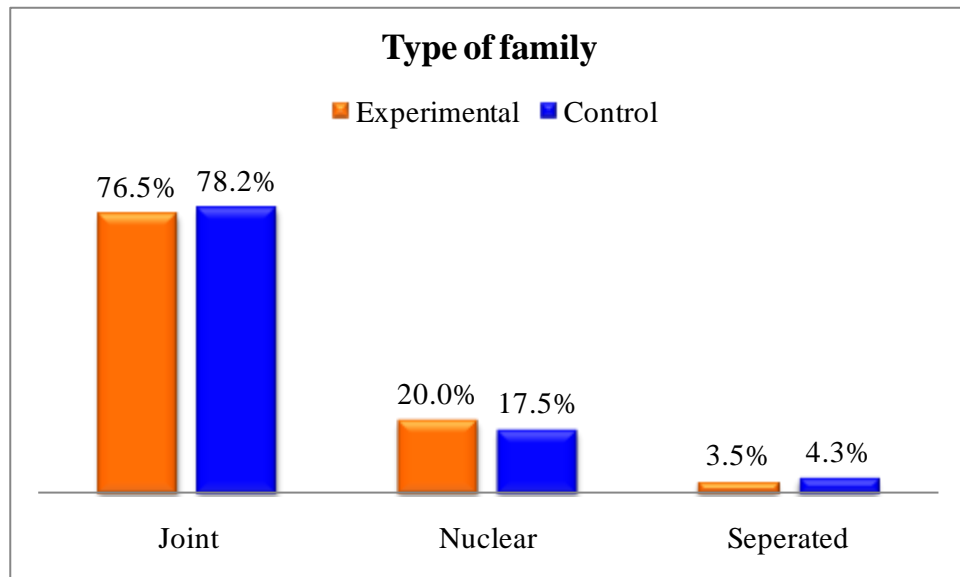


Figure No. 14: Distribution of women in both the groups according to type of family.

In experimental group, 64.3% of them had irregular menstrual pattern and 35.7% of them had regular menstrual pattern. In control group, 64.1% of them had irregular menstrual pattern and 35.9% of them had regular menstrual pattern.

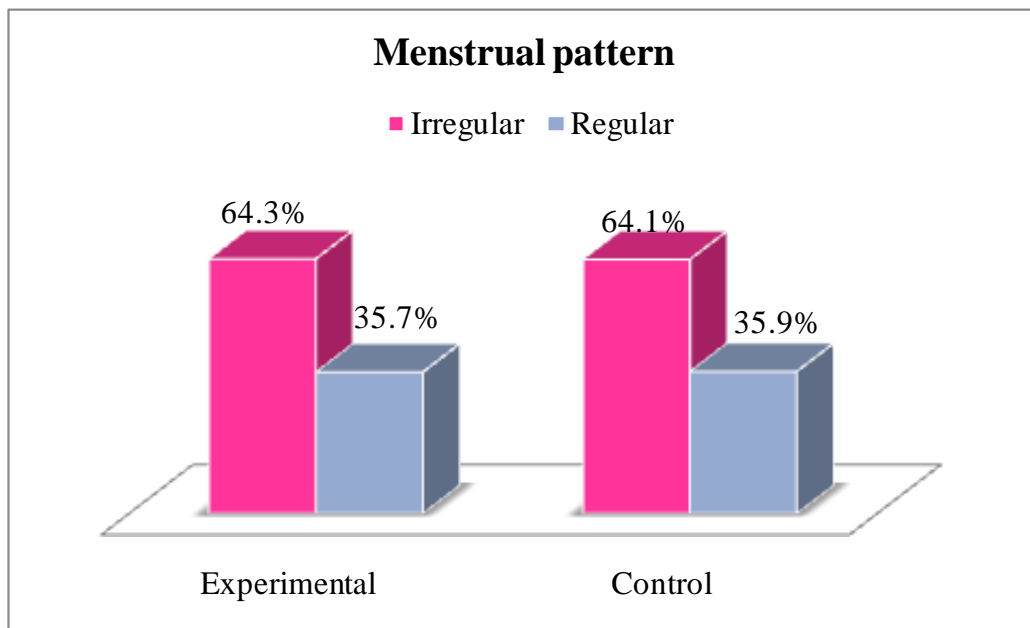


Figure No. 15: Distribution of women in both the groups according to the menstrual pattern.

Maximum 86.6% in experimental group, and 78.8% in control group had bleeding for 4-6 days, 6.8% of them had bleeding for less than 4 days, and 6.6% of them had bleeding for more than 6 days. In control group, 11.7% of them had bleeding for more than 6 days and 9.4% of them had bleeding for less than 4 days.

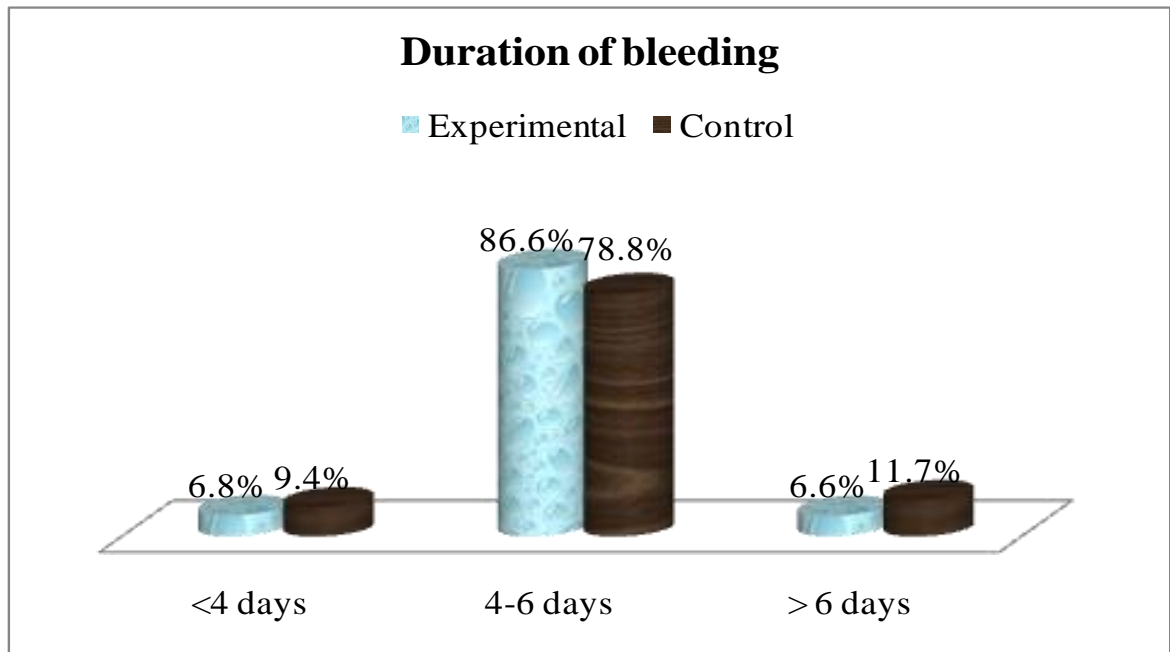


Figure No. 15 A: Distribution of women in both the groups according to the menstrual pattern (duration of bleeding).

**TABLE- 1D: Demographic description of the women
by frequency and percentage**

N=605, 605.

Demographic variable	Experimental		Control	
	Freq	%	Freq	%
Type of menstrual flow				
Scanty	41	6.8%	57	9.4%
Normal	524	86.6%	477	78.8%
Heavy	40	6.6%	71	11.7%
Menstrual problems				
Backache	30	5.0%	37	6.1%
Clots	9	1.5%	37	6.1%
Delayed	6	1.0%	0	0.0%
Menorrhagia -excess bleeding	40	6.6%	70	11.6%
No problem	202	33.4%	162	26.8%
Painful period	318	52.6%	299	49.4%

Majority 86.6% and 78.8% of them had normal flow respectively in experimental and control groups, 6.8% of them had scanty flow, and 6.6% of them had heavy flow in experimental group. In control group, 11.7% of them had heavy flow and 9.4% of them had scanty flow.

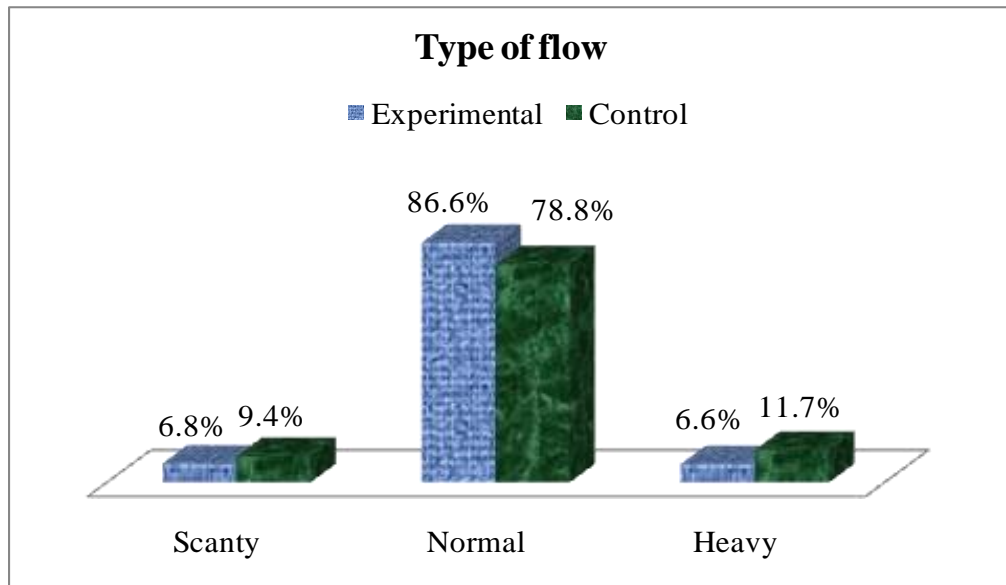


Figure No. 15 B: Distribution of women in both the groups according to the type of menstrual flow.

In experimental group, majority 52.6% of them had painful period ,33.4% of them had no menstrual problem, 6.6% of them had menorrhagia-excess bleeding, 5% of them had backache, 1.5% of them had clots and 1% of them had delayed menstruation, In control group also majority 49.4% of them had painful period , 26.8% of them had no menstrual problem , 11.6% of them had menorrhagia-i.e.excess bleeding ,6.1% of them had backache and 6.1% of them had clots.

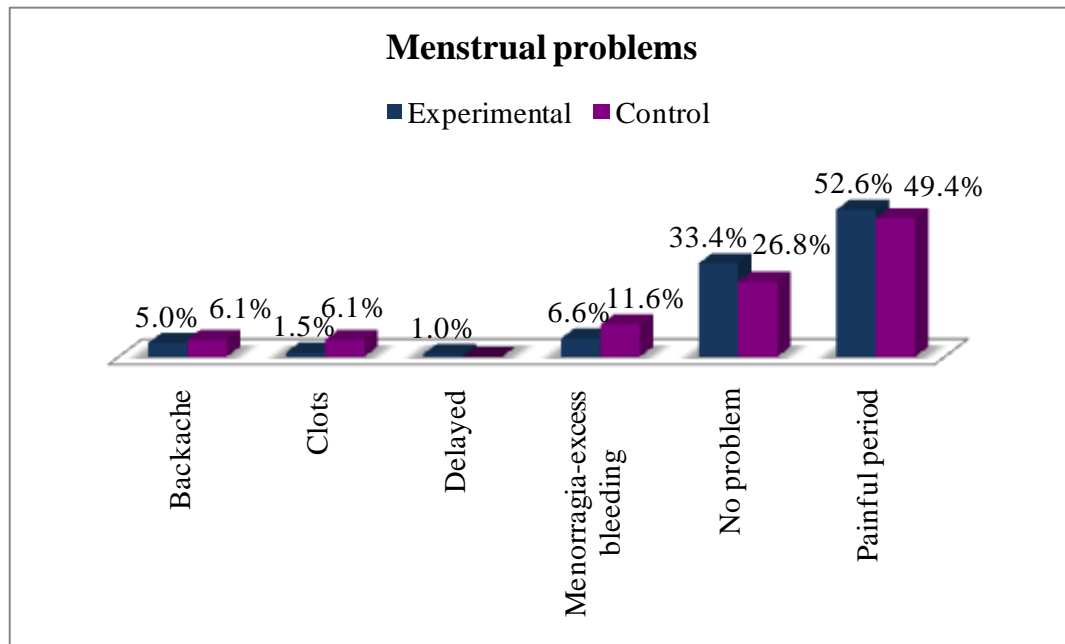


Figure No. 15 C: Distribution of women in both the groups according to the menstrual problems.

**TABLE -1E: Demographic description of the women
by frequency and percentage**

N=605, 605.

Gynecological Problems	Exp		Control	
	Freq	%	Freq	%
No problem	393	65.0%	391	64.6%
Problems	212	35.0%	214	35.4%

In experimental group, 35% of the women had gynecological problems. In control group, 35.4% of them had gynecological problems.

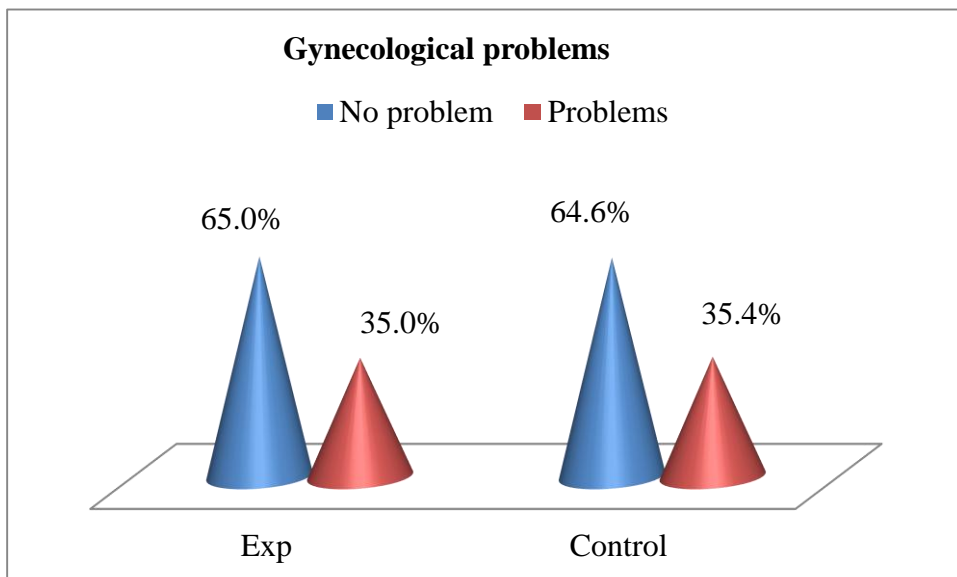


Figure No. 16: Distribution of women in both the groups according to the Gynecological problems.

TABLE- 1F: Demographic description of the women by frequency and percentage

N=605, 605.

Gynecological Problems	Exp		Control	
	Freq	%	Freq	%
No problem	393	65.0%	391	64.6%
White discharge	107	17.7%	104	17.2%
Itching	19	3.1%	22	3.6%
White discharge, itching	16	2.6%	8	1.3%
Swelling/lump in breast	14	2.3%	15	2.5%
Involuntary escape of urine while coughing/sneezing	11	1.8%	15	2.5%
Itching, swelling/lump in breast	8	1.3%	8	1.3%
Swelling/lump in breast, genital ulcers	5	0.8%	5	0.8%
Itching, swelling/lump in breast, genital ulcers	4	0.7%	3	0.5%
Some mass coming out of vagina	4	0.7%	7	1.2%
White discharge, involuntary escape of urine while coughing/sneezing	4	0.7%	6	1.0%
Genital ulcers	3	0.5%	6	1.0%
White discharge, genital ulcers	3	0.5%	1	0.2%
White discharge, swelling/lump in breast	3	0.5%	4	0.7%
Itching, genital ulcers	2	0.3%	3	0.5%
Swelling/lump in breast, involuntary escape of urine while coughing/sneezing	2	0.3%	0	0.0%
White discharge, itching, genital ulcer, some mass coming out of vagina	2	0.3%	0	0.0%
Some mass coming out of vagina, involuntary escape of urine while coughing/sneezing	1	0.2%	0	0.0%
Swelling/lump in breast, genital ulcers, involuntary escape of urine while coughing/sneezing	1	0.2%	0	0.0%
White discharge, some mass coming out of vagina	1	0.2%	3	0.5%
White discharge, clots	1	0.2%	0	0.0%
White discharge, itching, genital ulcer	1	0.2%	0	0.0%
White discharge, itching, involuntary escape of urine while coughing/sneezing	0	0.0%	2	0.3%
White discharge, itching, some mass coming out of vagina	0	0.0%	1	0.2%
White discharge, itching, genital ulcer, involuntary escape of urine while coughing/sneezing	0	0.0%	1	0.2%

TABLE- 1G: Demographic description of the women by frequency and percentage

N=605, 605.

Demographic variable	Experimental		Control	
	Freq	%	Freq	%
Parity				
0	35	5.8%	38	6.3%
1	54	8.9%	43	7.1%
2	281	46.4%	294	48.6%
3	174	28.8%	178	29.4%
4	60	9.9%	50	8.3%
5	1	0.2%	2	0.3%
Abortion				
0	338	55.9%	342	56.5%
1	206	34.0%	211	34.9%
2	57	9.4%	51	8.4%
3	4	0.7%	1	0.2%
Type of delivery				
Abnormal	22	3.6%	43	7.1%
Both	33	5.5%	16	2.6%
Nil	35	5.8%	38	6.3%
Normal	515	85.1%	508	84.0%
Place of delivery				
Home	146	24.1%	105	17.4%
Hospital	348	57.5%	392	64.8%
Both	76	12.6%	70	11.6%
Nil	35	5.8%	38	6.3%
Sexual problems				
Sexual abuse	2	0.3%	3	0.5%
Bleeding	7	1.2%	4	0.7%
Normal	430	71.1%	421	69.6%
Pain during intercourse	156	25.8%	169	27.9%
Pain and bleeding during sexual intercourse	8	1.3%	6	1.0%
Oral Sex	2	0.3%	2	0.3%
Contraceptive methods adopted by wife				
Cu-T	150	24.8%	131	21.7%
No	333	55.0%	327	54.0%
Oral pill	61	10.1%	81	13.4%
Tubectomy	61	10.1%	66	10.9%

In experimental group, majority 46.4% of them were para two, 28.8% of them were para three, 9.9% of them were para 4 , 8.9% of them were single para ,5.8% of them did not have children, and 0.2% of them were para 5. In control group 48.6% of them were para two, 29.4% of them were para three, 8.3% of them had 4 children , 7.1% of them were single para ,6.3% of them did not have children, and 0.3% of them were para 5.

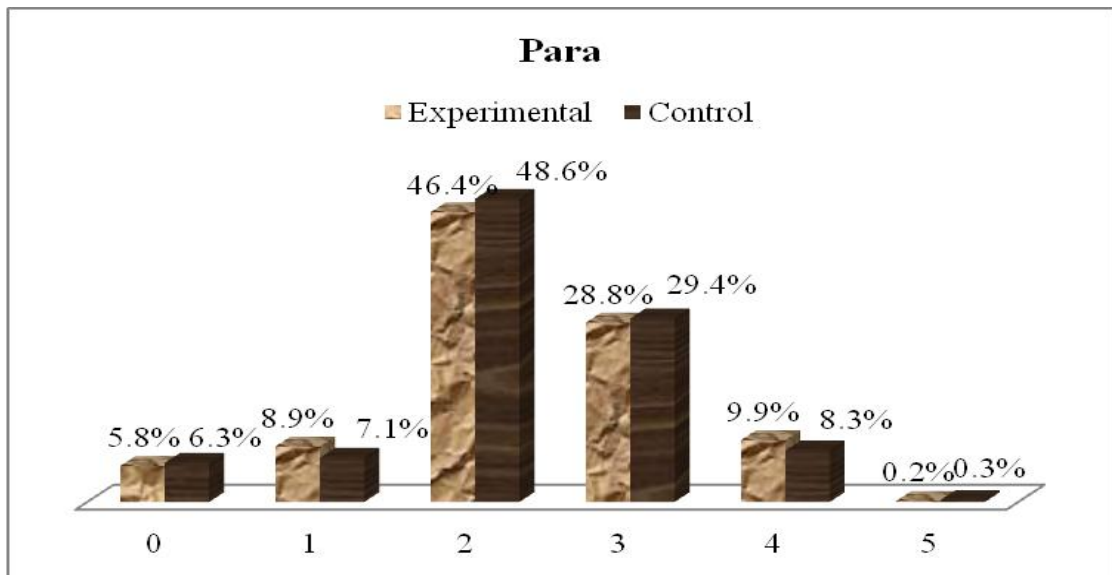


Figure No. 17 A: Distribution of women in both the groups according to parity

In experimental group, 55.9% of them had no abortion, 34% of them had one abortion, 9.4% of them had two abortions and 0.7% of them had three abortions. In control group, 56.5% of them had no abortion, 34.9% of them had one abortion, 8.4% of them had two abortions and 0.2% of them had three abortions

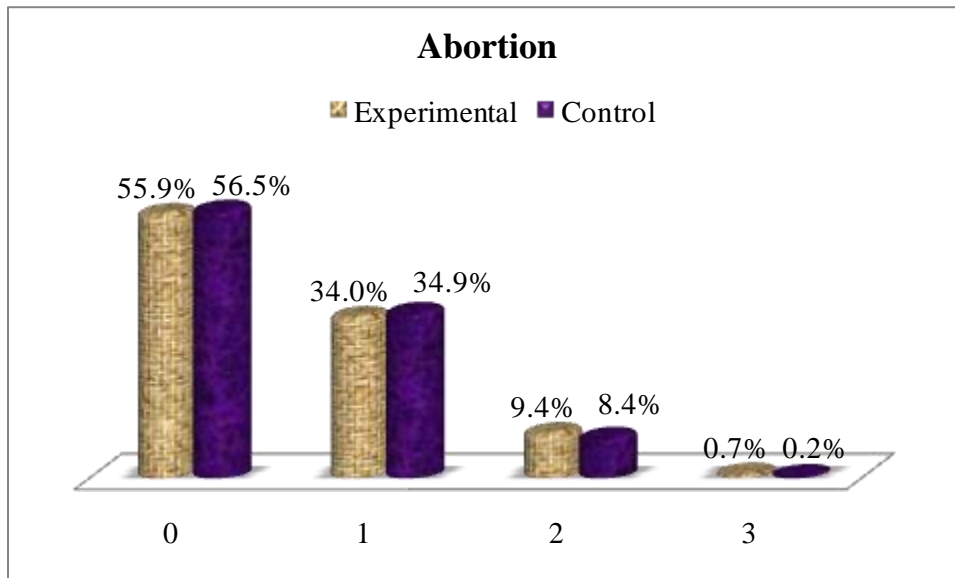


Figure No. 17 B: Distribution of women in both the groups according to number of abortions.

In experimental group majority 85.1% of them had normal deliveries , 5.8% of them had no deliveries, 5.5% of them had both (normal and abnormal) deliveries, and 3.6% of them had abnormal deliveries, In control group majority 84% of them had normal deliveries ,7.1% of them had abnormal deliveries, 6.3% of them had no deliveries, 2.6% of them had both (normal and abnormal) deliveries.

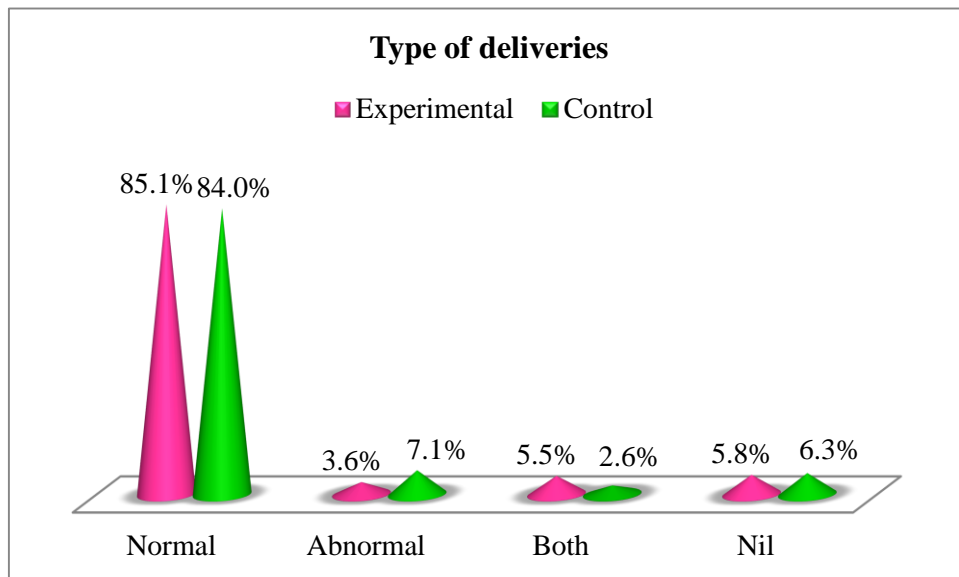


Figure No. 17 C: Distribution of women in both the groups according to type of deliveries.

In experimental group 57.5% of them had deliveries in hospital, 24.1% of them had deliveries at home, 12.6% of them had both deliveries (at home and in hospitals). In control group majority 64.8% of them had deliveries in hospital ,17.4% of them had deliveries at home, , 11.6% of them had both deliveries (at home and in hospitals).

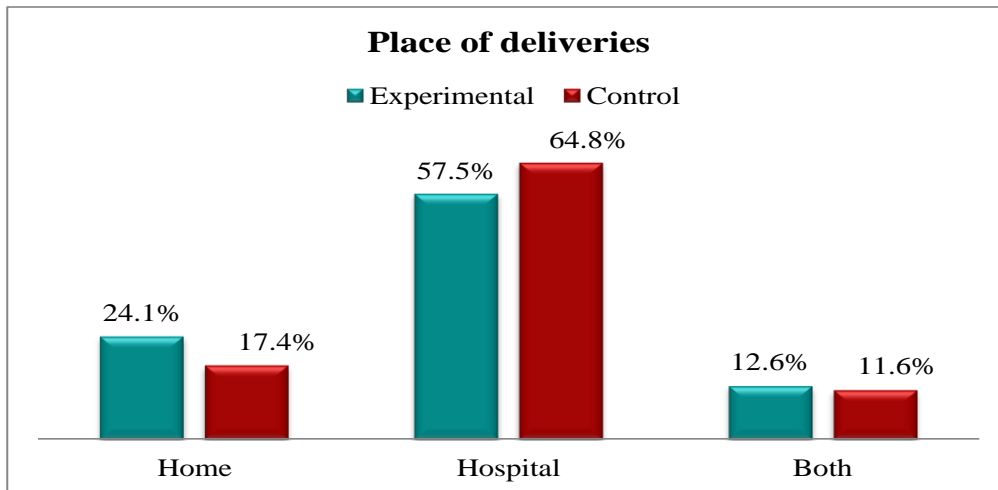


Figure No. 17 D: Distribution of women in both the groups according to the place of delivery.

In experimental group, majority 71.1% of them had normal sex, 25.8% of them had pain during intercourse, 1.3% of them had pain and bleeding during sexual intercourse , 1.2% of them had bleeding during intercourse,0.3% of them had sexual abuse, and 0.3% of them had anal and oral practice. In control group, 69.6% of them had normal sex, 27.9% of them had pain during intercourse , 1% of them had pain and bleeding during sexual intercourse , 0.7% of them had bleeding 0.5% of them had sexual abuse, and 0.3% of them had anal and oral sexual practice.

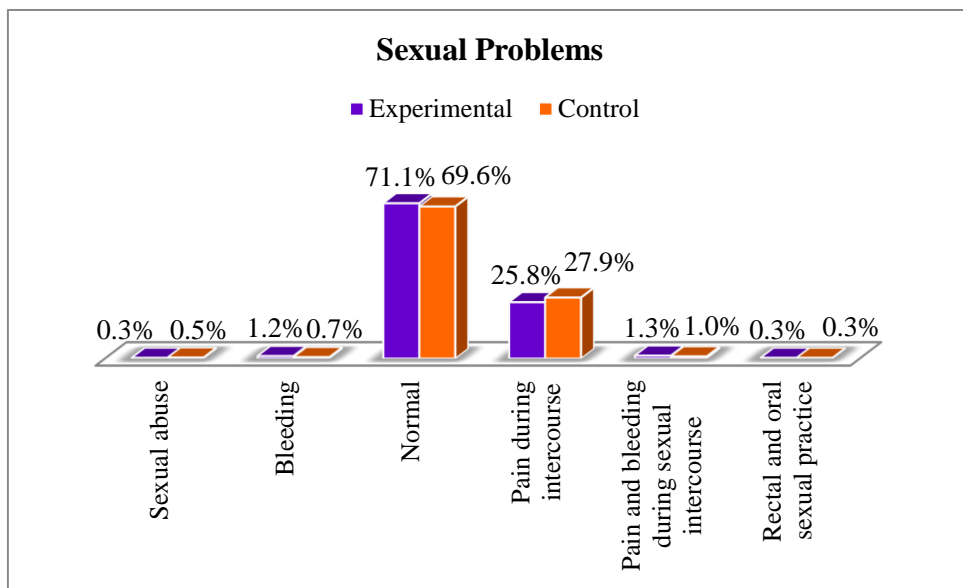


Figure No. 17 E: Distribution of women in both the groups according to sexual problems.

In experimental group, majority of the women 55% and 54% in experimental and in control group respectively were not using any contraceptive method. In experimental group out of those who were using contraceptives, 24.8% of them were using Cu-T, 10.1% of them had oral pill and 10.1% of them had tubectomy done. In control group, out of those who were using contraceptives, 21.7% of them were using Cu-T, 13.4% of them had oral pill and 10.9% of them had tubectomy done.

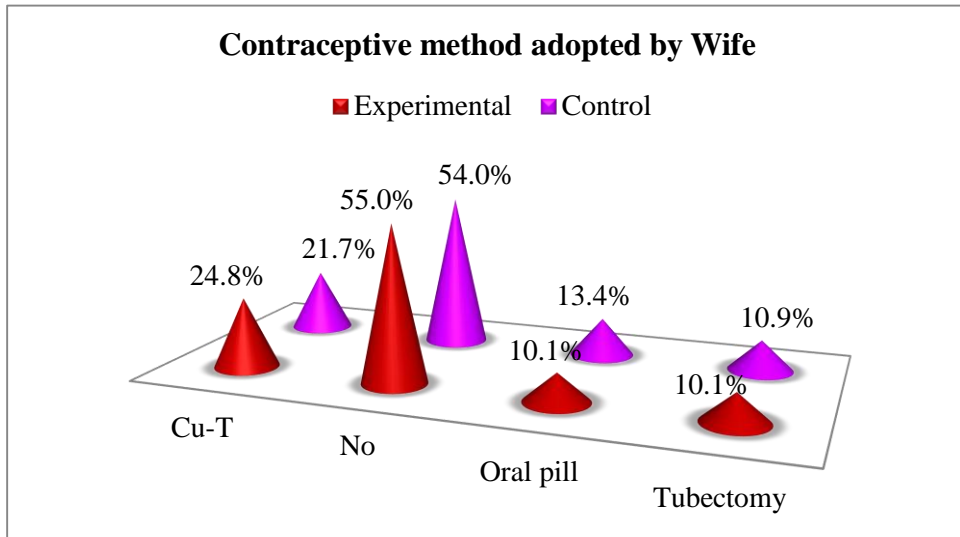


Figure No. 17 F: Distribution of women in both the groups according to contraceptive methods adopted by wife.

TABLE -1H: Demographic description of women regarding perceptions about contraceptives by frequency and percentage

N=605, 605.

Demographic variable	Experimental		Control	
	Freq	%	Freq	%
Perception about contraceptives				
Advice by elder family members	2	0.3%	2	0.3%
Affects in next pregnancy	1	0.2%	2	0.3%
Affects sexual relation	5	0.8%	9	1.5%
Causes abdominal pain	3	0.5%	8	1.3%
Causes bleeding	2	0.3%	5	0.8%
Causes health problems	14	2.3%	16	2.6%
Causes obesity	14	2.3%	11	1.8%
Culture	29	4.8%	36	6.0%
Divorced	3	0.5%	3	0.5%
Nil	494	81.7%	474	78.3%
Due to age	1	0.2%	0	0.0%
More bleeding during menses	1	0.2%	0	0.0%
Want to have a baby	34	5.6%	34	5.6%
Widow	2	0.3%	5	0.8%

Majority of the women 81.7% and 78.3% in experimental and control group did not give any answer related to perception regarding contraceptives .

TABLE- 1I: Demographic description of the women by frequency and percentage.

N=605, 605.

Demographic variable	Experimental		Control	
	Freq	%	Freq	%
Contraceptive methods adopted by husband				
No	538	88.9%	545	90.1%
Nirodh	46	7.6%	43	7.1%
Vasectomy	21	3.5%	17	2.8%
Participation of the partner				
No	490	81.0%	474	78.3%
Yes	115	19.0%	131	21.7%

88.9% and 90.1% in experimental and control group respectively do not use any contraceptives .In experimental group, 7.6% of the husbands were using nirodh and 3.5% of them had vasectomy. In control group, 7.1% of the husbands were using nirodh and 2.8% of them had undergone vasectomy.

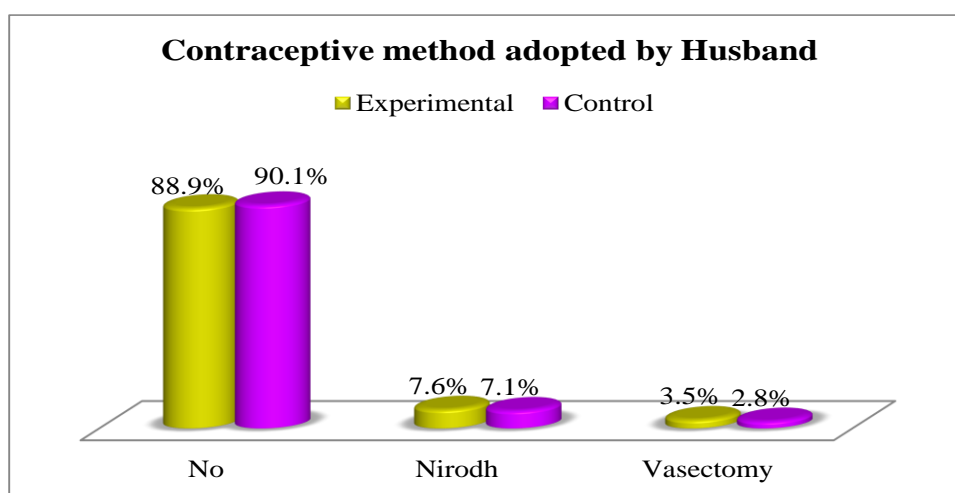


Figure No. 17 G: Distribution of women in both the groups according to contraceptive methods adopted by their husband.

In experimental group, only 19% of them had participation of the partner. In control group only 21.7% of them had participation of the partner.

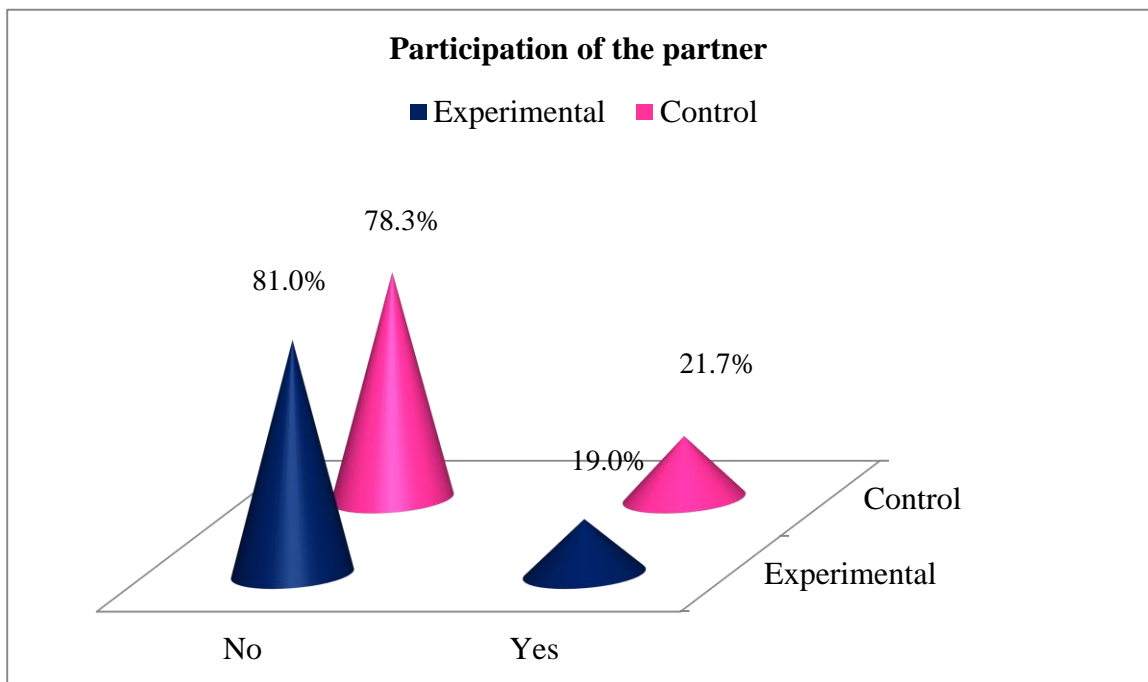


Figure No. 17 H: Distribution of women in both the groups according to their partner participation.

