TREATEMENT SEEKING BEHAVIOUR OF MARRIED WOMEN OF REPRODUCTIVE AGE BELONGING TO A RURAL COMMUNITY- A CROSS SECTIONAL STUDY

By

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DISSERTATION

SUBMITTED TO THE

KLE UNIVERSITY, BELGAUM, KARNATAKA

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OF THE REQUIREMENTS FOR THE DEGREE OF

M. D.
IN
COMMUNITY MEDICINE

Under the Guidance of

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MAY - 2009

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DECLARATION BY THE CANDIDATE

I hereby declare that this dissertation entitled **"TREATMENT SEEKING BEHAVIOUR OF MARRIED WOMEN OF REPRODUCTIVE AGE BELONGING TO A RURAL COMMUNITY." -A CROSS SECTIONAL STUDY.** *is a bona fide and genuine research work carried out by me under the guidance of* **Dr. H. N. SANGOLLI** **MD,** *Assoc. Professor, Department of community Medicine, Jawaharlal Nehru Medical College, Nehru Nagar, Belgaum-590010.*

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Dr. MD. SHAKIL AHMAD

LIST OF ABBREVATIONS USED

PHC	Primary Health Center
ANM	Auxiliary Nurse Midwife
ANC	Antenatal Checkup
BHMS	Bachelor of Homeopathic Medicine & Surgery
BAMS	Bachelor of Ayurvedic Medicine & Surgery
IUD	Intrauterine Device
KLE's	Karnataka Lingayath Educational Society
MCH	Maternal and Child Health
NA	Not applicable
NCAER	National Council of Applied Economic Research
OCP	Oral Contraceptive Pills
RHTC	Rural Health Training Center
RMP	Registered Medical Practitioner
NSSO	National Survey Sample Organization
IMP	Indigenous Medical Practitioners
RCH	Reproductive and child health

ABSTRACT

TITLE:

"Treatment seeking behavior of married women of reproductive age belonging to a rural community - A cross sectional study"

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KEY WORDS:

Treatment seeking behavior, married women, reproductive age group, rural community

BACKGROUND:

India is a country of villages where 72.2% of the people live in the rural area and women of reproductive age group (15-49 years) constitutes 21% of the total population. Majority of the women suffer from morbidity due to obstetric and gynecological problems. Many factors play an important role such as socio economic status, cultural acceptability, decision making power, the availability of health care services, or the treatment seeking behavior of these women.

OBJECTIVES:

To know the health seeking behavior of a married women of reproductive age and to know the types of health services utilized by them.

METHODOLOGY:

A one year community based cross sectional study. The study was conducted at Handignur PHC area in Belgaum district from January 2007-December 2007, with a sample size of 732. All married women of reproductive age group were included in the study, and data was collected by administering pre designed and pre tested structured proforma.

RESULTS:

The present study revealed that, 22.03% of the women were in the age group of 35-39 years. The literacy rate of the women was found to be 74.4%. The literacy rate of their husbands was found to be 82.4%. Joint family was the commonest being 81.28%. 71.3% of the women belonged to the category V of modified B G Prasad's group of socio economic status classification. All married women of reproductive age had the knowledge of the facilities available near their homes.

Door steps services were provided to all married women, 88.93% of the study participants said ANM's provided them with services. And all study participants said that they were curative, diagnostic, health educational, natal services, family planning and immunization. 88.93% said that the health facilities were provided at their door steps, all of the 732 women for general health problems, 79.09% of the women preferred to go the PHC/ sub center. 99.59%

said it was easy accessibility. 92.49% said that they were satisfied by the treatment. In case of 75.18% of the study participants their husband's made decisions for them regarding their general health problems.

For obstetrics care all 732 women preferred going to the PHC/ sub center. 39.34% said they made 1-2 visit for their ANC check up's. And to be noted that 21.03% of the women did not make a single visit as there was no PHC's/ sub center during the time of their pregnancy. 78.96% said they received iron and folic acid tablets during the time of their pregnancy. 54.78% women said the doctor provided it to them. 78.96% said they received injection tetanus toxoid injection during the time of their pregnancy. 78.96% of the women said that other checkup was also done. 66.12% said that they preferred the PHC/ sub center for the choice of place for getting delivered. 47.00% preferred the doctors conducting the deliveries. 75.80% women said their husbands took the decisions.

43.85% of the women complained of Dysmenorrhoea. The choice of health facility opted for the gynecological problems; 81.42% said that they preferred the PHC/ sub center. 81.42% women said because it was near to the house, all necessary and emergency drugs were available and all facilities were provided. 46.17% of the women said it was their own decision.

91.25% women said they were practicing either temporary or the permanent methods or their husbands were using temporary methods of family planning. 61.07% women were using copper T as the methods of family planning. 61.07% women said the doctors at the PHC/ sub center helped them in providing them the family planning methods. 48.35% women said it was their husband's decisions.

CONCLUSION:

The participants had a fair knowledge regarding treatment seeking, the availability of health care services and the types of services offered. For obstetric care they did not hesitate in deciding the choice of place to deliver as Handignur PHC/ sub center is providing all modern facilities, including a baby warmer and a neo natal resuscitation kit.

The key decision maker for general health problems, obstetric health problems and for family planning was the husbands, where as for the gynecological problems the majority of women made her own decisions.

As observed the women were more comfortable and satisfied after the public private partnership with KLES Dr. Prabhakar Kore's hospital. The women had this feeling that, if any complications arise, the ambulance service which was there 24hrs x7days would shift the patient to the higher center quickly.

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INTRODUCTION

Health seeking behaviour is a topic which has received considerable attention in recent years. The “quest for therapy”, all over the world is an important research issue since it reveals essential elements of people’s social behavior and provides insight into their perceived needs for different kinds of health services. The community diagnosis is the starting point for local health planning - at least in theory- and the study of how people use health care facilities is an important component of it.[1] Health care delivery in developing countries have been typically described in terms of insufficient medical and paramedical staff, unequal access to services, emigration of qualified personnel to jobs in other countries, and the concentration of man-power in the cities, leaving the under-served rural areas, has caused more than 80% of the population without access to appropriate medical care.[2]

The rural areas of developing countries are not “health care deserts”, but they have their own systems of beliefs and customs and their own kinds of indigenous health practitioners. As their adaptation to the impact of western medicine has become better understood, their potential contribution to the primary health care has been reconsidered.[2]

Health seeking behavior refers to those activities undertaken by individuals in response to symptoms experienced. It is a dynamic process in the house-hold, which combines knowledge, resources, decision making power and the availability of health facilities. It requires some basic knowledge for seeking treatment such as few

repeated episodes of any disease in household or any prior experience which helps in making a decision.[3]

Situation in India:

India is a country of villages where 72.2% of people live in rural areas.[4] Because of ignorance, illiteracy, cultural and religious factors, rural people are at higher risk of illness. Many factors play an important role such as socio-economic status, cultural acceptability, decision making power, the availability of health care services, or the treatment seeking behavior of the people. Health seeking behavior is influenced by large number of factors apart from knowledge and awareness like bio-social profile, their past experiences with health services, influences at community level, availability of alternate health care providers and their perceptions regarding efficiency and quality of services.[5]

In India, women of reproductive age group (15-49 years) constitute 21% of the total population, apart from the morbidity experienced by general population; women of reproductive age group also suffer from morbidity due to obstetric and gynecological problems. [4] Lack of education, cultural factors and gender inequality are the important reason for women not seeking treatment for their ailments.

Around 70% of the deliveries are conducted by untrained personnel, which will have an impact on maternal and infant mortality as well as morbidity. The, Ministry of Health and Family Welfare, Government of India, has promoted national programs such as Reproductive & Child Health & Janani Suraksha Yojana, so that there is an increase in the institutional delivers so as to bring down the maternal &

child deaths. Emphasis has been laid on training local dais, so as to bring down the mortality and morbidity. This practice has helped to some extent.

About 50% of illness episodes among rural women are not treated and the remaining take treatment from quacks and some rely on home based remedies. It is also observed that the drugs that are left over by the previous treatment episode, are consumed at the time of illness with similar symptoms.[6]

As women of reproductive age come under vulnerable group, it is important to know their treatment seeking behaviour, their decision making power, and utilization of health care services that are available. This study focuses how efficient is the present woman, in making decisions for availing the health care facilities, while the country is talking of women empowerment. The present study is an attempt in this direction.

ANNEXURE – I

INFORMED CONSENT FORM

STUDY: "TREATMENT SEEKING BEHAVIOR OF MARRIED WOMEN OF REPRODUCTIV AGE AT A RURAL COMMUNITY – A CROSS SCETIONAL STUDY"

Principal Investigator: **Dr. Md. Shakil Ahmad.**

Guide: **Dr. H. N. Sangolli**

Introduction

You are being invited to participate in this study to find out the treatment seeking behavior of married women of reproductive age belonging to sub-center under Handignur primary health center of Belgaum district.

Explanation of procedures

In this study you will have to answer a few prepared questions about your treatment seeking behaviors. A question would be some of the normal problems like cough, cold, fever, pain etc. and then you would be asked questions on obs / gyne. Problems the entire procedure may take about 30 minutes.

If you agree to participate, you will be continued asking questions but the moment you don't want to continue then you can leave.

Possible Benefits

The investigator does not promise or guarantee that you will receive direct benefit

being in the study. It will benefit for the whole community because by this study we will come to know how and where women go to seek treatment. This study will surely help in future for the development of the community.

Confidentiality

Your identity will not be revealed. All information collected will be collected and coded so that no one will know your identity.

Withdrawal

Participation in this study is voluntary. If you don't not wish to participate in this

study, you will not lose benefits to which you are entitled.

Costs of Participation

The cost of the study will be borne by the researcher. There will be no additional cost to you for participating in this study.

Payment of Participation

There will be no incentives to you for participating in this study.

Questions

If you have any questions about this study, you should contact Dr.H.N.SANGOLLI and Dr. MD SHAKIL AHMAD at 9886526402, if you have any questions about your rights as a study participant, you may contact Dr V.D. PATIL, Chairman, JNMC Institutional ethics committee on human subjects research at 0831 2741701.

Legal Rights

By signing this consent form, you are not waiving any of your legal rights.

Consent statement

I volunteer and consent to participate to participate in this study. I have read the concent or it has been read to me. The study has been fully explained to me and I may ask questions at any time.

_____ _____

Signature or Left Hand Thumb Impression
(Volunteer Subject) Date

_____ _____

Signature of Person Obtaining Consent Date

_____ _____

Signature of Witness Date

OBJECTIVES

1. To know the treatment seeking behaviour of married women of reproductive age (15-49 years).

2. To know the types of health services utilized by them.

ANNEXURE – II

PROFORMA

I – General Information

I - Q1 - Serial No:-

I - Q2 - Type of family
1) Nuclear family, 2) Joint family, 3) Broken family, 4) Extended family

I – Q3 - Literacy of husband: -
1) Illiterate, 2) Primary, 3) High school, 4) Higher secondary, 5) Degree

I – Q4 – Age: - _____

I – Q5 - Education:-
1) Illiterate, 2) Primary, 3) High school, 4) Higher secondary, 5) Degree

I – Q6 – Income status
1) Category I, 2) Category II, 3) Category III, 4) Category IV 5) Category V

I – Q7 – Religion: - _1) Hindu

I – Q8 – Village: - 1) Handignur

II- General Health problems

II – Q1- To which Health facility do you visit for your general problems like, cough, cold, fever, diarrhea etc.

