Information, Education, and Communication (IEC) Knowledge on Female Foeticide Among Rural Women: A Study

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ABSTRACT

Female foeticide, the gender-selective abortion of female foetuses following illegal sex determination, remains one of India's most pressing social and ethical challenges. Despite legal frameworks such as the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act (PCPNDT), 1994, and numerous government-led Information, Education, and Communication (IEC) initiatives, gender bias continues to influence reproductive decisions. This study investigates rural women's IEC knowledge on female foeticide in Mandya District, Karnataka. A structured questionnaire was administered to 385 respondents to evaluate awareness levels, information sources, and attitudes toward gender preference. Findings reveal that only 17.6% were aware of the term "female foeticide," while 67% lacked any knowledge of it. Neighbours (44.9%) were identified as the most common source of information, while health professionals accounted for only 4.1%. The study underscores significant gaps in IEC dissemination and highlights the need for localized, culturally sensitive, and participatory communication strategies to address gender discrimination at the grassroots level.

Keywords: Female foeticide, rural women, IEC awareness, PCPNDT Act, gender discrimination, health communication, reproductive justice

INTRODUCTION

India's cultural mosaic, with its thousands of castes and sub-castes, is marked by both diversity and deep-rooted patriarchy. Despite constitutional guarantees of gender equality, social structures in rural India often perpetuate discrimination against women through dowry, domestic violence, and the persistent preference for male children. The practice of female foeticide, defined as the abortion of a female foetus following illegal sex determination, epitomizes the intersection of technology, gender bias, and socio-economic pressure.

Legally, female foeticide violates Sections 312–318 of the Indian Penal Code (IPC) and the PCPNDT Act, 1994, which criminalizes sex-selective abortions and regulates diagnostic procedures. Yet, awareness of these laws remains alarmingly low among rural populations. As per the National Family Health Survey (NFHS-5, 2019– 21), Karnataka's child sex ratio (0–6 years) stands at 953 females per 1,000 males—an indicator of entrenched gender imbalance.

In this context, Information, Education, and Communication (IEC) plays a pivotal role in health and social transformation. Effective IEC strategies not only disseminate information but also foster dialogue, attitudinal change, and behavioral modification. This study examines the depth of IEC knowledge among rural women in Mandya District concerning female foeticide and investigates the socio-cultural and communicative factors influencing their awareness.

Review of Literature and Context

The socio-historical position of Indian women has evolved under the weight of patriarchal customs, economic dependency, and restricted access to education. Reformers such as Savitribai Phule and Raja Ram Mohan Roy

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championed women's empowerment through education and social reform. Yet, patriarchal norms persist, particularly in rural communities where gender roles are rigidly defined.

The World Health Organization (WHO, 2020) defines health as a state of physical, mental, and social wellbeing, emphasizing the role of equity and empowerment. Health communication, therefore, must extend beyond biomedical models to encompass social determinants, including gender power relations. The IEC framework integrates interpersonal communication, mass media, and community mobilization to promote awareness and behavioral change.

Paradoxically, the misuse of medical technology for prenatal sex determination has amplified gender discrimination. Studies such as Nanda, Gautam, and Verma (2018) highlight that even educated and economically privileged families engage in selective abortions, reflecting a cultural rather than informational deficit.

Government initiatives like Beti Bachao Beti Padhao (BBBP) have attempted to bridge this gap through IEC campaigns, media advocacy, and community mobilization. However, evaluations by the Ministry of Women and Child Development (2022) indicate inconsistent implementation at the grassroots level, particularly in rural areas where social hierarchies and limited media access constrain message penetration.

Objectives of the Study

1. To assess the level of IEC knowledge on female foeticide among rural women.
2. To examine the role of health workers, local leaders, and media in disseminating awareness.
3. To identify the socio-cultural and economic factors influencing gender preference.
4. To evaluate the effectiveness of existing government schemes and community-based interventions.

METHODOLOGY

This descriptive cross-sectional study was conducted in Bramhadevarahalli Village, Nagamangala Taluk, Mandya District, Karnataka. Employing a mixed-method design, the study combined quantitative and qualitative approaches.

A structured questionnaire was administered to 385 women, selected through purposive sampling. Data were gathered via direct interviews, telephonic conversations, and WhatsApp interactions to address literacy and accessibility variations. Key informant interviews were conducted with Anganwadi and ASHA workers, Gram Panchayat members, and schoolteachers.

Secondary data were obtained from government reports, newspaper archives, and FIR records. Quantitative data were analyzed using descriptive statistics, including frequencies and percentages.

Analysis and Interpretation

This study presents the detailed analysis and interpretation of the data collected from 385 respondents. The findings provide insights into the socio-demographic profile, awareness levels, and attitudinal trends related to gender preference and female foeticide. Each table is followed by a concise qualitative interpretation linking the data to broader socio-cultural and economic contexts.

Age Distribution of Respondents

Age Group	Frequency	Percentage
Below 20 years	17	4.4%

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21–30 years	156	40.5%
31–40 years	114	29.6%
41–50 years	70	18.2%
51–60 years	28	7.2%
Total	**385**	**100%**

The majority of respondents (40.5%) fall within the 21–30 years age bracket, representing women in their peak reproductive and family-building years. This distribution underscores the relevance of the study population for exploring reproductive health and gender preference attitudes, as decisions regarding childbirth and family planning are most prominent within this age range.