TABLE -1J: Demographic description of the women by frequency and percentage

Demographic variable	Experimental		Control	
	Freq	%	Freq	%
Medical History				
Acidity	1	0.2%	0	0.0%
Appendisectomy	7	1.2%	6	1.0%
Arthritis	9	1.5%	7	1.2%
Burns	2	0.3%	1	0.2%
Diabetes	14	2.3%	17	2.8%
Fibroids	7	1.2%	4	0.7%
Heart surgery in childhood	1	0.2%	1	0.2%
Hernia	7	1.2%	5	0.8%
Hypertension	28	4.6%	31	5.1%
Hysterectomy	3	0.5%	2	0.3%
Hysterectomy ,appendisectomy	0	0.0%	1	0.2%
Infertility	10	1.7%	8	1.3%
Joint pain	3	0.5%	0	0.0%
Laprotomy	5	0.8%	10	1.7%
Lump in abdomen	0	0.0%	1	0.2%
Lump in breast	1	0.2%	0	0.0%
Mitral valve stenosis	2	0.3%	1	0.2%
No	458	75.7%	461	76.2%
Heart surgery	2	0.3%	2	0.3%
Piles	7	1.2%	8	1.3%
Pneumonia	2	0.3%	2	0.3%
Pregnancy induced hypertension	2	0.3%	2	0.3%
Prolapse	7	1.2%	3	0.5%
Reproductive Tract Infections	10	1.7%	13	2.1%
Reproductive Tract Infections , Hypertension	0	0.0%	1	0.2%
Stomatitis	1	0.2%	1	0.2%
Tonsillectomy	15	2.5%	17	2.8%
Renal stone	1	0.2%	0	0.0%

Majority 75.7% and 76.2% in experimental and control group respectively women said that they don't have any medical problem.

SECTION II

**A: Analysis of data in detail among experimental and control groups
(Subject-wise increase in level of the knowledge of pre test & post-test between
both groups)**

TABLE-2A: Item Analysis (1-3.10)

Item		Experimental				Control			
		Pretest		Posttest		Pretest		Posttest	
		Freq	%	Freq	%	Freq	%	Freq	%
1	Meaning of RTI	206	34.0%	466	77.0%	232	38.3%	289	47.8%
2	Organs of the female reproductive Tract.	132	21.8%	407	67.3%	156	25.8%	160	26.4%
2.1	Different body sites where RTI occurs in women	145	24.0%	422	69.8%	157	26.0%	163	26.9%
3	Why Reproductive tract infections are more common in women than men?								
3.a. Natural factors									
3.1	Because of the structure of reproductive tract and larger surface area	154	25.5%	422	69.8%	173	28.6%	184	30.4%
3.2	Female Reproductive tract is wet due to discharge.	225	37.2%	453	74.9%	235	38.8%	248	41.0%
3.3	Women has to undergo investigation of reproductive infections/ Delivery/ Abortion/Contraceptive methods	101	16.7%	404	66.8%	90	14.9%	96	15.9%
3.4	More likely to suffer from complications.	42	6.9%	412	68.1%	41	6.8%	51	8.4%
3.5	More likely to suffer from asymptomatic infections and remain untreated	147	24.3%	444	73.4%	158	26.1%	167	27.6%
3.b. Social factors									
3.6	Lack of decision making power	192	31.7%	458	75.7%	216	35.7%	229	37.9%
3.7	Lack of knowledge	233	38.5%	470	77.7%	245	40.5%	261	43.1%
3.8	Lack of time	411	67.9%	501	82.8%	427	70.6%	431	71.2%
3.9	Shyness & Stigma	295	48.8%	471	77.9%	301	49.8%	309	51.1%
3.10	Financial dependence	206	34.0%	476	78.7%	223	36.9%	231	38.2%

In experimental group in pretest, 34% of the women and 77% of them in posttest knew the meaning of reproductive tract infections. In control group, 38.3% of them in pretest and 47.8 of them in posttest knew the meaning of reproductive tract infections. In experimental group, 21.8 % of them in pretest and 67.3% of them in posttest had knowledge about anatomy of the female reproductive tract. In control group, 25.8 % of them in pretest and 26.4% of them in posttest had knowledge about anatomy of the female reproductive tract. In experimental group, 24% of them in pretest and 69.8% of them in posttest knew the different body sites where reproductive tract infections occur in women. In control group, 26% of them in pretest and 26.9% of them in posttest knew the different body sites where reproductive tract infections occur in women.

In experimental group, in pretest majority of 67.9% and in posttest 82.8% and control group 70.6% in pretest and in posttest 71.2% of them stated that reproductive tract infections are more common in women than men because of lack of time.

In experimental group, in pretest majority of 48.8% and in posttest 77.9% and control group 49.8% in pretest and in posttest 51.1% of them stated that reproductive tract infections are more common in women than men due to shyness and stigma.

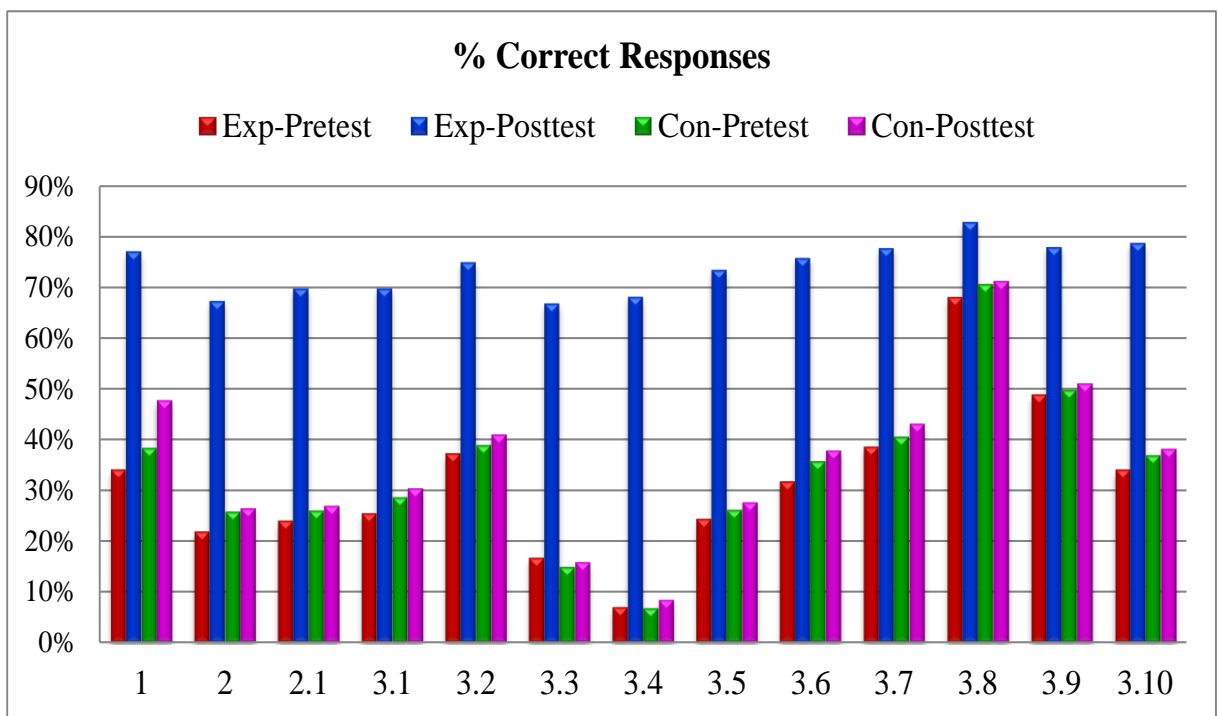


Figure No. 18 A: Item-wise increase in level of the knowledge of pre test & post-test between both group regarding reproductive tract infections.

TABLE-2B: Item Analysis (4-6.9)

Item	Experimental				Control				
	Pretest		Posttest		Pretest		Posttest		
	Freq	%	Freq	%	Freq	%	Freq	%	
4	Which of the following are the types of Reproductive Tract Infections?								
4.1	Infections due to overgrowth of organisms normally found in the genital tract of women	87	14.4%	401	66.3%	89	14.7%	93	15.4%
4.2	Sexually Transmitted Infections	193	31.9%	431	71.2%	208	34.4%	211	34.9%
4.3	Infections related to IUD insertion, unsafe childbirth and abortion techniques.	93	15.4%	388	64.1%	97	16.0%	126	20.8%
5	Names of Reproductive Tract Infections	93	15.4%	400	66.1%	105	17.4%	111	18.3%
5.1	Name some reproductive tract infections if yes	83	13.7%	393	65.0%	95	15.7%	99	16.4%
5.2	Is reproductive tract infection related to AIDS?	179	29.6%	459	75.9%	189	31.2%	197	32.6%
6	What are possible causes of RTI?								
6.1	Infectious agents(bacteria,virus,protozoa,fungus)	287	47.4%	418	69.1%	299	49.4%	300	49.6%
6.2	Sex with partner having signs and symptoms of RTI	217	35.9%	430	71.1%	220	36.4%	223	36.9%
6.3	Poor genital and menstrual hygiene	400	66.1%	487	80.5%	411	67.9%	417	68.9%
6.4	Poor general health/Low immunity	35	5.8%	444	73.4%	38	6.3%	61	10.1%
6.5	Unsafe procedures like unsafe deliveries / Abortions	81	13.4%	417	68.9%	72	11.9%	77	12.7%
6.6	Having sex after delivery (Puerperium)	136	22.5%	406	67.1%	150	24.8%	153	25.3%
6.7	Sex during menses	177	29.3%	467	77.2%	184	30.4%	199	32.9%
6.8	Unprotected sex	199	32.9%	412	68.1%	210	34.7%	212	35.0%
6.9	Being unfaithful (Multiple Partners)	139	23.0%	451	74.5%	157	26.0%	159	26.3%

In experimental group, in pretest 14.4% of them and in posttest 66.3% of them opined that infections due to overgrowth of organisms normally found in the genital tract of women are the reproductive tract infections. In control group, 14.7% of them in pretest and 15.4% of them in posttest opined that infections due to overgrowth of organisms normally found in the genital tract of women are the reproductive tract infections.

In experimental group, in pretest 13.7% of them and in posttest 65.% of them knew the names of reproductive tract infections. In control group, 15.7% of them in pretest and 16.4% of them in posttest knew the names of reproductive tract infections.

In experimental group, in pretest 66.1% and 80.5% of them in posttest opined in pretest that poor genital and menstrual hygiene is the possible cause of RTI/STI. In control group, 67.9% in pretest and 68.9% in posttest opined that poor genital and menstrual hygiene is the possible cause of RTI/STI. Very few of them from both groups in pretest (5.8% in experimental group and 6.3% in control group) stated that poor general health / low immunity are the possible cause of RTI/STI, in posttest (73.4% in experimental and 10.1% in control group) stated that poor general health / low immunity are the possible cause of RTI/STI.

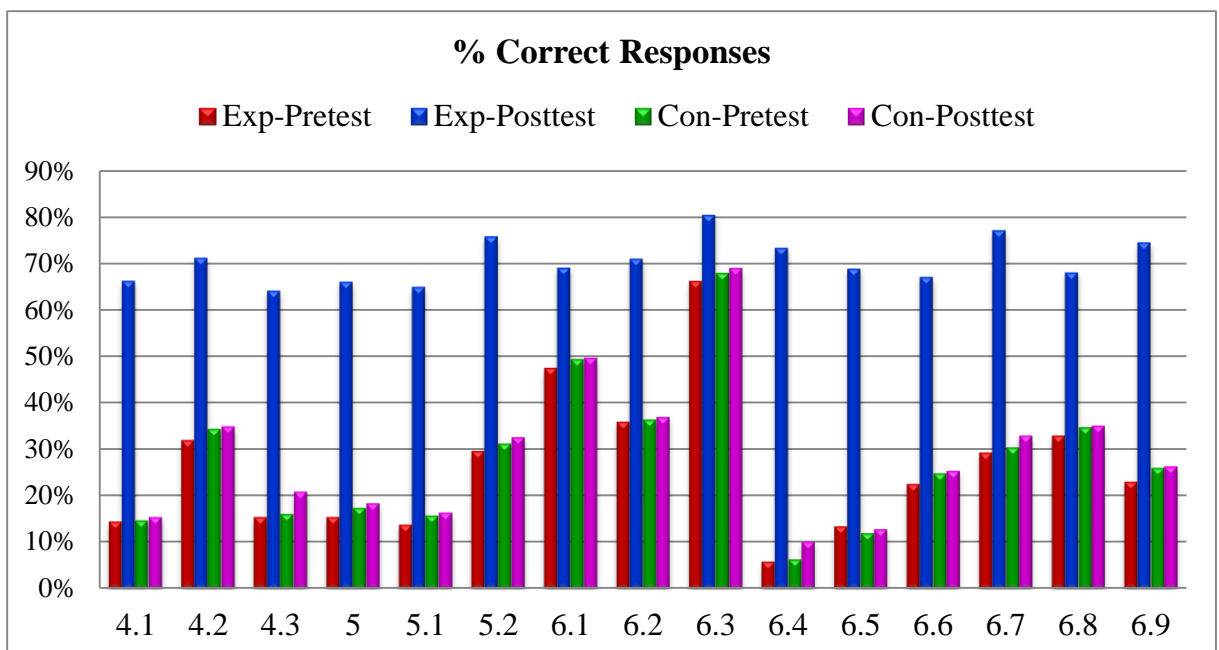


Figure No. 18 B: Item-wise increase in level of the knowledge of pre test & post-test between both group regarding reproductive tract infections

TABLE-2C: Item Analysis (7-8.8)

Item	Experimental				Control				
	Pretest		Posttest		Pretest		Posttest		
	Freq	%	Freq	%	Freq	%	Freq	%	
7	Which of the following are common sign and symptoms of RTI/STI?								
7.1	Unusual vaginal discharge with or without bleeding	178	29.4%	451	74.5%	182	30.1%	193	31.9%
7.2	Genital itching	33	5.5%	448	74.0%	37	6.1%	43	7.1%
7.3	Redness, rash, Sores, ulcers, warts	301	49.8%	455	75.2%	321	53.1%	321	53.1%
7.4	Burning sensation & Pain during urination	145	24.0%	433	71.6%	161	26.6%	166	27.4%
7.5	Swelling in the groin ,fever	33	5.5%	416	68.8%	28	4.6%	33	5.5%
7.6	Pain & bleeding during sexual intercourse	42	6.9%	445	73.6%	53	8.8%	56	9.3%
7.7	Lower abdominal / lumber pain (female)	289	47.8%	470	77.7%	323	53.4%	326	53.9%
7.8	Menstrual bleeding increases	156	25.8%	437	72.2%	184	30.4%	191	31.6%
8	How do reproductive tract infections spread?								
8.1	Unsafe sex	101	16.7%	402	66.4%	103	17.0%	105	17.4%
8.2	Blood transfusion	68	11.2%	385	63.6%	65	10.7%	68	11.2%
8.3	Mother to child	22	3.6%	379	62.6%	17	2.8%	20	3.3%
8.4	Sharing clothes(undergarments, menstrual cloth),	291	48.1%	477	78.8%	323	53.4%	330	54.5%
8.5	Sharing / Use of Public Toilet	420	69.4%	510	84.3%	418	69.1%	423	69.9%
8.6	Investigations & Treatment on Reproductive tract	69	11.4%	396	65.5%	67	11.1%	71	11.7%
8.7	Unsafe abortion & delivery	32	5.3%	406	67.1%	27	4.5%	39	6.4%
8.8	Use of unclean water for genital hygiene	395	65.3%	502	83.0%	389	64.3%	394	65.1%

In pretest very few of them i.e. 5.5% in and 6.1%; and in posttest, 74% and 7.1% in experimental and control group opined that genital itching are common signs and symptoms of RTI. In pretest 5.5% and 4.6%, in posttest 68.8% and 5.5% in experimental and control group opined that swelling in the groin and fever are common sign and symptoms of RTI. In pretest 6.9% and 8.8% in experimental and control group and in posttest 73.6% and 9.3% in experimental and control group opined that pain & bleeding during sexual intercourse are common sign and symptoms of RTI. In pretest, 49.8% and 53.1% in experimental and control group and in posttest 75.2% and 53.1% in experimental and control group stated that redness, rash, sores, ulcers and warts are common sign and symptoms of RTI. In pretest 47.8% and 53.4% in experimental and control group and in posttest 77.7% and 53.9% of

them in experimental and control group stated that lower abdominal /lumber pain are common sign and symptoms of RTI

In experimental group, in pretest, 65.3% of them in pretest and 83% of them on posttest and in control group 64.3 in pretest and 65.1% of them in posttest responded that reproductive tract infection is spread by the use of unclean water for genital hygiene. In experimental group, 48.1% of them in pretest and 78.8% of them in posttest and in control group, 53.4% in pretest and 54.5% of them in posttest opined that reproductive tract infection is spread by sharing clothes. In experimental group, in pretest 69.4% and 84.3% in posttest, whereas in control group, 69.1% in pretest and 69.9% of them in posttest stated that reproductive tract infection is spread by sharing/use of public toilet. In experimental group 3.6% in pretest and 62.6% in posttest whereas in control group 2.8% in pretest and 3.3% in posttest opined that reproductive tract infection transmitted through mother to child. In experimental group, 5.3% of them in pretest and 67.1% in posttest whereas in control group 4.5% in pretest and 6.4% in posttest stated that the reproductive tract infection spread through unsafe abortion and delivery.

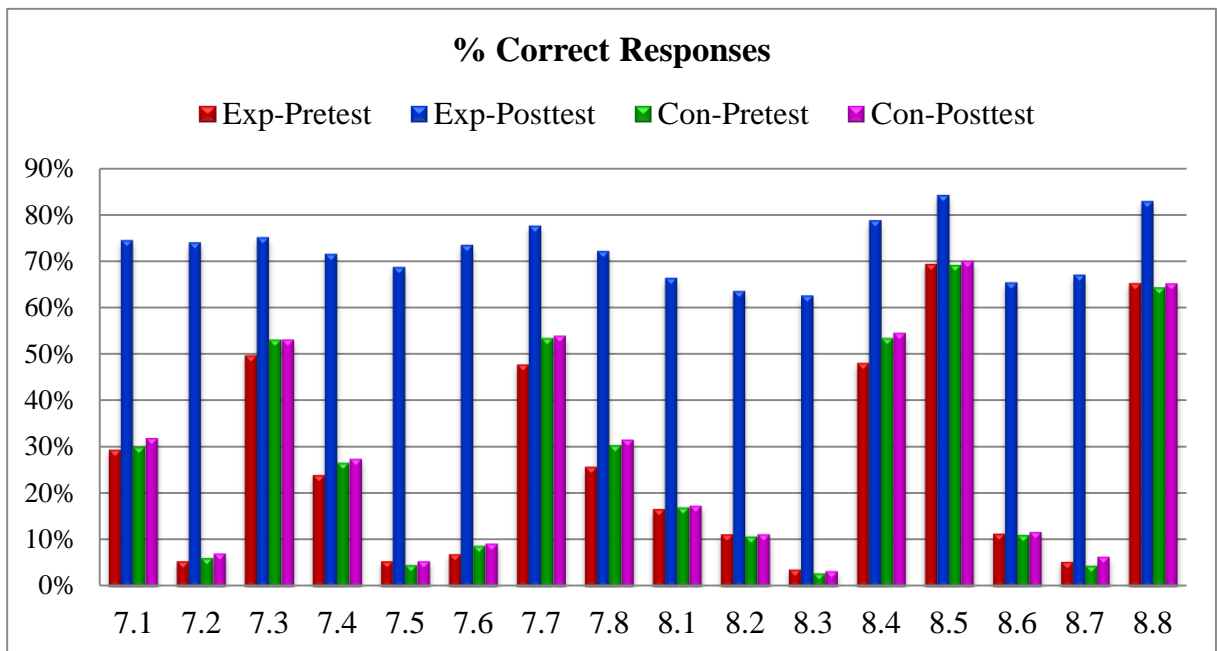


Figure No. 18 C: Item-wise increase in level of the knowledge of pre test & post-test between both group regarding reproductive tract infections

TABLE-2D: Item Analysis (9-9.5)

Item		Experimental				Control			
		Pretest		Posttest		Pretest		Posttest	
		Freq	%	Freq	%	Freq	%	Freq	%
9	What measures should be taken to treat reproductive tract infections								
9.1	Early diagnosis and prompt treatment	239	39.5%	431	71.2%	231	38.2%	233	38.5%
9.2	Correct and adequate treatment	99	16.4%	434	71.7%	101	16.7%	105	17.4%
9.3	Treatment of both the partners simultaneously	145	24.0%	428	70.7%	159	26.3%	162	26.8%
9.4	Avoid sex with infected partner	179	29.6%	433	71.6%	197	32.6%	201	33.2%
9.5	Any Other Home remedies								
	Home remedies	381	63.0%	383	63.3%	362	59.8%	361	59.7%
	Quacks	187	30.9%	113	18.7%	176	29.1%	179	29.6%
	Pharmacists	292	48.3%	293	48.4%	283	46.8%	280	46.3%
	Herbal medicine	437	72.2%	436	72.1%	415	68.6%	413	68.3%

Regarding measures for the treatment of RTI, in experimental group, in pretest 39.5% and 71.2% in posttest, whereas in control group, 38.2% in pretest and 38.5% of them in posttest stated that early diagnosis and prompt treatment should be taken.

In experimental group, in pretest 63% and 63.3% in posttest, whereas in control group, 59.8% in pretest and 59.7% of them in posttest stated that home remedies should be taken to treat reproductive tract infections. In experimental group, in pretest 72.2% and 72.1% in posttest, whereas in control group, 68.6% in pretest and 68.3% of them in posttest stated that herbal medicines should be taken to treat reproductive tract infections.

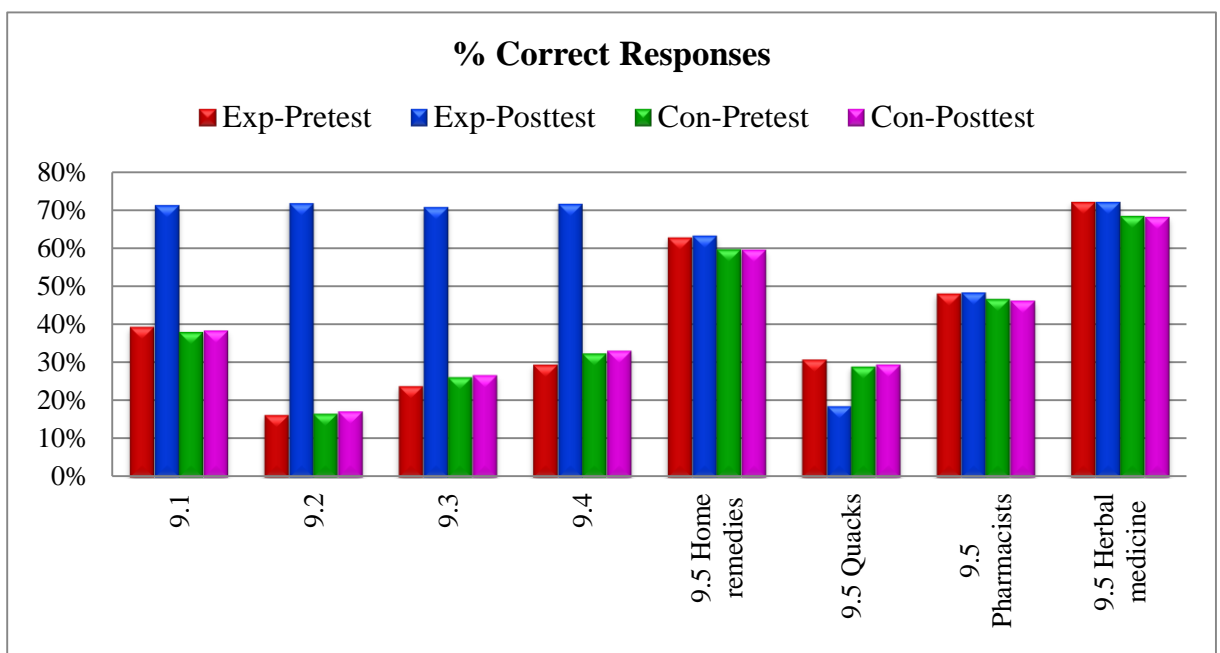


Figure No. 18 D: Item-wise increase in level of the knowledge of pre test & post-test between both group regarding reproductive tract infections

TABLE-2E: Item Analysis (10-11.9)

Item		Experimental				Control			
		Pretest		Posttest		Pretest		Posttest	
		Freq	%	Freq	%	Freq	%	Freq	%
10	What are the complications of reproductive tract infections?								
10.1	Infertility	13	2.1%	342	56.5%	18	3.0%	20	3.3%
10.2	Chronic pelvic pain	154	25.5%	434	71.7%	161	26.6%	166	27.4%
10.3	Premature birth, low birth eight baby.	67	11.1%	436	72.1%	69	11.4%	74	12.2%
10.4	Miscarriage ,Still birth	16	2.6%	433	71.6%	17	2.8%	22	3.6%
10.5	cervical cancer	218	36.0%	480	79.3%	231	38.2%	242	40.0%
10.6	Ectopic Pregnancy	21	3.5%	380	62.8%	20	3.3%	23	3.8%
10.7	Perinatal and Neonatal infections	0	0.0%	432	71.4%	0	0.0%	78	12.9%
10.8	Risk for HIV transmission	218	36.0%	469	77.5%	231	38.2%	236	39.0%
10.9	Systemic complications	366	60.5%	440	72.7%	360	59.5%	363	60.0%
10.10	Mental stress, Tension, depression	216	35.7%	484	80.0%	203	33.6%	208	34.4%
10.11	Effect on Marital status/divorce.	45	7.4%	442	73.1%	47	7.8%	41	6.8%
11	What are the preventive and control measures for RTI?								
11.1	Maintaining sexual hygiene,	245	40.5%	489	80.8%	251	41.5%	293	48.4%
11.2	Menstrual hygiene	341	56.4%	492	81.3%	375	62.0%	373	61.7%
11.3	Safer sex practices.	57	9.4%	417	68.9%	57	9.4%	61	10.1%
11.4	Avoid sex with infected partner	198	32.7%	454	75.0%	205	33.9%	210	34.7%
11.5	Removing stigma and bias improving the treatment seeking behavior	228	37.7%	460	76.0%	247	40.8%	250	41.3%
11.6	Having single partner, avoiding multiple Partners	221	36.5%	463	76.5%	242	40.0%	246	40.7%
11.7	Utilization of Safe delivery services.	122	20.2%	476	78.7%	137	22.6%	149	24.6%
11.8	Utilization of Safe abortion services	312	51.6%	495	81.8%	321	53.1%	327	54.0%
11.9	Public Awareness regarding RTI	347	57.4%	505	83.5%	360	59.5%	364	60.2%

In pretest, majority in experimental group 60.5% and in control group 59.5% responded that systemic complications occur if reproductive tract infections are not treated. None of them 0% from either group responded in pretest that prenatal and neonatal infections are the complications which are caused if reproductive infections are not treated, 2.6% and 2.8% in experimental and control group respectively opined miscarriage and still birth, 2.1% and 3% opined infertility, 3.5% and 3.3% opined ectopic pregnancy, 7.4% and 7.8% opined effect on marital status/divorce are the complications if reproductive tract infections are not treated. In pretest, in both groups only 9.4% of them knew that the safer sex practices are the preventive and control measures for RTI, in posttest which remained at 10.1 for control group and for experimental group it changed to 68.9%. 56.4% in experimental group and 62% in control group responded in pretest that menstrual hygiene, and 57.4% in experimental and 59.5% in control group stated public awareness regarding RTI will help as a preventive and control measure of RTI.

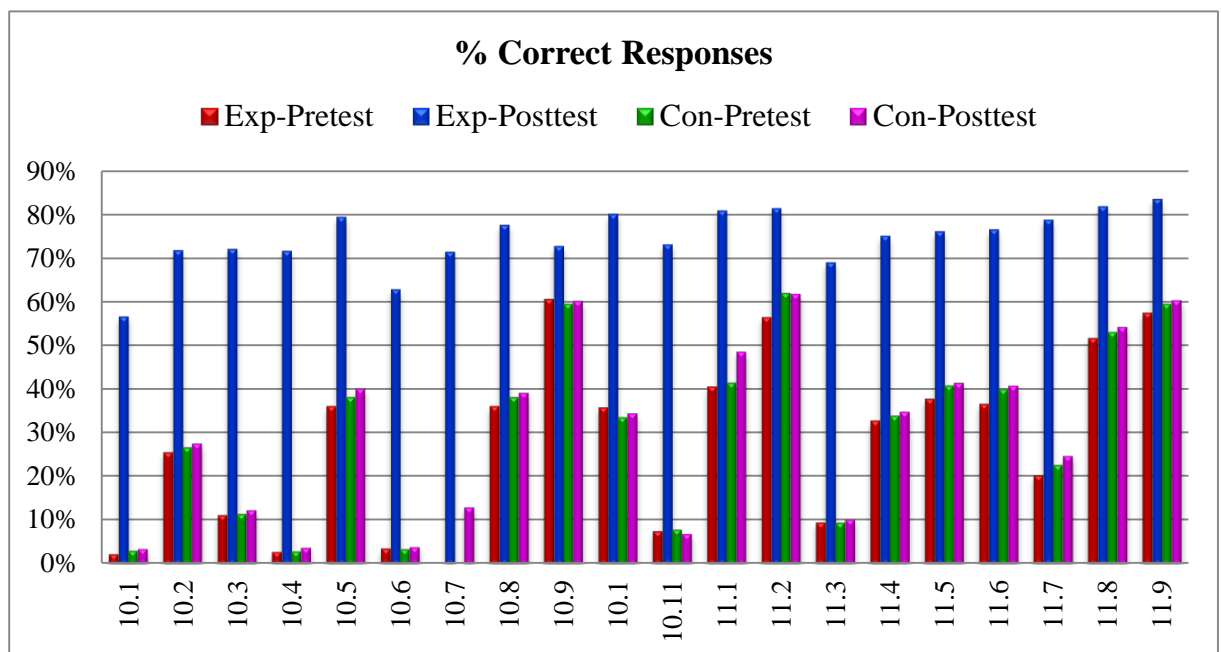


Figure No. 18 E: Item-wise increase in level of the knowledge of pre test & post-test between both groups regarding reproductive tract infections.

**Subject-wise increase in level of the practices of pre test & post-test between
both groups regarding reproductive tract infections**

Preventive practices (Hygienic practices)

TABLE 3A: Item Analysis (1.1-1.5)

Section	Group	Item	Pretest						Posttest					
			Never		Sometimes		Always		Never		Sometimes		Always	
			Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
A)Hygienic practices	Experimental group	1.1	0	0.0%	24	4.0%	581	96.0%	0	0.0%	27	4.5%	578	95.5%
		1.2	0	0.0%	69	11.4%	536	88.6%	0	0.0%	50	8.3%	555	91.7%
		1.3	298	49.3%	193	31.9%	114	18.8%	145	24.0%	129	21.3%	331	54.7%
		1.4	50	8.3%	224	37.0%	329	54.4%	52	8.6%	101	16.7%	452	74.7%
		1.5	2	0.3%	132	21.8%	471	77.9%	2	0.3%	112	18.5%	491	81.2%
		Overall Hygienic practices	350	11.6%	642	21.2%	2031	67.2%	199	6.6%	419	13.9%	2407	79.6%
	Control	1.1	1	0.2%	43	7.1%	561	92.7%	0	0.0%	46	7.6%	559	92.4%
		1.2	1	0.2%	69	11.4%	535	88.4%	1	0.2%	70	11.6%	534	88.3%
		1.3	262	43.3%	208	34.4%	135	22.3%	263	43.5%	213	35.2%	129	21.3%
		1.4	5	0.8%	348	57.5%	252	41.7%	5	0.8%	383	63.3%	217	35.9%
		1.5	2	0.3%	329	54.4%	274	45.3%	2	0.3%	358	59.2%	245	40.5%
		Overall Hygienic practices	271	9.0%	997	33.0%	1757	58.1%	271	9.0%	1070	35.4%	1684	55.7%

In experimental 96% and in control group 95.5% of the women had maintained their personal hygiene. In pretest, 49.3% of them from experimental groups 43.3% of the women in control group always do cleaning from vagina towards anus, whereas in posttest experimental women around 54.7% of them stated they always do cleaning from vagina to anus.

Preventive practices- Menstrual hygienic practices

TABLE 3B: Item Analysis (1.6-1.14)

Section	Group	Item	Pretest						Posttest					
			Never		Sometimes		Always		Never		Sometimes		Always	
			Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
B) Menstrual hygienic practices-	Experimental group	1.6	0	0.0%	108	17.9%	497	82.1%	0	0.0%	52	8.6%	553	91.4%
		1.7	73	12.1%	222	36.7%	310	51.2%	28	4.6%	109	18.0%	468	77.4%
		1.8	53	8.8%	213	35.2%	339	56.0%	54	8.9%	196	32.4%	355	58.7%
		1.9	215	35.5%	285	47.1%	93	15.4%	45	7.4%	157	26.0%	381	63.0%
		1.01	42	6.9%	308	50.9%	243	40.2%	28	4.6%	197	32.6%	358	59.2%
		1.11	42	6.9%	415	68.6%	136	22.5%	38	6.3%	252	41.7%	297	49.1%
		1.12	167	27.6%	335	55.4%	91	15.0%	290	47.9%	249	41.2%	46	7.6%
		1.13	201	33.2%	352	58.2%	52	8.6%	202	33.4%	350	57.9%	53	8.8%
		1.14	0	0.0%	397	65.6%	8	1.3%	0	0.0%	191	31.6%	214	35.4%
	Overall Hygienic practices	793	15.3%	2635	50.7%	1769	34.0%	685	13.3%	1753	34.0%	2725	52.8%	
	Control	1.6	2	0.3%	376	62.1%	227	37.5%	2	0.3%	378	62.5%	223	36.9%
		1.7	2	0.3%	377	62.3%	226	37.4%	131	21.7%	331	54.7%	143	23.6%
		1.8	55	9.1%	216	35.7%	334	55.2%	55	9.1%	214	35.4%	336	55.5%
		1.9	220	36.4%	287	47.4%	98	16.2%	216	35.7%	294	48.6%	95	15.7%
		1.01	59	9.8%	287	47.4%	259	42.8%	57	9.4%	298	49.3%	250	41.3%
		1.11	57	9.4%	387	64.0%	159	26.3%	59	9.8%	396	65.5%	152	25.1%
		1.12	99	16.4%	311	51.4%	195	32.2%	197	32.6%	303	50.1%	105	17.4%
		1.13	230	38.0%	320	52.9%	55	9.1%	232	38.3%	318	52.6%	55	9.1%
		1.14	0	0.0%	367	60.7%	11	1.8%	8	1.3%	348	57.5%	27	4.5%
Overall Hygienic practices		724	13.9%	2928	56.1%	1564	30.0%	957	18.3%	2880	55.1%	1386	26.5%	

82.1% in experimental group and 37.5% in control group always maintain menstrual hygiene. 56% in experimental group and 55.2% in control group always use cloth during menstrual period whereas 33.2% in experimental group and 38% of the control group never used sanitary napkins.