1) PHC, [(1) (0)] 2) KLE Hospital, 3) District Hospital, 4) PVT Doctor, 5) Others

II- Q2 – Why this facility
1) Near the house, [(1) (0)] (0) 2) Drugs available, [(1) (0)]
3) All facility provider, [(1) (0)] 4) All of the above [(1) (0)]

II – Q3 – Are you satisfied with the treatment given by that health facility?
1) Yes, 2) No

II – Q4 – Who decides for you to go to this health facility?
1) Self, 2) Husband, 3) In laws, 4) Others

III – Obstetric problems

III – Q1 – To which health facility do you go for obstetric care?
1) PHC, 2) KLE Hospital, 3) District Hospital, 4) PVT Doctor, 5) Others

III- Q2 – Why this facility?
1) Near the house, [(1) (0)] 2) Drops available, [(1) (0)] 3) All facility provider, [(1) (0)] 4) Others [(1) (0)]

III – Q3 – How many visits to the facility did you make?
1) 1 to 2, 2) 2 to 3, 3) 3 to 4, 4) No visit

III - Q4 – Did you receive Iron & Folic acid tablets?
1) Yes, 2) No

III – Q5 – If yes, then who gave you?
1) Doctor, 2) ANM, 3) Anganawadi worker, 4) Not received

III – Q6 – Did you receive injection, Tetanus toxide?
1) Yes, 2) No

III – Q7 - If yes, who gave?
1) Doctor, 2) ANM, 3) male health works, 4) Not received

III – Q8 - Any examination was done when you visited for the ante natal checkup?
1) Yes, 2) No

III - Q9 – If yes, what was done?
1) Height, [(1) (0)] 2) weight, [(1) (0)] 3) Blood pressure, [(1) (0)] 4) Blood examination, [(1) (0)] 5) Urine examination, [(1) (0)]
6) Physical examination [(1) (0)] 7) All of the above

III – Q10 – Which places do you choose/prefer for delivery?
1) Home/Dai, 2) Sub center/ PHC, 3) Dist. Hospital,
4) KLES Hospital, 5) Private Nursing home

III – Q11 – Whom do you prefer for conducting delivery?
1) Doctor, 2) Trained Dai, 3) Nurse, 4) Family members/ untrained Dai

III – Q12 – Who decides for you to seek obstetric care?
1) Self, 2) In laws, 3) Husband, 4) Others

IV – Gynecological Problems

IV – Q1 – Do you suffer from any of these problems like
1) Menorrhagia, 2) white discharge, 3) Dysmenorrhoea 4) others

IV - Q2 – To which health facility do you visit for your problems?
1) PHC, 2) KLES Hospital, 3) District Hospital, 4) PVT Doctor, 5) Others

IV- Q3 – Why this facility?
1) Near the house, 2) All facility provider, 3) All drugs available, 4) All of the above

IV – Q4 - Who decides it?
1) Self, 2) Husband, 3) In laws, 4) Others

IV – Q5 – Are there any health facility available around your residential area?
1) Yes, 2) No

IV – Q6 – If yes, which are they?
1) PHC, 2) Dist. Hospital, 3) Sub centre, 4) Private clinic

IV – Q7 – Are there any services provided to you at your door steps?
1) Yes, 2) No

IV – Q8 - If yes who provides it to you?
1) ANM, 2) male health works 3) Others

IV – Q9 – What type of service is provided?
1) Curative, 2) Diagnostic, 3) Health Education, 4) Natal Services, 5) Family Planning, 6) Immunization, 8) All

V – Family Planning services

V – Q1 – Are you using family planning method?
1) Yes, 2) No

V – Q2 – IF yes, which method?
1) Oral pills, 2) Copper T, 3) Tubectomy, 4) Condom, 5) Vasectomy

V-Q3 – Where did you receive family planning method?
1) Doctor, 2) ANM/male health worker, 3) Anganawadi worker, 4) Others

V – Q4- Who decides for you to choose health facility for family planning services
1) Self, 2) Husband, 3) In-Laws, 4) Others

REVIEW OF LITERATURE

Health and treatment seeking behaviour

Health related behaviour has been described by Kasi and Kobb as follows: Health behaviour –any activity undertaken by a person believing himself as healthy, for the purpose of preventing disease or detecting it at an asymptomatic stage.Illness behaviour – any activity undertaken by a person who feels ill, to define the state of his health and to discover a suitable remedy.Sick role behaviour– any activity undertaken by those who consider themselves ill, for the purpose of getting well.

Contemporary research in the field medical anthropology and sociology has advanced various theoretical formulations to account for health actions. Most notably the "Health Belief Model" by Rosen stock in 1966 and Becker 1974 proposed the role of perceived susceptibility. Perceived severity and perceived preventability together with internal or external cues to action and modifying and enabling factors, which will determine health behaviour.[7]

Treatment seeking and options available

Treatment seeking behaviour usually begins within the household, where illnesses are initially perceived and defined, and treatment is initiated by family members themselves. i.e., self care.[8]

Self-care involves the administration of traditional or other herbal remedies at home, or the use of medicines purchased over the counter, i.e., without a physician's prescription, at a local chemist shop.[9]

The type of disease has an influence on the choice of treatment options available. [10] People who utilize both modern and indigenous medical systems tend to

place illness in two broad categories; those are more likely to be cured by a physician and those more likely to respond to the ministrations of a healer. The course of an illness, The outcome of previous treatment for the same condition, and a variety of factors may redefine it and ignored or treated by one type of therapist, will depend not only upon the appropriateness of the specialist available but also upon variation in reputation for therapeutic success.[11]

India like China has pluralistic medical systems.[12] In the Indian context there exists a continuum on one axis between folk culture medicine to physicians who have undergone a course in Homeopathy, Ayurveda, Unani, Siddha or other limited training in traditional or cosmopolitan medicine. A second perpendicular axis forms a continuum between learned secular medicine (physicians at teaching and prestigious cosmopolitan medical hospitals) and learned religious medicine (religious scholars or learned priests with a reputation for unusual healing powers). Physicians with degree in indigenous medicine form an intermediate group between the polar, learned secular medicine and popular culture medicine.

Factors affecting treatment seeking behaviour

Treatment seeking behaviour is influenced by various factors. A study of the various curing strategies and factors relating to treatment seeking among mothers and their children (who constitute a vulnerable group of the population) has currently attracted attention.

Young [13] in his work in Mexican farming communities, developed formal models of treatment choice and other responses to illness based in large part on the responses of rural dwellers to questions about hypothetical illness episodes according to him. Illness episodes evoked predictable and patterned responses. From Young's

model four factors were identified as principal determinants of initial treatment choice; seriousness of the illness, knowledge of the illness and its remedy, degree of confidence in folk remedies for this illness, and expenses with the health – care alternatives.

A study from Africa, [14] examined the association of various household level factors with health related decision making outcomes. Some of these works suggest that while distance from the health care provider is an important determinant of parents' responses, its importance may some times be modified by other factors.

A study from rural Nigeria, [15] showed literacy to be positively associated with the use of western medicine, though the importance of the relationship between education and income levels was not explored using multivariate methods. In this sample, the more highly educated groups also had a more disdainful attitude towards traditional medicine.

Health care services in India:

India has rich, centuries old heritage of medical and health sciences. The philosophy of Ayurveda and the surgical skills associated with Charaka and Sushruta bear testimony to our ancient tradition in the scientific health care of our people. The approach of our ancient medical system was of a holistic nature, which took into account of all aspects of human health and disease over the centuries. With the intrusion of foreign influences and mingling of cultures, various systems of medicine evolved and have continued to be practiced widely. However the allopathic system of medicine has, in a relatively short period of time, made a major impact on the entire approach to health care and pattern of development of the health services infrastructure in the country.[16]

Over the last five decades, a vast network of health care services has been created.

The exciting model of health care has evolved over the last 200 yrs and some of its features are rooted in the circumstances of its origin and growth under the British rule, which totally ignored the prevailing indigenous systems and built up system suited to the western system of medicine (Allopathy). The exciting services began with provision of health care to their expatriates mostly in cantonments. Later some of these services were extended to the upper and the middle classes of the society. This urban based top-down and elite oriented pattern still continues to dominate the health services, in spite of the large expansion of the primary health centers in the last fifty years of independence. The outreach of services has not been able to cover the vulnerable sections of the society.

By and large, these are curative services based on hospitals and dispensaries and the health personnel needed for them. In spite of much rhetoric and efforts made after independence to develop promotive and preventive programs, the overwhelming curative orientation still continues to dominate the health scenario in the public sector and almost entirely in the private sector.[16]

A survey on treatment seeking behaviour among 573 women regarding symptoms of sexually transmitted infections were conducted for every married women of reproductive age group in 4 villages in the state of Gujarat, and included all married women residing there. Of the women who sought treatment for their symptoms, 60% approached the private allopathic sector, and 13% went to a government facility. They concluded that there was a need to standardized STI treatment algorithms which different types of providers can follow, and develop

guidelines / policies for the private health sector to address ethical issues related to sexually transmitted infection's treatment and HIV testing.[6]

In a study conducted in rural Haryana in 1991, it was observed that utilization of health care in women was low, 45% of the episodes were not treated. Many women resorted to informal care. Home remedies constituted 15% and self medication constituted 11%.[24]

A study conducted in Punjab in 1960's showed that 87% of all patients seen by indigenous medical practitioners (IMP's) were treated with one or more modern medications, either alone or in combination with traditional medications. The busier IMP's used more of the modern medications than less successful IMP's. Inappropriate treatment practices are common in India.[25]

In a study conducted by the Center for Development Studies, Thiruvananthapuram, India in 2000, revealed that the percentages of women having received antenatal care for the last child born during the 4 years prior to the survey were 88% in Andhra Pradesh, 85% in Karnataka and 95% in Tamil Nadu. The number of visits for antenatal check up during pregnancy was highest in Tamil Nadu (5 visits). The average number of visits made by women was 4.62 in Karnataka and 4.15 in Andhra Pradesh.[30]

Health services during five year plan periods [4]

	1st five year plan 1951-56	10th five year plan 2002-07
1. primary health centres	725	229367
2. sub-centres	NA	138368
3. CHCs	--	3076
4. hospital beds	125000	908168 (2001)
5. medical collages	42	222
6. allopathic doctors	65000	575600 (2001)
7. nurses	18500	839862
8. A.N.M's	12780	502503
9. health visitors	578	40536
10. health workers (f)	--	137407
11. health workers (m)	--	71053

Utilization of health care services

Utilization of health care services is determined to a large extent by their availability and accessibility. The role of place in defining equality to access is very important, as the distance which an individual has to travel to reach a health care facility as a direct bearing on the extent to which he / she will use it. Traveling a long distance to make use of a health care facility will affect the actual use of it, for it involves loss of time, effort and money.

According to National Council of Applied Economic Research (NCAER) survey (1992), the distance traveled for treatment of illness in urban and rural areas are. [17, 18]

	Urban		Rural	
Distance	**All India**	**Karnataka**	**All India**	**Karnataka**
Less than 1 Km	49.37	40.61	22.35	09.49
1-2 Kms	30.72	27.05	16.87	14.70
3-5 Kms	12.56	20.24	22.89	23.75
6-10 Kms	04.04	05.41	17.84	25.14
Over 10 Kms	03.31	06.69	20.05	26.92

(All figures are in percentages)

Utilization pattern depends on quality, type and nature of ailment according (NSSO) National Sample Survey Organization (1992), the type of hospital used for inpatient and outpatient were. [19, 20]

Type of hospitals		**Urban**	
		All India (in percentage)	**Karnataka (in percentage)**
Out patient	Government	24.40	28.20
	P.H.C	01.20	01.70
	Private	69.20	66.30
In patient	Government	59.50	43.50
	P.H.C	00.80	00.40
	Private	36.60	49.50

Note: government hospitals include public hospitals and public dispensaries. Private refers to private hospitals, nursing homes and private doctors.[14, 15]

In a study conducted at Chanditala PHC of Hooghly district of West Bengal in 1978, the authors observed that the distance did not have any influence on the

acceptability of medical care and immunization services. Acceptability of health care within 10 Kms of PHC using medical care, MCH and family welfare were 2.6%, 1.3% and 14.6% respectively compared to 57.1%, 85.5% and 44.4% of the families who lived in PHC village itself. Utilization of MCH services were higher with skilled laborers 51.1% followed by agricultural workers 32.9%. People with higher income utilized the PHC services least. Income seems to have significantly influencing the utilization of government public health services.[17]

In a study conducted at Arcot district, Tamilnadu in 1991, it was found that more than half of the households 59% preferred to go to private practitioners (registered, non-registered or indigenous) and only 28% used the services provided by a voluntary agency serving the block and 25% used the government service (primary, secondary and tertiary). Only 2% had adopted home treatment and 3% had gone to a medical shop, this was either for pain relieving medicine or just for simple cold, cough or fever. While 79% of the households had used allopathic treatment at some time, 33% had used homeopathic medicine.[22]

In a study conducted at rural Haryana in 1991, it was observed that, utilization of health care by women was low, 45% of the episodes were not treated. Many women reported to informal care. Home remedies constituted 15% of the services, whereas self-medication constituted 11%. Use of informal care was higher among urban women than rural women. In urban areas women sought treatment for 49% of the episodes reported by them and used 21 informal facilities for every 100 episodes. In contrast, rural women sought treatment for 57% of the episodes and used 15 informal facilities for every 100 episodes.