Occupational Distribution

Occupation	**Frequency**	**Percentage**
Coolie	198	51.4%
Daily wage worker	47	12.2%
Agricultural laborer	77	20.0%
Self-employed	23	6.0%
Private employee	3	0.7%
Government employee	14	3.6%
Others	23	6.0%
Total	**385**	**100%**

Over half of the respondents (51.4%) were daily wage laborers or "coolies," reflecting low-income, economically vulnerable households. Such occupational patterns often correlate with limited access to education and healthcare resources, thereby influencing awareness and perceptions of reproductive rights and gender equity.

Family Type and Gender Preference

Type of Family	**Frequency**	**Percentage**
Joint	133	34.5%
Nuclear	205	53.2%
Extended	47	12.2%
Total	**385**	**100%**

A majority (53.2%) of respondents lived in nuclear families. While nuclear households are typically associated with increased autonomy in decision-making, the persistence of gender-biased norms within these families

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suggests that traditional beliefs continue to influence reproductive choices even in less hierarchical family structures.

Marital Status of Respondents

Marital Status	Percentage
Married	100%

All respondents were married, enabling focused exploration of family dynamics, reproductive decision-making, and the role of spousal and in-law influence in shaping gender preferences.

Family Member Preference for a Male Child

Family Member	Frequency	Percentage
Husband	30	7.8%
Mother	142	36.9%
Father	10	2.6%
Mother-in-law	123	31.9%
Father-in-law	15	3.9%
Self	65	16.9%
Total	**385**	**100%**

The highest influence in preferring a male child originated from mothers (36.9%) and mothers-in-law (31.9%), together accounting for 68.8%. This pattern reflects the intergenerational transmission of patriarchal values, where women themselves perpetuate gender bias due to deeply ingrained cultural norms and social conditioning.

Awareness of Legal Aspects and Reasons for Foeticide

Awareness Level	Frequency	Percentage
Yes	68	17.7%
No	59	15.3%
Don’t know	258	67.0%
Total	**385**	**100%**

Nearly two-thirds of respondents (67%) were unaware of female foeticide, indicating a severe gap in community level awareness and information dissemination. This lack of knowledge highlights the limited reach and impact of government-led awareness campaigns and suggests the need for more localized and culturally sensitive communication strategies.

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Source of Information on the PCPNDT Act

Source	Frequency	Percentage
Newspaper	28	7.3%
Radio	30	7.8%
Television	61	15.8%
Friends/Relatives	47	12.2%
Mobile/Social Media	30	7.8%
Neighbors	173	44.9%
Health Professionals	16	4.1%
Total	**385**	**100%**

Informal community networks, particularly neighbours (44.9%), were the dominant information sources, surpassing institutional or professional channels. This reliance on interpersonal communication underlines the social fabric's role in shaping reproductive knowledge and suggests that future interventions should engage grassroots and peer-to-peer communication mechanisms.

Key Findings:

1. Only **3.9%** of respondents were aware of legal penalties associated with prenatal sex determination under the PCPNDT Act.
2. **23.4%** cited financial dependence on male children as the primary reason for female foeticide.
3. **19.2%** linked it to dowry-related pressures, while **17.6%** attributed it to poverty and economic hardship.

The findings reveal a complex intersection of economic insecurity and cultural patriarchy influencing female foeticide. The minimal awareness of legal consequences reflects both systemic outreach failure and persistent social acceptance of gender discrimination. Economic dependence on male offspring and dowry practices reinforce the cycle of preference for sons, perpetuating gender imbalance and inequality.

The cumulative findings demonstrate that gender preference and low awareness about female foeticide are deeply embedded in socio-economic vulnerability, traditional belief systems, and inadequate communication outreach.

While modernization and nuclear family systems indicate gradual social change, entrenched patriarchal values persist, particularly through matriarchal endorsement within families. The study emphasizes the urgent need for multidimensional interventions combining education, gender sensitization, and community-based health communication strategies to dismantle intergenerational bias.

The findings reveal a significant gap between policy-level communication efforts and community-level comprehension. Despite multiple IEC interventions, rural women's understanding of female foeticide remains superficial or nonexistent. The overreliance on informal social networks underscores the failure of structured communication channels, particularly the underutilization of health professionals as IEC agents.

The persistence of gender bias even among nuclear families indicates that modernization alone does not dismantle patriarchal conditioning. Consistent with communication for social change models, awareness must

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be coupled with empowerment and community dialogue. IEC programs must integrate local idioms, storytelling traditions, and participatory theatre to achieve cultural resonance.

Globally, comparable studies in South Asia (UNFPA, 2021) emphasize the importance of intersectional approaches that address literacy, economic security, and gender norms concurrently. Therefore, IEC strategies should transition from top-down information dissemination to bottom-up participatory engagement, empowering women as communicators and change agents within their communities.

CONCLUSION AND RECOMMENDATIONS

The study concludes that IEC awareness on female foeticide among rural women in Mandya District is critically low. Structural factors such as illiteracy, economic dependence, and patriarchal family systems inhibit the dissemination and assimilation of gender-sensitive information.

To strengthen community-level awareness, the following recommendations are proposed:

1. **Localization of IEC materials:** Translate messages into regional dialects and employ folk media formats like street plays and puppet shows.
2. **Integration with digital platforms:** Utilize community WhatsApp groups, local radio, and interactive voice response (IVR) systems for sustained engagement.
3. **Capacity building of health workers:** Train Anganwadi and ASHA workers as frontline communicators for gender-sensitive health education.
4. **Interdepartmental collaboration:** Coordinate between Women and Child Development, Health and Family Welfare, and Rural Development departments.
5. **Monitoring and evaluation frameworks:** Implement regular assessments to measure IEC outreach, comprehension, and behavioural outcomes.

Ultimately, combating female foeticide requires not just punitive legal measures but transformative communication, a continuous process of dialogue, reflection, and collective social reformation.

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