Preventive practices (Sexual practices)

TABLE 3C: Item Analysis (1.15-1.20)

Section	Group	Item	Pretest						Posttest					
			Never		Sometimes		Always		Never		Sometimes		Always	
			Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
C)Sexual practices:	Experimental group	1.15	299	49.4%	226	37.4%	72	11.9%	89	14.7%	194	32.1%	315	52.1%
		1.16	183	30.2%	312	51.6%	99	16.4%	52	8.6%	182	30.1%	364	60.2%
		1.17	295	48.8%	214	35.4%	73	12.1%	84	13.9%	184	30.4%	315	52.1%
		1.18	444	73.4%	126	20.8%	1	0.2%	511	84.5%	60	9.9%	6	1.0%
		1.19	433	71.6%	132	21.8%	6	1.0%	140	23.1%	157	26.0%	279	46.1%
		1.20	9	1.5%	17	2.8%	558	92.2%	9	1.5%	19	3.1%	555	91.7%
		Overall Hygienic practices	1663	47.5%	1027	29.4%	809	23.1%	885	25.2%	796	22.6%	1834	52.2%
	Control	1.15	302	49.9%	185	30.6%	101	16.7%	311	51.4%	190	31.4%	98	16.2%
		1.16	196	32.4%	272	45.0%	120	19.8%	204	33.7%	285	47.1%	110	18.2%
		1.17	299	49.4%	177	29.3%	92	15.2%	299	49.4%	183	30.2%	85	14.0%
		1.18	456	75.4%	106	17.5%	2	0.3%	451	74.5%	108	17.9%	3	0.5%
		1.19	433	71.6%	123	20.3%	8	1.3%	430	71.1%	125	20.7%	7	1.2%
		1.20	6	1.0%	23	3.8%	544	89.9%	6	1.0%	22	3.6%	543	89.8%
		Overall Hygienic practices	1692	49.1%	886	25.7%	867	25.2%	1701	49.2%	913	26.4%	846	24.5%

In pretest, in experimental group 49.4% and 49.9% in control never cleanse genital region before intercourse, 48.8% and 49.4% never used condom if either of the partner had symptom of RTI., 71.6% of the women in experimental and control group never followed safer sex practices in pretest, in Posttest control group percentage almost remained unchanged however in experimental group, 46.1% of them assured to always follow safer sexual practices. Majority of the women 92.2% in experimental group and 89.9% in control group were always faithful to partner/ husband.

TABLE- 3D: Antenatal practices

Aspect	Group	Item	Practices											
			Pretest						Posttest					
			Never		Sometimes		Always		Never		Sometimes		Always	
			Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Antenatal	Experimental group	1.21	223	36.9%	270	44.6%	112	18.5%	23	3.8%	187	30.9%	393	65.0%
		1.22	223	36.9%	270	44.6%	112	18.5%	23	3.8%	187	30.9%	393	65.0%
		Overall Antenatal practices	446	36.9%	540	44.6%	224	18.5%	46	3.8%	374	31.0%	786	65.2%
	Control	1.21	195	32.2%	282	46.6%	126	20.8%	194	32.1%	283	46.8%	126	20.8%
		1.22	195	32.2%	282	46.6%	126	20.8%	194	32.1%	283	46.8%	126	20.8%
		Overall Antenatal practices	390	32.3%	564	46.8%	252	20.9%	388	32.2%	566	46.9%	252	20.9%

In pretest 44.6% of the women from experimental group and 46.6% of the women from control group sometimes seek antenatal care during pregnancy .Only 15.5% in experimental and 20.2 % of the women always take decision regarding choice for place of delivery.

TABLE- 3E: Intra -natal practices

Aspect	Group	Item	Practices											
			Pretest						Posttest					
			Never		Sometimes		Always		Never		Sometimes		Always	
			Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Intra-natal	Experimental group	1.23	273	45.1%	150	24.8%	181	29.9%	24	4.0%	98	16.2%	479	79.2%
		1.24	245	40.5%	133	22.0%	193	31.9%	242	40.0%	93	15.4%	23	3.8%
		1.25a	320	52.9%	191	31.6%	94	15.5%	292	48.3%	212	35.0%	101	16.7%
		1.25b	92	15.2%	196	32.4%	291	48.1%	93	15.4%	196	32.4%	289	47.8%
		1.25c	175	28.9%	353	58.3%	77	12.7%	175	28.9%	353	58.3%	77	12.7%
		1.26a	186	30.7%	150	24.8%	254	42.0%	15	2.5%	88	14.5%	500	82.6%
		1.26b	248	41.0%	141	23.3%	207	34.2%	507	83.8%	74	12.2%	20	3.3%
		1.27	221	36.5%	225	37.2%	157	26.0%	18	3.0%	97	16.0%	489	80.8%
		Overall Intra-natal practices	1760	37.0%	1539	32.4%	1454	30.6%	1366	30.0%	1211	26.6%	1978	43.4%
	Control group	1.23	280	46.3%	138	22.8%	181	29.9%	165	27.3%	130	21.5%	259	42.8%
		1.24	230	38.0%	118	19.5%	200	33.1%	185	30.6%	116	19.2%	198	32.7%
		1.25a	292	48.3%	190	31.4%	122	20.2%	292	48.3%	191	31.6%	122	20.2%
		1.25b	118	19.5%	175	28.9%	272	45.0%	118	19.5%	177	29.3%	269	44.5%
		1.25c	200	33.1%	342	56.5%	61	10.1%	181	29.9%	328	54.2%	61	10.1%
		1.26a	174	28.8%	123	20.3%	286	47.3%	173	28.6%	122	20.2%	278	46.0%
		1.26b	261	43.1%	115	19.0%	199	32.9%	242	40.0%	115	19.0%	197	32.6%
		1.27	162	26.8%	254	42.0%	167	27.6%	161	26.6%	250	41.3%	162	26.8%
Overall Intra-natal practices		1717	36.8%	1455	31.2%	1488	31.9%	1517	33.8%	1429	31.8%	1546	34.4%	

In experimental and control group, respectively. in pretest, 45.1% and 46.3% of them would never prefer hospital delivery , in posttest 79.2% of them assured they will always prefer hospital delivery in experimental group,. In control group, 33.1% of them always preferred home delivery in pretest which remained around 32% in posttest. For experimental group, it was 31.9% in pretest and 3.8% in posttest .In pretest overall intranatal practice score in experimental and in control group respectively was 30.6% and 31.9% and posttest score in experimental group increased to 43.4%.

Table- 3F: Postnatal practices

Aspect	Group	Item	Practices											
			Pretest						Posttest					
			Never		Sometimes		Always		Never		Sometimes		Always	
			Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Postnatal	Experimental group	1.28	216	35.7%	235	38.8%	152	25.1%	19	3.1%	95	15.7%	490	81.0%
	Control	1.28	159	26.3%	253	41.8%	168	27.8%	158	26.1%	246	40.7%	166	27.4%

In pretest, 25.1% from experimental group and 27.8% of them from control group had responded that they always seek postnatal care. There is significant improvement in posttest in experimental group 81.0% assured to seek postnatal care (hygiene ,diet, exercise, care of breast, care of newborn, regular medical checkup).

TABLE- 3G: Contraceptive practices

Aspect	Group	Item	Practices											
			Pretest						Posttest					
			Never		Sometimes		Always		Never		Sometimes		Always	
			Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Contraceptive	Experimental group	1.29	260	43.0%	223	36.9%	117	19.3%	273	45.1%	211	34.9%	119	19.7%
		1.30	244	40.3%	245	40.5%	116	19.2%	148	24.5%	169	27.9%	288	47.6%
		Overall Contraceptive practices	504	41.8%	468	38.8%	233	19.3%	421	34.9%	380	31.5%	407	33.7%
	Control group	1.29	242	40.0%	179	29.6%	159	26.3%	254	42.0%	181	29.9%	157	26.0%
		1.30	207	34.2%	279	46.1%	115	19.0%	198	32.7%	275	45.5%	114	18.8%
		Overall Contraceptive practices	1616	38.7%	1647	39.5%	908	21.8%	1452	34.9%	1462	35.1%	1251	30.0%

In experimental group 43.0% and 40.0% in control group women showed self efficacy towards spacing. 40.5% and 46.1% in experimental and control group expressed they sometimes seek medical treatment immediately if suffered from complications due to contraceptives. Overall contraceptive practices assured by the women improved in experimental group.

TABLE- 3H: Abortion practices

Aspect	Group	Item	Practices											
			Pretest						Posttest					
			Never		Sometimes		Always		Never		Sometimes		Always	
			Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Abortion	Experimental group	1.31	320	33.3%	320	33.3%	320	33.3%	320	33.3%	320	33.3%	320	33.3%
		1.32a	110	18.2%	168	27.8%	325	53.7%	58	9.6%	170	28.1%	374	61.8%
		1.32b	381	63.0%	140	23.1%	46	7.6%	423	69.9%	138	22.8%	39	6.4%
		1.33	268	44.3%	167	27.6%	160	26.4%	36	6.0%	158	26.1%	393	65.0%
		Overall Abortion practices	320	33.3%	320	33.3%	320	33.3%	320	33.3%	320	33.3%	320	33.3%
	Control	1.31	367	60.7%	125	20.7%	111	18.3%	338	55.9%	126	20.8%	108	17.9%
		1.32a	177	29.3%	142	23.5%	283	46.8%	152	25.1%	127	21.0%	272	45.0%
		1.32b	392	64.8%	110	18.2%	32	5.3%	345	57.0%	88	14.5%	40	6.6%
		1.33	267	44.1%	159	26.3%	156	25.8%	273	45.1%	153	25.3%	166	27.4%
		Overall Abortion practices	1203	51.8%	536	23.1%	582	25.1%	1108	50.6%	494	22.6%	586	26.8%

33.3% and 60.7% in experimental and control group respectively never had self efficacy towards abortion.

26.4% and 25.8 in experimental and control group respectively always seek medical treatment if experienced any problem after abortion .For experimental group, in posttest improved to 65%.

53.7% and 46.8% in experimental and control group respectively expressed abortion should be done at approved hospital , 23.1% and 18.2% in experimental and control group respectively expressed sometimes they made attempt to perform abortion at home ,44.3% in experimental group and 44.1% in control group women never seek medical treatment if any problem arises after abortion .

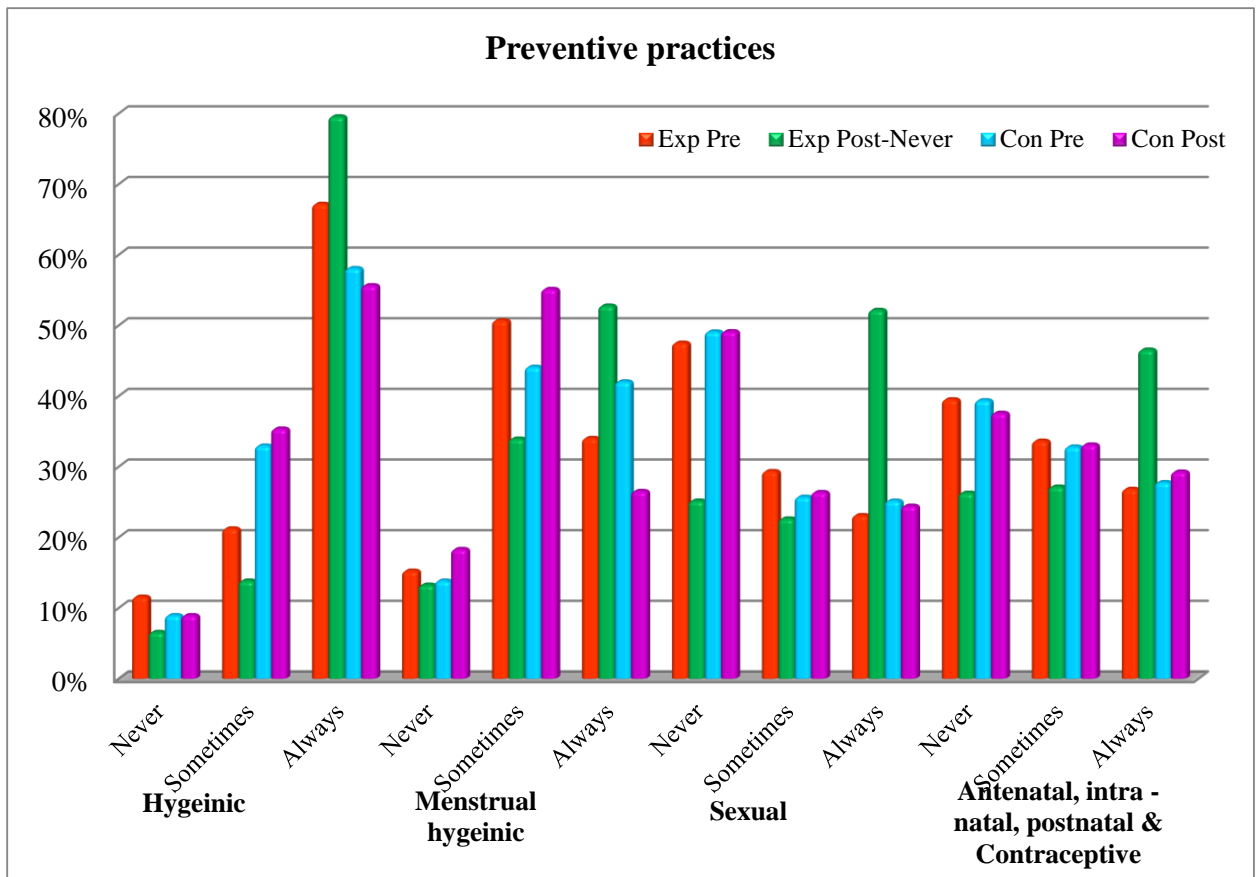


Figure No. 19A: Item-wise increase in level of the preventive practices of pre test & post-test between both group regarding reproductive tract infections

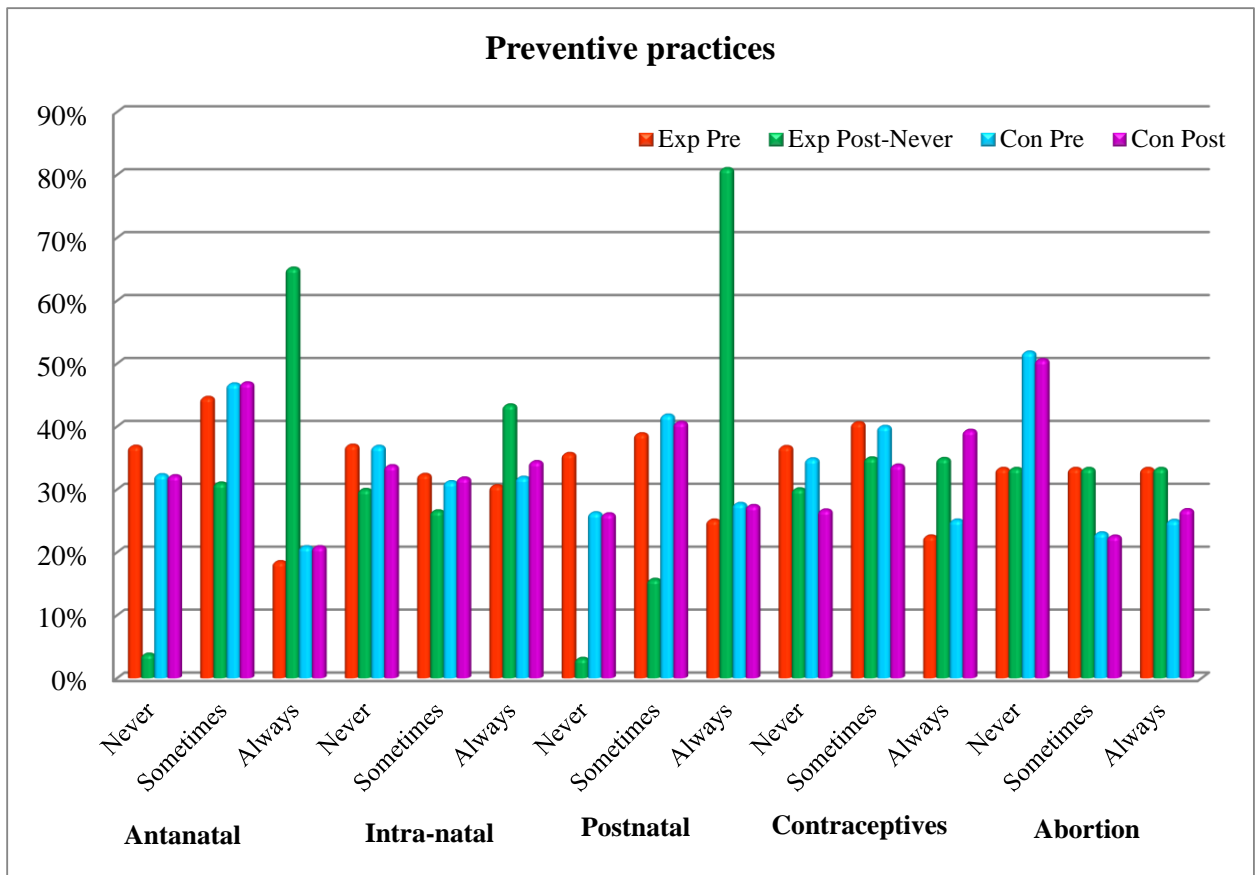


Figure No. 19B: Item-wise increase in level of the self expressed preventive practices of pre test & post-test between both groups.

TABLE – 3I: Curative practices

Group	Item	Practices											
		Pretest						Posttest					
		Never		Sometimes		Always		Never		Sometimes		Always	
		Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Experimental group	2.1	310	51.2%	175	28.9%	120	19.8%	48	7.9%	151	25.0%	406	67.1%
	2.2a	103	17.0%	189	31.2%	284	46.9%	69	11.4%	129	21.3%	105	17.4%
	2.2b	109	18.0%	202	33.4%	265	43.8%	98	16.2%	183	30.2%	222	36.7%
	2.2c	82	13.6%	225	37.2%	268	44.3%	80	13.2%	210	34.7%	222	36.7%
	2.2d	74	12.2%	118	19.5%	384	63.5%	167	27.6%	109	18.0%	311	51.4%
	2.2e	229	37.9%	214	35.4%	136	22.5%	231	38.2%	210	34.7%	136	22.5%
	2.2f	215	35.5%	229	37.9%	135	22.3%	217	35.9%	232	38.3%	137	22.6%
	2.2g	109	18.0%	302	49.9%	178	29.4%	108	17.9%	306	50.6%	181	29.9%
	2.2h	73	12.1%	116	19.2%	390	64.5%	154	25.5%	107	17.7%	339	56.0%
	2.2i	121	20.0%	273	45.1%	184	30.4%	124	20.5%	273	45.1%	187	30.9%
	2.2j	108	17.9%	186	30.7%	282	46.6%	113	18.7%	191	31.6%	278	46.0%
	2.3a	158	26.1%	205	33.9%	234	38.7%	149	24.6%	196	32.4%	253	41.8%
	2.3b	148	24.5%	255	42.1%	194	32.1%	141	23.3%	244	40.3%	213	35.2%
	2.3c.	192	31.7%	213	35.2%	180	29.8%	212	35.0%	183	30.2%	203	33.6%
	2.3d	272	45.0%	165	27.3%	152	25.1%	428	70.7%	129	21.3%	46	7.6%
	2.4	345	57.0%	178	29.4%	82	13.6%	36	6.0%	155	25.6%	414	68.4%
	2.5	329	54.4%	180	29.8%	78	12.9%	47	7.8%	177	29.3%	364	60.2%
	2.6	327	54.0%	190	31.4%	70	11.6%	73	12.1%	180	29.8%	335	55.4%
	2.7	326	53.9%	196	32.4%	65	10.7%	86	14.2%	201	33.2%	300	49.6%
		Overall Curative practices	3630	32.6%	3811	34.3%	3681	33.1%	2581	23.9%	3566	33.0%	4652

Table 3I contd...

Control	2.1	265	43.8%	182	30.1%	141	23.3%	278	46.0%	178	29.4%	142	23.5%
	2.2a	103	17.0%	212	35.0%	242	40.0%	102	16.9%	214	35.4%	239	39.5%
	2.2b	106	17.5%	195	32.2%	254	42.0%	105	17.4%	198	32.7%	251	41.5%
	2.2c	88	14.5%	226	37.4%	241	39.8%	87	14.4%	226	37.4%	241	39.8%
	2.2d	88	14.5%	97	16.0%	374	61.8%	86	14.2%	108	17.9%	373	61.7%
	2.2e	212	35.0%	215	35.5%	142	23.5%	208	34.4%	206	34.0%	139	23.0%
	2.2f	205	33.9%	226	37.4%	138	22.8%	206	34.0%	231	38.2%	140	23.1%
	2.2g	123	20.3%	301	49.8%	155	25.6%	124	20.5%	302	49.9%	153	25.3%
	2.2h	78	12.9%	121	20.0%	368	60.8%	79	13.1%	130	21.5%	367	60.7%
	2.2i	119	19.7%	240	39.7%	207	34.2%	117	19.3%	250	41.3%	208	34.4%
	2.2j	121	20.0%	152	25.1%	290	47.9%	123	20.3%	157	26.0%	295	48.8%
	2.3a	168	27.8%	197	32.6%	237	39.2%	170	28.1%	199	32.9%	235	38.8%
	2.3b	127	21.0%	285	47.1%	190	31.4%	127	21.0%	288	47.6%	189	31.2%
	2.3c	177	29.3%	263	43.5%	156	25.8%	179	29.6%	265	43.8%	155	25.6%
	2.3d	253	41.8%	192	31.7%	154	25.5%	253	41.8%	195	32.2%	152	25.1%
	2.4	315	52.1%	185	30.6%	104	17.2%	310	51.2%	191	31.6%	103	17.0%
	2.5	315	52.1%	156	25.8%	94	15.5%	308	50.9%	164	27.1%	93	15.4%
	2.6	328	54.2%	146	24.1%	91	15.0%	325	53.7%	150	24.8%	90	14.9%
	2.7	318	52.6%	165	27.3%	82	13.6%	314	51.9%	170	28.1%	81	13.4%
	Overall Curative practices	3509	32.1%	3756	34.4%	3660	33.5%	3501	31.9%	3822	34.8%	3646	33.2%

In pretest, 51.2% in experimental group and 43.8% in control group women expressed they never take immediate and complete treatment if experienced any symptom related to RTI . Regarding the reasons for not seeking medical treatment ,46.9% and 40% in experimental and control group respectively expressed , because they do not think as a disease ; 43.8% and 42% replied due to lack of time ,44.3% and 39.8% responded due to lack of money,63.5% and 61.8% expressed they feel shy to tell the problem ,64.5% and 60.8% expressed due to social stigma,46.6% and 47.9% in experimental and control group respectively expressed due to lack of decision making power. Regarding utilization of other measures than medical treatment they expressed in experimental and control group respectively, 38.7%and 39.2% practice home remedies, 32.1% and 31.4% practice herbal medicine, 29.8% and 25.8% approach Hakim/ Vaidu, 25.1% and 25.5% a practice of black magic.

Regarding immediate and complete treatment in experimental group 57% and in control 52.1% never took immediate and complete treatment .Regarding treatment along with husband/partner they expressed in experimental 54.4% and in control

group 52.1% never took treatment along with their husband/partner .Regarding avoiding sex with infected partner 54% in experimental and 54.2% in control group never practiced this. Regarding practice of safer sex 53.9% in experimental and 52.6% in control group expressed they never practiced safer sex. Experimental group showed significant improvement in curative practices in posttest as compared to pretest.

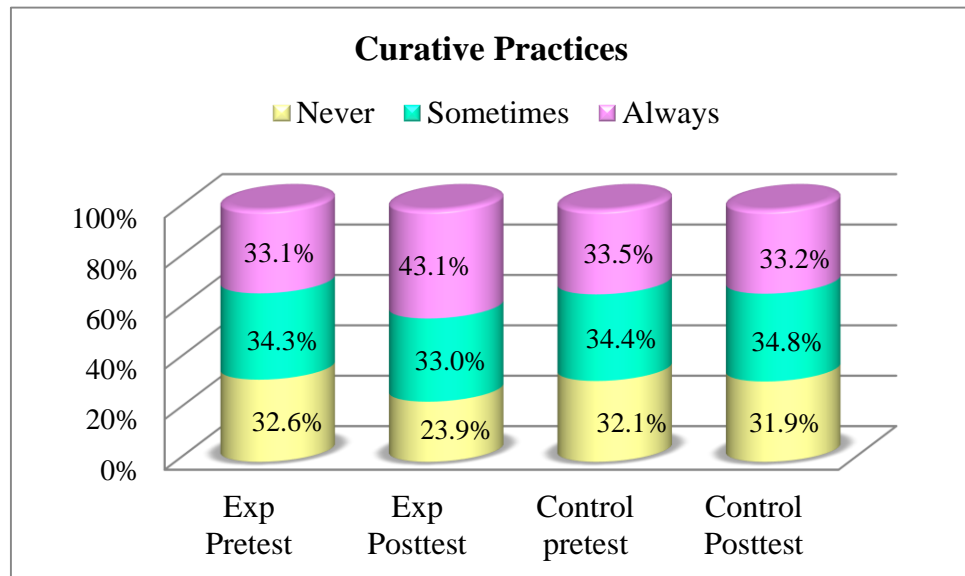


Figure No. 20: Item--wise increase in level of the curative practices of pre test & post-test between both group regarding reproductive tract infections.

TABLE – 3J: Awareness practices

Group	Item	Practices											
		Pretest						Posttest					
		Never		Sometimes		Always		Never		Sometimes		Always	
		Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Experimental	3.1a	291	48.1%	211	34.9%	103	17.0%	107	17.7%	274	45.3%	223	36.9%
	3.1b	292	48.3%	203	33.6%	109	18.0%	138	22.8%	258	42.6%	208	34.4%
	3.1c	315	52.1%	167	27.6%	123	20.3%	167	27.6%	219	36.2%	219	36.2%
	3.1d	502	83.0%	84	13.9%	19	3.1%	199	32.9%	187	30.9%	219	36.2%
	3.2	483	79.8%	94	15.5%	27	4.5%	28	4.6%	142	23.5%	375	62.0%
	Overall awareness practices	1883	62.3%	759	25.1%	381	12.6%	639	21.6%	1080	36.4%	1244	42.0%
Control	3.1a	312	51.6%	180	29.8%	109	18.0%	313	51.7%	180	29.8%	108	17.9%
	3.1b	322	53.2%	164	27.1%	115	19.0%	322	53.2%	167	27.6%	112	18.5%
	3.1c	340	56.2%	142	23.5%	120	19.8%	338	55.9%	145	24.0%	119	19.7%
	3.1d	505	83.5%	81	13.4%	18	3.0%	505	83.5%	80	13.2%	19	3.1%
	3.2	460	76.0%	98	16.2%	44	7.3%	460	76.0%	96	15.9%	47	7.8%
	Overall awareness practices	1939	64.4%	665	22.1%	406	13.5%	1938	64.4%	668	22.2%	405	13.5%

83% and 83.5% of the women in experimental and control group respectively never received information regarding RTI through health education. Overall 62.3% and 64.4% of the women responded they never followed awareness practices Regarding creating awareness among others ,79.8% and 76% of the women in experimental and control group respectively never share the information regarding RTI with others However, experimental group percentage of assured awareness practices raised significantly in posttest 42.0% as compared to pretest 25.1%.

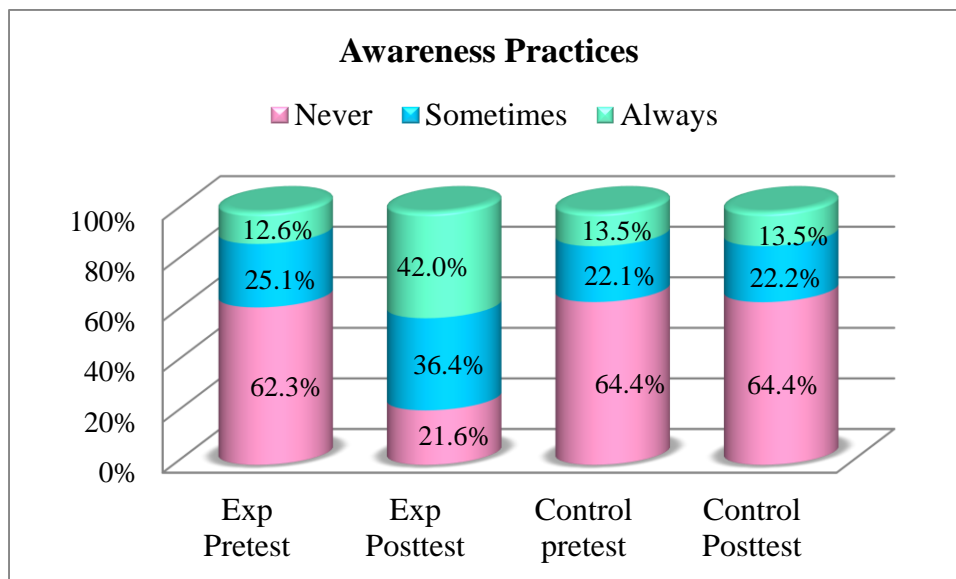


Figure No. 21: Item--wise increase in level of the awareness practices of pre test & post-test between both group regarding reproductive tract infections.

SECTION III

Analysis of data related to assess the knowledge and practices of women related to the common selected reproductive tract infections.

TABLE-4A: Assessment of pre-test knowledge of experimental and control groups.

Knowledge grade	Experimental		Control	
	Freq	%	Freq	%
Poor (Score 0-24)	429	70.9%	422	69.8%
Average (Score 25-48)	169	27.9%	169	27.9%
Good (Score 49-72)	7	1.2%	14	2.3%

In pretest, majority of 70.9% of the women in experimental group had poor knowledge (score 0-24) regarding reproductive tract infections, 27.9% of them had average knowledge (score 25-48) and only 1.2% of them had good knowledge (score 49-72) regarding reproductive tract infections. In pretest, majority of 69.8% of the women in control group had poor knowledge (score 0-24) regarding reproductive tract infections, 27.9% of them had average knowledge (score 25-48) and only 2.3% of them had good knowledge (score 49-72) regarding reproductive tract infections.

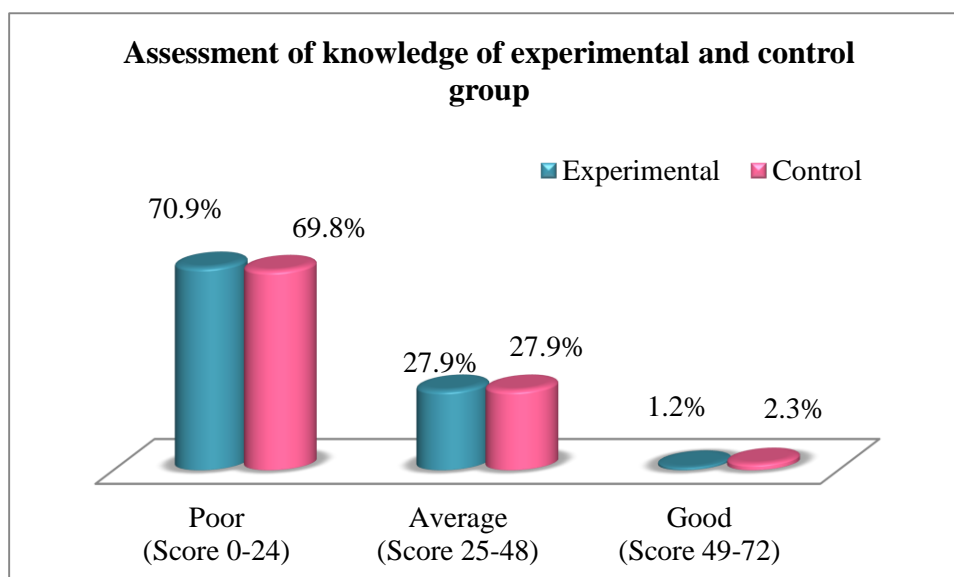


Figure No. 22: Knowledge level in experimental and control groups

TABLE-4B: Assessment of pre-test practice scores of experimental and control group

Practice grade	Experimental		Control	
	Freq	%	Freq	%
Poor (Score <41)	0	0.0%	14	2.3%
Average (Score 41-82)	197	32.6%	183	30.2%
Good (Score >82)	408	67.4%	408	67.4%

In pretest, majority of 67.4% of the women in experimental group had good practices (score >82) regarding reproductive tract infections, 32.6% of them had average practices (score 41-82) and none of them had poor practices (score <41) regarding reproductive tract infections. In pretest, majority of 67.4% of the women in control group had good practices (score >82) regarding reproductive tract infections, 30.2% of them had average practices (score 41-82) and only 2.3% of them had poor practices (score <41) regarding reproductive tract infections.

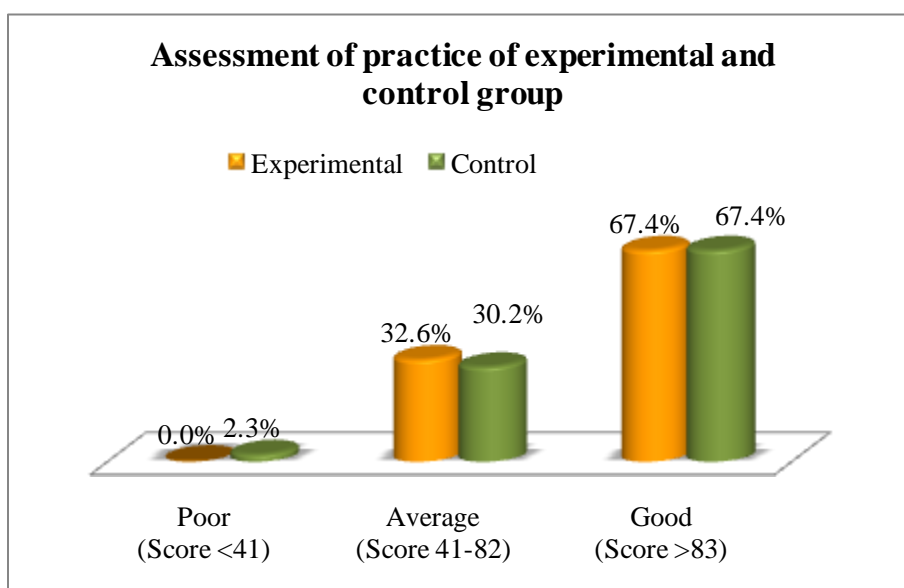


Figure No. 23: Pre-test practice level in experimental and control groups

SECTION IV

Analysis of data related to the effect of health education programme on knowledge of the women related to the common selected reproductive tract infections

TABLE-4C: Pre-test and post-test knowledge grades.

Knowledge grade	Pretest		Posttest	
	Freq	%	Freq	%
Poor (Score 0-24)	429	70.9%	55	9.1%
Average (Score 25-48)	169	27.9%	159	26.3%
Good (Score 49-72)	7	1.2%	391	64.6%

In pretest, majority of 70.9% of the women in experimental group had poor knowledge (score 0-24) regarding reproductive tract infections, 27.9% of them had average knowledge (score 25-48) and only 1.2% of them had good knowledge (score 49-72) regarding reproductive tract infections. Whereas in posttest, majority of 64.6% of the women had good knowledge (Score 49-72), 26.3% of them had average knowledge (score 25-48) and only 9.1% of them had poor knowledge (score 0-24) regarding reproductive tract infections.

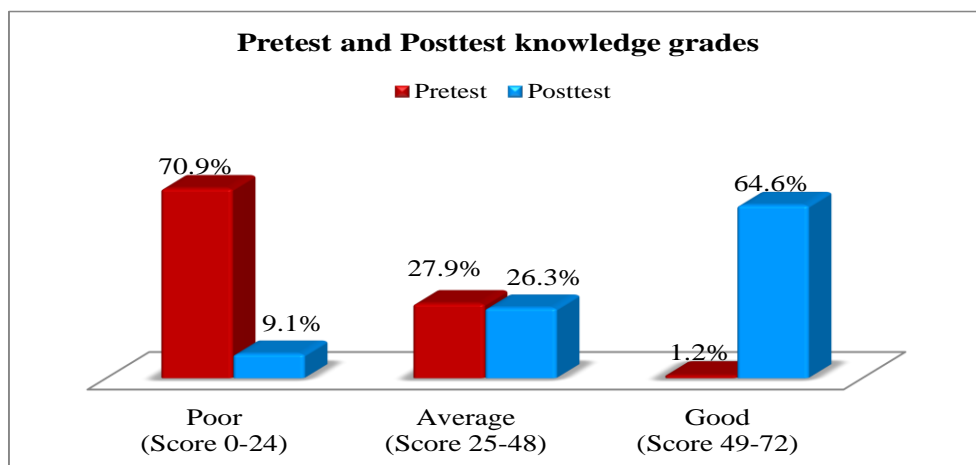


Figure No. 24: Knowledge grades in pre-test and post-test scores

TABLE- 4D: Comparison of average pre-test and post-test knowledge scores.