In rural areas, 24.2% of all facilities used and 30.3% of the formal facilities used by rural women were government facilities or home based care provided by government paramedical staff. In urban areas, 10% of the total facilities and 17.3% of formal facilities used were public sector services. Certain types of illnesses such as aches / pains, injuries, weakness were mostly treated in the informal sector, whereas fever and gastrointestinal infections were treated mostly in the formal sector. Health care utilization was related to nature of illness. Long term illness was not as frequently treated as short term illness.

For long term illness women adhered to a mode of treatment which gave them partial relief and not complete cure. For 12.4% of the episodes, treatment was not sought because health facilities were either not accessible or inadequate. Among the components of expenditure, doctor's fees, the cost of medicines and injections comprised the major part of out-patient expenditure. There was a considerable difference in the expenditure incurred on men and women in each facility.

Untrained personnel conducted around 70% of the deliveries in rural areas and 33% in urban areas. Only 38% of the deliveries were followed by post natal care, the percentage was higher in urban areas as compared to the rural areas.[23]

In a study conducted at rural health training center, Banaras Health University in 1997, it was found that the upper caste beneficiaries utilized the free services of RHTC 39.8% more than the others. Home remedies were used more by lower castes 38.8%. Most of the people visited the private practitioners in spite of free medical care services available through PHC and sub-centres of RHTC. Upper caste utilized the allopathy system followed by middle and lower castes. The home remedies and services of Ayurvedic practitioners were used maximum by the lower castes.[20]

In a study conducted at rural Sevagram, Wardha district, Maharashtra in 1997 found that, the most obvious reasons for seeking treatment at the tertiary level irrespective of the nature of the case, locality, age, etc. were economic, referrals and the fame of the health facility and expert doctors. The other common reasons were availability of expertise, insurance benefits and appropriate health care. Poor people preferred to go to tertiary health care institutions because of economic reasons, while the better off women went because they were referred. This shows the patients come here not by choice but the reasons beyond their direct control.[21]

In a study conducted among married women between the age group of 15-45 yrs at rural area, Aligarah in 2000, it was found that only 57.2% of the antenatal cases were registered, 78% at the rural health training centre, 15% at the community health centre and the remaining 6.8% by private practitioners. Of all ANC registrations, 66.1% got themselves registered in second trimester, while 18.6% and 15.2% women were registered in third and first trimester respectively. 62% of the registered cases had 3 or more ANC visits, while over 37% had 1 or 2 visits. 78% of cases registered with the rural health training centre had 3 or more ANC visits, while only one case registered at a source other than RHTC, completed at mandatory 3 ANC visits. All thee registered 59 ANC cases were protected with at least one dose of Tetanus toxoid (TT), while only 55 cases were given a second dose or booster. The drop-out rate was nearly 7%. The iron and folic acid consumption was even quite low being 1.7%, 16.9% and 81.3% for more than 100 tablets, 51 to 100 tablets and 1 to 50 tablets respectively.

The specific types of care rendered during the antenatal check-ups were, pallor / hemoglobin estimation which was most frequently done 93%. pulse rate, urine examination and other blood investigations were done with equal frequency in about

80% of the registered cases. Blood pressure and weight recording were done in 90% and 78% of the registered cases respectively.

The reasons for non-availing of ANC services were lack of knowledge 11.4%, obstacles 36.4% and socio-cultural taboos 52.3%. Barely 90% of the deliveries were domiciliary and out of which 3% were stillbirths. Among the 82 home deliveries, 46.60% of the deliveries were attended by trained persons, among whom 40.2% were doctors and the remaining 6.40% by trained persons.

Among the ever married women, 72% did not use any method of contraception, 28% were using any one of the modern methods and among them 38.3% used condoms, 32.7% used OCP's and 8.4% had IUD's, showing thereby that over 79% depended on spacing methods. The remaining 20.6% relied on terminal methods, tubectomy being the predominant method over vasectomy (10.1).[22]

In a study conducted at rural Bangladesh in 2001, it was found that there was no major difference in health seeking behaviour between elderly people and younger adults. The most commonly consulted type of health care provider was a para-professional such as traditional healer, medical assistant or a community health worker. Household's poverty status emerged as a major determinant of health seeking behaviour. The chances that individuals from poor households would seek treatment from unqualified allopathic practitioners were more compared to the qualified allopathic practitioners. Level of education and poverty emerged as the two most significant determinants of health seeking behaviour.[24]

In a study conducted in Mexico in 2003 found that, the majority of population had access to care; the pressing issue was the underutilization of preventive services among adults. Most of the people had a regular provider or place to go when sick.[29]

ANNEXURE – III

KEY TO MASTER CHART

1. Serial No.		
2. Type of family	1	Nuclear family
	2	Joint family
	3	Broken family
	4	Extended family
3. Literacy status of husband		
4. Age of woman in years		
5. Literacy status of woman: -	1	Illiterate
	2	Primary school
	3	High school
	4	Higher secondary school
	5	Graduation
6. Socio economic status	1	Category I
	2	Category II
	3	Category III
	4	Category IV
	5	Category V
7. Religion:	1	Hindu
8. Village: -	1	Handignur
	2	Borkanatti
	3	Kurihal

11. Utilization

	1	PHC / sub center
	2	KLE Hospital
	3	District Hospital
	4	PVT Doctor
	5	Others

12. Why	1	Near the house
	2	Drugs available
	3	All facility provided
	4	All of the above
13. Satisfaction	1	Yes
	2	No

14. Decision maker	1	Self
	2	Husband
	3	In laws
	4	Others

15. Choice of facility for obstetric care

	1	PHC / sub center
	2	KLE Hospital
	3	District Hospital
	4	PVT Doctor
	5	Others

16 Why this facility?

1 Near the house

2 Drops available

3 All facility provided

4 Others

17. No of ANC visits

1 1

2 2

3 3 or more

4 None

18. Received Iron & Folic acid tablets

1 Yes

2 No

19. Provider of IFA tablets

1 Doctor

2 ANM

3 Anganawadi worker

4 Did not receive

20. Received injection tetanus toxoid

1 Yes

2 No

21. Provider of injection T T

1 Doctor

2 ANM

3 Male health worker

4 Did not receive

22. Any examination done?

1 Yes

2 No

23. What was done?

1 Height measurement

2 Weight measurement

3 Blood pressure measurement

4 Blood examination

5 Urine examination

6 Physical examination

7 All of the above

24. Choice / preferred place for delivery

1 Home

2 Sub center / PHC

3 Dist. Hospital

4 KLE's Hospital

5 Private Nursing home

25. Preferred person for delivery

1 Doctor

2 Trained Dai

3 Nurse

4 Family member / Traditional Dai

26. Decision maker

1 1Self

2 In laws

3 Husband

4 Others

27. Gynacological problems

1 Menorrhagia

2 White discharge

3 Dysmenorrhoea

4 Others

28. Choice / preferred place for treatment

1 PHC / sub center

2 KLE Hospital

3 District Hospital

4 PVT Doctor

5 Others

29. Why this facility?

1 Near the house

2 All facility provided

3 All drugs available

4 All of the above

30. Decision maker

1 Self

2 In laws

3 Husband

4 Others

31. Health facility available near house

1 Yes

2 No

32. Which facility

1 PHC

2 District Hospital

3 Sub centre

4 Private clinic

33. Services provided at door steps

1 Yes

2 No

34. Care provider

1 ANM

2 Male health works

3 Others

35 Types of services

1 Curative

2 Diagnostic

3 Health education

4 Natal services

5 Family planning

6 Immunization

7 All

36. Using any family planning methods

1 Yes

2 No

37. Method of family planning

1 Oral pills

2 Copper T

3 Tubectomy

4 Condom

5 Vasectomy

38. Care provider for family planning

1 Doctor

2 ANM / male health worker

3 Anganawadi worker

4 Others

39. Decision maker for family planning

1 Self

2 Husband

3 In-laws

4 Others

METHODOLOGY

Place of study:

All married women of reproductive age group, (15-49 years), residing at villages Handignur, Borkanatti, and Kurihal, of Belgaum District at least for one year preceding the survey. Handignur village is situated 12 kilometers North East of Belgaum city. The total population of the PHC is 24,160. Three sub-centers come under PHC Handignur, Sub-center Handignur being the headquarters the other two villages under sub-center Handignur are Borkanatti and Kuriharl. Total no of households is 762. Total no of married women of reproductive age (15-49 yrs) is 732. total no of registered medical practitioner - 2, total no of male health workers – 2, total no of female health workers – 4, total no of lady health visitors – 1, total no of RMP's – 4, BHMS – 11, BAMS (Ayurveda) – 5, Quacks – 3.

Methods of Collection of the Data:

Questionnaires was prepared which includes information on socio demographic variables, treatment seeking behavior for general health problems, obstetric care gynecological problems, & family planning the types of health services that are used by them and who actually takes the decision for seeking treatment.

Study Design

It was community based cross sectional study for a period of one year.

Study period

January-2007 to December-2007

Sample size

732, all married women of reproductive age (15-49 years) living under the sub center Handignur.

Inclusion Criteria

1. All married women of reproductive age group (15-49 years).
2. All married women of reproductive age group (15-49 years), residing at their home since one year.

Procedure: Handignur Primary Health Center has four sub-centers; with a total population of 24,160.Out of four one of the sub-centers was randomly selected. All villages under this sub-center were included and from these villages all married women of reproductive age were included in the study. The required information was collected through door to door personal interview.

Socio economic status: Per capita income in Rupees per month was classified using the modified BG Prasad classification.[32]

Social class.	Prasad's classification 1961	Modified Prasad's classification In study period 2008 July (per capita income in Rs/month)
I	100 and above	2534 and above.
II	50—99	1267 to 2058
III	30-49	760 to 1241
IV	15-29	380 to 735
V	<15	Less than 380

Average consumer price index = 514.[33]

Modification was done with aid of multiplication factor, which was obtained as below:

$$\text{M.F.} = \frac{\text{Average consumer price index for the study period}}{100} \text{ x } 4.93$$

$$= 514/100\text{x } 4.93 = 25.34$$

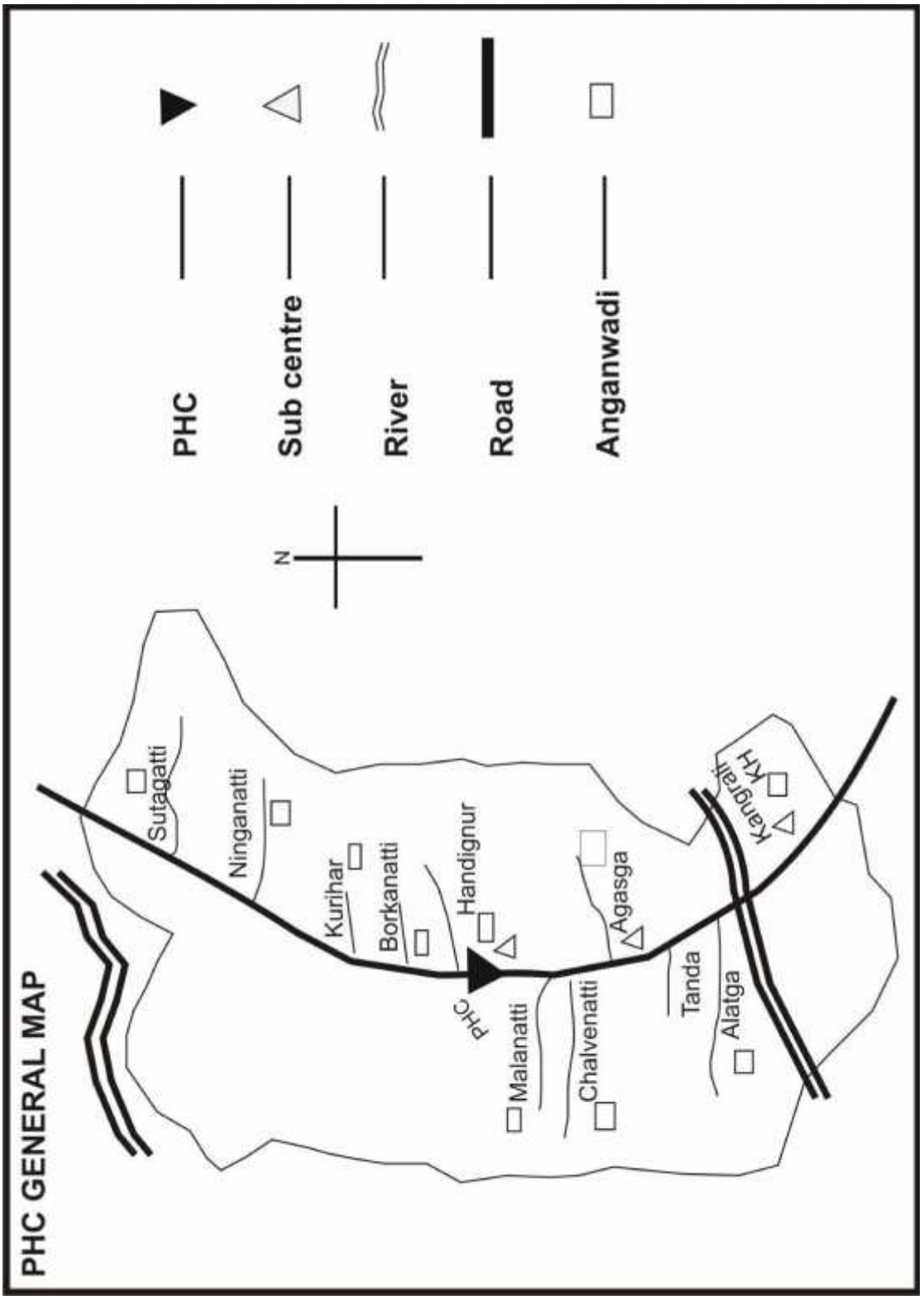


Fig -1- Map of PHC Handignur showing the study area

Fig -2- Interviewing the women under the study, at village Borkanatti.

Fig -3 - Interviewing the women at her door steps, at village Handignur.

RESULTS

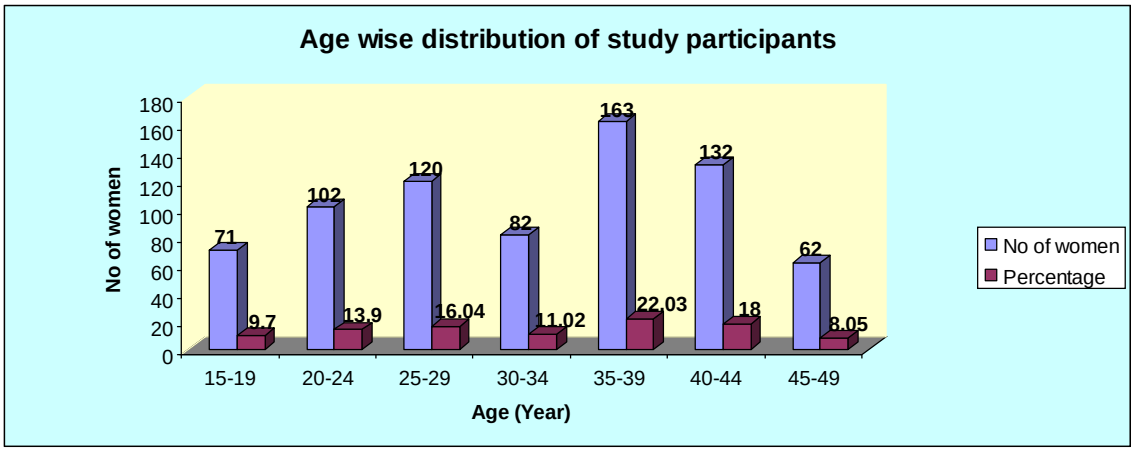
DEMOGRAPHIC PROFILE OF STUDY PARTICIPANTS

The observation stated below are the findings of the present study conducted upon 732 study participants, married women of reproductive age of Handignur sub centre, Belgaum district, Karnataka state.

Table 1: Age wise distribution of study participants

Age of women in years	No of women	Percentage
15-19	71	9.7
20-24	102	13.9
25-29	120	16.04
30-34	82	11.02
35-39	163	22.03
40-44	132	18
45-49	62	8.05
Total	**732**	**100.0**

Figure no 4.

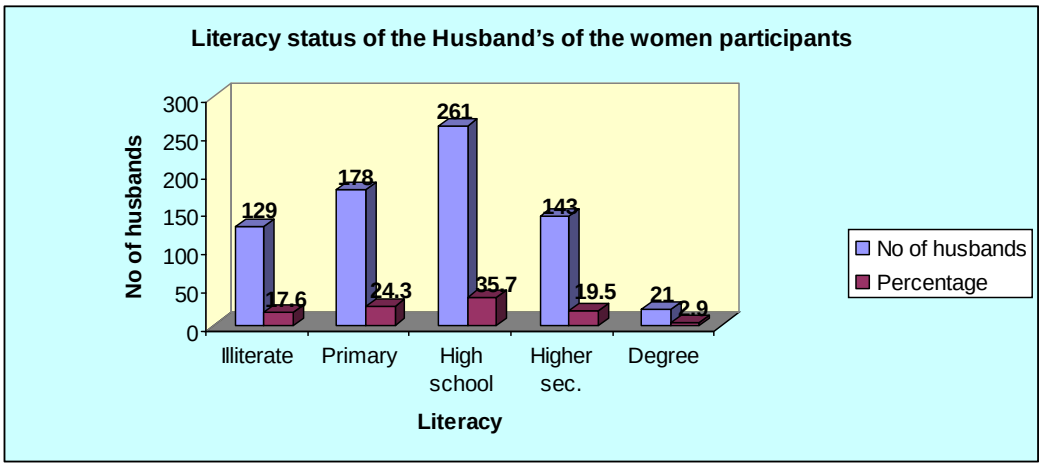


Among the total 732 married women studied majority of them were between the age group of 35-39 years (22.03%). Mean age of patients studied was 35.6 ± 8.87 years.

Table 2: Literacy status of the husbands of the women participants

Literacy status of husbands	No of husbands	Percentage
Illiterate	129	17.6
Primary school	178	24.3
High school	261	35.7
Higher sec. school	143	19.5
Graduation	21	2.9
Total	**732**	**100.0**

Figure no 5.

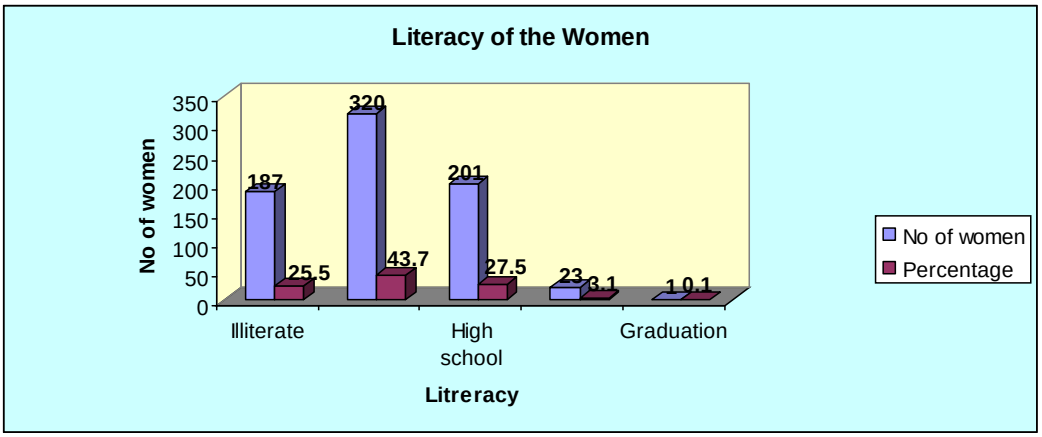


In the present study it was observed that out of 732 husbands of study participants, 129 (17.6%) were illiterate, 178 (24.3%) of husbands had primary school education, 261 (35.7%) were of high school education, 143 (19.5%) were of higher secondary school level and only 21 husbands (2.1%) were graduates.

Table 3: Literacy status of the women

Literacy status of women	No of women	Percentage
Illiterate	187	25.5
Primary school	320	43.7
High school	201	27.5
Higher sec. school	23	3.1
Graduation	1	0.1
Total	**732**	**100.0**

Figure no 6.

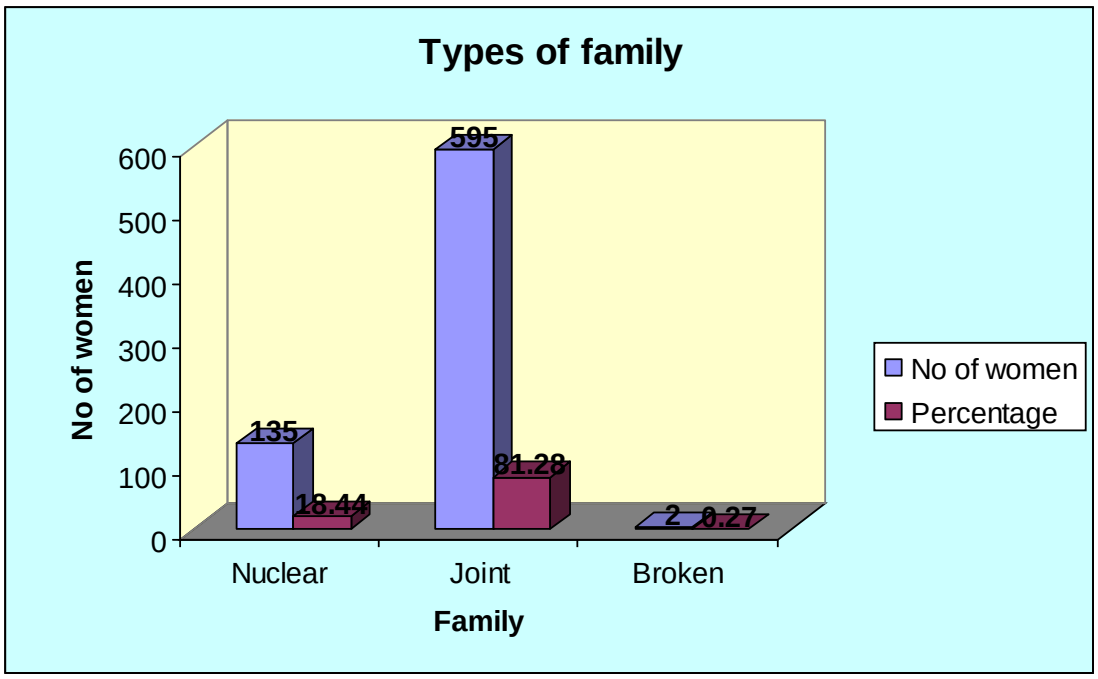


In this study it was observed that out of 732 study participants, 187 (25.5%) were illiterate, 320 (43.7%) of women had primary school level, 201 (27.5%) had high school level of education, 23 (3.1%) had higher secondary school level and only 1 woman (0.1%) was graduate.

Table 4: Types of family

Type of family	No of women	Percentage
Nuclear	135	18.44
Joint	595	81.28
Broken	2	0.27
Total	**732**	**100.0**

Figure no 7.