	Mean	SD	df	T	p-value
Pretest	21.2	13.5	604	53.5	0.000
Posttest	51.6	16.1			

Paired t-test for effectiveness:

Paired t-test was applied to compare scores before and after health education to respondents. The t-value was found to be 53.5 and corresponding p-value was 0.000. Since p-value is less than 0.05, null hypothesis was rejected and research hypothesis was accepted. Researcher concluded at 5% level of significance and 604 degrees of freedom that knowledge scores of women improved significantly after receiving health education on reproductive tract infections. Thus, the health education on reproductive tract infections is proved to be effective in improving the knowledge and creating awareness.

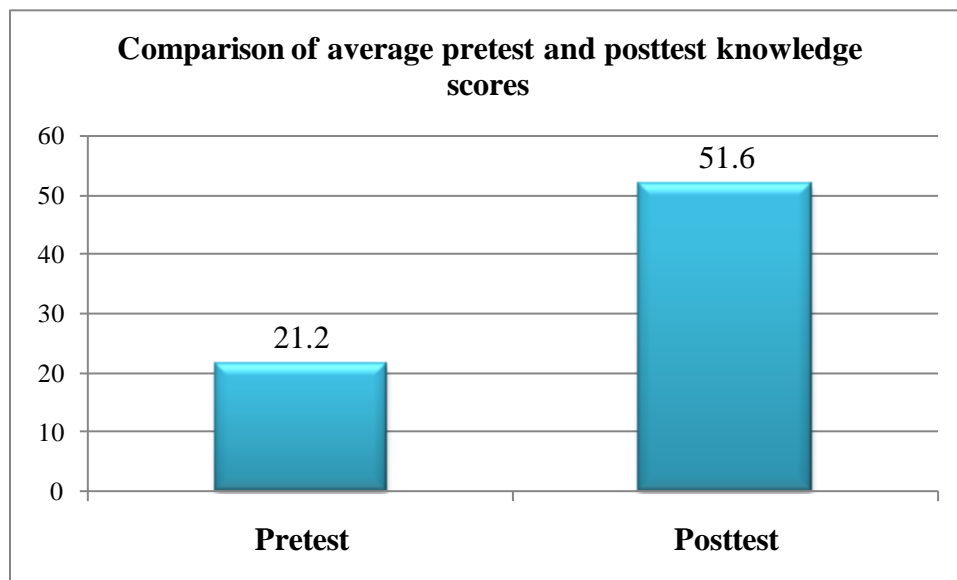


Figure No. 25: Comparison of average pre-test and post-test knowledge scores

Comparison of knowledge of experimental and control group:

TABLE-4E: Compare effect of health education on knowledge scores of experimental and control groups

Group	Mean	SD	Df	z	p-value
Control	0.9	4.8	1208	49.2	0.000
Experimental	30.4	13.9			

Two sample z-test was applied to compare effect of health education on knowledge scores of experimental and control groups. The z-value was found to be 49.2 and corresponding p-value was 0.000. Since p-value is less than 0.05, null hypothesis was rejected and research hypothesis was accepted. Researcher concluded at 5% level of significance and 1208 degrees of freedom that knowledge scores of women in experimental group improved significantly as compared to those in control group. Thus, the health education on reproductive tract infections is proved to be effective in improving the knowledge.

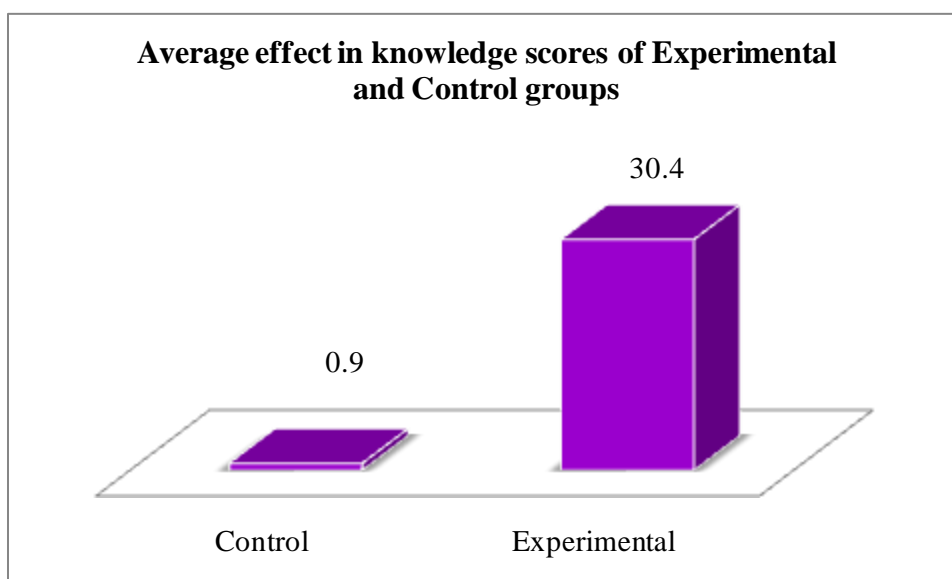


Figure No. 26: Average effect in knowledge scores of experimental and control groups.

Analysis of data related to the effect of health education on the practices of the women related to the common selected reproductive tract infections.

TABLE -4F: Comparison of average pre-test and post-test practice grades.

Practice grade	Pretest		Posttest	
	Freq	%	Freq	%
Poor (Score <41)	0	0.0%	0	0.0%
Average (Score 41-82)	197	32.6%	158	26.1%
Good (Score >82)	408	67.4%	447	73.9%

In pretest, majority of 67.4% of the women in experimental group had good practices (score >82) regarding reproductive tract infections, 32.6% of them had average practices (score 41-82) and none of them had poor practices (score <41) regarding reproductive tract infections, whereas in posttest majority of 73.9% of the women in experimental group had good practices (score >82) regarding reproductive tract infections, 26.1% of them had average practices (score 41-82) and none of them had poor practice score (Score <41) .

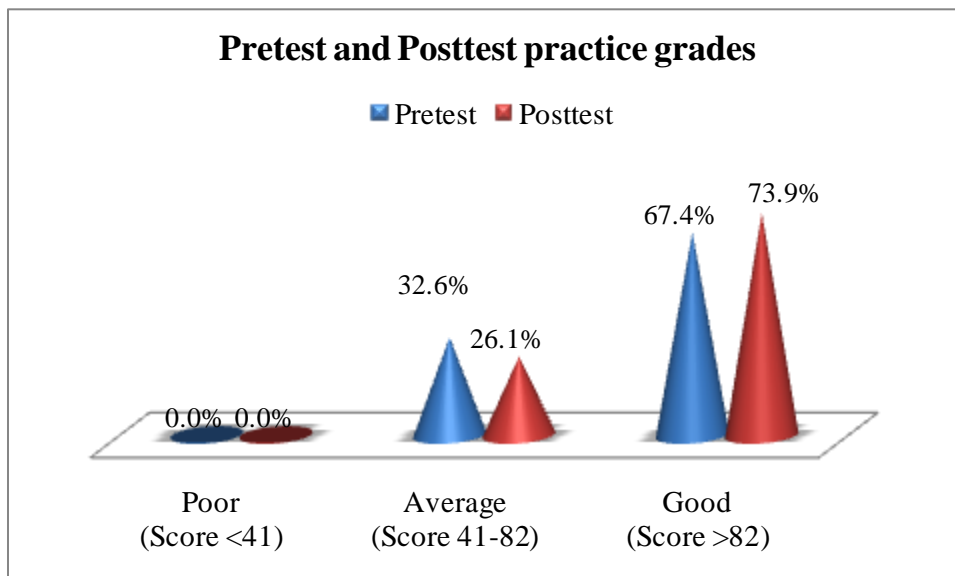


Figure No. 27: Comparison of average pre-test and post-test practice scores

TABLE-4G: Comparison of pre-test and post-test practice scores after health education programme.

	Mean	SD	df	T	p-value
Pretest	60.4	10.6	604	49.9	0.000
Posttest	78.7	7.9			

Paired t-test was applied to compare practice scores before and after health education to respondents. The t-value was found to be 49.9 and corresponding p-value was 0.000. Since p-value is less than 0.05, null hypothesis was rejected and research hypothesis was accepted. Researcher concluded at 5% level of significance and 604 degrees of freedom that practice scores of women improved significantly after receiving health education on reproductive tract infections. Thus, the health education on reproductive tract infections is proved to be effective in improving the practices assured by the women..

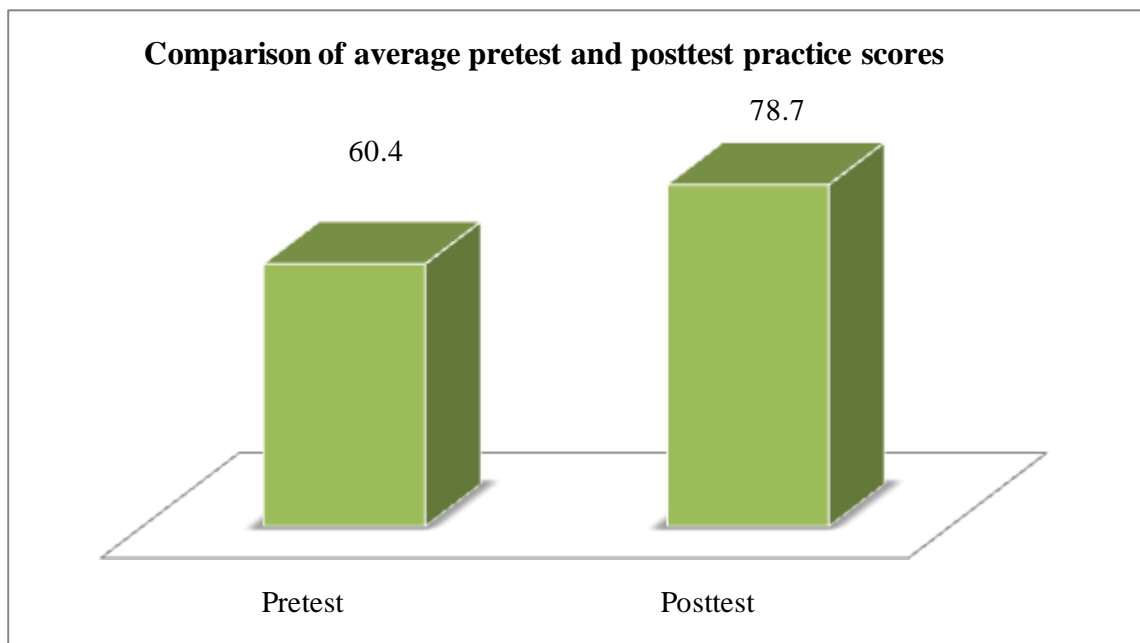


Figure No. 28: Comparison of average pre-test and post-test practice scores

TABLE-4H: Comparison of practices of experimental and control groups

Group	Mean	SD	Df	z	p-value
Control	-2.3	8.3	1208	41.1	0.000
Experimental	18.3	9.0			

Two sample z-test was applied to compare effect on practice scores of experimental and control groups. The z-value was found to be 41.1 and corresponding p-value was 0.000. Since p-value is less than 0.05, null hypothesis was rejected and research hypothesis was accepted. Researcher concluded at 5% level of significance and 1208 degrees of freedom that practice scores of women in experimental group improved significantly as compared to those in control group. Thus, the health education on reproductive tract infections is proved to be effective in improving the practices assured by the women..

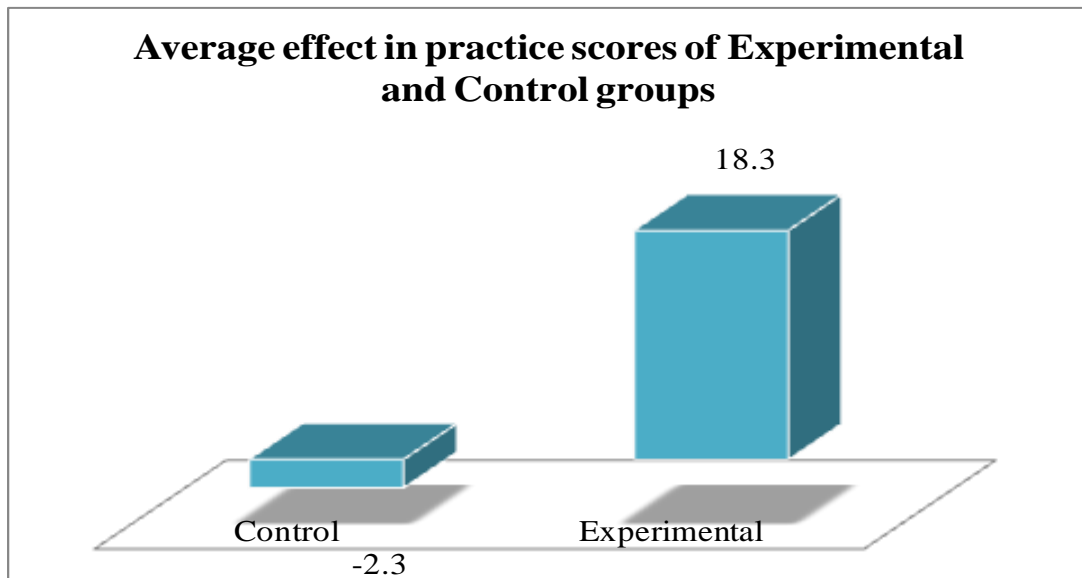


Figure No. 29: Average effect in practice score of experimental and control groups.

SECTION V

An Analysis of data related to correlation between knowledge and practices regarding reproductive tract infections.

The correlation between knowledge and practices was assessed using Pearson's correlation coefficient. The significance of this correlation was assessed by the t-test for significance of correlation coefficient.

TABLE-5A: Correlation between knowledge and practices.

Statistics	value
Pearson's correlation coefficient	0.6
T	25.0
p-value	0.000

The Pearson's correlation coefficient was found to be 0.6. There was positive correlation between knowledge and practices of women regarding reproductive tract infections. The significance of this correlation was assessed using t-test for testing significance of correlation coefficient. T-value was found to be 25 at 5% level of significance. Corresponding p-value was found to be 0.000. The null hypothesis of no correlation between knowledge and practice was rejected at 1208 degrees of freedom. More the knowledge of the women, better are their practices assured by them regarding reproductive tract infections.

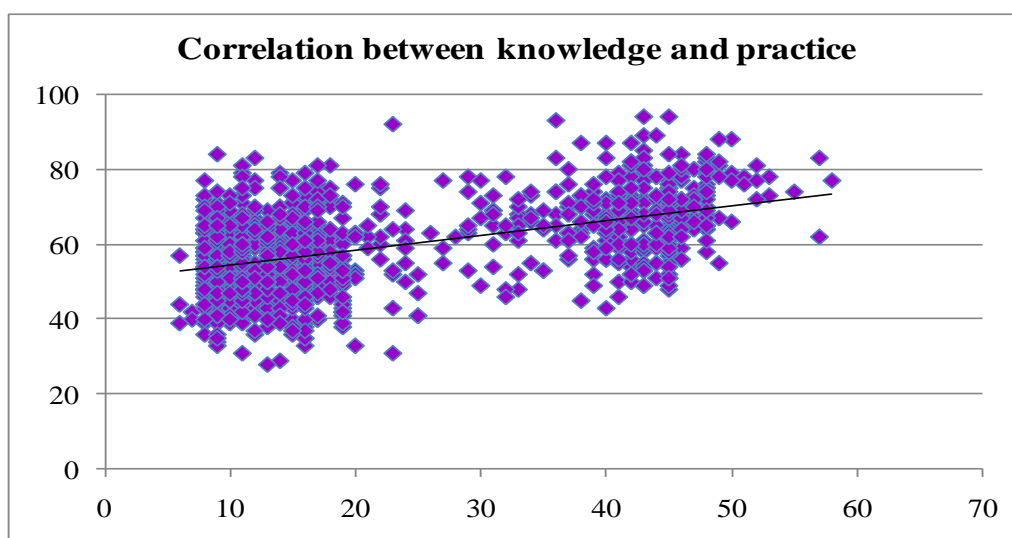


Figure No. 30: Correlation between knowledge and practices.

SECTION VI

The investigator has tried to classify the responses given by respondents according to the different demographic variables. This assessment was done using ANOVA (Analysis of variance). Following table gives the summary of the ANOVA results.

TABLE-5B: An Analysis of data to find association between knowledge with selected demographic variables :

Demographic variable	F	P
Age	1.0	0.433
Age at marriage	0.6	0.598
Religion	0.6	0.565
Marital status	2.0	0.117
Self Education	1.1	0.338
Husband Education	0.5	0.787
Self Occupation	2.3	0.033
Husband Occupation	2.1	0.035
Monthly family income	1.0	0.384
Type of family	0.9	0.424
Menstrual problems	0.7	0.667
Gynecological problems	1.0	0.504
Place of delivery	0.7	0.640
Past medical History	1.2	0.192
Participation of the partner	0.2	0.804

Since p-values corresponding to self occupation and husband's occupation are small (less than 0.05), null hypothesis is rejected. Self occupation and Husband's occupation are the demographic variables which were found to have significant association with knowledge of women regarding reproductive tract infections.

Women having business were found to have the highest average knowledge score and the cattle rearing women had the least. Husbands with other occupation and no occupation were found to have the least knowledge whereas the working husbands had more knowledge regarding reproductive tract infection.

SECTION VII

This assessment was done using ANOVA (Analysis of variance). Following table gives the summary of the ANOVA results.

TABLE-5C An Analysis of data to find association between practices with selected demographic variables

Demographic variable	F	p-value
Age	0.9	0.494
Age at marriage	1.0	0.386
Religion	1.1	0.326
Marital status	1.3	0.263
Self Education	0.6	0.672
Husband Education	0.8	0.554
Self Occupation	3.3	0.003
Husband Occupation	1.8	0.070
Monthly family income	4.7	0.001
Type of family	1.7	0.185
Menstrual problems	0.9	0.545
Gynecological problems	1.3	0.161
Place of delivery	3.6	0.003
Past medical History	1.3	0.114
Participation of the partner	1.2	0.294

Since p-values corresponding to self occupation, monthly family income and place of delivery are small (less than 0.05), null hypothesis is rejected. Self occupation, monthly family income and place of delivery are the demographic variables which were found to have significant association with practices assured by the women regarding reproductive tract infections.

Women having business or working were found to have the higher average practice scores than those cattle rearing. Women from the low income group were found to have lower practice scores as compared to those from higher income group.

Women who had delivered at home as well as hospital were found to have better assured practices as compared to others who had either delivered at home or in hospital.

Summary:

All above findings of the study reveals that health education programme is effective to improve the knowledge and practices assured by the women regarding reproductive tract infections in rural area. There was positive correlation between knowledge and practices assured by the women regarding reproductive tract infection. As the knowledge increases there is improvement in practices assured by the women. Self occupation and husband's occupation , women having business, the working husbands are the demographic variables which were found to have significant association with knowledge of the women regarding reproductive tract infections. Self occupation, monthly family income and place of delivery are the demographic variables which were found to have significant association with practices assured by the women regarding reproductive tract infections.

CHAPTER VI

SUMMATION, FINDINGS, DISCUSSION, CONCLUSION, IMPLICATIONS, LIMITATIONS AND RECOMMENDATIONS.

This chapter presents a summary of the study, the conclusion of its implications for nursing and health care services followed by its limitations. The chapter is completed with suggestions and recommendations for future research in this field.

SUMMATION:

The main aim of the study was “to assess the effect of health education programme on knowledge and practices related to common selected reproductive tract infections among the married women in rural area of Pune District.”

The data was analyzed according to the objectives of study, which were:

- To assess the knowledge of the married women related to common selected reproductive tract infections.
- To assess the practices of the married women related to common selected reproductive tract infections.
- To assess the effect of health education programme on knowledge and practices of the women related to common selected reproductive tract infections.
- To correlate the knowledge of the married women with their practices.
- To find the association between knowledge and practices regarding common selected reproductive tract infections with selected demographic variables.

Section I: - It deals with the analysis of the demographic data.

Section II: - It deals with the analysis of data related to knowledge scores before and after planned health education programme.

Section III: - It includes analysis of data related to effectiveness of health education on knowledge scores in control and experimental group.

Section IV: - It deals with the analysis of data related to practice scores before and after health education programme.

Section V: - It includes analysis of data related to effectiveness of health education programme on practice scores in control and experimental group.

Section VI: - It consists of analysis of data to find the correlation between knowledge and practices.

Section VII: - It consists of analysis of data to find the association between knowledge and practices with selected demographic variables such as age, education, occupation, income, menstrual and gynecological problems place of delivery and participation of the partner.

Investigator has considered sociological aspects in the study because health includes the social components. Most of the diseases include social causes and social consequences along with the medical problems. It helps nurses to know social life and understand the human society, it develops scientific attitude towards customs and traditions and culture.. To understand the epidemiology of diseases nurses should know that society is a complex network of human social relations. It helps to understand to find the health behaviour of the people. A study undertaken is related to reproductive tract infections to improve reproductive health is a genuine issue for the women which is common disease related to socio-demographic determinants .The disease can be prevented and treated if proper awareness methods by understanding socio-demographic determinants in women .

The scarcity of health care services, especially in rural areas, is a restraint for women to seek medical help. Also, health-care is often out of reach for common people. Since a majority of the women are not economically independent, they hesitate to spend money on their health.

Given the various forms of discrimination suffered by women, their low status in society and the consistent neglect of their health, there can be no two opinions on the fact that women urgently require special attention in health care. It is necessary that women's literacy level in rural areas should be enhanced, more employment opportunities to be given to them, and they should have a voice in decision-making. Women should not be treated as mere reproductive machines. They are a precious human resource and their contribution to the nation's socio-economic development is significant. It is very important that women's health is given top priority in our national agenda.

Indian women should be liberated from the restraints of exploitation, subjugation, superstition, degradation, illiteracy and injustice. It should be realized that every issue is a woman's issue, and their contribution and role in the family as well as in the economic development and social processes are essential. There should be

recognition of the dignity of women's work and proper understanding of its dimensions. Women's up-liftment depends on two prerequisites: self-reliance and economic independence. The three issues of Information, Education and Communication (IEC) effort are vital for the up-liftment of women.

Firstly, women should be given education. First of all, females should be given knowledge. Education will extend their outlook and make them conscious of their rights, responsibilities and obligations in the community. Women should be motivated to take part in state policies. So they have speech in policy-making choices. Women should work as equivalent associates with men in all areas of life. They should help develop up a modern and designed community. The immoral custom of dowry has led to countless numbers of simple younger lifestyles going up in fire. Lately, several Functions have been approved to protect females. These consist of the Dowry Prohibition Act, 1961, the Indecent Reflection of Women (Prohibition) Act, 1956, the Percentage of Sati (Prevention) Act, 1987, the reduction of Wrong Visitors Act or SITA, 1956 etc. More such acts should be approved, and possible problems should be obstructed as these have far-reaching effects for ladies in the nation.

Women should be given a unique part in our preparing procedure, and in the mobilization of regional abilities and sources. They should be introduced into the popular of nationwide growth not as beneficiaries but as members and partakers along with men, and as rightful persons of Public Protection.

Validation for selecting the study was based on the fact that the due to absence of literacy, superstitions and taboos are still accepted in our country. The reasons for the gap between what is and the what ought to be, may be the collective effect of deficiency of knowledge, absence of education for females, frequent misconceptions, misunderstandings, superstitions, ethnic background, social background, values, traditions and trust don't permit the individual and groups to differentiate their age old methods and to look at new system. Hundreds of globally research and assessment have shown that knowledge of females is highly associated with the confidence to look at new ways, the desire to do and use wellness services, approximately 340 million new cases of treatable reproduction system attacks and intimately passed on attacks occur each year with 151 thousand of them in South and South east Japan. Reproductive system attacks often cause pain and lost economic efficiency. Reproductive system deaths is high among females of creating countries causing in

harmful repercussions on wellness and social well being of females. Majority of females in Indian continue to suffer from reproduction system attacks causing into pelvic inflammation related illnesses, salpingitis, pelvic bond, sterility, cervical cancer and serious pelvic pain. Although early recognition and treatment of RTIs can prevent and reduce the harshness of long lasting follow up, many attacks go unseen.

Investigator correlates this theory and practice in context with the feminist theory did retain the critical Marxist stance that stressed theoretical knowledge must be generated and used for emancipatory practice. Feminist sociology is understood as a critical enterprise on three counts:

- It takes a woman-centered perspective.
- It interrogates the core concepts and assumptions of sociology from this perspective.
- It asks how social change can be effected to produce a more humane social world.

Feminist sociology theory strengthens the critical emphasis in sociology by its insistence that sociological work be critical and change-oriented, not only towards society but also towards sociology itself (Lengermann and Niebrugge- Brantley, 1990:318).

Radical feminism is a perspective within feminism that calls for a radical reordering of society in which male supremacy is eliminated in all social and economic contexts. Radical feminists seek to abolish patriarchy by challenging existing social norms and institutions, rather than through a purely political process. This includes challenging the notion of traditional gender roles, opposing the sexual objectification of women, and raising public awareness about rape and violence against women.

Early radical feminism, arising within second-wave feminism in the 1960s, typically viewed patriarchy as a trans-historical phenomenon prior to or deeper than other sources of oppression, "not only the oldest and most universal form of domination but the primary form" and the model for all others. Later politics derived from radical feminism ranged from cultural feminism to more synergetic politics that placed issues of class, economics, etc. on a par with patriarchy as sources of oppression. Radical feminists locate the root cause of women's oppression in patriarchal gender relations, as opposed to legal systems (as in liberal feminism) or class conflict (as in anarchist feminism, socialist feminism, and Marxist feminism).

- Reproductive rights defined by feminists in the 1970s as a basic human right, it includes the right to abortion and birth control, but implies much more. To be realised, reproductive freedom must include not only woman's right to choose childbirth, abortion, sterilisation or birth control, but also her right to make those choices freely, without pressure from individual men, doctors, governmental or religious authorities. It is a key issue for women, since without it the other freedoms we appear to have, such as the right to education, jobs and equal pay, may prove illusory. Provisions of childcare, medical treatment, and society's attitude towards children are also involved.
- Changing the organizational sexual culture, e.g., breaking down traditional gender roles and reevaluating societal concepts of femininity and masculinity (a common demand in US universities during the 1980s). In this, they often form tactical alliances with other currents of feminism.

Reproductive rights are legal rights and freedoms relating to reproduction and reproductive health. The World Health Organization defines reproductive rights as follows:

Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence.

Women's reproductive rights may include some or all of the following: the right to legal and safe abortion; the right to birth control; freedom from coerced sterilization and contraception; the right to access good-quality reproductive healthcare; and the right to education and access in order to make free and informed reproductive choices. Reproductive rights may also include the right to receive education about sexually transmitted infections and other aspects of sexuality, and protection from practices such as female genital mutilation (FGM).

Reproductive rights began to develop as a subset of human rights at the United Nation's 1968 International Conference on Human Rights. The resulting non binding Proclamation of Teheran was the first international document to recognize one of

these rights when it stated that: "Parents have a basic human right to determine freely and responsibly the number and the spacing of their children. States, though, have been slow in incorporating these rights in internationally legally binding instruments. Thus, while some of these rights have already been recognized in hard law, that is, in legally binding international human rights instruments, others have been mentioned only in non binding recommendations and, therefore, have at best the status of soft law in international law, while a further group is yet to be accepted by the international community and therefore remains at the level of advocacy.

Issues related to reproductive rights are some of the most vigorously contested rights' issues worldwide, regardless of the population's socioeconomic level, religion or culture.

The issue of reproductive rights is frequently presented as being of vital importance in discussions and articles by population concern organizations such as Population Matters.

Present study is related to educate women regarding reproductive tract infections which has vital role in maintenance of their reproductive health. In rural community women are ignorant about their reproductive health rights so in context to feminist theory, health education regarding reproductive tract infections is given to the women in experimental group and knowledge and practices are assessed.

Social situations and social environment have influence on the occurrence of disease, prevention of illness and health. Unhealthy life styles and high-risk behaviour predisposes sicknesses. For healthier life maintenance modification of life style is required. Individual and societies tend to respond to health problems in a manner consistent with their culture, norms and values. Factors like social, cultural, political, and economic such as lack of information, lack of education and awareness, prevalent myths, misconceptions, superstitions, ethnicity, cultural background, beliefs, customs and faith etc. do not permit women to discriminate their age old practices and to adopt new system which has definite influence over health maintenance. So the health care providers should arrange Information Education and Communication (IEC) campaigns through mass media activities emphasizing the public on healthy life style and individual responsibility for healthcare. Another important factor in improving the health status is, efficient and sustainable community participation. There is need to train communities to create self-help groups and sustainable health services system by

utilising the locally available resources. Factors definitely enhance the outreach of health services to educate the community by providing training hence to create an awareness investigator implemented a health education program regarding reproductive tract infections.

The study assumes that health education is the accepted strategy for enhancing knowledge and to create awareness among women.

The study attempted to examine the following hypothesis:

- **H₁** - The post-test knowledge and practice score of the women in relation to the reproductive tract infections will be significantly higher than their pretest knowledge score.
- **H₂**-There will be significant co-relation between knowledge and practice score of the women.
- **H₃** - There will be significant association between pre-test level of knowledge score of the women in relation to the reproductive tract infections and the selected demographic variables i.e. age, age at marriage, education of self and husband, occupation of self and husband, monthly family income, place of delivery and partner participation
- **H₄** - There will be significant association between pre-test level of practice score of the women in relation to the reproductive tract infections and the selected demographic variables i.e. age, age at marriage, education of self and husband, occupation of self and husband, monthly family income, place of delivery, and partner participation.

The independent variable was health education programme on reproductive tract infections and the dependent variables were the knowledge and practice score, scores of the subjects in pre and post-test. The extraneous variables such as age, education of self and husband, occupation of self and husband, family income and partner participation.

- The research approach adopted for the study is an experimental approach because the present study is aimed at developing health education programme related to reproductive tract infections among the married women in rural area of Pune District and determining its effectiveness statistically. For generating necessary

data demographic details were collected, a structured questionnaire was developed to assess their knowledge and 3-point Likert scale was used to assess their practices.

Development of the structured questionnaire involved the steps of question construction preparing a blue print, item writing, content validation and establishing reliability. A Pilot study was conducted to establish the feasibility of the tool. Pilot study was conducted at Wagholi 10th April to 6th June 2011 on total 120 married women residing at Wagholi, 60 control and 60 experimental. The tool was found valid and reliable.

- For the final study population consisted of total 1210 samples between 15 -49 years of age selected by probability proportionate multistage sampling technique. Pune district includes 13 tehsils. Probability proportionate multistage sampling technique was used for sample selection. From each tehsil two villages were selected randomly (one for experimental and one for control group), from these two villages samples with sample size proportionate to tehsil population was taken for experimental and control group. Random sampling technique was used to select samples from each village. Total 605 for control group and 605 samples for experimental group were selected for the study.

With the permission letter the formal written permission was obtained from District Health Officer. Data was collected from 1st September 2011 to 17th January 2013 from rural area of Pune District.

- On, day one (pre-test day) purpose of the study was explained to each women and confidentiality of her responses was assured. The pre testing took 45 minutes to one hour. After pre-test, the same day health education was administered to the subjects. Post-test was conducted on 15th day and data was collected from the subjects. The data gathered was analysed using descriptive and inferential statistics. The following analysis was computed:
 - The items in the demographic data variables were computed in terms of frequency and percentage.
 - Item-wise increase in level of the knowledge of pre test & post-test between both groups regarding reproductive tract infections.
 - Item -wise increase in level of the self expressed of pre test & post-test between both groups regarding reproductive tract infections.

- Paired t-test was applied to compare knowledge scores before and after health teaching.
- Paired t-test was applied to compare practice scores before and after health education to respondents.
- Two sample z-test was applied to compare effect on knowledge scores of experimental and control groups.
- Two sample z-test was applied to compare effect on practice scores of experimental and control groups
- Pearson's correlation coefficient followed by the t-test for significance of correlation coefficient was used for analysis of data related to find correlation between knowledge and practices regarding reproductive tract infections.
- Analysis of data to find association between knowledge and selected demographic variables was done using ANOVA (Analysis of variance).

Major findings of the study:

The findings of the study were based on the objectives of the study:

❖ Demographic details:

In experimental group, maximum 23.6% of them were from age group 26-30 years, and least 1.8% of the women were from age group 15-20 years. In control group also maximum 23.3% of them were from age group 26-30 years, least 4.1% of the women were from age group 15-20 years, In the present study majority of the women were in the age group between 26-30 years. Similar findings were revealed in the study, RTI/STI prevalence among urban and rural women of Surat: A community-based study India's (Kosambia JK et.al)

In experimental group majority, 77.5% of them were 18-22 years at marriage, 20.7% of them were less than 18 years 1% of them were 23-27 years and only 0.8% of them were 28-32 years at marriage. In control group, 78.8% of them were 18-22 years, 19.8% of them were less than 18 years at marriage, 0.8% of them were 23-27 years and only 0.5% of them were 28-32 years at marriage.

Regarding child marriage in India though the Prohibition of Child Marriage Act 2006 bans marriage below age 18 for girls and age 21 for boys, but in rural areas where family, caste and community pressures are more effective than any legislature. According to UNICEF's State of the World's Children 2009 report, 47% of India's

women aged 20–24 were married before the legal age of 18, with 56% in rural areas. The report also showed that 40% of the world's child marriages occur in India. After marriage there is mainly a superior complex towards men and their discrimination in marital relationships.

In experimental group, majority of 90.2% of them were Hindu, 8.9% of them were Muslim and 1% of them were Christian. In control group, majority of 90.2% of them were Hindu, 8.1% of them were Muslim and 1.7% of them were Christian.

In experimental group, majority of 95.5% of them were married, 2% of them were divorced, 1.8% of them were widow and 0.7% of them were separated. In control group, majority of 93.6% of them were married, 2.8% of them were widow, 2% of them were divorced and 1.7% of them were separated.

On the subject of education of self the largest part of an experimental group, 44.8% of them had primary education whereas in control group 44.1% of them had primary education in experimental group 28.1% of them were illiterate, in control group 25% of them were illiterate, only 5.5% of them had higher secondary education and 3.6% of them were graduates and 1.3% of them had some other education. In control group, only 7.3% of them had higher secondary education and 4.6% of them were graduates and 2.3% of them had some other education. As per Population Census of India 2011, the Literacy rate of India has shown as improvement of almost 9 percent. It has gone up to 74.04% in 2011 from 65.38% in 2001, thus showing an increase of 9 percent in the last 10 years. It consists of male literacy rate 82.14% and female literacy rate is 65.46%. Kerala with 93.9% literacy rate is the top state in India. Lakshadweep and Mizoram are at second and third position with 92.3% and 91.06% literacy rate respectively. Bihar with 63.08% literacy rate is the last in terms of literacy rate in India

.Regarding their husband education in experimental group, majority 34.2% of them had secondary education, 13.1% of the women had illiterate husbands, only 1% of them had post graduation and 1.3% of them had some other education. In control group majority 34.2% of them had secondary education, 26.3% of their husbands had primary education, 12.1% of the women had illiterate husbands, only 1.3% of them had post graduation.

Regarding occupation of the women, 46% of them were housewives in experimental group, and 44% of them were housewives in control group and only 3.8% of them

were doing service in experimental group, 2.5% of them had business in control group.

Regarding occupation of their husband in experimental group, majority 38.5% of them were farmers, 16.9% of them were doing service ,10.6% of them had their husbnads doing business, 10.2% of them were labourers 9.1% of their husbands were rearing cattle, 7.3% of them were working in company, 4.3% of them had some other occupation and 3.1% of them had poultry. In control group majority 36.7% of them were farmers , 25% of them were doing service, 9.3% of them were labourers, 8.1% of their husbands were rearing cattle, 7.1% of them were working in company, 6.3% of them had their husbnads doing business, , 4.5% of them had poultry and 3.1% of them had some other occupation.

The maximum 38.5% husbands were farmers, which resembles with Employment Scenario in Maharashtra: An Overview. Economic Survey of Maharashtra 2010-11 reveals that the maximum employment of 242 lacs (56 per cent) was observed in agriculture and allied activities .61.5% were having non agricultural activities it can be said the there has been a shift of the workers from agriculture activities to various non-agricultural activities in the state. Reasons for such a shift can be that land is limited and it cannot support the growing population, therefore, people fail to find gainful employment in agriculture and Maharashtra being an industrially developed state, due to industrialization and urbanization employment generation in non-agricultural activities has attracted the workers to shift from agriculture to non agricultural activities .The growth performance of agriculture in Maharashtra was highly impressive is the early part of the green revolution period but deterioration has occurred after 1980-81 (Sawant S.D.)

Regarding husband stay in experimental group, only 17.5% of the women had their husbands staying outstation and in control group 18.8% of them had their husbands staying outstation.

On the subject of income in experimental group, majority 43.5% of them had income Rs. 5,001-10,000, 12.7% of them had family income less than Rs. 5000, In control group, majority 39.8% of them had income Rs. 5001-10,000 and 13.9% of them had family income less than Rs. 5,000.

In experimental group, 76.5% of them had joint family, 20% of them had nuclear family and 3.5% of them were separated. In control group, 78.2% of them had joint

family, 17.5% of them had nuclear family and 4.3% of them were separated. Mostly in rural culture in India still joint family is commonly seen.

In experimental group, majority of women 86.6% of them had bleeding for 4-6 days and 6.6% of them had bleeding for more than 6 days. In control group, majority 78.8% of them had bleeding for 4-6 days 9.4% of them had bleeding for less than 4 days, and 11.7% of them had bleeding for more than 6 days. In experimental group, majority, 86.6% of them had normal flow, 6.8% of them had scanty flow and 6.6% of them had heavy flow. In control group, majority 78.8% of them had normal flow, 11.7% of them had heavy flow and 9.4% of them had scanty flow.

Majority of the women 64.3% and 64.1% in experimental and control group respectively had irregular menstrual pattern and 52.6% and 49.4% in experimental and control group respectively experienced painful period.

Women 35% and 35.4% in experimental and control group respectively had gynecological problems.

Shabnam Omidvar revealed findings in her study that menstrual disorders frequently affect the quality of life of adolescents and young adult women and can be indicators of serious underlying problems. Delayed, irregular, painful, and heavy menstrual bleeding are common occurrence among younger age

Majority of the women 46.4% and 48.6% in experimental and control group respectively had two children, This finding reveals that we meet less than 50% of two child norm policy as per the 11th Five-Year Plan 2007-2012 which established the time bound objective of achieving the Total Fertility Rate of 2.1 by 2012.

In experimental group, majority 55.9% of them had no abortion, 34% of them had one abortion, 9.4% of them had two abortions and 0.7% of them had three abortions. In control group majority 56.5% of them had no abortion, 34.9% of them had one abortion, 8.4% of them had two abortions and 0.2% of them had three abortions.

In experimental group majority 85.1% of them had normal deliveries 3.6% of them had abnormal deliveries, 5.5% of them had both (normal and abnormal) deliveries, and 5.8% of them had no deliveries. In control group majority 84% of them had normal deliveries 7.1% of them had abnormal deliveries, 2.6% of them had both (normal and abnormal) deliveries, and 6.3% of them had no deliveries.

In experimental group majority 57.5% of them had deliveries in hospital, 24.1% of them had deliveries at home, 12.6% of them had both, deliveries at home and in

hospitals. In control group majority 64.8% of them had deliveries in hospital, 17.4% of them had deliveries at home, 11.6% of them had both places at home and in hospitals. As per National Family Health Survey (NFHS-3;2005-06)for 72 percent of deliveries that took place at home, the mother reported that she did not feel that it was necessary to deliver in a health facility, and for more than a quarter (26 percent), the mother said that delivery in a health facility is too expensive. Forty-seven percent of births in the five years preceding the survey were assisted by health personnel, including 35 percent by a doctor and 10 percent by an auxiliary nurse midwife, nurse, midwife, or lady health visitor. More than one-third of births (37 percent) were assisted by a traditional birth attendant, and 16 percent were assisted by only friends, relatives, or other persons (NFHS-3)2005-06.

In experimental group, majority 71.1% of them had normal sex, 25.8% of them had pain during intercourse, 1.3% of them had pain and bleeding during sexual intercourse, 1.2% of them had bleeding during intercourse,0.3% of them had sexual abuse, and 0.3% of them had anal and oral practice. In control group, 69.6% of them had normal sex, 27.9% of them had pain during intercourse, 1% of them had pain and bleeding during sexual intercourse, 0.7% of them had bleeding 0.5% of them had sexual abuse, and 0.3% of them had anal and oral practice. Women are shy to discuss on sexual matters .In this study 71.1% of the women said they have normal sexual pattern very few 28.9% openly told their sexual problems.

Various types of culture exist in societies. Within each culture there are customs. These customs start even before birth and continues till life. Even after death, all rituals are performed according to customs of the culture. The various customs may accompany pregnancy, childbirth and weaning, the aim being successful reproduction and to protect the life of mother and baby. If we look at them from a modern, scientific point of view, however, not all of these customs will be considered helpful. Some of these, indeed, may be positively harmful. So attitudes and practices in respect health matters can be changed by educating them and creating awareness regarding their reproductive health

Regarding education in India, though primary education is free for girls attendance is less, parents are not willing to send girls in schools due to feeling of security and for household work. Literacy Rate for Women is 54% and for males is 76%. Illiterate girls become illiterate mothers which affects their quality of care ,poor quality care affects

child health resulting in higher mortality , morbidity and malnutrition in children, mothers with little education are less likely to adopt appropriate health-promoting behaviors,

In experimental group, 55% of the women were not using any contraceptive method. Out of those who were using contraceptives, 24.8% of them were using Cu-T, 10.1% of them had oral pill and 10.1% of them had tubectomy. In control group, 54% of the women were not using any contraceptive method. Out of those who were using contraceptives, 21.7% of them were using Cu-T, 13.4% of them had oral pill and 10.9% of them had tubectomy. The contraceptive prevalence rate for currently married women in India is 56 percent, up from 48 percent in (NFHS-2. 2009), 48.3% of married women were estimated to use a contraceptive method, i.e. more than half did not. About three-fourths of these were using female sterilization, which is by far the most prevalent birth-control method in India. Condoms, at a mere 3% were the next most prevalent method. Meghalaya, at 20%, had the lowest usage of contraception among all Indian states. Bihar and Uttar Pradesh were the other two states that reported usage below 30%.

Overall contraceptive prevalence was 45.2% of which 34.2% had used a permanent method. Among the current users, the contraceptive had been availed mainly from either PHC (31.5%) or hospital (42.1%). Around half the women (53.1%) had received counseling and in 20.3% information regarding other methods. Contraceptive knowledge, practices and utilization of services in the rural areas of India (an ICMR task force study).Dhillon, B.S., Chandhiok, N., et.al. reveal similar findings ,only 54.4% actually used any contraceptive methods; 66.7% of the men said that the decision should be a joint one, 66.4% wanted to limit their family size. Approximately one fourth of the men had never heard of voluntary sterilization. No one in the study group was aware of the mini-pill, diaphragm or Norplant. In the study group, 26.8% of the men did not want their wives to use intrauterine devices and 31.7% of them did not agree with women using the contraceptive pills. Among those unwilling to use a condom (46.3%), 70.1% stated that it might interrupt intercourse. If a contraceptive pill for males could be used, 25.2% of members of the group would be prepared to use it. Only 17.5% men in the study group had contacted a doctor or a health foundation to obtain information.

Baitule M. suggested that there was an association between presence of gynaecological diseases and use of female methods of contraception, but this could explain only a small fraction of the morbidity. In the rural areas of developing countries, gynaecological and sexual care should be part of primary health care.

Santhya KG reveals that, the main sources of family planning information were TV/radio, followed by friends and newspapers/magazines. In order to encourage men's involvement in family planning, the use of mass media and continual training programs, to reach both men and women, could be very useful. (Population Council, New Delhi, India) In experimental group, only 19% of them had participation of the partner. In control group only 21.7% of them had participation of the partner.

❖ **Findings related to item-wise analysis of knowledge regarding reproductive tract Infections:**

Items in Table-2a shows (Regarding meaning of RTI, female reproductive organs and sites of RTI)

Regarding the meaning of reproductive tract infections, in experimental group in pretest, 34% of the women and 77% of them in posttest knew the meaning of reproductive tract infections and in control group, 38.3% of them in pretest and 47.85% of them in posttest.

Regarding pretest knowledge on anatomy of the female reproductive tract in experimental and control group 21.8 % and 25.8 % respectively knew anatomy of female reproductive tract and increase in posttest knowledge 67.3% in experimental group.

Regarding different body sites where reproductive tract infections occur in women in experimental group and control group pretest score was 24% and 26% and posttest score improved to 69.8% in experimental group.

Majority of them in experimental and control group in pretest 67.9% and 71.2% stated that reproductive tract infections are more common in women than men because women are more likely to suffer from asymptomatic infections. In posttest improved to 82.8% in experimental group.

Majority of them in experimental group and control group, in pretest 48.8% and 49.8% respectively stated that reproductive tract infections are more common in women than men due to shyness and stigma. Post-test score improved to 77.9% in experimental group.

Items in Table- 2B represents:

Regarding types of reproductive tract infections, in experimental group and in control group 14.4% and 14.7% respectively in pretest opined that infections due to overgrowth of organisms normally found in the genital tract of women are the reproductive tract infections and posttest score increased to 66.3% in experimental group.

Regarding the names of RTI, in pretest 15.4% and 17.4% in experimental and control group, knew the names of reproductive tract infections.

Regarding the possible causes of RTI/STI majority of them from both groups in pretest, 66.1% in experimental and 67.9% in control group opined in pretest that poor genital and menstrual hygiene is the possible cause of RTI/STI., in pretest 5.8% in experimental group and 6.3% in control group stated that poor general health / low immunity are the possible cause of RTI/STI.

Items in Table-2C indicate: Regarding common signs and symptoms of RTI.

In pretest. 5.5% in and 6.1 in experimental and control group respectively opined that genital itching is common sign and symptoms of RTI. In pretest 5.5% and 4.6%, in experimental and control group respectively opined that swelling in the groin and fever are common sign and symptoms of RTI. In pretest 6.9% and 8.8% in experimental and control group opined that pain & bleeding during sexual intercourse are common sign and symptoms of RTI. In pretest, 49.8% and 53.1% in experimental and control group respectively stated that redness, rash, sores, ulcers and warts are common sign and symptoms of RTI. In pretest 47.8% and 53.4% in experimental and control group stated that lower abdominal /lumber pain are common sign and symptoms of RTI.

Regarding the spread of RTI –Majority in pretest experimental group 65.3% and in control group 64.3% responded that reproductive tract infection is spread by the use of unclean water for genital hygiene. In experimental group, 48.1% and in control group, 53.4% in pretest opined that reproductive tract infection is transmitted by sharing clothes. Majority in experimental group, in pretest 69.4%, whereas in control group, 69.1% stated that reproductive tract infection is spread by sharing/use of public toilet. Few in experimental group 3.6% in pretest whereas in control group 2.8% in pretest opined that reproductive tract infections are transmitted through mother to child. In experimental group, 5.3% of them in pretest whereas in control group 4.5%

in pretest stated that the reproductive tract infection spreads through unsafe abortion and delivery.

Items in Table-2D indicate: Regarding the treatment of RTI

In pretest, majority of the respondents in experimental group, in pretest 72.2%, whereas in control group, 68.6% stated that herbal medicines are used to treat reproductive tract infections.

Items in Table-2E represents:

Regarding the complications of RTI In pretest, in both groups majority of them in experimental group 60.5% and in control group 59.5% responded that systemic complications occur if reproductive tract infections are not treated. None of them 0% from either group responded in pretest that prenatal and neonatal infections are the complications which are caused if reproductive infections are not treated, 2.6% and 2.8% in experimental and control group respectively opined miscarriage and still birth, 2.1% and 3% opined infertility, 3.5% and 3.3% opined ectopic pregnancy, 7.4% and 7.8% opined effect on marital status/divorce are the complications if reproductive tract infections are not treated.

Regarding preventive and control measures, in both groups only 9.4% of them knew that the safer sex practices are the preventive and control measures for RTI, Majority 56.4% in experimental group and 62% in control group responded in pretest that menstrual hygiene, and 57.4% in experimental and 59.5% in control group stated public awareness regarding RTI will help as a preventive and control measure of RTI.

Table -3A shows: Item analysis of practices regarding reproductive tract infections (Preventive practices) Hygienic practices -

Regarding hygienic practices majority of the women in experimental 96% and control group 95.5% had maintained their personal hygiene. Regarding genital hygiene, in pretest, 49.3% of them from experimental group and 43.3% of the women in control group never do cleaning from vagina towards anus; whereas in posttest experimental women around 54.7% of them stated they always do cleaning from vagina to anus.

Table - 3 B shows: Menstrual hygienic practices-

Regarding menstrual hygienic practices majority of the women 82.1% in experimental group and 37.5% in control group always maintain menstrual hygiene. 56% in experimental group and 55.2% in control always use cloth during menstrual period

whereas 33.2% in experimental group and 38% of the control group never used sanitary napkins.

Table - 3 C shows: Sexual practices-

Regarding sexual practices in pretest, in experimental group 49.4% and 49.9% in control never cleanse genital region before intercourse, 48.8% and 49.4% never used condom if either of the partner had symptom of RTI, 71.6% of the women in both experimental or control group expressed that they never followed safer sex practices.

Table - 3D indicates: Antenatal practices.

Regarding antenatal practices - In pretest 44.6% of the women from experimental group and 46.6% of the women in pretest from control group sometimes seek antenatal care during pregnancy. Only 15.5% in experimental and 20.2 % of the women always take decision regarding choice for place of delivery.

Table- 3E Regarding Intra-natal practices –

Regarding Intra-natal practices In experimental and control group, in pretest, 45.1% and 46.3% respectively would never prefer hospital delivery. 28.9% in pretest in experimental group and 33.1% in control group always preferred home delivery.

Table- 3F Regarding post-natal practices

Regarding postnatal practices, in pretest, 25.1% of the respondents from experimental group and 27.8% of them from control group had responded that they always seek postnatal care. (Hygiene, diet, exercise, care of breast, care of newborn, regular medical checkup).

Table- 3G –Contraceptive practices

Regarding contraceptive practices in experimental group 43.0% and 40.0% in control group women showed self efficacy towards spacing. 40.5% and 46.1% in experimental and control group expressed they sometimes seek medical treatment immediately if suffered from complications due to contraceptives.

Table- 3H –Abortion practices:

Regarding abortion practices 26.4% and 25.8 in experimental and control group respectively always seek medical treatment if experienced any problem after abortion .For experimental group, score in posttest improved to 65%.

53.7% and 46.8% in experimental and control group respectively expressed abortion should be done at approved hospital , 23.1% and 18.2% in experimental and control group respectively said sometimes they made attempt to perform abortion at home

,44.3% in experimental group and 44.1% in control group women never seek medical treatment if any problem arises after abortion .

Table – 3I indicates: Curative practices.

Regarding seeking of medical treatment ,majority 51.2% in experimental group and 43.8% in control group women expressed they never seek medical treatment immediately if experienced any symptom related to RTI. Regarding the reasons for not seeking medical treatment ,46.9% and 40% in experimental and control group respectively expressed , because they do not think as a disease ; 43.8% and 42% replied due to lack of time ,44.3% and 39.8% responded due to lack of money,63.5% and 61.8% expressed they feel shy to tell the problem ,64.5% and 60.8% expressed due to social stigma,46.6% and 47.9% in experimental and control group respectively expressed due to lack of decision making power.

Regarding utilization of other measures than medical treatment they expressed in experimental and control group respectively, 38.7%and 39.2% practice home remedies, 32.1% and31.4% practice herbal medicine, 29.8% and 25.8% approach Hakim/ Vaidu, 25.1% and 25.5% a practice of black magic.

Regarding immediate and complete treatment in experimental group 57%and in control 52.1% never took immediate and complete treatment .Regarding treatment along with husband/partner they expressed in experimental 54.4% and in control group52.1% never took treatment along with their husband/partner .Regarding avoiding sex with infected partner 54% in experimental and54.2% in control group never practiced this. Regarding practice of safer sex 53.9% in experimental and 52.6% in control group expressed they never practiced safer sex.

Table – 3J indicates: Awareness practices.

Regarding receiving the information on RTI, 83% and 83.5% of the women in experimental and control group respectively never received information regarding RTI through health education. Overall 62.3% and 64.4% of the women responded they never followed awareness practices

Regarding creating awareness among others 79.8% and 76% of the women in experimental and control group respectively never share the information regarding RTI with others However, experimental group percentage of following awareness practices score significantly in posttest as compared to pretest.

4. Analysis of data related to the effect of health education programme on knowledge related to the common selected reproductive tract infections

Table - 4C indicates:

In pretest, majority of 70.9% of the women in experimental group had poor knowledge (score 0-24) regarding reproductive tract infections, 27.9% of them had average knowledge (score 25-48) and only 1.2% of them had good knowledge (score 49-72) regarding reproductive tract infections. Whereas in posttest, majority of 64.6% of the women had good knowledge (Score 49-72), 26.3% of them had average knowledge (score 25-48) and only 9.1% of them had poor knowledge (score 0-24) regarding reproductive tract infections.

Table - 4D indicates: Comparison of average pre-test and post-test knowledge scores:

Paired t-test was applied to compare scores before and after health education to respondents. The t-value was found to be 53.5 and corresponding p-value was 0.000. Since p-value is less than 0.05, null hypothesis was rejected and research hypothesis was accepted. Researcher concluded at 5% level of significance and 604 degrees of freedom that knowledge scores of women improved significantly after receiving health teaching on reproductive tract infections. Thus, the health teaching on reproductive tract infections is proved to be effective in delivering the knowledge and awareness. The knowledge scores of women in experimental group improved significantly as compared to those in control group. Thus, the health teaching on reproductive tract infections is proved to be effective in improving the knowledge.

5. Analysis of data related to the effect of health education programme on practices related to the common selected reproductive tract infections:

In pretest, majority of 67.4% of the women assured in experimental group good practices (score >82) regarding reproductive tract infections, 32.6% of them had average practices (score 41-82) and none of them had poor practices (score <41) regarding reproductive tract infections, whereas in posttest majority of 73.9% of the women assured in experimental group good practices (score >82) regarding reproductive tract infections, 26.1% of them had average practices (score 41-82) and none of them had poor practices (Score <41) .

Table-4G: Comparison of pre-test and post-test practice scores after health education programme:

Paired t-test was applied to compare practice scores before and after health teaching to respondents. The t-value was found to be 49.9 and corresponding p-value was 0.000. Since p-value is less than 0.05, null hypothesis was rejected and research hypothesis was accepted. Researcher concluded at 5% level of significance and 604 degrees of freedom that assured practices of women improved significantly after receiving health education on reproductive tract infections. Thus, the health education on reproductive tract infections is proved to be effective in improving the practices assured by the women.

Table-4H: Comparison of practices of experimental and control groups:

Two sample z-test was applied to compare effect on practice scores of experimental and control groups. The z-value was found to be 41.1 and corresponding p-value was 0.000. Since p-value is less than 0.05, null hypothesis was rejected and research hypothesis was accepted. Researcher concluded at 5% level of significance and 1208 degrees of freedom that practice scores of women in experimental group improved significantly as compared to those in control group. Thus, the health teaching on reproductive tract infections is proved to be effective in improving the practices assured by the women.

Table-5A: An Analysis of data related to correlation between Knowledge and practices regarding reproductive tract infections:

The correlation between knowledge and practices was assessed using Pearson's correlation coefficient. The significance of this correlation was assessed by the t-test for significance of correlation coefficient. The Pearson's correlation coefficient was found to be 0.6. There was positive correlation between knowledge and assured practices of women regarding reproductive tract infections. The significance of this correlation was assessed using t-test for testing significance of correlation coefficient. T-value was found to be 25 at 5% level of significance. Corresponding p-value was found to be 0.000. The null hypothesis of no correlation between knowledge and practice was rejected at 1208 degrees of freedom. More the knowledge of the women, better are their assured practices regarding reproductive tract infections.

Table -5B indicates: An Analysis of data to find association between knowledge and selected demographic variables:

Since p-values corresponding to self occupation and husband's occupation are small (less than 0.05), null hypothesis is rejected. Self occupation and Husband's occupation are the demographic variables which were found to have significant association with knowledge of women regarding reproductive tract infections.

Table- 5C indicates: An Analysis of data to find association between practices and selected demographic variables:

Since p-values corresponding to self occupation, monthly family income and place of delivery are small (less than 0.05), null hypothesis is rejected. Self occupation, monthly family income and place of delivery are the demographic variables which were found to have significant association with practices assured by the women regarding reproductive tract infections.

DISCUSSION

WHO and UNICEF have repeatedly emphasized that too early pregnancies (teenager), too late (35 and over), too close (less than 2 years) and too many (4 and over) are not safe or conducive to the health of either mother or child.

Another important cause of maternal ill-health is anaemia. It contributes to premature births, low birth weight babies and high pre-natal mortality. It is directly responsible for 20% of all maternal deaths and is a contributing factor for 20% more, according to available statistics. Out of an estimated 500,000 maternal deaths globally, only 1% occur in developed countries, with the highest number in South Asia. WHO has estimated that 61% of all women in the child-bearing age (15-49 years) are anaemic. In India, over 80,000 mothers die per year, i.e. almost 10 per hour.

Women often have to bear the triple burden of a job, housework and children. This causes a lot of strain for her. Working women also face a lot of occupational health hazards, for example, Women construction workers often suffer from backaches while women doing intricate work like embroidery suffer from eyestrain.

The paucity of health care services, especially in rural areas, is a deterrent for women to seek medical help. Also, health-care is often out of reach for common people. Since a majority of the women are not economically independent, they hesitate to spend money on their health.

Given the various forms of discrimination suffered by women, their low status in society and the consistent neglect of their health, there can be no two opinions on the fact that

women urgently require special attention in health mailers. It is necessary that women's literacy level is enhanced, more employment opportunities are given to them, and they have a voice in decision-making. Women should not be treated as mere reproductive machines. They are a precious human resource and their contribution to the nation's socio-economic development is significant. It is imperative that women's health is given top priority in our national agenda.

The findings of the study have been discussed with reference to the objectives and hypothesis stated in chapter 1 and with findings of other studies.

Demographic details-

Regarding age at marriage in experimental group, majority 77.5% of them were 18-22 years, 20.7% of them were less than 18 years. In control group, majority 78.8% of them were 18-22 years, 19.8% of them were less than 18 years at marriage and least 0.5% of them were 28-32 years at marriage, As per DLHS- 3 Mean age at marriage for girls (marriages that occurred in the rural area during 18.9 years. Several national level policies formulated since 2000, including the National Population Policy 2000, the National Youth Policy 2003, the National Policy for the Empowerment of Women and, most recently, the Prohibition of Child Marriage Act 2006, have advocated special programme attention to delay age at marriage and to enforce existing laws against child marriage. Programmatically also, several initiatives, including the Balika Samridhi Yojana, have been launched to prevent early marriage. Despite these commitments, substantial proportions of girls continue to marry in adolescence. As recently as 2005–06, more than two-fifths (47%) of women aged 20–24 were married by 18 years nationally. While the situation of married young women in India has been increasingly documented, evidence on the ways in which early marriage limits girls' lives and compromises their reproductive health.

Even though the state of Maharashtra is one of the most socially and economically progressive states in the country, data are drawn from the Youth in India, study findings underscore the prevalence of early marriage among young women in the state of those aged 20–24, almost one in 10 young women was married before age 15 and over one-third before age 18. Young women in rural areas were twice as likely as urban young women to be married before age 18; 46% of rural young women compared to 22% of urban young women were married before age 18.

In a report of the State Level Workshop on “Adolescent Reproductive and Sexual Health in Maharashtra,” says marriage and conception is initiated early in Maharashtra, 40% of all females marry before the age of 18. At present more than two lacs women in Maharashtra give birth in the adolescent age group and are exposed to higher maternal mortality particularly in the districts of Beed, Jalna, Osmanabad, Parbhani and Latur.(Mr. Sandip Chakraborty)

On the subject of education of self, the largest part of an experimental group, 44.8% of them had primary education whereas in control group 44.1% of them had primary education in experimental group .

Government of India has taken several measures to improve the literacy rate in villages and towns of India. State Government of India has taken several measures to improve the literacy rate in villages and towns of India. State Governments has been directed to ensure and improve literacy rate in districts and villages where people are very poor..In the present study findings majority of the women had primary education in both the groups whereas 28.1% and 25% illiterate among experimental and control groups respectively which indicates that awareness has been improved regarding female literacy in rural population.

Regarding self occupation ,in experimental group, 46% of them were housewives, 18.3% of them were farming, 9.4% of them were labourers, 8.8% of them were rearing cattle , 8.3% had poultry ,5.5% of them had business, and 3.8% of them were doing service. In control group also, 44% of them were housewives, 19% of them were farming, 10.6% of them were doing service. 9.3% of them were rearing cattle, 8.3% of them were labourers, 6.4% had poultry and 2.5% of them had business, Though 46% and 44% of the women were housewives rest of them were engaged in some economic activities .these findings resembles with the Employment Scenario of Maharashtra which shows the work participation rate in Maharashtra according to the Census of India 2001.Out of the total females in rural areas, 43.6% were engaged in economic activities, This clearly shows that women in rural areas actively participate in the economic activities for their livelihood. Majority of the women in experimental group and in control group had income between Rs. 5001-10000, India’s average Per Capita Income is Rs. 60,972/-, which is one of the lowest in the world. Some European Countries have over 50 times per capita income as compared to India. As Per capita Income 2010-11.Maharashtra state is Rs.83471/- .

Majority of the women 64.3% and 64.1% in experimental and control group respectively had irregular menstrual pattern and experienced 52.6% and 49.4% in experimental and control group respectively painful period. . A few studies from south India indicated that 1 and 12% of women encountered shorter (<21 days) and longer cycles (>35 days), respectively. In accordance to these reports, Indra P. Kambo et.al,¹⁶⁶ concludes in their study, the commonest problem mentioned by the women in most of the districts was backache followed by low abdominal pain and menstrual problems. The most common menstrual disorders were irregular frequency of menstruation (80.7%), premenstrual syndrome (54.0%), irregular duration of menstruation (43.8%), dysmenorrhoea (38.1%), Dysmenorrhea is an important menstrual disorder in adolescence, and common in young women with ovulatory cycles. Recently, it has become an important public health problem among the female population; prevalence rate reported from different states of India appears to be as follows: Delhi, 63.75% and Chennai, 61%. In certain regions, prevalence rate are as high as 71 to 93%.

Women 35% and 35.4% in experimental and control group respectively had gynecological problems. Women in experimental and control group 65.0% and 64.6% respectively said they did not suffer from gynecological problem this finding shows that though women suffer from gynaecological conditions they take it as normal not as a disease so there is less reporting by them.

In experimental group majority 57.5% and in control group majority 64.8% of them had deliveries in hospital, In experimental group 24.1% of them had deliveries at home and in control group 17.4% of them had deliveries at home, Though Government is emphasising on institutional deliveries nearly about 1/4th deliveries are conducted at home. More efforts are needed by health care providers to create awareness regarding institutional deliveries.

In experimental group, 7.6% of the husbands were using nirodh and 3.5% of them had vasectomy. In control group, 7.1% of the husbands were using nirodh and 2.8% of them had vasectomy. Similar findings in a psychosocial study conducted in Southern India report that use of condom in a rural setting was low as 2.2% and vasectomy even low at less than 1%. Study has shown that men neglected attitudes are often a major reason why their wives fail to practice family planning even when the latter are motivated to do so.

In experimental group, only 19% of them had participation of the partner. In control group only 21.7% of them had participation of the partner. Ensuring greater male participation is one of the key components of the programme of Action at the International conference on Population and Development and it is a thrust area of the Reproductive and Child health programme of the Government Of India. (Balaiah D. Ghule et.al.)

1. Assessment of knowledge of women regarding reproductive tract infections

In pretest, majority of 70.9% of the women in experimental group had poor knowledge (score 0-24) regarding reproductive tract infections, 27.9% of them had average knowledge (score 25-48) and only 1.2% of them had good knowledge (score 49-72) regarding reproductive tract infections. Whereas in posttest, majority of 64.6% of the women had good knowledge (Score 49-72), 26.3% of them had average knowledge (score 25-48) and only 9.1% of them had poor knowledge (score 0-24) regarding reproductive tract infections. The finding on pre-testing the knowledge of women 70.9% of the women in experimental group had poor knowledge and 69.8% of the women in control group had poor knowledge regarding reproductive tract infections, the data suggest that they have deficit of knowledge regarding reproductive tract infections. Studies conducted focusing on rural women with low socioeconomic status also revealed similar patterns of insufficient knowledge and health behaviors to protect against RTIs and STI (Harms et al., 1998; Shun et al., 2003). This indicates the need for imparting necessary education and information on the reproductive tract infections.

Research performed by Kabiru A Rabiou reveals that even though most of the participants had heard of RTI's, they confirmed inadequate understanding of the topic. The occurrence of signs of RTI's in this research is great compared to that revealed in other studies and most of those who revealed signs desired wellness good care. What this means is that wellness involvement actions instructed towards decreasing morbidities from RTI's need not focus mainly on treatment of RTI's but rather on disease avoiding techniques. These include teaching women about ways of avoiding RTI's such as the prevention of risky sexual behaviors and use of hurdle birth control pill methods as reproduction system attacks are RTI precautionary programs should be incorporated into other reproductive health programs such as family planning, expectant mothers and child wellness services with a view to

offering an extensive based reproduction medical care. Hashima-E-Nasreen in her research indicates that the main and key element for risks of RTIs/STDs in the research area is lack of know-how.

Regarding the meaning of reproductive tract infections, in experimental group in pretest, 34% of the women and 77% of them in posttest knew the meaning of reproductive tract infections and in control group, 38.3% of them in pretest and 47.85% of them in posttest .

Regarding pretest knowledge on anatomy of the female reproductive tract in experimental and control group 21.8 % and 25.8 % respectively knew anatomy of female reproductive tract and increase in posttest knowledge 67.3% in experimental group.

Regarding different body sites where reproductive tract infections occur in women in experimental group and control group pretest score was 24% and 26% and posttest score improved to 69.8% in experimental group.

Majority of them in experimental and control group group, in pretest 67.9% and 71.2% stated that reproductive tract infections are more common in women than men because women are more likely to suffer from asymptomatic infections. In posttest improved to 82.8% in experimental group.

Majority of them in experimental group and control group , in pretest 48.8% and 49.8% respectively stated that reproductive tract infections are more common in women than men due to shyness and stigma. Posttest score improved to 77.9% in experimental group.

Regarding the spread of RTI –Majority in pretest experimental group 65.3% and in control group 64.3% responded that reproductive tract infection is spread by the use of unclean water for genital hygiene.

In experimental group, 48.1% and in control group, 53.4% in pretest opined that reproductive tract infection is transmitted by sharing clothes.

Majority in experimental group, in pretest 69.4%, whereas in control group, 69.1% stated that reproductive tract infection is spread by sharing/use of public toilet. Few in experimental group 3.6% in pretest whereas in control group 2.8% in pretest opined that reproductive tract infections are transmitted through mother to child. In experimental group, 5.3% of them in pretest whereas in control group 4.5% in pretest stated that the reproductive tract infection spreads through unsafe abortion and

delivery. These findings resembles with the study by Maxine Whittaker modern pressures, traditional problems in rural women of Vietnam described the causes which are direct and indirect causes of the vaginal discharge. Common causes are unclean water uses to maintain hygiene of vagina especially during menstruation.

Regarding spread of reproductive tract infections respondents had a varying view on the mode of transmission of vaginal discharge, though a greater proportion of women (58%), boys (49%) and girls (86%) said they did not know how one gets STD. Some rightly said that it spreads by sex and unhygienic health practice. Regarding treatment, many adults (men – 44% and women – 50%) and adolescents (boys – 48% and girls – 33%) felt a woman should seek treatment from traditional healers if she gets vaginal discharge. They believed herbs as more effective for this disease. Their second and third choices of seeking treatment were medical doctors, and pharmacists or village doctors respectively. The popular view of women and girls as to the remedy for this disease was nutritious food and cool diet e.g. coconut milk. In contrast, a considerable proportion, 20.3%, of girls reported they did not know what the treatment should be.

Shailendra K.B., et.al. concludes that the knowledge regarding various aspects of RTI such as causes, symptoms, complications, prevention, and treatment was found to be poor. There was no statistically significant association between any of the socio-demographic variables of the women and their knowledge levels. However other studies done elsewhere also report poor knowledge among women. Only 22% of the women knew that partner also needs to be treated in case of a RTI and only 12% of those women who had symptoms of RTI in the past 1 year had their partner also treated, which is similar to the findings reported in an earlier study where only 10% of the partners were treated.

Regarding the treatment of RTI

In pretest, majority of the respondents in experimental group, in pretest 72.2%, whereas in control group, 68.6% stated that herbal medicines are used to treat reproductive tract infections.

Similar findings were revealed in the study by Bhatti L. et.al regarding health seeking behavior .Women preferred to go to Hakims and take herbal solutions. Similarly, Prasad J. H, conducted a study on reproductive system infections s in Tamil Nadu, they revealed regarding therapy looking for actions of the females among characteristic females, 65% had not desired any therapy for their gynecologic

problems (not shown). Of them, 58% revealed that they felt the symptom was not worrying and so there was no need for therapy. Other less common reasons were absence of a female provider in the nearby wellness good care center, lack of privacy and distance in your house. Of the 35% who had desired therapy, 21% of them had opted for herbal solutions or traditional medicinal practices, 57% had contacted not qualified private practitioners and 13% had gone to CHAD Hospital. Only 9% had desired wellness good care at the government primary wellness centers.

Assessment of practices of women regarding reproductive tract infections:

In pretest, majority of 67.4% of the women in experimental group had good practices (score >82) regarding reproductive tract infections, 32.6% of them had average practices (score 41-82) and none of them had poor practices (score <41) regarding reproductive tract infections, whereas in posttest majority of 73.9% of the women in experimental group had good practices (score >82) regarding reproductive tract infections, 26.1% of them had average practices (score 41-82) and none of them had poor practices (Score <41) .

Regarding hygienic practice-. Regarding genital hygiene, in pretest, 49.3% of them from experimental group and 43.3% of the women in control group never do cleaning from vagina towards anus; whereas in posttest experimental women around 54.7% of them stated they always do cleaning from vagina to anus.

Regarding menstrual hygienic practices. 56% in experimental group and 55.2% in control always use cloth during menstrual period whereas 33.2% in experimental group and 38% of the control group never used sanitary napkins.

Regarding sexual practices in pretest, in experimental group 49.4% and 49.9% never cleanse genital region before intercourse, 48.8% and 49.4% never used condom if either of the partner had symptom of RTI, 71.6% of the women in both experimental or control group expressed that they never followed safer sex practices.

Regarding antenatal, intranatal, postnatal, contraceptive and abortion practices:

Regarding antenatal practices -44.6% of the women in pretest from experimental group and 46.6% of the women in pretest from control group sometimes seek antenatal care during pregnancy . Only 15.5% in experimental and 20.2 % of the women always take decision regarding choice for place of delivery .These finding indicate that in India though we speak about women empowerment decision making is still not taken by her.

Regarding intranatal practices -In experimental and control group, in pretest, 45.1% and 46.3% respectively would never prefer hospital delivery. 28.9% in pretest in experimental group and 33.1% in control group always preferred home delivery. Regarding postnatal practices, in pretest, 25.1% of the respondents from experimental group and 27.8% of them from control group had responded that they always seek postnatal care. (Hygiene, diet, exercise, care of breast, care of newborn, regular medical checkup).

Regarding contraceptive practices in experimental group 43.0% and 40.0% in control group women showed self efficacy towards spacing. 40.5% and 46.1% in experimental and control group expressed they sometimes seek medical treatment immediately if suffered from complications due to contraceptives.

Regarding abortion practices in pretest 33.3% and 60.7% in experimental and control group respectively never shown self efficacy for abortion, 26.4% and 25.8 in experimental and control group respectively always seek medical treatment if experienced any problem after abortion .For experimental group, in posttest assured practices improved to 65%. 53.7% and 46.8% in experimental and control group respectively expressed abortion should be done at approved hospital , 23.1% and 18.2% in experimental and control group respectively said sometimes they made attempt to perform abortion at home ,44.3% in experimental group and 44.1% in control group women never seek medical treatment if any problem arises after abortion .

In the 1983-84 ICMR abortion study, of the 55 percent of abortions conducted in the first trimester, only about 25 percent were conducted by certified doctors or other health staff (Indian Council of Medical Research 1988; World Bank 1996). Sex selective abortions and delay of accessing abortion services for an unwanted pregnancy are the two most common reasons for second trimester abortions (Mathai 1997). A strong son preference and the availability of prenatal diagnostic techniques have resulted in an increased use of prenatal sex tests, even among rural poor. Making the decision to abort a pregnancy can be difficult and cause delays in abortion seeking. Factors that cause delays in accessing abortion services include not initially recognizing the pregnancy, postponing communicating the news of an unwanted pregnancy to a decision maker, lack of awareness of available abortion services, lack of resources (financial, transport etc.) to access available services and fear of social

stigmatization but often the decision-making role is taken by husbands, mothers-in-law or other household members or community level health care providers. Decision makers may support a woman's choice, pressure her into having an abortion or object to her having an abortion. Sinha et al. (1998)

Research performed in Uttar Pradesh exposed, the greater part of ladies (32 out of 49) who wished to abort their unexpected maternity first mentioned the probability with their spouse. Mothers-in-law, sisters-in law, health employees, neighbors and other family members were also mentioned (Sinha et al.1998). On the other hand, concern with disapproval, resistance or assault can outcome in females concealing the abortion from her family (Ganatra2001; Gupte et al. 1996).