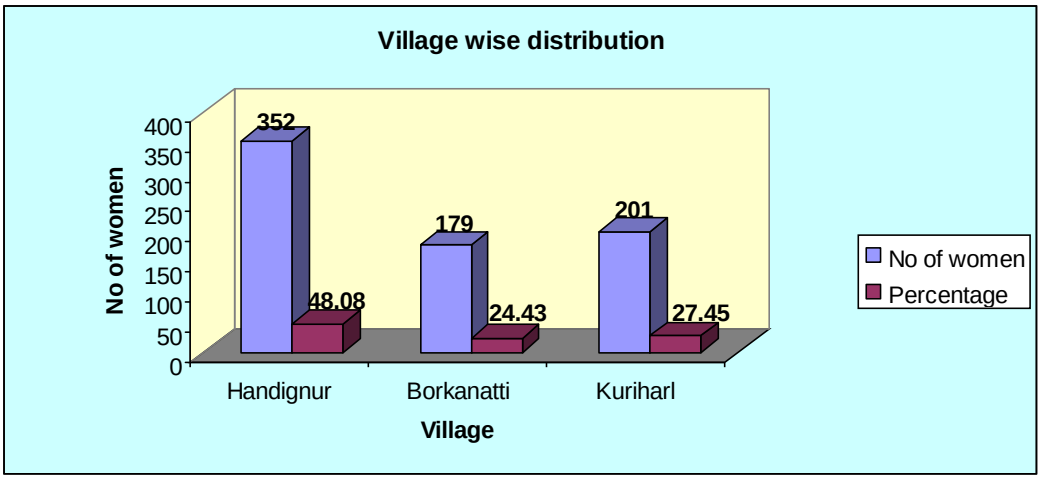


In this study out of 732 study participants, 135 (18.44%) belonged to nuclear family, 595 (81.28%) study participants were from joint family, and 2 (0.27%) were from broken family.

Table 5: Village wise distribution

Villages	No of women	Percentage
Handignur	352	48.08
Borkanatti	179	24.43
Kurihal	201	27.45
Total	**732**	**100.0**

Figure no 8.



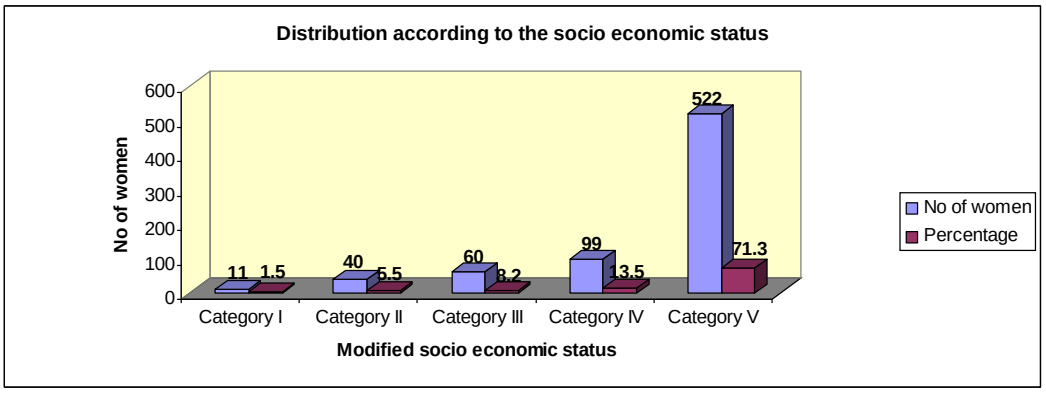
In this study the total participants were 732. Out of them 352 (48.08%) were from village Handignur where PHC and sub-center are situated, 179 (24.43%) were from village Borkanatti, and 201 women (27.44%) were from village Kurihal.

Table 6: Distribution according to the socio economic status

(Modified B G Prasad's classification)

Socio economic status (Modified B G Prasad's classification)	No of women	Percentage
Category I	11	1.5
Category II	40	5.5
Category III	60	8.2
Category IV	99	13.5
Category V	522	71.3
Total	**732**	**100.0**

Figure no 9.



In this study socio economic status was assessed as per modified B G Prasad's classification, out of 732 study participants, 11 (1.5%) women belonged to category I, 40 (5.5%) women belonged to category II, 60 (8.2%) belonged to category III, 99 (13.5%) belonged to category IV and 522 (71.3%) belonged to category V.

The health facility available near the residence

When asked about any health facility located near the residence, all of 732 (100%) study participants were aware about PHC/ sub-centre and 352 (48.08%) had knowledge about private clinic.

Table 7: The awareness about health facilities available near their house

Availability of health facility	No of women	Percentage
PHC/ Sub centre	732	100
Private clinic	352	48.08

* (Because multiple answers were provided the total exceeded 100%).

When asked about any health facility available near the house, 732 women said the PHC's / sub-centre was near to their house and easily accessible. And only 352 women said that the private clinic was also easily accessible.

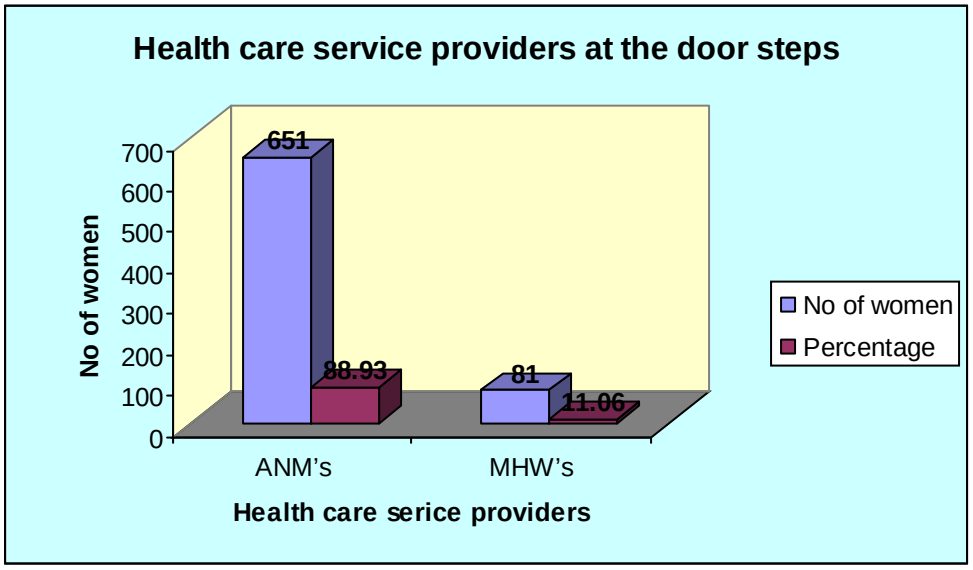
Health care services provided at the door steps

In this study all the 732 women (100%) accepted that health care facility was also provided at their door steps.

Table: 8: Health care service providers at the door steps

Health care providers at door steps	No of women	Percentage
ANM's	651	88.93
MHW's	81	11.06
Total	**732**	**100.0**

Figure no 10.



In this study out of 732 study participants, 651 (88.93 %) women said that the ANM's were providing them services at their door steps, and 81 (11.06%) women said that the Male health workers were providing them services at their door steps.

Types of Health services provided at the door steps

In the present study all 732 study participants said that the services provided at the door steps were curative, diagnostic, health education, natal services, family planning and immunization.

II. GENERAL HEALTH PROBLEMS

Table: 9 Health facilities used for general health problems

Types of Health facility used	No of women	Percentage
PHC / Sub centre	579	79.09
Private doctors	29	3.96
Others	124	16.93
Total	**732**	**100.0**

In this study 579 (79.09%) study participants availed the PHC/ Sub centre for general health problems, 29 (3.96%) of the study participants visited a private doctor for general health problems, and 124 (16.93%) of study participants went to others like traditional healers for general health problems.

Table: 10: Reasons for using this health facility (PHC/ sub-centre) for general health problems

Reasons for using this health facility	No of women	Percentage
Near the house	729	99.59
All essential drugs available	65	8.87
All facilities provided	30	4.09
All of the above	352	48.08

* (Because multiple answers were provided the total exceeded 100%).

In this study the reasons that the study participants gave for utilizing PHC/ sub-centre were multiple, out of 732 study participants, 732 (99.59%) women said they prefer the PHC/ sub-centre because it was close to the house, 65 (8.87%) said the reason was because all essential drugs were available their, 30 (4.09%) said because all necessary facilities were provided at the PHC/ sub-centre, and 352 (48.08%) women said that all the reasons were true.

Table: 11: Satisfied for using this health facility for general health problems

Satisfied for using this health facility	No of women	Percentage
Yes	677	92.48
No	55	7.51
Total	**732**	**100.0**

In this study out of 732 study participants, 677 (92.48%) women were satisfied with the treatment given at the PHC/sub-centre, and 55 (7.51%) women were not satisfied.

Table: 12: Decision maker for using this health facility for general health problems

Decision makers	No of women	Percentage
Self	153	20.90
Husband	555	75.18
In laws and Others	24	3.27
Total	**732**	**100.0**

In this study among the 732 study participants, 153 (20.90%) women said it would be their own decision for a health facility, 555 (75.18%) women said it would be their husbands decision, 23 (3.14%) women said it would be their in law's decision, and 1 (.13%) woman said it was others' decision to choose a health facility for general health problems.

III. OBSTRECTRIC CARE

Health facilities used for obstetrics care

In this study out of 732 study participants all 732 women said they were using the PHC/ Sub-centre for their obstetrics care.

Table: 13: Reasons for using these health facilities for obstetrics care

Reasons for using this health facility	No of women	Percentage
Near the house	729	99.59
All drugs available	65	8.87
All facilities provided	30	4.09
All of the above	352	48.08

*(Because multiple answers were provided the grand total exceeded 100%).

In this study the reasons that the study participants gave for utilizing PHC / sub-centre were multiple, out of 732 study participants, 729 (99.59%) women preferred the PHC / sub-centre for obstetric care was because it was close to the house, 65 (8.87%) said the reason was because all necessary drugs were available at PHC, 30 (4.09%) said because all necessary facilities were provided at the PHC / sub-centre, and 352 (48.08%) women said that all the reasons were true.

Table: 14: Number of visits made to the PHC / Sub centre during ANC

Number of visits	No of women	Percentage
Once	288	39.34
Twice	110	15.02
3 or more	180	24.59
No visit at all	154	21.03
Total	**732**	**100.0**

In this study 288 (39.34%) study participants had visited the PHC/sub-centre once during ANC, 110 (15.02%) women had visited twice, 180 (24.59%) women had visited 3 or more times and 154 (21.03%) did not make any visit during ANC as there was no health facility available in and around during their pregnancy.

Table: 15 Number of women who received Iron and Folic acid tablets

Received Iron & Folic acid tablets	No of women	Percentage
Yes	578	78.96
No	154	21.03
Total	**732**	**100.0**

In this study the 578 (78.96%) study participants received iron and folic acid tablets during ANC, and 154 (21.03%) did not receive any iron and folic acid tablets during ANC as there was no health facility available in and around during the time of their pregnancy.

Table: 16: Providers for Iron and Folic acid tablets during pregnancy

Iron & Folic acid tablets providers	No of women	Percentage
Doctor	401	54.78
ANM's	103	14.07
Male health workers	74	10.10
Not received at all	154	21.03
Total	**732**	**100.0**

In this study the 401 (54.78%) study participants received iron from the doctor at the PHC/sub-centre, 103 (14.07%) women received iron and folic acid tablets from the ANMs, 74 (10.10%) women received iron and folic acid tablets from male health workers, and 154 (21.03%) women did not receive any iron and folic acid tablets during ANC as there was no health facility available in and around during the time of their pregnancy.

Table: 17: Women who received injection tetanus toxoid during pregnancy

Received injections Tetanus Toxoid	No of women	Percentage
Yes	578	78.96
No	154	21.03
Total	**732**	**100.0**

In this study 578 (78.96%) participants received injection tetanus toxoid during ANC, and 154 (21.03%) women did not receive any injection of tetanus toxoid

during ANC as their was no health facility available during the time of their pregnancy.