In non-urban places, uncertified suppliers flourish because they can offer abortion services cheaply, and are often situated nearer to women's homes than legal suppliers (Parivar Seva Sanstha 1998). As a consequence of restricted access to safe suppliers in non-urban places, rates of risky abortion are thought to be considerably higher in non-urban than in towns (Kerrigan et al. 1995).

Regarding Curative practices:

Regarding seeking of medical treatment ,majority 51.2% in experimental group and 43.8% in control group women expressed they never seek medical treatment immediately if experienced any symptom related to RTI. Regarding the reasons for not seeking medical treatment ,46.9% and 40% in experimental and control group respectively expressed , because they do not think as a disease ; 43.8% and 42% replied due to lack of time ,44.3% and 39.8% responded due to lack of money,63.5% and 61.8% expressed they feel shy to tell the problem ,64.5% and 60.8% expressed due to social stigma,46.6% and 47.9% in experimental and control group respectively expressed due to lack of decision making power.

Regarding utilization of other measures than medical treatment they expressed in experimental and control group respectively, 38.7%and 39.2% practice home remedies, 32.1% and31.4% practice herbal medicine, 29.8% and 25.8% approach Hakim/ Vaidu, 25.1% and 25.5% a practice of black magic.

Regarding immediate and complete treatment in experimental group 57%and in control 52.1% never took immediate and complete treatment .Regarding treatment along with husband/partner they expressed in experimental 54.4% and in control group52.1% never took treatment along with their husband/partner .Regarding

avoiding sex with infected partner 54% in experimental and 54.2% in control group never practiced this. Regarding practice of safer sex 53.9% in experimental and 52.6% in control group expressed they never practiced safer sex.

Before marriage girl child is supposed to remain in the protection and care of her parents, after marriage she becomes the property and responsibility of her husband, who is supposed to take care of her and keep her in his power. Under the existing cultural and social norms of India a married girl / woman is taken for granted as domestic labourer. Some areas of Indian society, women are accustomed from birth to be submissive not only to their future husbands, but also to the females in their husband's family especially, their mother-in-law. Accordingly any noncompliance might lead to the woman being hated and neglected by her own family.

Regarding awareness practices:

Regarding receiving the information on RTI, 83% and 83.5% of the women in experimental and control group respectively never received information regarding RTI through health education. Overall 62.3% and 64.4% of the women responded they never followed awareness practices

Regarding creating awareness among others 79.8% and 76% of the women in experimental and control group respectively never share the information regarding RTI with others. However, experimental group percentage of following awareness practices raised significantly in posttest as compared to pretest. There is need to create awareness time to time at grass root level,

2. Administration of Health education plan:

Health education was given to the women after the pretest in experimental group which was prepared in Marathi language so that the group will be able to understand easily. To create an interest among the women different audiovisual aids were prepared which were in Marathi language and simple to understand. Models were shown to explain organs of female reproductive system and sites of reproductive tract infections so actually when they saw the models they understood and gave the feedback. They said when we saw it we could immediately understand the reproductive organs also they could point out the sites of reproductive tract infections on model which was shown. Charts, posters, flip charts, flash cards, roller, slide show, puppet show were used for health education. Among these methods models, roller, puppet show and slide show were found really interesting and effective because

when puppet show , roller and slide show was shown they appreciated these methods and really gave good response.

3. Analysis of data related to the effect of health education on the knowledge of the women related to the common selected reproductive tract infections

Paired t-test was applied to compare scores before and after health teaching to respondents. The t-value was found to be 53.5 and corresponding p-value was 0.000. Since p-value is less than 0.05, null hypothesis was rejected and research hypothesis was accepted. Researcher concluded at 5% level of significance and 604 degrees of freedom that knowledge scores of women improved significantly after receiving health teaching on reproductive tract infections. Thus, the health teaching on reproductive tract infections is proved to be effective in delivering the knowledge and awareness.

4. Analysis of data related to the effect of health education on the practices of the women related to the common selected reproductive tract infections:

Paired t-test was applied to compare practice scores before and after health teaching to respondents. The t-value was found to be 49.9 and corresponding p-value was 0.000. Since p-value is less than 0.05, null hypothesis was rejected and research hypothesis was accepted. Researcher concluded at 5% level of significance and 604 degrees of freedom that practice scores of women improved significantly after receiving health education on reproductive tract infections. Thus, the health education on reproductive tract infections is proved to be effective in improving the practices assured by the women.

Comparison of practices of experimental and control group:

Two sample z-test was applied to compare effect on practice scores of experimental and control groups. The z-value was found to be 41.1 and corresponding p-value was 0.000. Since p-value is less than 0.05, null hypothesis was rejected and research hypothesis was accepted. Researcher concluded at 5% level of significance and 1208 degrees of freedom that practice scores of women in experimntal group improved significantly as compared to those in control group. Thus, the health teaching on reproductive tract infections is proved to be effective in improving the practices assured by women..

These findings resemble a descriptive study conducted on rural women in Hunchun, China indicates the urgent need for culturally relevant and effective reproductive

health education for rural women. Community-based interventions should be implemented in order to reduce the extreme health disparity gap in women of rural China (Chunyu Li.et.al)

Chinese proverb can support this--if I hear, I forget,if I see, I remember and if I do, I remember forever. So practice is more important and useful for learning and education.

Following studies also resemble the present study findings:

The data reveals a fact that administration of health education affected experimental group more. In relation to the same issue the findings of the study (Kirby D, Obasi A et.al) suggest that a large majority of school-based sex education and HIV interventions reduced reported risky sexual behaviours in developing countries.

Zhang T, Wu YQ, et.al. conducted study reveals that comprehensive health education intervention programs had significant impact on knowledge about RTIs/STDs among the target population, indicating that the Reproductive Health/Family Planning Project implemented in the rural areas of China had been successful.

Aggarwal AK Kumar R, et.al, conducted study of a community-level health-education intervention on reproductive tract infections/sexually transmitted diseases (RTIs/STDs) was conducted in three villages of Haryana in north India. The findings of the study suggest that health-education strategy through home visits, RTI case management and counselling, and organizing a weekly clinic and occasional camps and health-education talks can increase the level of awareness about RTIs/STIs among both men and women and improve clinic attendance.

Rangappa Manjula, Sangappa V et.al. concludes that an educational interventional study on adolescent reproductive health among pre-university girls in Davangere district, South India and another study which was conducted by Bhasin et.al. in East Delhi to study the impact of educational intervention about AIDS. Both these studies indicate significant change in knowledge following intervention, with $P < 0.001$.

Cheng et al. conducted a study to evaluate the feasibility and effectiveness of a life planning skills training program by using participatory method among rural senior high school students in Shanghai Country Henan Province, China. The interaction effects in ordinal logistic regression analysis were found on HIV/AIDS-related knowledge ($P < 0.0001$), attitude towards daily contacts with HIV-positive individuals

($P < 0.0001$) and subjects protection self-efficacy ($P < 0.001$) suggesting the intervention increased subjects knowledge significantly, changed attitudes positively, and improved their protection self-efficacy. The intervention also significantly improved subject's communication with teachers and individuals with HIV/AIDS issues ($P < 0.0001$).

Study conducted by Zong-min Jiang to evaluate the impacts of reproductive tract infections (RTIs) intervention on RTIs-related knowledge, attitudes, practices and prevalence of married women at reproductive age. It is an effective way to conduct community-based intervention to increase women's RTIs knowledge, improve RTIs-related attitudes, promote good individual health behaviors, so as to decrease RTIs prevalence.

Rusakenikos S. Mbizyo MT, et al. carried out a study with the objective to determine the impact of an intervention package on knowledge levels of various reproductive health issues through trend analysis. The students from the intervention schools were more likely to have correct knowledge over time on aspects of reproductive biology.

A significant linear trend ($P = 0.017$) was observed in the area of family planning and contraception. The general trend of knowledge levels in old areas of reproductive health pregnancy risk, STDs, and HIV/AIDS showed an upward trend from 20% to 96%.

Tang Yongjun conducted study on the prevalence of STI/RTI among rural women in Sichuan, China. Education and communication interventions should reach men as well as women in these rural communities. Access to user-friendly, quality care should contribute to maintain a low burden of STIs.

Hawkes S., concludes in her study that a low prevalence of reproductive tract infections, coupled with a high level of reported risk behaviour, indicated a need for primary programmes that would prevent an increase in the incidence of reproductive tract infections, sexually transmitted infections and HIV infection.

Study conducted by S. P. RAO, in his study clearly showed that an educational intervention program can bring about a desirable change in knowledge among adolescent girls regarding reproductive health.

Rao Vikas, Savargaonkar D, The study highlights a need to strengthen the RTI/STI control programme particularly in tribal areas.

5. Correlation of knowledge with practices

The Pearson's correlation coefficient between knowledge and practices was found to be 0.6. There was positive correlation between knowledge and assured practices of women regarding reproductive tract infections. The significance of this correlation was assessed using t-test for testing significance of correlation coefficient. T-value was found to be 25 at 5% level of significance. Corresponding p-value was found to be 0.000. The null hypothesis of no correlation between knowledge and practice was rejected at 1208 degrees of freedom. More the knowledge of the women, better are their assured practices regarding reproductive tract infections.

6. Association of knowledge and practices with selected demographic variables

Since p-values corresponding to self occupation and husband's occupation are small (less than 0.05), null hypothesis is rejected. Self occupation and Husband's occupation are the demographic variables which were found to have significant association with knowledge of women regarding reproductive tract infections.

Since p-values corresponding to self occupation, monthly family income and place of delivery are small (less than 0.05), null hypothesis is rejected. Self occupation, monthly family income and place of delivery are the demographic variables which were found to have significant association with practices assured by the women regarding reproductive tract infections.

CONCLUSION:

Following conclusions were drawn from the study:

Majority 67.9% and 70.6% of women in experimental and control group respectively stated that reproductive tract infections is more common in women than men because of they consider it as normal and are more likely to suffer from asymptomatic infections and remain untreated due to shyness and stigma. There was lack in knowledge regarding possible causes of RTI/STI 5.8% and 6.3% very few of them from experimental and control group respectively stated that poor general health/low immunity is possible cause of reproductive tract infections. In pre test 5.5% and 6.1% in experimental and control group respectively opined that genital itching, swelling in the groin, fever, pain and bleeding during sexual intercourse are common signs and symptoms of reproductive tract infections. Regarding mode of transmission 3.6% and

2.8% in experimental and control group respectively opined that it is transmitted through mother to child and 5.3% and 4.5% responded through unsafe abortion and delivery.

63% and 63.3% of the women in experimental and control group respectively responded that when RTI symptoms are seen it is treated by home and herbal remedies. None of them from either group responded in pre test that prenatal and neonatal infections are the complications which are caused if reproductive tract infections are not treated.

Regarding practices assured by the women, 33.8% and 33.2% of women in control and experimental group never used sanitary napkins during menstruation, majority 71.6% of the women in control and experimental group never followed safer sex practices, 46.6% of the women in pretest and 44.6% of women in experimental group sometimes seek antenatal care during pregnancy and seek medical treatment immediately if any problem arises during pregnancy.

In experimental group there was significant improvement in the responses in post-test as compared to pre-test in preventive practices.. Experimental group showed significant improvement in curative practices in post-test as compared to pre-test ,regarding awareness practices 62.3% and 64.4% of women in both the groups never followed awareness practices in pre-test, however experimental group percentage of following practice increased significantly in post-test as compared to pre-test.

Knowledge and practice scores of the women in experimental group improved significantly as compared to those in control group. Thus the health education on reproductive tract infections is proved to be effective in improving knowledge and practices assured by the women in experimental group.

There was positive correlation between knowledge and practices assured by the women regarding reproductive tract infections. More the knowledge of the women better are their assured practices regarding reproductive tract infections. Self occupation and husband's occupation are the demographic variables which were found to have significant association with knowledge of the women.

Self occupation, monthly family income and place of delivery are the demographic variables which were found to have significant association with practices assured by the women regarding reproductive tract infections.

Limitations:

Present study points out the following limitations:

- This study is limited to married women between 15-49 years of age
- The setting of the study is limited to rural area of Pune district
- Study is limited to self expressed practices.
- The assessment of effect of health education is limited to once post-test conducted on 15th day of dissemination of health education programme

SCOPE OF STUDY FINDINGS:**Implications to sociology:**

Application of this study helps to educate the women by increasing their knowledge through health education programme which motivates their behaviour and habits to improve their practices regarding reproductive tract infections.

1. To identify the failure health measures of the women to utilize the health facilities and to analyze the reason for such resistance among the community members.
2. Its application delivers fruitful attention in the social system towards their attitudes, cultural practices related to health and illness. The distribution and the causal factors of health and disease are studied in relation to the social factors such as status, income, education, occupation and their practices.

The socio-economic progress of the nation depends upon the progress of the villages scientific method of investigations has to be conducted to find out the ways of dealing the health problems identifying the strategies will help to overcome the problems. Developing the right attitudes among the rural communities to prevent reproductive tract infections and to promote reproductive health, among the women residing in rural area. It will help the national programs under taken for the development and welfare of the society. Some of the rural development program in India are Rural health education, Community development program, National adult education program, integrated rural development program, Family welfare program and Development of women and children in rural areas. Rural development programs can be executed successfully only through the active involvement of local people, Community participation and various functioning departmental agencies. The present study will help as remedial measure to overcome rural problem of the women in improving their reproductive health.

Implications of the study in nursing:

Sexual and reproductive health has been defined by the international community as a state of complete physical, mental, and social well being, and not just merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. It is an essential component of young people's ability to become well-adjusted, responsible and productive members of society. Reproductive health is a universal concern, but is of special importance for women particularly during the reproductive years. Although most reproductive health problems arise during the reproductive years, in old age general health continues to reflect earlier reproductive life events. Women bear by far the greatest burden of reproductive health problems. Women are at risk of complications from pregnancy and childbirth; they also face risks in preventing unwanted pregnancy, suffer from the complications of unsafe abortion, bear most of the burden of contraception, and are more exposed to contracting, and suffering the complications of reproductive tract infections, particularly sexually transmitted diseases (STDs). Among women of reproductive age, 36% of all healthy years of life lost is due to reproductive health problems such as unregulated fertility maternal mortality and morbidity and sexually transmitted diseases including HIV/AIDS. Reproductive health is a health issue but encompasses more than biomedical aspects and goes beyond the health sector. The determinants of reproductive ill-health lie in poverty, gender and other forms of inequity, social injustice, marginalisation and development failures. All sectors affect and are affected by reproductive health.

All agencies and all sectors have roles and responsibilities in promoting reproductive health. One of the key actions needed to improve reproductive health is the empowerment of women especially through education resources for women's education both in-school and out of school (youth groups, workplaces, adult literacy and income generation groups etc. encourage the incorporation into reproductive health programmes of such concerns as the eradication of harmful practices affecting women's health, as well as various forms of violence.

Reproductive tract infections could be prevented with little or no medical intervention if people are adequately informed about the likely complications and encouraged to take necessary precaution and prevention in time. The findings of

the present study have implications for nursing in practice, education, administration, research and public education.

Nursing practice:

One role of nursing is providing patients care. A second important, but sometimes overlooked, role is education. In the event of ever changing disease manifestations, knowledge explosion, technological and ever-growing challenges of public health nursing, administrator's have a responsibility to provide nurses with substantive continuing education opportunities. This will enable the nurses in updating their knowledge, acquiring special skills and demonstrating high-quality care by deputing them for in-service education programmes, special courses, workshops, conferences can be arranged and attended by the nursing staff. Necessary administrative support should be provided for the development of such educational materials, nursing personnel should be motivated to devote their time for health education programmes for the women to improve their reproductive tract infections.

Results of the present study can be used to create awareness among women at grass root level which will improve their promotive, preventive, curative and awareness practices regarding reproductive tract infections to maintain their reproductive health.

Nursing education:

With changing health care trends, nursing education must emphasize primary health care approach focusing on prevention than cure and thus, empowering the prospective nurses to be well prepared to assist client and community at large to develop.

Newer techniques are introduced in nursing all over the world. Importance is now awareness and promotion than curative aspect of health. With changing needs of society, newer components must be incorporated in the nursing curriculum.

The nursing students should be taught to use their individual skills in educating community regarding reproductive tract infections. To do this they must first learn about the aspects of reproductive health. This is an essential part in nursing.

Opportunities should be given to nursing students to develop and use educational material on prevention of reproductive tract infections in variety of settings like school, family, community and hospital. Nursing education and practice should go hand in hand.

Nursing education is a means through which nurses are prepared for sound scientific practice. Nursing education had shown tremendous changes in respect to curriculum.

Health education is also one of the important aspects in promotion of health and prevention of illness.

Nursing administration:

In the event of ever changing community trends and health focus, nursing administration has a responsibility to provide nurses with continuing education. This enables them in updating their knowledge and acquiring new skills.

Nursing administration can depute them to various workshops, conferences, and special courses; also in service education, a program can be arranged for the nursing staff.

Administrator can impart knowledge about newer trend in societal needs and in training the subordinates. Necessary administrative support should be provided for the development of health educational materials. Nursing personnel should be motivated to communicate with the people especially women on their reproductive health matters .Administrators can take up projects on education of women by organising workshops .Nursing administrator should contribute by preparation the educational material, conducting various health education programmes, so awareness can be created among women regarding reproductive tract infections.

Evidence based care is an important function of an administrator. Findings of the study can be adopted as routine activity at different setting's, regular in service training can be organized for the nursing personnel.

Nursing research:

In recognition of the move towards developing evidence-based practice in health promotion, there is a need to improve the quality of health promotion research in reproductive health with more emphasis on well-designed and evaluated programmes. Such research will be concerned with gathering precise information about the knowledge regarding reproductive tract infections, correlating with practices, investigating new and better methods of health seeking behaviour, seeking ways to create awareness by assessing and improving knowledge and practices among women. The nurse researcher should be able to conduct the research on various aspect of reproductive tract infections awareness and prevention of reproductive tract infections to improve reproductive health. So as to generate more scientific data, finding of study will provide the baseline data about reproductive tract infections and strategies adopted to educate people regarding reproductive tract infections, improve

their health seeking behavior and adopt better practices in prevention of reproductive tract infections and it can be used for further research qualitative, and quantitative research studies in this area. Results of the present study can encourage nurse professionals to utilize the intervention in different settings. It will also help in programmes run by government in ministry of health and family welfare, NRHM (National Rural Health Mission), ICMR, prevention of RTI/STI and HIV/AIDS activities.

Public education:

Nurses can make a difference in promotion of reproductive health of the women with community organisations, schools, and the media.

Professionals in maternal health improve the public health delivery systems specifically for women, and their families through advocacy and education at the intermediate level, nurses can train paramedical, voluntary workers, teachers, community leaders, community health workers and community in prevention and control of reproductive tract infections.

At the community level, encourage people to make healthy choices and develop educational programs that promote healthy lifestyles. The health education programme should be launched by trained professionals. Research results can be used for assessment, quality assurance, develop policy strategy, draft legislation, evaluate proposed legislation or monitor program progress.

Needs to be integrated within the community i.e. community participation and requires collaboration and cooperation with other sectors, developing relationships between community. Often voluntary groups or nongovernmental organizations (NGOs) might be of help to follow up the application and control measures.

They also promote more efficient use of health services, adopt self-care practices and participate actively in the design and implementation of various national health programs. Public health professionals try to prevent problems from happening or re-occurring through implementing educational programs, developing policies, administering services, regulating health systems, Educational and behavioral training programmes could be implemented through a variety of different channels.

Recommendations:

On the basis of the findings of the study, it is recommended that:

- A similar study may be replicated on a large sample; at state, national and international level; thereby findings can be generalized globally for a large population.
- A similar study may be conducted repeatedly in same area for reinforcement.
- A similar study may be conducted including the dimensions of people's attitude, health seeking behaviour and actual practices towards prevention and control related to reproductive tract infections.
- Similar kind of studies can be under taken in different settings and different target population.
- A comparative study can be carried to ascertain the knowledge regarding reproductive tract infections between urban and rural community.
- Qualitative and longitudinal studies can be undertaken to actually observe their practices.
- A study can be conducted to compare the effectiveness of health education with other teaching strategies.
- Teaching programmes may be designed for teachers and community leaders to disseminate knowledge regarding reproductive tract infections.
- More research-based legislation and programs aimed at preventing reproductive tract infections in collaboration with family welfare programmes which will be more creative and cost-effective intervention initiatives.

Knowledge is a human right as well as health. So human being should gain knowledge for self - health care to survive in the dynamic society. Health education is an integral component of health programme. The health programme cannot become fruit of success without sufficient background of health education. Creation of awareness, giving knowledge, making positive attitude and obtaining active involvement of people in the health programme can definitely be possible through proper methodological and scientific ways of health education. Investigator concludes that, health education is an effective method in increasing the knowledge and improving practices of the women in rural area regarding reproductive tract infections. The finding concluded that the health education programme developed by

researcher was found to be effective in enhancing the knowledge and improving practices assured by the women regarding reproductive tract infections among women in rural area.

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APPENDIX-6

CERTIFICATE OF TRANSLATION

This is to certify that I have translated the tool and consent form used by Mrs. Madhuri S. Shelke in her study “A study to assess the effect of health education programme on knowledge and practices related to common selected reproductive tract infections among the married women in rural area of Pune district.” From English to Marathi.

Name: Mr. M.A. JADHAV

Qualification: M.A.Marathi (Lit) M.Ed.

Mr. M.A. JADHAV

APPENDIX-7

CERTIFICATE FOR LANGUAGE EDITING

This is to certify that the entire thesis of Mrs. Madhuri S. Shelke on “A study to assess the effect of health education programme on knowledge and practices related to common selected reproductive tract infections among the married women in rural area of Pune district.” is edited by me.

Name: Mr. S.Y.Garje

Qualification: M.A.English (Lit)M.Ed.

Mr. S.Y. Garje

APPENDIX - 1

Permission to conduct study in rural area

20/3/2010

From,

Yashwantrao Chavan Bhavan,

Health Dept.

Zilla Parishad,

Pune.

To,

Mrs. Madhuri S. Shelke,

Tilak Maharashtra Vidyapeeth ,

Pune.

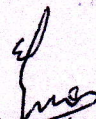
Sub: Permission to conduct research in rural area of Pune District.

Ref: O. No./ADM/2010/2453 DATED 17TH March 2010

With reference to the above subject , we hereby give permission to conduct research in rural area of Pune District.

We assure you necessary cooperation.

Yours,


**District Health Officer
Zilla Parishad Pune**

APPENDIX - 10

BLUE PRINT FOR KNOWLEDGE QUESTIONNAIRE

SR. NO.	CONTENT	ITEM NUMBER	TOTAL
1	What do you mean by reproductive tract infections (RTI)?	1.1	1
2	Do you know the organs of female reproductive system? if yes name them,	2,2.1	2
2.1	Do you know the different body sites where reproductive tract infections occur in women? if yes name them,		
3	Why reproductive tract infections are more common in women than men?	3.1,3.2,3.6,3.7,3.8,3.3,3.4,3.5, ,3.9,3.10	10
4	Which of the following are the types of Reproductive Tract Infections?	4.1,4.2,4.3	3
5	Do you know names of Reproductive Tract Infections? If yes , name them -----	5,5.1	3
5.1	Is reproductive tract infections related to AIDS?		
6	What are possible causes of Reproductive Tract Infections?	6.1,6.2,6.3,6.4,6.5,6.6,6.7,6.8,6.9	9
7	Which of the following are common sign and symptoms of RTI/STI ?	7.1,7.2,7.3,7.4,7.5,7.6,7.7,7.8	8
8	How does reproductive tract infections spread?	8.1,8.2,8.3, 8.4, ,8.5,,8.6,8.7, 8.8,	8
9	What measures should be taken to treat reproductive tract infections?	9.1,9.2,9.3,9.4,9.5a,9.5b,9.5c, 9.5d	8
10	What are the complications of reproductive tract infections?	10.1, 10.2, 10.3, 10.4, 10.5, 10.6, 10.7, 10.8, 10.9, 10.10, 10.11.	11
11	What are the preventive and control measures for RTI?	11.1,11.2,11.3,11.4,11.5,11.6,11.7,11.8,11.9	9
	TOTAL	72	72

APPENDIX - 11

BLUE PRINT FOR PRACTICE QUESTIONNAIRE

SR. NO.	CONTENT	ITEM NUMBER	TOTAL
1	PREVENTIVE PRACTICES- A) Hygienic practices:	1.1,1.2,1.3,1.4,1.5	5
	B) Menstrual hygienic practices-	1.6,1.7,1.8,1.9,1.10,1.11,1.12,1.13,1.14,	9
	C) Sexual practices:	1.15,1.16,1.17,1.18,1.19,1.20	6
	D) Antenatal, intra -natal ,postnatal and Contraceptive practices	1.21,1.22,1.23, ,1.24, ,1.25a,1.25b,1.25c,,1.26a,1.26b, 1.27,1.28,1.29,1.30,1.31,1.32a,1.32b,1.33	17
2	CURATIVE PRACTICES	2.1,2.2a,2.2b,2.2c,2.2d,2.2e,2.2f ,2.2g,2.2h,2.2i,2.2j,2.3a,2.3b,2.3c,2.3d,2.4,2.5,2.6,2.7	19
3	AWARENESS PRACTICES	3.1a,3.1b,3.1c,3.1d, ,3.2	5
	TOTAL	61	61

APPENDIX - 12

HEALTH EDUCATION PROGRAMME ON REPRODUCTIVE TRACT INFECTIONS

Topic- Health Education on reproductive tract infections.

Group- Women residing in rural area of Pune district.

Place- Villages in rural area of Pune District.

Duration- One to one and half hours.

Teaching aids- Charts, posters, flip charts, flash cards, models, scroller, puppet show.

Method of teaching- Lecture cum discussion.

Name of the health educator- Mrs. M.S. Shelke

General Objective/Aim-

At the end of the health education programme women are able to gain knowledge regarding reproductive tract infections.

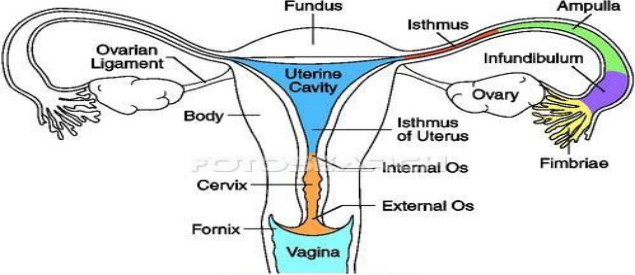
Specific objectives-

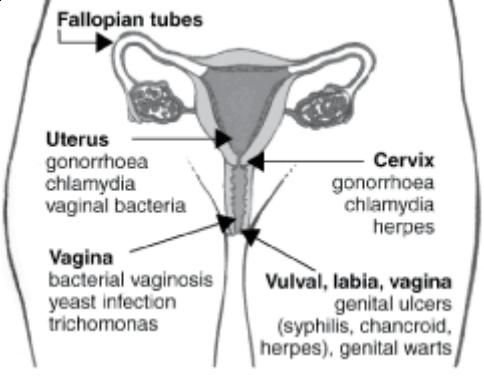
At the end of the health education programme women are able to :

1. Get introduced to the topic.
2. Describe the organs of female reproductive tract.
3. To enumerate the different body sites where reproductive tract infections occur in women.
4. To discuss the meaning, types of reproductive tract infections and enlist the names of common reproductive tract infections.
5. To reason out why reproductive tract infections are common in women than men.
6. To understand the possible causes and modes of transmission of common selected reproductive tract infections.
7. To understand common signs and symptoms of reproductive tract infections.
8. To understand the treatment modalities and management of common selected reproductive tract infections.
9. To understand complications of reproductive tract infections.
10. To enumerate the measures for prevention and control of reproductive tract infections and importance of safer sex practices.
11. To understand promotive, preventive practices, curative and awareness practices regarding reproductive tract infections.
12. To get the feedback.

Sr. No.	Time	Objective	Subject Matter	Teaching/ Learning Activity	A. V. Aids used
1	5 min.	Women get introduced with the topic.	<p>Introduction:</p> <p>“Good morning to all of you”</p> <p>The spread of reproductive tract infections (RTIs) and sexually transmitted diseases (STDs) including AIDS in India has been a major public health threat, affecting women the most, who have been the silent sufferers. Reproductive infections cause a large proportion of the global burden of ill-health especially reproductive health of the women. An estimated 340 million new cases of curable reproductive tract infections and sexually transmitted infections occur each year and among women, non- sexually transmitted reproductive tract infections are more common. They affect more than health. The morbidity associated with RTIs also affects the economic productivity and quality of life of many individual women and men, and consequently, of whole community and nation. So there is need to gain knowledge regarding reproductive tract infections, so that we can prevent and control this and improve our health.</p>	Lecture	Chart

Sr. No.	Time	Objective	Subject Matter	Teaching/ Learning Activity	A. V. Aids used
2	10 min.	To describe the organs of female reproductive tract.	<p>The female reproductive tract organs are divided into two parts. External genitalia and internal. The external female genitals are the mons pubis, the clitoris, the labia majora, and the labia minora. Together, along with the opening of the vagina, they are known as the vulva. Surface area is large, flat and wider in females than males.</p> <p>Internal organs include- Vagina, cervix, uterus, fallopian tubes and ovary,</p> <p>Vagina: The vagina is a canal that joins the cervix (the lower part of uterus) to the outside of the body. It also is known as the birth canal.</p> <ul style="list-style-type: none"> • Uterus (womb): The uterus is a hollow, pear-shaped organ that is the home to a developing foetus. The uterus is divided into two parts: the cervix, which is the lower part that opens into the vagina. • Ovaries: The ovaries are small, oval-shaped glands that are located on either side of the uterus. The ovaries produce eggs and hormones. • Fallopian tubes: These are narrow tubes that are attached to the upper part of the uterus 	Explaining the model, and discussion	Poster, female reproductive tract model (External and internal organs)

Sr. No.	Time	Objective	Subject Matter	Teaching/ learning Activity	A. V. Aids used
					
3	5min.	To enumerate the different body sites where reproductive tract infections occur in women	<p>Body sites where reproductive tract infections occur in women are shown in the diagram.</p> <ol style="list-style-type: none"> 1. Infections in the area of the vulva, vagina and cervix are referred as lower reproductive tract infections. Vaginitis, cervical infections 2. Infections in the uterus, fallopian tubes and ovaries are considered upper reproductive tract infections. They are often a direct complication of lower reproductive tract infections, particularly sexually transmitted ones. Pelvic inflammatory disease is one of the most serious consequences. 	Explaining the model, and discussion	Poster, model of female reproductive tract.

Sr. No.	Time	Objective	Subject Matter	Teaching/ learning Activity	A. V. Aids used
					
4	10 min	To discuss the types of reproductive tract infections and enlist the names of common	<p>Meaning of reproductive tract infections</p> <p>Reproductive tract infections are infections of the reproductive tract They affect both women and men.</p> <p>In women, overgrowth of endogenous microorganisms normally found in the vagina may cause RTI (yeast infection, bacterial vaginosis). Medical interventions may provoke iatrogenic infection in several ways ,endogenous organisms from the vagina or sexually transmitted organisms in the cervix may be pushed during a trans-cervical procedure into the upper genital tract and cause serious infection of the uterus, fallopian tubes and other pelvic</p>	Lecture cum discussion	Charts

			<p>organs. Organisms from outside the body can also be introduced into the upper genital tract during medical procedures if infection control is poor. In men, sexually transmitted infections are much more common than endogenous or iatrogenic infections. Reproductive tract infections (RTIs) refer to three different types of infection which affect the reproductive tract:</p> <p>Endogenous infections;are probably the most common RTIs worldwide. They result from an overgrowth of organisms normally present in the vagina. Endogenous infections include bacterial vaginosis and candidiasis. These infections can be easily treated and cured.</p>		
			<p>Iatrogenic infections;</p> <p>occur when the cause of infection (a bacterium or other micro-organism) is introduced into the reproductive tract through a medical procedure such as menstrual regulation, induced abortion, the insertion of an IUD or during childbirth. This can happen if surgical instruments used during the procedure have not been properly sterilized, or if an infection that was already present in the lower reproductive tract is pushed through the cervix into the upper reproductive tract.</p>		

Sexually transmitted infections (STIs):

are caused by viruses, bacteria, or parasitic micro-organisms that are transmitted through sexual activity with an infected partner. About 30 different sexually transmitted infections have been identified, some of which are easily treatable, many of which are not. HIV, the virus that causes AIDS, is perhaps the most serious sexually transmitted infection as it eventually leads to death. STIs affect both men and women, and can also be transmitted from mothers to children during pregnancy and childbirth

Some common syndromes caused by infection that primarily affect the reproductive tract

Syndro me	RTI/STI	Organism	Type	Sexually transmitted	Curable
Genital ulcer	Syphilis	Treponem a pallidum	bacteri al	yes	yes
	Chancroid	Haemophi lus ducreyi	bacteri al	yes	yes

Sr. No.	Time	Objective	Content/ Subject Matter						Teaching/ Learning Activity	A. V. Aids used
				Herpes	Herpes simplex virus (HSV • 2)	viral	yes	no		
				Granuloma inguinale (donovanosis)	Klebsiella granulomatis	bacteria	yes	yes		
				Lymphogranuloma venereum	Chlamydia trachomatis	bacteria	yes	yes		
				Bacterial vaginosis	multiple	bacteria	no	yes		
				Lymphogranuloma venereum	Chlamydia trachomatis	bacteria	yes	yes		
				Bacterial vaginosis	multiple	bacteria	no	yes		
			Discharge	Yeast infection	Candida albicans	fungal	no	yes		

				Gonorrhoea	Neisseria gonorrhoeae	bacterial	yes	yes		
				Chlamydia	Chlamydia trachomatis	bacterial	yes	yes		
				Trichomoniasis	Trichomonas vaginalis	protozoal	yes	yes		
			Other	Genital warts	Human papilloma virus (HPV)	virus	yes	no		

Sr. No.	Time	Objective	Content/ Subject Matter	Teaching/ Learning Activity	A. V. Aids used
5.	3min	To reason out why women are more vulnerable for reproductive tract infections. reproductive tract infections	<p>You have seen the organs of female reproductive system.</p> <ul style="list-style-type: none"> • Because of the structure and larger surface area of genital tract the reproductive tract is wide; thereby increasing the chances of acquiring infection. Childbirth, abortion and contraceptive use further expose women's genital tract to infection. • Female genital tract is wet due to secretions • Women have to undergo investigation of reproductive tract, delivery/childbirth, abortion and contraceptive methods further expose women's genital tract to infection. More likely to suffer from complications and asymptomatic infections which remain untreated 	Lecture cum discussion	Poster
6	7min	To understand the possible causes of reproductive tract infections and how they	<p>There are various factors which cause reproductive tract infections</p> <ul style="list-style-type: none"> • Infectious agents (bacteria, virus, protozoa, fungus) • Sex with partner having signs and symptoms of RTI • Poor genital and menstrual hygiene • Poor general health/Low immunity • Unsafe procedures like unsafe deliveries, abortions, contraceptive 	Lecture cum discussion	Chart, Puppet show

		spread(transmitted)	<p>methods, diagnostic procedures of reproductive tract.</p> <ul style="list-style-type: none"> • Having sex after delivery (Puerperium), Sex during menses, • Unprotected sexual intercourse • Being unfaithful (Multiple Partners) 		
			<p>Modes of transmission (spread)-</p> <p>Following are the modes of transmission of reproductive tract infections:</p> <p>Unsafe sex, Blood transfusion, Mother to child, Sharing clothes(undergarments, menstrual cloth), Use of Public Toilet, Investigations & treatment on reproductive tract, Unsafe abortion & delivery, Use of unclean water for genital hygiene</p>		
7	8min	To understand common signs and symptoms of reproductive tract infections.	<p>Clients having reproductive tract infections usually present with one or more of the following complaints-</p> <ul style="list-style-type: none"> • Unusual vaginal discharge with or without bleeding • Genital itching • Redness, rash, Sores, ulcers, warts • Burning sensation & pain during urination • Swelling in the groin ,fever 	Lecture cum discussion	scroller, chart

			<ul style="list-style-type: none"> • Pain & bleeding during sexual intercourse • Lower abdominal / lumber pain (female) • Menstrual irregularities ,dysmenorrhea, heavy menstrual bleeding 		
8	7min	To understand the treatment and management of common selected reproductive tract infections.	<p>If you go to doctor and take the treatment further complications can be avoided. Both you and your husband/partner should go to doctor</p> <ul style="list-style-type: none"> • Early diagnosis and prompt treatment • Correct and adequate treatment • Importance of partner referral and treatment of both the partners simultaneously • Avoid sex with infected partner • Practice safer sex ,correct and advice consistent use of condom for partner • Schedule return visit after 7 days • Avoid douching 	Lecture cum discussion	Charts puppet show
			<p>Education following STI/RTI treatment</p> <p>complete their treatment and avoid reinfection</p> <ul style="list-style-type: none"> • Seek treatment from their clinic or doctor. Do not take self-medication or getting medication from unlicensed sources. 		

			<ul style="list-style-type: none"> • Complete their course of treatment. Stopping treatment too early, as soon as symptoms disappear, is a common reason for treatment failure. Not to share medicines. • Encourage partner treatment Partner treatment is indicated for women who have genital ulcers, signs of cervicitis or PID, but careful counselling is needed to avoid misunderstanding and potential conflict between partners. • How to take medications. • Abstaining or having protected sex during treatment. • Importance of partner referral. • Counselling. 		
9	5min	To understand complications of reproductive tract infections .	<p>Reproductive tract infections if remain untreated may lead to serious upper tract infections of the uterus,fallopian tubes and ovaries. They are referred to as pelvic inflammatory diseases.</p> <ul style="list-style-type: none"> • Infertility • Chronic pelvic pain • Premature birth, low birth weight baby ,Miscarriage ,Stillbirth • cervical cancer • Ectopic Pregnancy 	Lecture cum discussion	poster

			<ul style="list-style-type: none"> • Prenatal and Neonatal infections 								
			<ul style="list-style-type: none"> • Risk for HIV /AIDS transmission • Systemic complications <p>Mental stress, Tension, depression, Effect on marital status/divorce</p>								
10	10min	To enumerate the measures for prevention and control of reproductive tract infections and importance of safer sex practices	<p>Strategies for Primary prevention of RTIs</p> <table border="1"> <thead> <tr> <th>Type of infection</th> <th>Prevention strategy</th> </tr> </thead> <tbody> <tr> <td>Sexually transmitted infections</td> <td> Delaying sexual initiation Reducing number of sexual partners Follow safer sex practices Use of condom Diagnostic tests Use of barrier methods maintain genital hygiene </td> </tr> <tr> <td>Endogenous</td> <td>Maintain personal hygiene, health seeking behavior, avoid douches and use of harmful intra-vaginal substances., do not take antibiotics /medications without medical advice.</td> </tr> </tbody> </table>	Type of infection	Prevention strategy	Sexually transmitted infections	Delaying sexual initiation Reducing number of sexual partners Follow safer sex practices Use of condom Diagnostic tests Use of barrier methods maintain genital hygiene	Endogenous	Maintain personal hygiene, health seeking behavior, avoid douches and use of harmful intra-vaginal substances., do not take antibiotics /medications without medical advice.	Lecture cum discusssion	scroller, chart
Type of infection	Prevention strategy										
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Endogenous	Maintain personal hygiene, health seeking behavior, avoid douches and use of harmful intra-vaginal substances., do not take antibiotics /medications without medical advice.										

			<p>Iatrogenic</p> <p>Improve access to safe delivery and abortion services, and contraceptive practices.</p>		
			<p>2.Strategies for Secondary prevention of RTIs-</p> <p>Serologic screening, urine, pelvic examination, prompt and complete treatment, abstinence during treatment, prophylaxis .</p> <p>3.Tertiary prevention, minimizing the impact of complications of infection.</p> <p>To prevent and control reproductive tract infections you have to remember following -</p>		
			<ul style="list-style-type: none"> • Maintaining sexual hygiene, Safer sex practices, Avoid sex with infected partner, Removing stigma and bias • improving the treatment seeking behavior, Having single partner, avoiding multiple Partners, Utilization of safe delivery services, Utilization of safe abortion services, Public awareness regarding reproductive tract infections 		Lecture cum discussion

			<ul style="list-style-type: none"> • Education about safer sex <p>We know that certain behaviours increase the risk of STI transmission. Some of these involve unprotected sexual contact with body fluids in the vagina, mouth, or anus. With others, such as sex work, it may be hard for the person to use condoms or other prevention methods.</p> <p>Safer sex can be more pleasurable for both partners because it is less likely to cause worry, discomfort, or disease. Emphasize that safer sex is real sex—couples can talk about sex together to learn different ways of pleasing each other.</p> <p>Safer sex is any sexual activity that reduces the risk of passing STI and HIV from one person to another. Safer sex does not allow semen, vaginal fluid, or blood to enter the body through the vagina, anus, or any open sore or cut.</p> <p>Some safer sex practices</p> <ul style="list-style-type: none"> • Use a condom every time you have sex (especially with new partners). • Reduce the number of your sex partners—sex with an uninfected monogamous partner is the safest. 		
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Sr. No.	Time	Objective	Content/ Subject Matter	A. V. Aids used	Teaching/ Learning Activity
			<ul style="list-style-type: none"> • Keep away from unsafe sexual practices, like "dry sex", which may break the skin—the vagina should be wet inside when you have intercourse. • If you have anal sex, always use a condom with lubrication because the mucous membrane there can tear easily. <p>DO NOT have intercourse or oral sex if you or your partner has genital sores or an abnormal discharge.</p>		
11	10min	To understand preventive ,promotive ,antenatal,intranatal ,postnatal, contraceptive and abortion practicea,curative and	<p>To maintain reproductive health and prevention of reproductive tract infections you should maintain good practices as follows-</p> <p>1.Hygienic practices: Maintain personal hygiene ,maintain genital tract hygiene, cleaning is of should be done from vagina towards anus , always wear clean clothes and clean undergarments,</p> <p>2. Menstrual hygienic practices- Maintain genital tract hygiene 3-4 hourly, If you are using cloth during menstrual period it should be changed after every 4-6 hours, cloth should be clean and dried before use, it should be</p>	Lecture cum discussion.	Posters, flash cards, puppet show.

		<p>awareness practices regarding reproductive tract infections.</p>	<p>kept in clean place. Do not use the same cloth for next menstrual cycle. , If you are using sanitary pads it should be changed after every 3-4 hourly and dispose it in proper place.</p> <p>3. Sexual practices: Clean genital region before and after intercourse, If you or your partner have symptoms of reproductive tract infection tell him to use condom during sexual intercourse Follow safer sex practices , be loyal/faithful with your partner/husband</p>		
			<p>4. Antenatal, intra -natal, postnatal and Contraceptive practices</p> <p>- Seek antenatal care during pregnancy(Regular check up , diet, hygiene, immunization, rest and sleep, exercise, investigations), Seek medical treatment immediately if any problem arises during pregnancy</p> <p>Intranatal practices- Always go to recognized hospital for delivery , after delivery try to give attention hygiene ,diet, exercise, care of breast, care of newborn, regular medical check up, Take medical treatment immediately if you and child. Adopt proper use of contraceptive methods any complication consult medical person or doctor. Abortion should be conducted in approved hospital/health centre do not make any attempt or intravaginal substances for abortion at home self,</p>		

		<p>relatives, friends, quacks or</p> <p>5. Curative practices- Seek medical treatment immediately , if experiences any symptoms related to reproductive tract infection, Do not practice other measures than medical treatment such as going to hakim, vaidus, or quacks, do not try black magic or any medicine on your own, Take immediate and complete treatment, Take treatment along with husband / partner Avoid sex with infected partner, Follow safer sex practices</p> <p>6. AWARENESS PRACICES – You should be aware of information regarding health matters through mass media, medical personnel and whatever knowledge you gain share it with others,</p>		
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Sr. No.	Time	Objective	Subject Matter	Teaching/ Learning Activity	A. V. Aids used
12	10 min	To get the feedback.	<p>SUMMARY AND CONCLUSION:-We have seen today what the meaning of reproductive tract infections, organs of female reproductive tract, the different body sites where reproductive tract infections occur in women. reason why women are vulnerable to get reproductive tract infections, types and names possible causes and modes of transmission, common signs and symptoms, treatment modalities and management, complications, measures for prevention and control, safer sex promotive and preventive, antenatal, intra-natal, postnatal, contraceptive, abortion curative and awareness practices regarding reproductive tract infections. Government is conducting various programmes, providing health facilities for women's health especially reproductive health, but it will be effective only with your cooperation and active participation.</p>	Discussion, clarification of the doubts	Review of all A.V.Aids

APPENDIX - 13

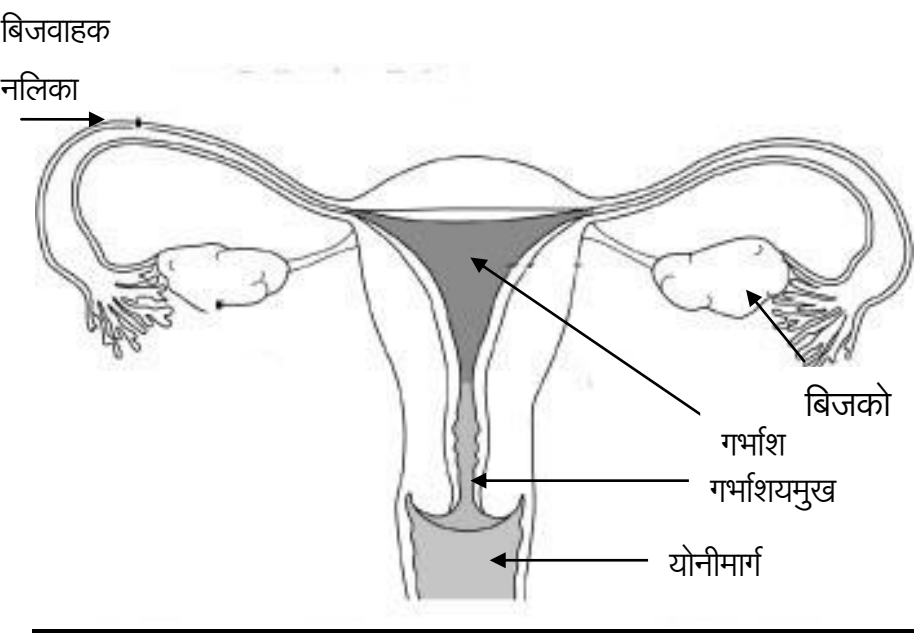
आरोग्यशिक्षण आराखडा (पूर्व नियोजन)

विषय	:-	स्त्री प्रजननसंस्थेचे जंतुसंसर्ग.
गट	:-	ग्रामीण भागातील महिला (वयोगट १५ ते ४९ वर्षे)
ठिकाण	:-	पुणे जिल्हयातील ग्रामीण भाग.
वेळ	:-	१ ते १ १/२ तास.
दृकश्राव्य साधने	:-	तक्ता, भित्तीपत्रके, फ्लिप चार्टस, फ्लॅश कार्डस, मॉडेल्स, माहिती पत्रके, पपेट शो, रोलर.
शिकविण्याची पध्दत	:-	व्याख्यान व चर्चा
ध्येय	:-	आरोग्यशिक्षण दिल्यानंतर जमलेल्या गटातील महिलांना स्त्री प्रजननसंस्थेचे जंतुसंसर्ग, लैंगिक रोग याविषयीचे ज्ञान मिळू शकेल.
उद्देश	:-	आरोग्यपाठाच्या शेवटी जमलेल्या गटाला खालील बाबींविषयी ज्ञान मिळेल.

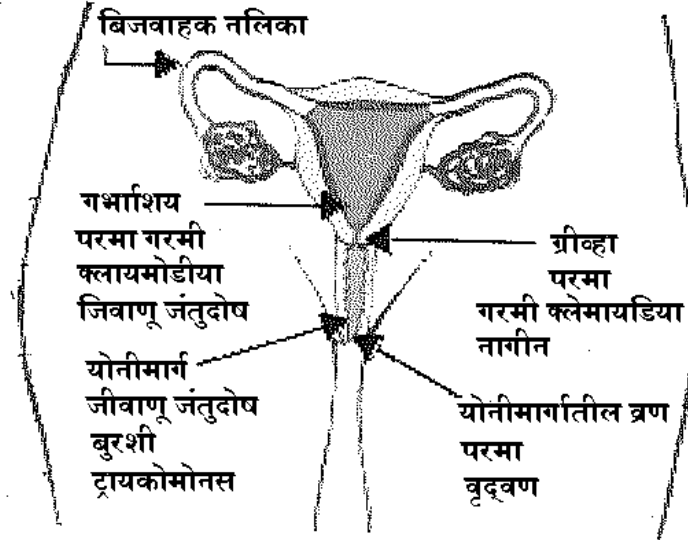
- १) विषयाची तोंड ओळख
- २) स्त्रीजननसंस्थेचे अवयवांची माहिती करून घेणे.
- ३) प्रजनन संस्थेचा संसर्ग कोणत्या भागात होतो याविषयी माहिती घेणे.
- ४) प्रजनन संस्थेच्या जंतुसंसर्गाचा अर्थ, प्रकार व तसेच प्रजनन संस्थेच्या जंतुसंसर्गाची नावे समजून घेणे.
- ५) प्रजननसंस्थेचे आजाराचे प्रमाण पुरुषांपेक्षा स्त्रियांमध्ये अधिक आहे हे समजणे.
- ६) प्रजननसंस्थेचे जंतुसंसर्गाची संभवित कारणे व त्यांचा प्रसार कसा होतो हे समजणे.

- ७) प्रजननसंस्थेच्या जंतूसंसर्गाची सर्वसाधारण चिन्हे व लक्षणे समजणे.
- ८) प्रजननसंस्थेचा संसर्ग झाल्यास उपचार व व्यवस्थापन करणे.
- ९) प्रजननसंस्थेच्या संसर्गाचे धोके/गुंतागुंत समजणे.
- १०) प्रजननसंस्थेच्या जंतूसंसर्गाबाबतचे प्रतिबंधात्मक उपाय तसेच सुरक्षित लैंगिक संबंधाचे महत्व पटवून देणे.
- ११) प्रतिबंधात्मक, प्रसुतीपूर्व, प्रसुतीवेळी, प्रसुतीनंतर, कुटुंबनियोजन विषयक, गर्भपातविषयक चालिरिती तसेच उपचारात्मक व जागृतीविषयक योग्य चालिरिती विषयक माहिती करून घेणे.
- १२) स्त्रियांकडून माहितीची आढावा घेणे.

अ.क्र.	उद्देश	विषयाचा मजकूर	शिकवणाऱ्याची व शिकण्याची पध्दत	दृकश्राव्य साधने
१)	विषयाबद्दल माहिती ५ मिनिटे	<p>प्रस्तावना - "सुप्रभात" मी सर्व प्रथम येथे असलेल्या सर्व महिलांचे स्वागत करते. मासिकपाळी, गरोदरपण, बाळांतपण, गर्भपात, कुटूंबनियोजनाच्या साधनांचा वापर या सर्व स्त्रि जीवनाच्या नेहमीच्या बाबी असतात. आणि या जननसंस्थेच्या निरनिराळ्या आजारांना कारणीभूत ठरू शकतात. यातला महत्वाचा आजार आहे, स्त्रि जननसंस्थेला होणारा जंतू संसर्ग. स्त्रिसुलभ लज्जा, संकोच आणि इतर सामाजिक परिस्थितीमुळे बऱ्याच स्त्रिया ही दुखणी अंगावर काढतात. निमुटपणे, सोसत रहातात आणि आजार बळावल्यावरच वैद्यकीय उपचारांकडे वळतात. या आजारांमुळे स्त्रियांचे आरोग्य खालावतेच शिवाय एचआयव्ही विषाणू बाधा होण्याची शक्यता वाढते. संपूर्ण जगात हा महत्वाचा सामाजिक आरोग्याचा प्रश्न आहे.</p> <p>विकसनशील देशात हा आजार जास्त प्रमाणात दिसून येतो. दरवर्षी ३४० कोटी लोकांना या आजाराची लागण होते. या आजाराचे प्रमाण कमी करण्यासाठी आरोग्य विभाग व आपणा सर्वांचे प्रयत्न महत्वाचे आहेत. ही गरज समजून मी आपणास आज या विषयाची माहिती देणार आहे.</p>	व्याख्यान	चार्ट

अ.क्र.	उद्देश	विषयाचा मजकूर	शिकवणाऱ्याची व शिकण्याची पध्दत	दृकश्राव्य साधने
२)	<p>स्त्रिप्रजनन संस्थेच्या अवयवांची माहिती करून घेणे.</p> <p>१० मिनिटे</p>	<p>स्त्रिजननेद्रियाचे दोन भाग पडतात. १) बाह्य जननेंद्रिये-यातील योनीमार्ग हा भाग रुंद असतो व सतत ओलसर असतो.</p> <p>२) अंतर जननेंद्रिये - योनी, ग्रीव्हा, गर्भाशय, बिजवाहक नलिका व अंडाशय (बिजकोश)</p> <p>बिजवाहक नलिका</p>  <p>बिजको गर्भाश गर्भाशयमुख योनीमार्ग</p>	<p>मॉडेल समजावून सांगणे व माहिती देणे</p>	<p>पोस्टर आणि मॉडेल</p>

अ.क्र.	उद्देश	विषयाचा मजकूर	शिकवणाऱ्याची व शिकण्याची पध्दत	दृकश्राव्य साधने
३)	प्रजनन संस्थेचा जंतूसंसर्ग कोणत्या भागात होतो हे समजणे ५ मिनिटे	<p>प्रजनन संस्थेचा जंतू संसर्ग आकृतीत दर्शविलेल्या भागात दिसून येतो.</p> <p>१) योनी मार्ग, योनी, ग्रीव्हा, (या अवयवांच्या जंतूसंसर्गाला खालील जननमार्गाचा जंतूसंसर्ग म्हणतात)</p> <p>२) गर्भाशय बिजवाहक नलिका, अंडकोष (या अवयवांच्या जंतू संसर्गाला वरील जननमार्गाचा जंतूसंसर्ग म्हणतात). हा खालील भागात झालेल्या जंतूसंसर्गाचा विपरीत परिणाम आहे. विशेषतः लैंगिक आजार व योनीदाह.</p>	मॉडेल समजावून सांगणे व माहिती देणे	पेष्टर आणि मॉडेल



अ.क्र.	उद्देश	विषयाचा मजकूर			शिकवणाऱ्याची व शिकण्याची पध्दत	दृकश्राव्य साधने
४)	प्रजनन संस्थेच्या जंतु-संसर्गाचा अर्थ, प्रकार तसेच प्रजनन संस्थेच्या जंतु-संसर्गाची नावे समजून घेणे. १० मिनिटे	प्रजनन संस्थेतील अवयवांना झालेल्या जंतु संसर्गाला प्रजनन संस्थेचा जंतूसंसर्ग म्हणतात.			चार्ट,	व्याख्यान व चर्चा
			कोठून येतात	कसे पसरतात	सर्वसाधारण उदाहरण	
		शरीरांतर्गत उत्पन्न झालेला जंतूसंसर्ग	सुक्ष्मजंतु योनीमार्गात दिसून येतात.	सर्वसाधारणपणे एका माणसाकडून दुसऱ्या माणसाकडे याचा प्रसार होत नाही, पण जंतुच्या जास्त वाढीमुळे लक्षणे दिसून येतात.	योनी मार्गातील जंतूसंसर्ग यीस्ट जंतूसंसर्ग.	
		लैंगिक संबंधातून होणारे जंतूसंसर्ग	प्रजनन संस्थेचा जंतूसंसर्ग जोडीदाराशी लैंगिक संबंध ठेवल्यास	बधित व्यक्तीशी लैंगिक संबंध ठेवल्यास.	परमा, उपदंश, मृदुव्रण, ट्रिकोमोनीयासीस, नागीण, नायटल, बॉट, एच.आय.व्ही.	
				या सर्व क्रियांच्या दरम्यान सुक्ष्मजीव प्रजनन मार्गाच्या वरील बाजूस ढकलले जातात व त्यामुळे गर्भाशयाला, बीजनलिकेला आणि कटिरातील इतर अवयवांना गंभीर स्वरूपाचा जंतूसंसर्ग होऊ शकतो.		

अ.क्र.	उद्देश	विषयाचा मजकूर			शिकवणाऱ्याची व शिकण्याची पध्दत	दृकश्राव्य साधने	
			कोठून येतात	कसे पसरतात			सर्वसाधारण उदाहरण
				जर योग्य प्रमाणात निर्जंतुकता नसेल तर, दुषित सुया आणि उपकरण (उदा. युटेराईन साउंड) यामुळे ही जंतुसंसर्ग होऊ शकतो.		चार्ट,	व्याख्यान व चर्चा
		वैद्यकीय कृतीमुळे होणारा जंतुसंसर्ग	शरिराच्या आतील किंवा बाहेरील- १) परजीवी (योनीमार्ग) २) प्रजनन संस्थेच्या जंतुसंसर्ग (ग्रीवामुख किंवा योनीमार्ग) ३) बाहेरून दुषितपणा झाल्यास	तपासणी करताना गरोदरपणामध्ये, प्रसुतीच्या वेळी, प्रसुती झाल्यानंतर किंवा कुटुंबनियोजनाच्या वेळी (उदा. तांबी बसविताना) आणि इतर स्त्रियोगासंबंधीच्या वैद्यकीय कृती करताना जंतुसंसर्ग पसरू शकतो.	गर्भपात किंवा इतर ग्रीवामुखातून करण्यात येणाऱ्या इतर कृतीमुळे कटिरातील अवयवांवर सुज किंवा लालसरपणा येतो, तसेच गरोदरपणात व प्रसुतीनंतरच्या कालावधीमध्ये जंतुसंसर्गामुळे गुंतागुंत वाढू शकते.		

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५)	प्रजननसंस्थेचे आजाराचे प्रमाण पुरुषांपेक्षा स्त्रियांमध्ये अधिक आहे हे समजणे. ३ मिनिटे	आपण सुरुवातीला जननेंद्रियाची अवयव व रचना पाहिली. त्यामध्ये निसर्गतः १) प्रजननमार्ग हा पसरट व पृष्ठभाग जास्त असल्यामुळे लैंगिक संबंदातून इजा होण्याची शक्यता जास्त असते. तसेच हा मार्ग स्त्रावयुक्त असल्यामुळे सतत ओलसर रहातो. त्यामुळे जंतूसंसर्गाचे प्रमाण व तो दिर्घकालीन राहण्याची शक्यता जास्त असते. २) स्त्रियांना जननमार्गाच्या तपासण्या, प्रसुती, गर्भपात व कुटूंबनियोजनाच्या पध्दती यांना समोरे जावे लागते त्यामुळे जंतू संसर्गाची शक्यता वाढते. ३) स्त्रियांमध्ये विपरीत परिणामांची शक्यता जास्त असते. व लक्षणे दिसत नसलेल्या संसर्गावर लवकर उपचार घेतले जात नाहीत. सामाजिक कारणे :- निर्णयशक्तीचा आभाव, आर्थिक परावलंबन, लज्जा/लांछन, योनीस्त्राव सामान्य प्रसंग समजणे आणि अज्ञान.	व्याख्यान व चर्चा	पोष्टर
६)	प्रजननसंस्थेचे जंतूसंसर्गाची संभवित कारणे व त्यांचा प्रसार कसा होतो हे समजणे. ७ मिनिटे	अ) खालील कारणामुळे प्रजनन संस्थेचे जंतूसंसर्ग होतो. <ul style="list-style-type: none"> ● जीवजंतू (जिवाणू, विषाणू, बाह्यपरजिवी जंतू, बुरशी) ● जंतूसंसर्ग असलेल्या व्यक्तीशी लैंगिक संबंध ● जननेंद्रियाच्या अस्वच्छता / मासिक पाळीच्या अस्वच्छता ● सर्वसाधारण आरोग्य खालावणे / रोग प्रतिकार शक्ती कमी होणे. ● असुरक्षित बाळांतपण / गर्भपात / कुटूंबनियोजनाची साधने / जननेंद्रियाच्या तपासण्या ● सुतिकावस्थेत व मासिक पाळीत संभोग करणे. ● असुरक्षित संभोग ● एकापेक्षा जास्त जोडीदार, जोडीदाराशी एकनिष्ठ नसणे. 	चार्ट पपेट शो	व्याख्यान व चर्चा

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		<p>ब) प्रजनन संस्थेच्या जंतूसंसर्गाचा प्रसार</p> <ul style="list-style-type: none"> ● असुरक्षित लैंगिक संबंध ● रक्तामार्फत ● मातेकडून बाळाला ● एकमेकांचे कपडे वापरल्याने (अंतरवस्त्रे आणि मासिकपाळीचे कपडे) ● सार्वजनिक स्वच्छतागृहाचा वापर केल्याने ● जननेंद्रियावर उपचार करतेवेळी ● असुरक्षित गर्भपात / बाळंतपणामध्ये ● दुषित पाण्याचा वापरामुळे (जननेंद्रियाच्या स्वच्छतेसाठी) 	चार्ट	व्याख्यान व चर्चा
७)	<p>प्रजननसंस्थेच्या जंतूसंसर्गाची सर्वसाधारण चिन्हे व लक्षणे समजणे.</p> <p>८ मिनिटे</p>	<ul style="list-style-type: none"> ● प्रजनन संस्थेचा जंतूसंसर्ग झालेल्या व्यक्तीस एक किंवा जास्त खालील तक्रारी दिसून येतात. ● योनीमार्गावाटे पांढरे पाणी जाते (श्वेतपदर) योनीमार्गावाटे पिवळसर, हिरवट, रक्तमिश्रीत अथवा दुर्गंधीयुक्त स्त्राव जाणे. ● जननेंद्रियाभोवती कंड फुटणे (खाज येणे) ● जननेंद्रियाभोवती लाली येणे, पुरळ उठणे, फोड येणे, जखम होणे. ● लघवीच्यावेळी वेदना होणे, जळजळणे. 	रोलर आणि चार्ट	व्याख्यान व चर्चा

		<ul style="list-style-type: none"> ● जांघेमध्ये सूज येणे (गाठी) थंडी-ताप येणे. ● संभोगाच्यावेळी वेदना होणे. रक्तस्राव होणे. ● ओटीपोटात सतत दुखणे, कंबर दुखणे. ● मासिक पाळीत त्रास होणे. 		
८)	<p>प्रजननसंस्थेचा संसर्ग झाल्यास उपचार व व्यवस्थापन करणे.</p> <p>७ मिनिटे</p>	<ul style="list-style-type: none"> ● प्रजनन संस्थेच्या जंतू संसर्गाची लक्षणे दिसून आल्यास - ● ताबडतोब तपासण्या करून वैद्यकीय सल्ला घ्यावा. ● आजार लपवून न ठेवता ताबडतोब व संपूर्ण उपचार घ्यावा. ● जोडीदार व स्वतः एकाच वेळी डॉक्टरांकडे जावून उपचार घ्यावा. ● संसर्गीत जोडीदाराशी लैंगिक संबंध टाळावा ● घसगुती उपाय वैदु / भोंदू साधूकडून ए औषध विक्रेत्यांकडून ए परस्पर औषधे घेणे टाळावे. ● सुरक्षित संभोगाची तत्वे अवलंबावीत निरोधचा योग्यरितीने वापर करावा. ● योनीतून धुउ नये, डूश घेऊ नये. ● आठवडयाने तपासणी करावी. ● औषधे कधी घ्यावीत हे समजून घ्यावेत. ● वैद्यकीय सल्ला घ्यावा. 	चार्ट आणि पपेट शो	व्याख्यान व चर्चा

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९)	प्रजननसंस्थेच्या संसर्गाचे धोके/गुंतागुंत समजणे. ५ मिनिटे	<ul style="list-style-type: none"> ● प्रजनन संस्थेच्या आजारांवर वेळीच उपचार न केल्यास खालील धोके संभवतात. ● वंध्यत्व ● ओटीपोटात सतत दुखणे ● अपुर्णकाळात प्रसुती ● गर्भपात, मृत बालक जन्मणे ● कर्करोग (ग्रीव्हेचा) ● गर्भनलिकेत गर्भधारणा होणे ● बाळास जंतूसंसर्ग होणे ● एच.आय.व्ही. संक्रमण वाढण्याचा धोका ● इतर अवयवांवर विपरीत परिणाम होणे ● ताणतणाव नैराश्य ● वैवाहित जीवनात बिघाड घटस्फोट 	पोष्टर	व्याख्यान व चर्चा

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१०)	<p>प्रजननसंस्थेच्या जंतूसंसर्गाबाबतचे प्रतिबंधात्मक उपाय तसेच सुरक्षित लैंगिक संबंधाचे महत्त्व पटवून देणे.</p> <p>१० मिनिटे</p>	<p>१) प्रजनन मार्गाच्या जंतूसंसर्गाच्या प्रतीबंधात्मक उपयांसाठी प्राथमिक धोरणे. प्रकार प्राथमिक धोरणे लैंगिक आजार</p> <p>१) संभोगाची उशीराने सुरुवात. २) अनेक व्यक्तींशी शरीर संबंध ठेवू नये. ३) सुरक्षित संभोग ४) निरोधचा योग्यरितीने वापर ५) निदान, चिकित्सा ६) आजार पूर्ण बरा होईपर्यंत लैंगिक संबंध टाळावेत.</p> <p>अंतर्गत जंतूमुळे होणारे</p> <p>१) शारीरिक स्वच्छता २) आरोग्याच्या सवयी ३) योनीमार्गे डूश टाळावे ४) योनीमार्गात हानीकारक पदार्थ वापरू नये. ५) वैद्यकीय सल्ल्याशिवाय औषोधोपचार घेऊ नयेत.</p>	रोलर आणि चार्ट	व्याख्यान व चर्चा

		<p>वैद्यकीय उपकरणांनी सुरक्षित बाळंतपण, गर्भपात, संतती प्रतिबंधक साधनांचा वापर, मान्यताप्राप्त दवाखान्यातच करावा.</p> <p>२) प्रजनन संस्थेच्या संसर्गाचा प्रतिबंध करण्यासाठी दुय्यम स्वरूपाचे धोरण- निदान चिकित्सा - रक्त, लघवी, ओटी पोटाची तपासणी व स्त्रावांची तपासणी, व पॅपस्मिअर टेस्ट</p> <p>वैद्यकीय उपचार - पती-पत्नी दोघांनी एकाच वेळी डॉक्टरांचा सल्ला घेणे. आजार पूर्ण बरा होईपर्यंत लैंगिक संबंध टाळावे किंवा निरोधचा कटाक्षाने वापर करावा.</p> <p>रोग प्रतिबंधक उपाय - उदा. ह्यूमन पॅपीलोमा विषाणूसाठी लस घेणे.</p> <p>' रूग्णांना सुरक्षित लैंगिक संबधाबद्दल शिक्षण देणे -</p> <p>आपल्याला माहित आहे की, काही चुकीच्या वागणुकीमुळे लैंगिक मार्गाच्या जंतुसंसर्गाचा प्रसार योनी, तोंड किंवा गुद्दवार यांमध्ये असुरक्षित लैंगिक संबंध आला, तर प्रजनन संस्थेच्या जंतुसंसर्गाचे प्रसार होवू शकतात.</p> <p>जर इतरांशी म्हणजेच लैंगिक व्यवसाय करणाऱ्या व्यक्तींशी लैंगिक संबंध ठेवण्याआधी निरोधचा वापर सक्तीने करणे किंवा इतर सुरक्षितता पाळण्यास सांगणे.</p> <p>सुरक्षित लैंगिक संबंध हे दोन्ही जोडीदारांसाठी आनंददायी असतात, कारण, त्यामुळे काळजी, आजार किंवा भिती राहत नाही. सुरक्षित लैंगिक संबंध यावर भर देणे गरजेचे आहे.</p> <p>सुरक्षित लैंगिक संबधामुळे प्रजनन संस्थेचा जंतुसंसर्ग आणि एच.आय.व्ही. हे एका व्यक्तिकडून दुसऱ्या संक्रमित होण्याचा धोका कमी होऊ शकतो. सुरक्षित लैंगिक संबधामुळे वीर्य, योनी स्त्राव किंवा रक्त हे योनी, गुद्दवार किंवा अन्य कोणत्याही भेग किंवा जखमेद्वारे शरिरात प्रवेश करू शकत नाही.</p>		
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		<p>सुरक्षित लैंगिक संबंधाच्या काही पध्दती :-</p> <p>१) लैंगिक संबंधाच्यावेळी नेहमी निरोधचा वापर करणे. (विशेषतः नव्या जोडीदाराशी)</p> <p>२) लैंगिक संबंधासाठी जोडीदारांची संख्या कमी करणे किंवा बाधित नसलेल्या एकाच जोडीदाराशी संबंध ठेवणे हे सर्वात सुरक्षित आहे.</p> <p>३) संभोग करण्याऐवजी मसाज, चोळणे, स्पर्श, चुंबन, अलिंगन किंवा लिंग उत्तेजित करणे. (हस्तमैथुन) हे करण्याचा प्रयत्न करावा.</p> <p>४) असुरक्षित लैंगिक संबंधाच्या पध्दतीपासून दूर रहा. उदा. योनीमार्ग ओला असल्याशिवाय संभोग करू नये. त्यामुळे तेथील त्वचा फाटू शकते.</p> <p>५) जर तुम्हाला गुद्द्वारातून लैंगिक संबंध करायचे असल्यास नेहमी कंडोमचा वापर करावा, जर वापर केला नाही, तर गुद्द्वाराजवळील ग्रंथीवरचे (म्युकस नॅब्रेन) पातळ आवरण फाटू शकतो.</p> <p>जर तुमच्या जोडीदाराच्या जनन मार्गात जखमा असतील किंवा अस्वाभाविक स्त्राव असेल, तर संभोग किंवा तोंडातून संभोग करणे टाळावे.</p>		
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अ.क्र.	उद्देश	विषयाचा मजकूर	शिकवणाऱ्याची व शिकण्याची पध्दत	दृकश्राव्य साधने
११)	प्रतिबंधात्मक, प्रसुतीपूर्व, प्रसुतीवेळी, प्रसुतीनंतर, कुटुंबनियो जन विषयक, गर्भपातविषयक चालिरिती तसेच उपचारात्मक व जागृतीविषयक योग्य चालिरिती विषयक माहिती करून घेणे. १० मिनिटे	स्त्रियांनी स्वतःचे प्रजनन आरोग्य चांगले राखण्यासाठी व प्रजनन संस्थेच्या जंतूसंसर्गाचा प्रतिबंध करण्यासाठी चांगल्या चालिरिती अवलंबिणे गरजेचे आहे. १) स्वच्छतेविषयी चालिरिती - वैयक्तिक स्वच्छता राखणे, जननेंद्रियाची स्वच्छता राखणे, योनीमार्गाकडून गुद्द्वाराकडे स्वच्छता करणे. स्वच्छ कपडे घालणे, स्वच्छ अंतरवस्त्रे वापरणे. २) मासिक पाळीच्यावेळी स्वच्छतेविषयक चालिरिती - दर तीन-चार तासांनी बाह्य जननेंद्रियाची स्वच्छता राखणे, जर मासिक पाळीच्या वेळी कपडा वापरत असाल तर तो स्वच्छ साबण पाण्याने धुवून उन्हात वाळवून वापरावा, दर चार ते सहा तासांनी बदलावा, तो स्वच्छ ठिकाणी ठेवावा. तोच कपडा परत परत वापरू नये. जर सॅनिटरी पॅड वापरत असाल तर तो तीन ते चार तासांनी बदलावा व योग्य रितीने त्याची विल्हेवाट लावावी. ३) लैंगिक चालिरिती - जननेंद्रियाची संभोगापूर्वी व संभोगानंतर स्वच्छता करावी. जर दोघांपैकी एकाला प्रजनन संस्थेचा जंतूसंसर्ग झालेला असेल तर संभोग टाळावा अथवा निरोधचा वापर करावा. सुरक्षित संभोग अवलंबावा. जोडीदाराशी / पतीशी एकनिष्ठ रहावे.	पोस्टर	व्याख्यान व चर्चा

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		<p>४) प्रसुतीपूर्व, प्रसुतीवेळी, प्रसुती पश्चात, संतती प्रतिबंधक व गर्भपात विषयक चालिरिती- प्रसुतीपूर्व काळात काळजी घ्यावी (वेळच्यावेळी निदान, समतोल आहार, स्वच्छता, लसीकरण, झोप व विश्रांती, व्यायाम, तापसणी) वैद्यकीय सल्ला व उपचार वेळच्यावेळी करावे. प्रसुतीवेळी काळजी - बाळांतपण मान्यताप्राप्त दवाखान्यातच करावे. प्रसुतीनंतर बाळाची व स्वतःची काळजी घ्यावी. स्वच्छता, आहार, व्यायाम, स्तनांची काळजी, नवजात बाळाची काळजी, नियोजित वैद्यकीय सल्ला. काही त्रास झाल्यास (तुम्हाला अथवा बाळाला) ताबडतोब वैद्यकीय सल्ला घ्यावा.</p> <p>योग्य कुटूंबनियोजनाचा साधनांचा वापर करावा. काही त्रास झाल्यास डॉक्टरांकडे जावे.</p> <p>गर्भपात मान्यताप्राप्त डॉक्टरांकडेच करावा. घरी गर्भपात करू नये अथवा योनीमार्गात काही ठेवून गर्भपात घडवून आणू नये, गर्भपात घरी, स्वतःहून, नातेवाईक, भोंदू, वैदूकडून करू नये.</p> <p>५) उपचारात्मक चारिरिती - ताबडतोब वैद्यकीय उपचार घ्यावा. हकीम, वैदू, भोंदू, चेटूक किंवा स्वतःहून औषोधपार करू नये. पतीसोबत एकाच वेळी उपचार सुरू करावेत. उपचार ताबडतोब व पूर्ण घ्यावा, पतीला जंतूसंसर्ग असल्यास संभोग टाळावा किंवा सुरक्षित संभोग अवलंबावा.</p> <p>६) जागृती विषयक चालिरिती -</p> <p>आरोग्यविषयक माहिती घेण्याचा सतत प्रयत्न करावा. वर्तमानपत्र, मासिके, टिव्ही, रेडीओ, आरोग्य कर्मचारी व ही माहिती इतरांना देण्याचा प्रयत्न करावा.</p>		

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१२	१० मिनिटे	<p>सारांश व निष्कर्ष –</p> <p>आज आपण प्रजनन संस्थेच्या जंतूसंसर्गाचा अर्थ, प्रजनन संस्थेचे अवयव, निरनिराळे भाग ज्या ठिकाणी स्त्रियांना जंतूसंसर्ग होतो, प्रकार व नावे, कारणे व प्रसार माध्यमे, सर्वसाधारण चिन्ह व लक्षणे, उपचारात्मक उपाययोजना, धोके, प्रतिबंधात्मक उपाययोजना, सुरक्षित संभोगाचे अवलंबन तसेच प्रतिबंधात्मक प्रसुतीपूर्व, प्रसुतीवेळी, प्रसुतीनंतर, कुटूंबनियोजन, गर्भपात, उपचारात्मक व जागृतीविषयक चालिरिती पाहिल्या. आरोग्यविभाग स्त्रियांच्या प्रजनन आरोग्यासाठी बरेच उपक्रम राबवित आहे. परंतू आपणा सर्वांचे सहकार्य असेल तरच हे ध्येय साध्य करता येईल.</p> <p>आपण सर्वांनी माझे म्हणणे शांतपणे ऐकले त्याबद्दल धन्यवाद :</p>		दृकश्राव्यांचा मागोवा

APPENDIX : 2

LETTER REQUESTING OPINION AND SUGGESTIONS OF THE EXPERTS FOR THE CONTENT VALIDITY OF THE TOOLS

Date:-

To,

Sub: Letter requesting expert opinion for establishing the content validity of research tool.