Table: 18: Providers for injection Tetanus Toxoid during pregnancy

Injection Tetanus Toxoid providers	No of women	Percentage
Doctor	401	54.78
ANMs	103	14.07
Male health workers	74	10.10
Not received at all	154	21.03
Total	**732**	**100.0**

In this study the 401 (54.78%) study participants were provided injection tetanus toxoid by the doctor at the PHC, 103 (14.07%) women received injection tetanus toxoid from the ANMs, 74 (10.10%) women received injection tetanus toxoid from male health workers, and 154 (21.03%) women did not receive any injection tetanus toxoid during ANC as there was no health facility available nearby during the time of their pregnancy.

Table: 19: Any other check up's done during Pregnancy (ANC)

Any other check up's during ANC	No of women	Percentage
Yes	578	78.96
No	154	21.03
Total	**732**	**100.0**

In this study the 578 (78.96%) study participants received any other check up's during ANC, and 154 (21.03%) women had not received any check up's during ANC as there was no health facility available in and around during the time of their pregnancy.

The other check up's done during Pregnancy (ANC)

In this study the 578 (78.96%) study participants received other check up's included measurement of height, weight & blood pressure, urine examination, blood examination and general physical examination.

Table: 20: Preferred place for conducting delivery

Preferred place for delivery	No of women	Percentage
Home	154	21.03
PHC / Sub centre	484	66.12
District hospital	24	3.27
KLE hospital	43	5.87
Private nursing home	27	3.68
Total	**732**	**100.0**

In this study 154 (21.03%) study participants preferred home for conducting delivery as there was no health facility available during pregnancy, 484 (66.12%) preferred PHC / sub-centre for conducting delivery, 24 (3.27%) preferred district hospital, 43 (5.87%) preferred KLE hospital, and 27 (3.68%) women preferred private nursing homes for conducting delivery.

Table: 21: Preferred person for conducting delivery

Preferred person for conducting delivery	No of women	Percentage
Doctor	344	47.00
Trained dai	96	13.11
Nurse / ANM	138	18.85
Family member / Untrained dai	154	21.04
Total	**732**	**100.0**

In this study out of 732 study participants 344 (47%) women preferred to get delivered by the doctor who is available at the PHC, 96 (13.11%) women preferred getting delivered by a trained dai, 138 (18.85%) preferred getting delivered by the nurse / ANM, 154 (21.04%) women had been delivered by their family members or untrained dais as there was no medical facility available nearby during pregnancy.

Table: 22: Decision maker for using this health facility for obstetric care

Decision makers	No of women	Percentage
Self	153	20.90
Husband	555	75.82
In laws and Others	24	3.28
Total	**732**	**100.0**

In this study the decision makers for using the health facilities for obstetric care were, 153 (20.90%) women made their own decisions, 555 (75.82%) women's husbands made the decision, 23 (3.14%) women's in laws made the decision, and for one woman (.14%) others who made decision to use the facilities for obstetrics care.

IV. GYNECOLOGICAL HEALTH PROBLEMS

Table: 23: Types of gynecological problems

Types of problems	No of women	Percentage
Menorrhagia	110	15.02
White discharge	226	30.87
Dysmenorrhoea	321	43.85
Others	75	10.24
Total	**732**	**100.0**

In this study out of 732 study participants who complained of gynecological problems, there were 110 (15.02%) women who complained of menorrhagia, 226 (30.87%) women complained of white discharge, 321 (43.85%) women complained of dysmenorrhoea, and 75 (10.24%) women had other problems.

Table: 24: Choice of health facility for gynecological problems

Choice of health facility	No of women	Percentage
PHC / Sub centre	596	81.42
KLE hospital	32	4.37
District hospital	71	9.69
Private hospital	18	2.45
Others	15	2.04
Total	**732**	**100.0**

The choice of health facility for gynecological problems given as, out of 732 women 596 (81.42%) women preferred PHC / sub centre, 32 (4.37%) women preferred the KLE hospital, 71 (9.69%) preferred the district hospital, 18 (2.45%) women preferred the private hospitals and 15 (2.04%) women preferred other places for gynecological problems.

Table: 25: Reasons for using this health facility for gynecological health problems

Reasons for using this facility	No of women	Percentage
Near the house	34	4.64
All drugs available	30	4.09
All facilities provided	72	9.83
All of the above	596	81.42
Total	**732**	**100.0**

* (Because multiple answers were provided, the grand total exceeded 100%)

In this study the reasons given for using this health facility for gynecological problems were, 34 (4.64%) women said that it was near to their house, 30 (4.09%) women said it was because all drugs were available, 72 (9.83%) women said because all facilities were provided their, and 596 (81.42%) females said all the reasons were true and that was the reason for using the facility.

Table: 26: Decision maker for using this health facility for gynecological problems

Decision makers	No of women	Percentage
Self	338	46.17
Husband	294	40.16
In laws	76	10.38
Others	24	3.27
Total	**732**	**100.0**

In this study out of 732 study participants, 338 (46.17%) women made their own decision for using the particular health facility for gynecological problems, 294 (40.16%) women were advised by their husbands, 76 (10.38%) women were advised by their in laws, and 24 (3.27%) women consulted others for using the facility for the treatment of gynecological problems.

V. FAMILY PLANNING

Table 27: Utilization of family planning methods

Utilization of family planning methods	No of women	Percentage
Yes	668	91.25
No	64	8.74
Total	**732**	**100.0**

In this study out of 732 study participants 668 (91.25%) women practiced family planning and 64 (8.74%) women did not opt for family planning.

Table 28: Types of family planning method used by the couples

Types of methods used	No of couples	Percentage
Oral contraceptive pills	57	8.53
Copper T	448	67.06
Tubectomy	159	23.80
Condoms	4	0.59
Total	**668**	**100.0**

In this study out of 732 study participants, 668 women were using any method of family planning, 57 (8.53%) women were using oral contraceptive pills as contraceptive methods, 79 (67.06%) women had got copper T inserted, 31 (23.80%) women had undergone tubectomy, 6 (0.59%) women said their husbands were using condoms.

Table 29: Care providers for family planning methods

Care providers	No of women	Percentage
Doctor	408	61.07
ANM's / Male health workers	260	38.92
Total	**668**	**100.0**

In this study out of 668 study participants were using family planning methods, 408 (61.07%) women were provided family planning methods by doctors, 260 (38.92%) women took help from the ANM's or the male health worker for family planning methods.

Table: 30: Decision makers for using family planning methods

Decision makers	No of women	Percentage
Self	261	39.07
Husband	323	48.35
In laws	28	4.19
Others	56	8.38
Total	**668**	**100.0**

In this study out of 732 study participants, only 668 couples were using family planning methods. Out of 668 participants, 261 (39.07%) women made their own decision for using for using contraceptive methods, 323 (48.35%) women had taken

the advice of their husbands, 28 (4.19%) women took advice by their in laws, and 56 (8.38%) women had consulted others for using contraceptive methods.

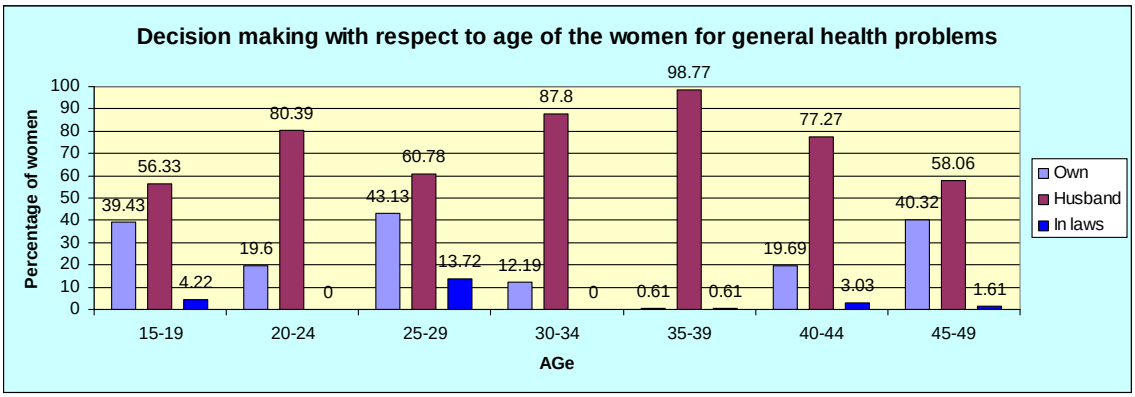
Table: 31: Decision making with respect to age of the women for general health problems

Age of woman in years	Own	Husband	In laws	Total
15-19	28 (39.4)	40 (56.3)	3 (4.2)	71 (100)
20-24	20 (19.60)	82 (80.3)	0 (0)	102 (100)
25-29	44 (43.1)	62 (60.78)	14 (13.72)	120 (100)
30-34	10 (12.19)	72 (87.80)	0 (0)	82 (100)
35-39	1 (0.61)	161 (98.77)	1 (0.61)	163 (100)
40-44	26 (19.69)	102 (77.27)	4 (3.03)	132 (100)
45-49	25 (40.32)	36 (58.06)	1 (1.61)	62 (100)
Total	**154 (21.03)**	**555 (75.81)**	**23 (3.14)**	**732 (100.0)**

X^2 =91.409 DF=6 P= .000

* (Figures in parentheses indicate row percentages)

Figure no 12.



In this study decision making with respect to age was as follows: in 15-19 years 39.43% women made their own decision, 56.33% women consulted their husbands, 4.22% women consulted their in laws, In 20-24 years group women 19.60% women made their own decision, 80.39% women consulted their husbands, and none consulted their in laws, In 25-29 years group women 43.13% made their own decision, 60.78% women consulted their husbands, 13.72% women consulted their in laws, In 30-34 years group women 12.19% women made their own decision 87.80% women consulted their husbands, and none of the women consulted their in laws, In 35-39 years group of women, 0.61% women made their own decision, 98.77% women consulted their husbands and 0.61% women consulted their in laws, In 40-44 years group women, 19.69% women made their own decision, 77.27% women consulted their husbands and 3.03% women consulted their in laws, In 45-49 years group women, 40.32% made their own decision, 58.06% women consulted their husbands and 1.61% women consulted their in laws for decision to take treatment for general health problems.

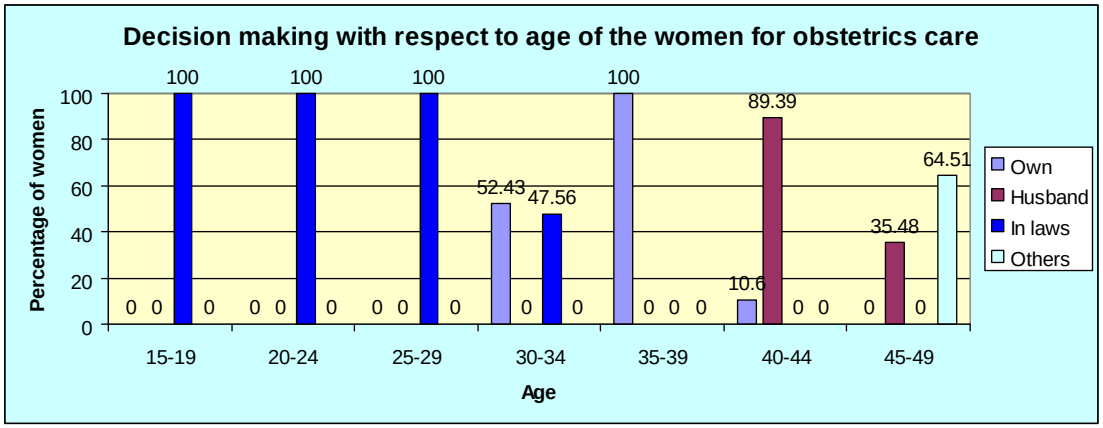
Table: 32: Decision making with respect to age of the women for obstetric care

Age of woman in years	Own	Husband	In laws	Others	Total
15-19	0 (0)	0 (0)	71 (100)	0 (0)	71 (100)
20-24	0 (0)	0 (0)	102 (100)	0 (0)	102 (100)
25-29	0 (0)	0 (0)	120 (100)	0 (0)	120 (100)
30-34	43 (52.43)	0 (0)	39 (47.56)	0 (0)	82 (100)
35-39	163 (100)	0 (0)	0 (0)	0 (0)	163 (100)
40-44	14 (10.60)	118 (89.39)	0 (0)	0 (0)	132 (100)
45-49	0 (0)	22 (35.48)	0 (0)	40 (64.51)	62 (100)
Total	**220 (30.05)**	**140 (19.12)**	**332 (45.35)**	**40 (5.46)**	**732 (100.0)**

X^2= 491.371 DF= 3 P= .000

*(Figures in parentheses indicates row percentages)

Figure no 13.