Respected Sir / Madam,

This is to introduce, Mrs. M. S. Shelke of Ph. D. student of Tilak Maharashtra Vidyapeeth, Pune. I am conducting **“A Study to assess the effect of health education programme on knowledge and practices related to common selected reproductive tract infections among the married women in rural area of Pune District.”**

I request you to kindly go through the content of the data collection tool in terms of it's relevance, accuracy and give your valuable suggestions.

Tool enclosed with:

1. Objectives of the study
2. Assessment tool
3. Health education plan.

Thank you in anticipation.

Yours faithfully,

Mrs. M. S. Shelke

APPENDIX : 3

CERTIFICATE OF VALIDATION

This is to certify that the tool constructed by Mrs. Madhuri S. Shelke, Ph. D student of Tilak Maharashtra Vidyapeeth, Gultekdi Campus, Pune-411037, to be used in the study **“A Study to assess the effect of health education programme on knowledge and practices related to common selected reproductive tract infections among the married women in rural area of Pune District.”**

The tool has been validated by me.

Signature :- _____
Name :- _____
Designation :- _____
Date :- _____
Place :- _____

APPENDIX-4

LIST OF EXPERTS CONSULTED FOR THE CONTENT VALIDITY

Sr. No.	Name of the expert	Designation
1	Dr. Mrs.T Bhattacharjee	Principal, College of Nursing, B.V.CON.Dhankawadi, Pune.
2	Mrs. Mangala A. Joshi	Principal, Sinhgad College of Nursing, Narhe Ambegaon, Pune.
3	Dr. Sneha A.Pitre	Professor/ Vice principal, College of Nursing, B.V.CON.Dhankawadi, Pune.
4	Mrs. Preeti Londhe	Principal, Sasoon General Hospital, Pune.
5	Mrs. Pravina Mahadalkar	Professor, College of Nursing, B.V.CON.Dhankawadi, Pune.
6	Mrs. Minimol Louis	Associate Professor, College of Nursing, B.V.CON.Dhankawadi, Pune.
7	Mrs. Sujata Sawant	Associate Professor, Sinhgad College of Nursing, Narhe Ambegaon, Pune.
8	Mrs. Jayashree G.	Associate Professor, M.G.M. College Of Nursing, Vashi-Navi Mumbai.
10	Mrs. Jyosna R.Deshpande	Lecturer, College of Nursing, B.V.CON. Dhankawadi, Pune.

Sr. No.	Name of the expert	Designation
11	Mrs. Neelima J. Pandit	Nursing co-ordinator University College Of Cork, Ireland Group, Ireland.
12	Dr. A.B. Patil	Additional district Health Officer(ADHO) Pune Zilla Parishad, Pune.
13	Dr. D.A.Bora	Medical Officer, Khanapur PHC,Pune.
14	Dr.S.R. Randive	Taluka Health Officer, THO Office, Pune.
15	Dr. C.M.Gojamgunde	District Quality Assurance Co-ordinator, HFWPTC, Aundh, Pune.
16	Dr. V.S.Gaikwad	Medical Officer, Wagholi PHC, Pune.
17	Dr. Manju Jilla	M.D. Gynaecology and Obstetrics, Jilla Superspecialty Hospital, Aurangabad.
18	Dr. Anjali Karad	M.D. Gynaecology and Obstetrics, Karad Hospital, Aurangabad.
19	Mrs. Juby Chaco	Associate Professor, K.B.CON,Aurangabad.
20	Dr. A.V.Umbranikar	M.D. Gynaecology and Obstetrics, Meera Maternity Hospital, Pune.
21	Mrs. Vaishali Chirmade	Statistician
22	Dr. Vishal Jadhav	H.O.D.Sociology Dept. TMV,Pune.
23	Dr.Jagan Karade	H.O.D.Sociology Dept. Shivaji University, Kolhapur.
24	Professor P.S Vivek	Professor of Sociology, University of Mumbai
25	Dr. M.T Joseph	Department of Sociology, University of Mumbai

APPENDIX - 8
DATA COLLECTION TOOL

SECTION – 1: DEMOGRAPHIC DATA RELATED TO WOMEN

I. Personal information:

Code No.....

Name of the village.....

Household code.....

1A) Age :

- a. 15 to 20 years
- b. 21 to 25 years
- c. 26 to 30 years
- d. 31 to 35 years
- e. 36-40 years
- f. 41-45 years
- g. 46-49 years

1B) Age at marriage:

- a. Below 18 years
- b. 18-22
- c. 23-27
- d. 28-32
- e. 33-37
- f. Above 37 years

2) Religion :

- a. Hindu
- b. Muslim
- c. Christian
- d. Any other (Specify - _____)

3).Marital status:

- a. Divorced
- b. Separated
- c. Widow

4A.) Education of self:

- a. Illiterate
- b. Primary education
- c. Secondary education
- d. Higher Secondary education
- e. Graduate
- f. Post graduate.
- g. Any other (Specify - _____)

4B.) Education of the husband:

- a. Illiterate
- b. Primary education
- c. Secondary education
- d. Higher Secondary education
- e. Graduate
- f. Post graduate.
- g. Any other (Specify - _____)

5A.) Occupation of self:

- a. Housewife.
- b. Service
- c. Business

- d. Farming
- e. labourer
- e. Any other (Specify – _____)

5B.) Occupation of the husband:

- a) Service
- b) Farming
- c) Labourer
- d) Unemployed
- e) Any other. (specify _____)

5C) Husband staying outstation for work-YES/NO

6) Monthly family income in Rupees (Rs.

- a. Below Rs. 5000/-
- b. Rs. 5,001-10,000/-
- c. Rs. 10,001-15,000/-
- d. Rs. 15,001-20,000/-
- e. Rs. 20,001 & above.

7) Type of family:

- a. Nuclear
- b. Joint
- c. separated

8) Menstrual data:

- a. Regular
- b. Irregular
- c. Duration

- d. Type of flow
- e. Problems related to menstruation

9) Information about reproductive health (gynecological, obstetrical, sexual data):

- a. Gynecological data
- b. Obstetrical data
- c. Sexual data

10A) Contraceptive methods adopted by self :

- a. Oral pills
- b. Intrauterine device
- c. Tubal ligation
- d. Any other

10B) Contraceptive methods adopted by husband:

- a. Condom
- b. Vasectomy
- c. Any other

10C) Reason for not using contraceptive methods:

11) Medical history-

12) Participation of partner-

ASSESSMENT TOOL

Section B –TOOL TO ASSESS KNOWLEDGE OF THE WOMEN REGARDING REPRODUCTIVE TRACT INFECTIONS

SR.NO.	ITEM	YES	NO
1	What do you mean by reproductive tract infections?		
1.1	It is the infection of reproductive tract		
1.2	It is the stomach infection		
1.3	It is the infection of respiratory tract		
1.4	It is the infection Urinary system		
2	Do you know the organs of female reproductive system? If yes name them		
2.1	Do you know the different body sites where reproductive tract infections occur in women? If yes name them.		
3	Why reproductive tract infections are more common in women than men?(Natural and social factors)		
3.1	3a. Natural Because of the structure of reproductive tract and larger surface area.		
3.2	Female Reproductive tract is wet due to discharge.		
3.3	Women has to undergo investigation of reproductive tract / Delivery/ Abortion/Contraceptive methods		
3.4	More likely to suffer from complications.		
3.5	More likely to suffer from asymptomatic infections and remain untreated		

3.6	3b.Social Lack of decision making power		
3.7	Lack of knowledge		
3.8	Lack of time		
3.9	Shyness & Stigma		
3.10	Financial dependence		
4	Which of the following are the types of reproductive Tract Infections?		
4.1	Infections due to overgrowth of organisms normally found in the genital tract of women		
4.2	Sexually Transmitted Infections		
4.3	Infections related to intrauterine device insertion, unsafe childbirth and abortion techniques.		
5	Do you know names of reproductive tract infections?		
5.1	if ,yes name some reproductive tract infections		
5.2	Is reproductive tract infection related to AIDS?		
6	What are possible “causes of reproductive tract infections?		
6.1	Infectious agents(bacteria, virus, protozoa, fungus)		
6.2	Sex with partner having signs and symptoms of RTI		
6.3	Poor genital and menstrual hygiene		
6.4	Poor general health/Low immunity		
6.5	Unsafe procedures like unsafe deliveries / Abortions		
6.6	Having sex after delivery (Puerperiun)		
6.7	Sex during menses		
6.8	Unprotected sex		

6.9	Being unfaithful (Multiple Partners)		
7	Which of the following are common signs and symptoms of reproductive tract infections?		
7.1	Unusual vaginal discharge with or without bleeding.		
7.2	Genital itching		
7.3	Redness, rash, sores, ulcers, warts		
7.4	Burning sensation & pain during urination		
7.5	Swelling in the groin ,fever		
7.6	Pain & bleeding during sexual intercourse		
7.7	Lower abdominal / lumber pain (female)		
7.8	Excess menstrual bleeding		
8	How the reproductive tract infections spread?		
8.1	Unsafe sex		
8.2	Blood transfusion		
8.3	Mother to child		
8.4	Sharing clothes(undergarments, menstrual cloth).		
8.5	Use of public toilet.		
8.6	Investigations & treatment of reproductive tract infection.		
8.7	Unsafe abortion & delivery.		
8.8	Use of unclean water for genital hygiene.		
9	What measures should be taken to treat reproductive tract infections?		
9.1	Early diagnosis and prompt treatment.		
9.2	Correct and adequate treatment.		
9.3	Treatment of both the partners simultaneously.		
9.4	Avoid sex with infected partner.		
9.5	Any other; a.Home remedies.		
b.	Quacks.		
c.	Pharmacists.		

d.	Herbal medicine		
10	What are the complications of reproductive tract infections?		
10.1	Infertility		
10.2	Chronic pelvic pain		
10.3	Premature birth, low birth weight baby		
10.4	Miscarriage ,still birth		
10.5	Cervical cancer		
10.6	Ectopic pregnancy		
10.7	Prenatal and neonatal infections		
10.8	Risk for HIV /AIDS transmission		
10.9	Systemic complications		
10.10	Mental stress, tension, depression		
10.11	Effect on marital status/divorce		
11	What are the preventive and control measures for reproductive tract infections?		
11.1	Maintaining sexual hygiene,		
11.2	Maintaining menstrual hygiene		
11.3	Safer sex practices.		
11.4	Avoid sex with infected partner		
11.5	Removing stigma and bias, improving the treatment seeking behaviour.		
11.6	Having single partner, avoiding multiple partners		
11.7	Utilization of safe delivery services.		
11.8	Utilization of safe abortion services		
11.9	Public awareness regarding reproductive tract infections		

**SECTION -C: TOOL TO ASSESS SELF EXPRESSED PRACTICES OF THE
WOMEN REGARDING REPRODUCTIVE TRACT INFECTIONS**

Instructions :-

Please list your practices under the following headings and teak (√) in the appropriate column.

1) PREVENTIVE PRACTICES-

a) Hygienic practices:

SR.NO.	ITEM	ALWAYS	SOMETIMES	NEVER
1.1	Maintain personal hygiene			
1.2.	Maintain genital tract hygiene			
1.3	Cleaning is done from vagina towards anus			
1.4	Use of clean undergarments			
1.5	Wear clean clothes			

b) Menstrual hygienic practices :

SR.NO.	ITEM	Always	Sometimes	Never
1.6	Maintain personal hygienic practices during menstruation			
1.7	Maintain genital tract hygiene 3-4 hourly			
1.8	Use of cloth during menstrual period			
1.9	Cloth is changed after every 4-6 hours			
1.10	Cloth is cleansed and dried before use			

1.11	Cloth is kept in clean place			
1.12	Reusing the same cloth			
1.13	Use of sanitary napkins			
1.14	Sanitary pad is changed after every 3-4 hours			

c) Sexual practices :

SR.NO.	ITEM	Always	Sometimes	Never
1.15	Cleanse genital region before intercourse			
1.16	Cleanse genital region after intercourse			
1.17	Use of condom during sexual intercourse if either partner shows symptoms of reproductive tract infection			
1.18	Sexual practice during menstrual period			
1.19	Follow safer sex practices			
1.20	Being faithful to partner/husband			

d) Antenatal, intra -natal, postnatal and Contraceptive practices :

SR.NO.	ITEM	Always	Sometimes	Never
1.21	Antenatal practices Seek antenatal care during pregnancy (Regular check up , diet, hygiene, immunization, rest and sleep, exercise, investigations)			
1.22	Seek medical treatment immediately if any problem arises during pregnancy			

1.23	Intranatal practices-choice for place of delivery-			
1.23a	prefer hospital delivery (Specify reason)			
1.24				
1.24a	prefer home delivery (Specify reason)			
1.25	Decision taken regarding the choice for place of delivery by- a. self b. husband c. family member/relatives			
1.26	Delivery conducted by- a. Trained personnel (Doctor, nurse, health worker) b. Untrained personnel(relatives, friends.)			
1.27	Immediately seek medical advice if any problem arises during intranatal period.			
1.28	Seek postnatal care(hygiene ,diet, exercise, care of breast, care of newborn, regular medical check up)			
1.29	Self efficacy towards spacing, use of contraceptive devices .			
1.30	Take medical treatment immediately if suffered from complications due to contraceptive device.			
1.31	Self efficacy with respect to abortion.			
1.32	a. Abortion is conducted in approved hospital/health centre.			

	b. Attempted to perform abortion at home by self, relatives, friends, quacks or others(specify)			
1.33	Seek medical treatment , if experienced any problem occurs after abortion.			

2) CURATIVE PRACTICES -

SR.NO.	ITEM	Always	Sometimes	Never
2.1	Seek medical treatment immediately , if experiences any symptoms related to Reproductive Tract Infection			
2.2	If do not seek medical treatment specify reasons			
	a) Do not think as a disease			
	b) Lack of time			
	c) Lack of Money			
	d) Feel Shy to tell the problem.			
	e) Non co-operation of husband			
	f) Non co-operation of any other family member			
	g) Lack of Transportation			
	h) Social Stigma			
	i) Non availability of Medical services			
	j) Lack of decision making power			
2.3	Practice other measures than medical treatment a. Home remedies before taking treatment b. Herbal medicine c. Hakim/ vaidu d. Black magic			
2.4	Take immediate and complete treatment			

2.5	Take treatment along with husband / partner			
2.6	Avoid sex with infected partner			
2.7	Follow safer sex practices			

3) AWARENESS PRACTICES -

SR.NO.	ITEM	Always	Sometimes	Never
3.1	Receive Information regarding Reproductive Tract Infection through-			
	a. Mass media (Radio, T.V. print material etc.)			
	b. Doctor			
	c. Health care providers (Nurses, Others)			
	d. Health education			
3.2	Share the information regarding reproductive tract infections with others.			

APPENDIX - 9

प्रजनन संस्थेच्या जंतुसंसर्गाविषयक प्रश्नावली वैयक्तिक माहिती

कोड नं. :

घर क्रमांक :

गावाचे नांव : तालुका :

१) वय :-

अ) सध्याचे वय		ब) विवाहाचे वेळीचे वय	
अ)	१५ ते २० वर्षे	अ)	१८ वर्षापेक्षा कमी
ब)	२१ ते २५ वर्षे	ब)	१८ ते २२ वर्षे
क)	२६ ते ३० वर्षे	क)	२३ ते २७ वर्षे
ड)	३१ ते ३५ वर्षे	ड)	२८ ते ३२ वर्षे
इ)	३६ ते ४० वर्षे	इ)	३३ ते ३७ वर्षे
ई)	४१ ते ४५ वर्षे	ई)	३७ वर्षा पुढे
प)	४६ ते ४९ वर्षे		

२) धर्म :-

धर्म :	हिंदू	मुस्लिम	ख्रिश्चन	इतर

३) वैवाहिक स्थिती :-

वैवाहिक स्थिती	घटस्फोटीत	विभक्त	विधवा

४) शिक्षण :-

	अशिक्षित	प्राथमिक शिक्षण	माध्यमिक शिक्षण	उच्च माध्यमिक शिक्षण	पदवीधर	पदव्युत्तर	इतर
अ) स्वतःचे							
ब) पतीचे							

५) व्यवसाय :-

	गृहिणी	नोकरी	व्यावसायिक	शेती	मजूर	इतर
अ) स्वतःचा						
	नोकरी	व्यावसायिक	शेती	मजूर	बेरोजगार	इतर
ब) पतीचा						
क) पतीस नोकरी/ व्यावसायासाठी परगावी रहावे लागते का?		होय	नाही			

६) कुटुंबाचे मासिक उत्पन्न :-

कुटुंबाचे मासिक उत्पन्न		
१)	रु. ५,०००/- पेक्षा कमी	
२)	रु. ५,००१/- ते रु. १०,०००/-	
३)	रु. १०,००१/- ते रु. १५,०००/-	
४)	रु. १५,००१/- ते रु. २०,०००/-	
५)	रु. २०,००१/- पेक्षा जास्त.	

७) कुटुंबाचा प्रकार :-

अ) स्वतंत्र	ब) विभक्त	क) एकत्र

८) मासिक पाळीविषयक माहिती :-

अ) नियमित	ब) अनियमित	क) कालावधी	ड) मासिक पाळीचा प्रवाह	इ) मासिक पाळीच्या तक्रारी

९) प्रजनन आरोग्य विषयक माहिती (स्त्री रोग विषयक, प्रसुतीविषयक व लैंगिक माहिती.) :-

अ)	स्त्री रोग विषयक						
ब)	प्रसुतीविषयक माहिती.	मुले	गर्भपात	स्वाभाविक	अस्वाभाविक	दवाखाना	घरी
	प्रसुतीविषयक तक्रारी						
क)	लैंगिक माहिती.						

१०) कुटुंबनियोजनाविषयक माहिती :-

अ) कुटुंबनियोजनाची साधने वापरता काय?	होय		नाही	
असल्यास, खालीलपैकी कोणती साधने वापरता.				
अ-१) स्वतः	ब-१) पती			
गर्भनिरोधक गोळ्या		निरोधका वापर		
तांबी		पुरुष नसबंदी शस्त्रक्रीया		
स्त्री नसबंदी शस्त्रक्रीया		इतर		
इतर				
ब) कुटुंबनियोजनाची साधने वापरत नसल्यास, कारणे काय?				

११) वैद्यकीय माहिती :-

१२) जोडीदाराचा सहभाग :-

जोडीदाराचा सहभाग :-	होय	नाही

प्रजननसंस्थेच्या जंतुसंसर्गाबाबतची ज्ञान विषयक प्रश्नावली.

१) प्रजनन संस्थेचा जंतुसंसर्ग म्हणजे काय ?

अ. क्र.	तपशील	होय	नाही
१.१)	जननेंद्रियांचा जंतुसंसर्ग		
१.२)	पोटाचा जंतुसंसर्ग		
१.३)	श्वसनमार्गाचा जंतुसंसर्ग		
१.४)	मूत्रमार्गाचा जंतुसंसर्ग		

अ. क्र.	तपशील	होय	नाही
२	स्त्रियांच्या प्रजनन संस्थेच्या अवयवांची माहिती आहे काय? होय असल्यास, अवयवांची नावे सांगा.		
२.१)	प्रजनन संस्थेच्या जंतू संसर्ग शरीराच्या कोणत्या भागात दिसतो हे माहित आहे का? होय असल्यास नावे सांगा.		

३) स्त्रियांमध्ये प्रजनन संस्थेच्या जंतुसंसर्गाचे प्रमाण पुरुषांच्या तुलनेत अधिक आहे.

कारण

अ. क्र.	तपशील	होय	नाही
३.१	स्त्रियांचा प्रजनन मार्ग पसरट व पृष्ठभाग जास्त असल्यामुळे इजा होण्याची शक्यता जास्त असते.		
३.२	प्रजननमार्ग सतत ओलसर व स्त्रावयुक्त असल्यामुळे		
३.३	जननमार्गाच्या तपासण्या / बाळंतपण / गर्भपात / संतती प्रतिबंधक साधनांचा वापर (कॉपरटी)		
३.४	विपरीत परिणामाचे प्रमाण जास्त असते.		
३.५	प्रजननसंस्थेच्या जंतुसंसर्गाची लक्षणे सामान्य समजून त्यावर उपचार न घेणे.		
३.६	निर्णयशक्तीचा अभाव (पुरुष प्रधान संस्कृती)		
३.७	माहितीचा अभाव		
३.८	स्त्रिया वेळेअभावी लवकर उपचार घेत नाही.		
३.९	लज्जा/काळीमा		
३.१०	आर्थिक परावलंबन		

४) प्रजननसंस्थेच्या जंतुसंसर्गाचे प्रकार कोणते ?

अ. क्र.	तपशील	होय	नाही
४.१	जीवजंतूमुळे होणारे आजार		
४.२	लैंगिक संबंधातून पसरणारे आजार		
४.३	असुरक्षित बाळंतपण/अवैध गर्भपात, योग्य निर्जंतुकीकरण, न करता करता वापरलेल्या हत्यारांमुळे (म्हणजेच वैद्यकीय उपचार घेताना.)		

अ. क्र.	तपशील	होय	नाही
५	प्रजननसंस्थेच्या आजारांची नावे माहित आहे का ?		
५.१	होय असल्यास कोणते ?		
५.२	प्रजनन संस्थेचा जंतुसंसर्ग एडसशी संबंधित आहे का ?		

६) प्रजननसंस्थेच्या संसर्गाची संभावित कारणे कोणती ?

अ. क्र.	तपशील	होय	नाही
६.१	जीवजंतूमुळे		
६.२	जंतुसंसर्ग असलेल्या व्यक्तिशी लैंगिक संबंधामुळे		
६.३	जननेंद्रियाच्या अस्वच्छतेमुळे / मासिक पाळीच्या अस्वच्छतेमुळे		
६.४	सर्वसाधारण आरोग्य खालावल्याने (रोग प्रतिकार शक्ती कमी झाल्याने)		
६.५	असुरक्षित बाळांतपण / गर्भपातामुळे		
६.६	सुतिकावस्थेतील संभोगामुळे		
६.७	मासिक पाळीतील शरीर संबंधामुळे		
६.८	असुरक्षित संभोग		
६.९	अनेक जोडीदार		

७) प्रजनन संस्थेच्या जंतुसंसर्गाची लक्षणे कोणती ?

अ. क्र.	तपशील	होय	नाही
७.१	योनीमार्गावाटे पांढरे पाणी जाते (श्वेतपदर) योनीमार्गावाटे पिवळसर, हिरवट, रक्तमिश्रीत अथवा दुर्गंधीयुक्त स्त्राव जाणे.		
७.२	जननेंद्रियाभोवती कंड फुटणे (खाज येणे)		
७.३	जननेंद्रियाभोवती लाली येणे, पुरळ उठणे, फोड येणे, जखम होणे.		

अ. क्र.	तपशील	होय	नाही
७.४	लघवीच्यावेळी वेदना होणे, जळजळणे.		
७.५	जांघेमध्ये सूज येणे (गाठी) थंडी-ताप येणे.		
७.६	संभोगाच्यावेळी वेदना होणे. रक्तस्राव होणे.		
७.७	ओटीपोटात सतत दुखणे, कंबर दुखणे.		
७.८	मासिक पाळीत त्रास होणे.		

८) प्रजननसंस्थेच्या जंतुसंसर्गाचा प्रसार कसा होतो ?

अ. क्र.	तपशील	होय	नाही
८.१	असुरक्षित लैंगिक संबंध		
८.२	रक्तामार्फत		
८.३	मातेकडून बाळाला		
८.४	एकमेकांचे कपडे वापरल्याने (अंतरवस्त्रे आणि मासिकपाळीचे कपडे)		
८.५	सार्वजनिक स्वच्छतागृहाचा वापर केल्याने.		
८.६	जननेंद्रियावर उपचार करतेवेळी		
८.७	असुरक्षित गर्भपात / बाळंतपणामध्ये		
८.८	दुषित पाण्याचा वापरामुळे (जननेंद्रियाच्या वच्छतेसाठी)		

९) प्रजनन संस्थेचे जंतुसंसर्गाची लक्षणे दिसून आल्यास काय उपचार करावे ?

अ. क्र.	तपशील	होय	नाही
९.१	लक्षणे दिसल्यास व्यक्तीने ताबडतोब तपासण्या करून वैद्यकीय सल्ला घ्यावा.		
९.२	आजार लपवून न ठेवता ताबडतोब व संपूर्ण उपचार घ्यावा.		
९.३	जोडीदार व स्वतः एकाच वेळी डॉक्टरांकडे जावून उपचार घ्यावा.		
९.४	संसर्गीत जोडीदाराशी लैंगिक संबंध टाळावा		
९.५	इतर रु. घरगुती उपायए वैदु / भोंदू साधूकडूनए औषध विक्रेत्यांकडूनए वनऔषधी इ.		

१०) प्रजनन संस्थेच्या जंतुसंसर्ग झालेल्या व्यक्तीने उपचार न घेतल्यास कोणते शारिरीक विपरीत (वाईट) परिणाम होतात ?

अ. क्र.	तपशील	होय	नाही
१०.१	बंध्यत्व		
१०.२	ओटीपोटात सतत दुखणे		
१०.३	अपूर्णकाळात प्रसुती		
१०.४	गर्भपात, मृत बालक जन्मणे		
१०.५	कर्करोग (ग्रीव्हेचा)		
१०.६	गर्भनलिकेत गर्भधारणा होणे		
१०.७	बाळास जंतूसंसर्ग होणे		
१०.८	एच.आय.व्ही. संक्रमण वाढण्याचा धोका		
१०.९	इतर अवयवांवर विपरीत परिणाम होणे		
१०.१०	ताणतणाव नैराश्य		
१०.११	वैवाहित जीवनात बिघाड घटस्फोट		

११) प्रजननमार्ग जंतुसंसर्गाचा प्रतिबंध कसा करावा ?

अ. क्र.	तपशील	होय	नाही
११.१	जननेंद्रियाची स्वच्छता राखणे		
११.२	मासिक पाळीच्यावेळी स्वच्छता राखणे		
११.३	सुरक्षित लैंगिक संबंध ठेवणे		
११.४	दोघांपैकी एकाचा लैंगिक जंतुसंसर्ग असल्यास लैंगिक संबंध टाळावेत ?		
११.५	न लाजता स्वतःवर व जोडीदारावर ताबडतोब उपचार करावेत.		
११.६	जोडीदाराशी एकनिष्ठ राहणे.		

११.७	सुरक्षित प्रसुतीसेवांचा फायदा घ्यावा. ;प्रसुती दवाखान्यात अथवा प्रशिक्षित दायीकडून करून घ्यावे.द्ध		
११.८	सुरक्षित गर्भपाताच्या सेवांचा फायदा घ्यावा.		
११.९	आपल्या समाजात या विषयावर जनजागृती निर्माण करावी.		

प्रजननसंस्थेच्या जंतुसंसर्गाबाबत स्त्रियांच्या स्वदर्शक चालिरिती (३)

	नेहमी	कधी कधी	कधीच नाही
१) प्रतिबंधात्मक चालिरिती			
अ) स्वच्छतेचे विषयक चालिरिती			
१.१) दररोज वैयक्तिक स्वच्छता राखते.			
१.२) दररोज जननेंद्रियाची स्वच्छता करते.			
१.३) योनीमार्गाकडून (पुढून) गुदद्वाराकडे (मागे) स्वच्छ करते.			
१.४) दररोज स्वच्छ अर्तःवस्त्रे वापरते.			
१.५) दररोज स्वच्छ कपडे घालते.			
ब) मासिक पाळीच्या स्वच्छतेविषयक चालिरिती :-			
१.६) मासिक पाळीच्यावेळी वैयक्तिक स्वच्छता राखते.			
१.७) जननेंद्रियाच्या भागाची ३-४ तासांनी स्वच्छता राखते.			
१.८) मासिक पाळीच्यावेळी कापडाची घडी वापरते.			
१.९) ४ ते ६ तासांनी कापडाची घडी बदलते.			
१.१०) कापडाची घडी साबण व पाण्याने स्वच्छ धुऊन उन्हात वाळवते.			
१.११) कापडाची घडी स्वच्छ ठिकाणी ठेवते.			
१.१२) प्रत्येक पाळीच्यावेळी परत तीच कापडाची घडी वापरते.			
१.१३) सॅनिटरी नॅपकीन (पॅड) चा वापरते.			
१.१४) ओले झाल्यावर वरचेवर (नॅपकीन) ४-६ तासांनी बदलते.			
क) लैंगिक चालिरिती :-			
१.१५) संभोगापूर्वी जननेंद्रियाची स्वच्छता करते.			
१.१६) संभोगानंतर जननेंद्रियाची स्वच्छता करते.			
१.१७) दोघांपैकी एकालाही प्रजनन संस्थेची संसर्ग लक्षणे दिसल्यास संभोगाच्यावेळी कण्डोम / निरोधचा वापर करतात.			

१.१८) मासिकपाळीच्यावेळी शरीरसंबंध ठेवते.			
१.१९) नेहमी सुरक्षित संबंध अवलंबिते.			
१.२०) एकमेकांशी एकनिष्ठ रहातात.			
ड) प्रसुतीपूर्व, प्रसुतीच्यावेळी, प्रसुतीनंतर व कुटुंबनियोजनाविषयी चालिरिती.			
१.२१) प्रसुतीपूर्व काळात काळजी घेते (वैद्यकीय तपासणी, आहार, स्वच्छता, लसीकरण, विश्रांती व झोप, व्यायाम)			
१.२२) गरोदरपणात त्रास झाल्यास ताबडतोब वैद्यकीय इलाज करते.			
१.२३) प्रसुतीसंदर्भात चालिरिती - दवाखान्यात प्रसुती करून घेते. अ) कारण की,			

	नेहमी	कधी कधी	कधीच नाही
१.२४) घरी प्रसुती करून घेते. अ) कारण की,			
१.२५) प्रसुती कोठे करायची याचा निर्णय- अ) स्वतः घेते. ब) पती घेतो. क) नातेवाईक घेतात.			
१.२६) अ) बाळांतपण प्रशिक्षित व्यक्तिकडून करून घेते (डॉक्टर, नर्स, आरोग्य सेवक) ब) अप्रशिक्षित व्यक्तीकडून करून घेते.			
१.२७) काही त्रास झाल्यास ताबडतोब वैद्यकीय उपचार करून घेते.			
१.२८) बाळांतपणानंतर काळजी घेते.(स्वच्छता, आहार, स्तनांची काळजी, नवजात बाळाची काळजी, नियमित वैद्यकीय			

तपासणी)			
१.२९) कुटुंबनियोजनाची साधने वापरण्याचा निर्णय स्वतः घेते.			
१.३०) कुटुंब नियोजनाच्या साधनांचा त्रास झाल्यास वैद्यकीय इलाज करून घेते.			
१.३१) गर्भपाताविषयीचा निर्णय स्वतः घेते.			
१.३२) अ) गर्भपात मान्यताप्राप्त दवाखान्यात करून घेते. ब) गर्भपात घरी करून घेते. होय असल्यास, कोणाकडून.			
१.३३) गर्भपातानंतर काही त्रास झाल्यास ताबडतोब वैद्यकीय उपचार घेते.			
२) उपचार विषयक चालीरीती			
२.१) प्रजनन संस्थेच्या संसर्गाचे कोणतेही लक्षण दिसल्यास त्वरीत वैद्यकीय उपचार घेते.			
२.२) नसल्यास – उपचार न घेण्याची कारणे. ए) हा आजार आहे असे समजत नाही. बी) वेळे अभावी. सी) पैशाअभावी. डी) त्रास सांगण्यास लाज वाटते. इ) पतीकडून सहकार्य मिळत नाही. एफ) नातेवाईकांकडून सहकार्य मिळत नाही. जी) वाहन सुविधा मिळत नाही. एच) समाजाकडून तिरस्कार. आय) गवैद्यकीय सेवांचा अभाव. जे) निर्णय क्षमतेचा अभाव.			

	नेहमी	कधी कधी	कधीच नाही
२.३ वैद्यकीय उपचारातील इतर उपचार			
अ) घरगुती उपचार.			
ब) वनऔषधी			
क) वैदु			
ड) तंत्र मंत्र			
२.४) ताबडतोब व पूर्ण उपचार घेणे.			
२.५) दोघे (पती व पत्नी) एकाच वेळी उपचार घेतात.			
२.६) संसर्गित व्यक्तीसोबत संबंध टाळते.			
२.७) सुरक्षित संभोगाचा अवलंब करते.			
३) जागृतिविषयक चालीरिती			
३.१) प्रजनन संस्थेच्या आजाराविषयी माहिती मिळते. होय असल्यास कोणाकडून?			
अ) प्रसारमाध्यमांचा वापर प्रामुख्याने रेडिओ/टिव्ही व इतर.			
ब) डॉक्टर			
क) आरोग्यसेवा पुरविणाऱ्या व्यक्ती.			
ड) आरोग्य शिक्षण.			
३.२) आरोग्यविषयक माहिती इतरांना देणे.			

APPENDIX – 5

Marathi Consent Form

संमतीपत्रक

मी सौ. याद्वारे संमती देते की
“स्त्रियांच्या प्रजननसंस्थेच्या जंतुसंसर्गाविषयक ज्ञान व स्वदर्शक चालिरिती त्याविषयी दिलेल्या
आरोग्य शिक्षणानंतर झालेला बदल” संशोधनासाठी लागणारी पुरेशी माहिती मला दिलेली आहे. या
संशोधनामध्ये सहभागी होण्यास माझी संमती आहे.

सही