In this study decision making with respect to age was as follows; 15-19 years group, no women made their own decision, no women consulted their husbands, 100% women consulted their in laws. In 20-24 years group, no women made their own decision, no women consulted their husbands, and 100% women consulted their in laws. In 25-29 years group, no women made their own decision, no women consulted their husbands, and 100% women consulted their in laws. In 30-34 years group women 52.43% women made their own decision no women consulted their husbands, and 47.56% of the women consulted their in laws. In 35-39 years group of women, 100% women made their own decision, no women consulted their husbands and no women consulted their in law. In 40-44 years group women, 10.60% women made their own decision, 89.39% women consulted their husbands and no women consulted their in laws. In 45-49 years group, no women made their own decision, 35.48% women consulted their husbands, no women consulted their in laws, and 64.51% women consulted others for decision for obstetric care.

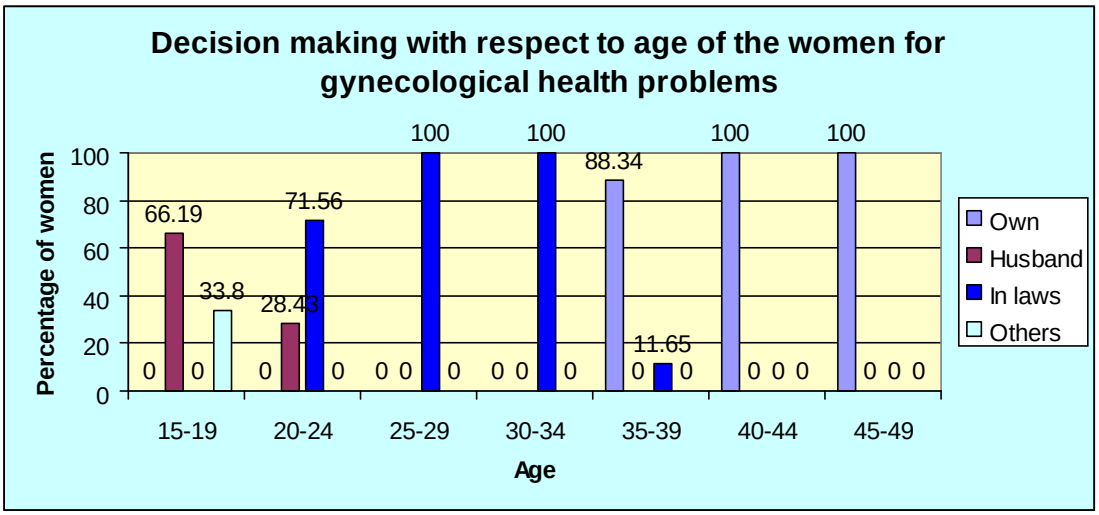
Table: 33: Decision making with respect to age of the women for gynecological health problems

Age of women in years	Own	Husband	In laws	Others	Total
15-19	0 (0)	47 (66.19)	0 (0)	24 (33.80)	71 (100)
20-24	0 (0)	29 (28.43)	73 (71.56)	0 (0)	102 (100)
25-29	0 (0)	0 (0)	120 (100)	0 (0)	120 (100)
30-34	0 (0)	0 (0)	82 (100)	0 (0)	82 (0)
35-39	144 (88.34)	0 (0)	19 (11.65)	0 (0)	163 (100)
40-44	132 (100)	0 (0)	0 (0)	0 (0)	132 (100)
45-49	62 (100)	0 (0)	0 (0)	0 (0)	62 (100)
Total	**338 (46.17)**	**76 (10.38)**	**294 (40.16)**	**24 (3.27)**	**732 (100.0)**

X^2= 514.549 DF= 6 P= .000

*(Figures in parentheses indicates row percentages)

Figure no 14.



In this study decision making with respect to age was as follows; In 15-19 years group no women made their own decision, 66.19% women consulted their husbands, no women consulted their in laws, and 33.80% women consulted others. In 20-24 years group women no women made their own decision, 28.43% women consulted their husbands and 71.56% women consulted their in laws. In 25-29 years group no women made their own decision, no women consulted their husbands, 100% women consulted their in laws. In 30-34 years group, no women made their own decision no women consulted their husbands, and 100% women consulted their in laws. In 35-39 years group, 88.34% women made their own decision, no women consulted their husbands and 11.65% women consulted their in laws, in 40-44 years group, 100% women made their own decision, no women consulted their husbands and no women consulted their in laws. In 45-49 years group, 100% women made their own decision, no women consulted their husbands, no women consulted their in laws, and no women consulted others for decision to take treatment for gynecological health problems.

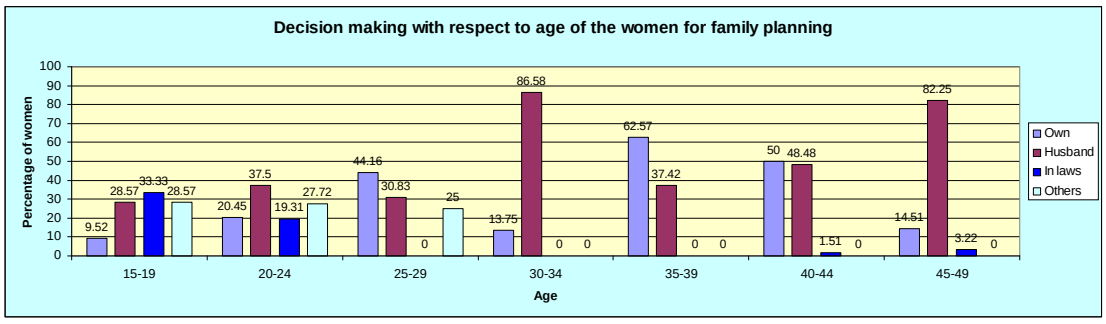
Table: 34: Decision making with respect to age of the women for family planning

Age of women in years	Own	Husband	In laws	Others	Total
15-19	2 (9.52)	6 (28.57)	7 (33.33)	6 (28.57)	21 (100)
20-24	18 (20.45)	33 (37.5)	17 (19.31)	20 (27.72)	88 (100)
25-29	53 (44.16)	37 (30.83)	0 (0)	30 (0)	120 (100)
30-34	11 (13.75)	71 (86.58)	0 (0)	0 (0)	82 (100)
35-39	102 (62.57)	61 (37.42)	0 (0)	0 (0)	163 (100)
40-44	66 (50)	64 (82.25)	2 (3.22)	0 (0)	132 (100)
45-49	9 (14.51)	51 (82.25)	2 (3.22)	0 (0)	62 (100)
Total	**261 (39.09)**	**323 (49.70)**	**28 (4.19)**	**56 (8.38)**	**668 (100.0)**

X^2= 282.887 DF= 12 P= .000

*(Figures in parentheses indicates row percentage)

Figure no 15.



In this study decision making with respect to age was as follows, 15-19 years 9.52% women made their own decision, 28.57% women consulted their husbands, 33.33% women consulted their in laws, and 28.57% women consulted others. In 20-24 years group women 20.45% women made their own decision, 37.5% women consulted their husbands, 19.31% women consulted their in laws and 27.72% women consulted others, In 25-29 years group women 44.16% women made their own decision, 30.83% women consulted their husbands, no women consulted their in laws and 25% women consulted others, In 30-34 years group women 13.75% women made their own decision 86.58% women consulted their husbands, and no women consulted their in laws, In 35-39 years group of women, 62.57% women made their own decision, 37.42% women consulted their husbands and no women consulted their in laws, In 40-44 years group women, 50% women made their own decision, 48.48% women consulted their husbands and only 1.51% women consulted their in laws, In 45-49 years group women, 14.51% women made their own decision, 32.25% women consulted their husbands, only 3.22% women consulted their in laws, and no women consulted others for decision to take for family planning.

Table: 35: Impact of literacy status of the women on utilization of general health problems

Literacy status of women	Own	Husband	In laws	Total
Illiterate	52 (27.80)	124 (66.31)	11 (5.8)	187 (100)
Primary school	66 (20.62)	247 (77.18)	7 (2.18)	320 (100)
High school	33 (16.41)	164 (81.59)	4 (1.99)	201 (100)
Higher secondary school	3 (9.37)	19 (82.60)	1 (4.34)	23 (100)
Graduation	0 (0)	1 (100)	0 (0)	1 (100)
Total	**154 (21.03)**	**555 (75.81)**	**23 (3.14)**	**732 (100.0)**

X^2= 16.84 DF= 8 P= 0.0318

* (Figures in parentheses indicate row percentages)

In this study decision making with respect to education was as follows, in illiterates 27.80% women made their own decision, 66.31% women consulted their husbands, 5.88% women consulted their in laws, and no women consulted others. In primary school educated group, 20.62% women made their own decision, 77.18% women consulted their husbands, and 2.18% women consulted their in laws, In high school educated group, 16.41% women made their own decision, 81.59% women consulted their husbands, and 1.99% women consulted their in laws, In higher secondary educated group, 9.37% women made their own decision 82.60% women

consulted their husbands, and 4.34% women consulted their in laws, and no women consulted others for decision to take treatment for general health problems.

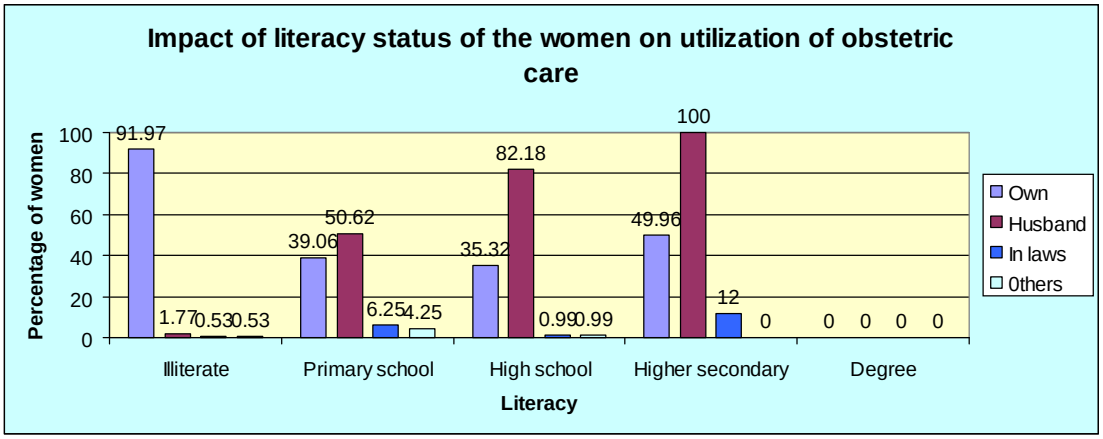
Table: 36: Impact of literacy status of the women on utilization of obstetric care

Literacy status of women	Own	Husband	In laws	Others	Total
Illiterate	172 (91.97)	13 (1.77)	1 (0.53)	1 (0.53)	187 (100)
Primary school	125 (39.06)	162 (50.62)	20 (6.25)	13 (4.06)	320 (100)
High school	71 (35.32)	125 (62.18)	2 (0.99)	3 (01.49)	201 (100)
Higher secondary	10 (49.96)	13 (56.52)	0 (0)	0 (0)	23 (100)
Degree	0 (0)	1 (100)	0 (0)	0 (0)	1 (100)
Total	**378 (51.63)**	**314 (42.89)**	**23 (3.14)**	**17 (2.32)**	**732 (100.0)**

X^2= 185.36 DF= 8 P= <.0001

* (Figures in parentheses indicate row percentages)

Figure no 16.



In this study decision making with respect to education was as follows, in illiterate group, 91.97% women made their own decision, 1.77% women consulted their husbands, 0.53%women consulted their in laws, and 0.53% women consulted others. In primary school educated group, 39.06% women made their own decision, 50.62% women consulted their husbands, 6.25% women consulted their in laws and 4.06% women consulted others. In high school educated group, 35.32% women made their own decision, 62.18% women consulted their husbands, 0.99% women consulted their in laws and 1.49% women consulted others. In higher secondary educated group, 49.96% women made their own decision, 56.52% women consulted their husbands, and no women consulted their in laws, and no women consulted others for decision to take treatment for obstetric care.

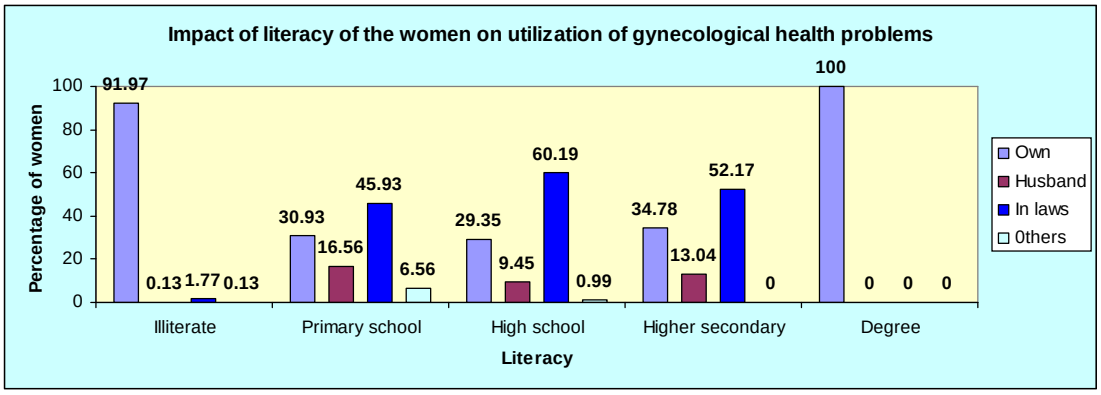
Table: 37: Impact of literacy status of women on utilization of gynecological health problems

Literacy status of women	Own	Husband	In laws	0ttheirs	Total
Illiterate	172 (91.97)	1 (0.13)	13 (1.77)	1 (0.13)	187 (100)
Primary school	99 (30.93)	53 (16.56)	147 (45.93)	21 (6.56)	320 (100)
High school	59 (29.35)	19 (9.45)	121 (60.19)	2 (0.99)	201 (100)
Higher secondary	8 (34.78)	3 (13.04)	12 (52.17)	0 (0)	23 (100)
Degree	1 (100)	0 (0)	0 (0)	0 (0)	01 (100)
Total	**338 (46.17)**	**76 (10.38)**	**294 (40.16)**	**24 (3.27)**	**732 (100.0)**

X^2= 238.36 DF= 12 P= <.0001

* (Figures in parentheses indicate row percentages)

Figure no 17.



In this study decision making with respect to education was as follows; in illiterate group, 91.97% women made their own decision, 0.53% woman consulted their husbands, 6.95% women consulted their in laws, and 0.53% woman consulted others. In primary school educated group, 30.93% women made their own decision, 16.56% women consulted their husbands, and 45.93% women consulted their in laws, and 6.56% women consulted others. In high school educated group, 29.35% women made their own decision, 9.45% women consulted their husbands, 60.19% women consulted their in laws, and 0.99% women consulted others. In higher secondary educated group, 34.78% women made their own decision, 13.04% women consulted their husbands, and 52.17% women consulted their in laws, and no women consulted others. In graduate women, 100% woman made their own decision for treatment of general health problems.

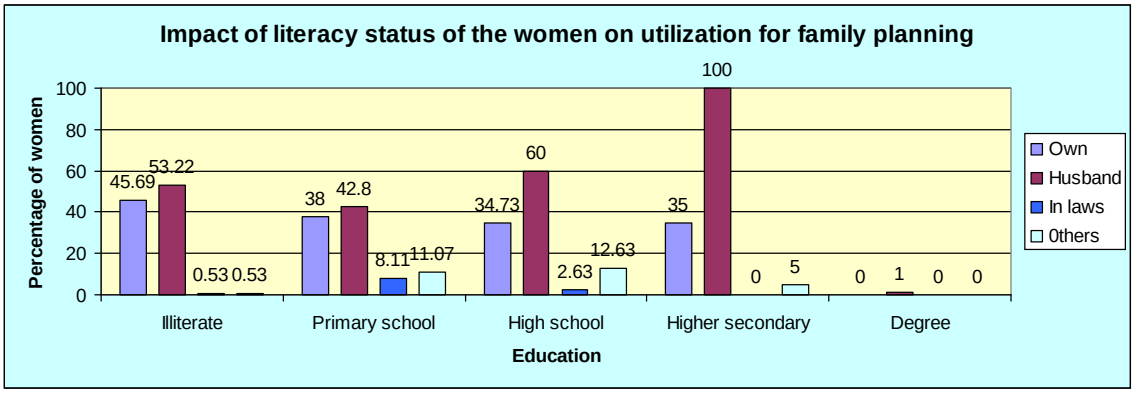
Table: 38: Impact of literacy status of women on utilization for family planning

Literacy status of women	Own	Husband	In laws	others	Total
Illiterate	85 (45.69)	99 (53.22)	1 (0.53)	1 (0.53)	186 (100)
Primary school	103 (38)	116 (42.80)	22 (8.11)	30 (11.07)	271 (100)
High school	66 (34.73)	95 (50)	5 (2.63)	24 (12.63)	190 (100)
Higher secondary school	7 (35)	12 (60)	0 (0)	1 (5)	20 (100)
Graduation	0 (0)	1 (100)	0 (0)	0 (0)	1 (100)
Total	**261 (39.07)**	**223 (33.38)**	**28 (0.14)**	**56 (8.38)**	**668 (100.0)**

X^2= 45.73 DF= 12 P=<.0001

* (Figures in parentheses indicate row percentages)

Figure no 18.



In this study decision making with respect to education was as follows; in illiterate group, 45.69% women made their own decision, 53.22% woman consulted their husbands, 0.53% women consulted their in laws, and 0.53% woman consulted others. In primary school educated group, 38% women made their own decision, 42.80% women consulted their husbands, 8.11% women consulted their in laws and 11.07% women consulted others. In high school educated group, 34.73% women made their own decisions, 50% women consulted their husbands, 2.63% women consulted their in laws, and 12.63% women consulted others. In higher secondary school educated group, 35% women made their own decision, 60% women consulted their husbands, and no women consulted their in laws, and 5% woman consulted others. In graduate women, 100% woman consulted their husband for using of family planning methods.

Table: 39: Decision making with respect to socio economic status of family for general health problems

Socio economic status of family	Self	Husband	In laws	Total
Category I	1 (9.09)	9 (81.81)	1 (9.09)	11 (100)
Category II	5 (12.5)	33 (82.5)	2 (5)	40 (100)
Category III	14 (23.33)	46 (76.66)	0 (0)	60 (100)
Category IV	20 (20.20)	76 (76.76)	3 (3.03)	99 (100)
Category V	114 (21.83)	391 (74.90)	17 (3.25)	522 (100)
Total	**154 (21.03)**	**555 (75.18)**	**23 (3.14)**	**732 (100.0)**

X^2= 6.43 DF= 8 P= 0.5992

* (Figures in parentheses indicate row percentages)

In this study decision making with respect to socio economic status was as follows; in category I, 9.09% woman made their own decision, 81.81% women consulted their husbands, 9.09% woman consulted their in laws, and no woman consulted others. In category II group, 12.5% women made their own decision, 82.5% women consulted their husbands, 5% women consulted their in laws, and no women consulted others. In Category III group, 23.33% women made their own decision, 76.66% women consulted their husbands, no women consulted their in laws, and no women consulted others. In Category IV group, 20.20% women made their own decision 76.76% women consulted their husbands, 3.03% women consulted their in laws, and no women consulted others. In Category V group, 21.83% woman made their own decision, 74.90% consulted their husbands, 3.25% women consulted their in laws and none consulted others for treatment of general health problems.

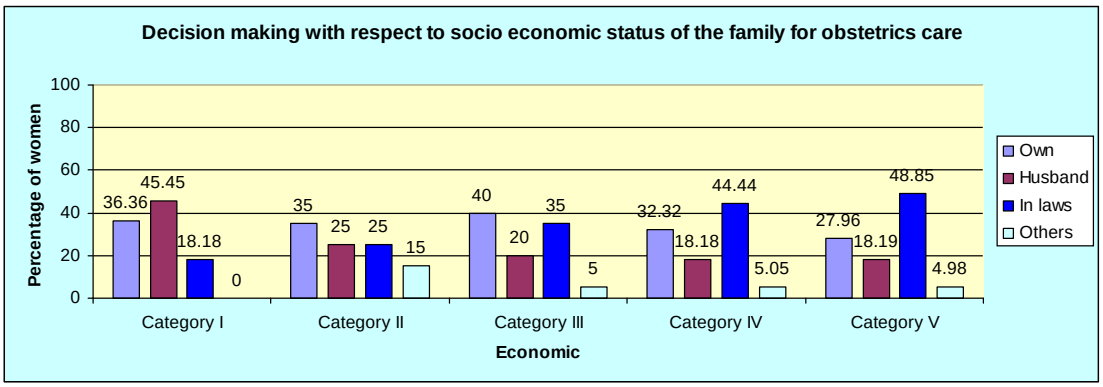
Table: 40: Decision making with respect to socio economic status of family for obstetric care

Socio economic status of family	Own	Husband	In laws	Others	Total
Category I	4 (36.36)	5 (45.45)	2 (18.18)	0 (0)	11 (100)
Category II	14 (35)	10 (25)	10 (25)	6 (15)	40 (100)
Category III	24 (40)	12 (20)	21 (35)	3 (5)	60 (100)
Category IV	32 (32.32)	18 (18.18)	44 (44.44)	5 (5.05)	99 10(0)
Category V	146 (27.96)	95 (18.19)	255 (48.85)	26 (4.98)	522 (100)
Total	**220 (30.05)**	**140 (19.12)**	**332 (45.35)**	**40 (5.46)**	**732 (100.0)**

X^2= 24.21 DF= 12 P= 0.019

* (Figures in parentheses indicate row percentages)

Figure no 19.



In this study decision making with respect to socio economic status was as follows; in category I, 36.36% women made their own decision, 45.45% women consulted their husbands, 18.18% women consulted their in laws, and no woman consulted others. In category II group women 35% women made their own decision, 25% women consulted their husbands, 25% women consulted their in laws, and 15% women consulted others. In Category III group, 40% women made their own decision, 20% women consulted their husbands, 35% women consulted their in laws, and 5% women consulted others. In Category IV group, 32.32% women made their own decision 18.18% women consulted their husbands, 44.44% women consulted their in laws, and 5.05% women consulted others. In Category V group, 27.96% woman made their own decision, 18.19% consulted their husbands, 48.85% women consulted their in laws and 4.98% women consulted others for obstetric care.

Table: 41: Decision making with respect to socio economic status of family for gynecological health problems

Socio economic status of family	Own	Husband	In laws	Total
Category I	1 (9.09)	10 (90.90)	0 (0)	11 (100)
Category II	5 (12.5)	33 (82.5)	2 (5)	40 (100)
Category III	14 (23.33)	46 (76.66)	0 (0)	60 (100)
Category IV	22 (22.22)	74 (74.74)	3 (3.03)	99 (100)
Category V	114 (21.83)	391 (74.90)	17 (3.25)	522 (100)
Total	**156 (21.31)**	**554 (75.68)**	**22 (0.27)**	**732 (100.0)**

X^2= 5.87 DF= 8 P= 0.6618

* (Figures in parentheses indicate row percentages)

In this study decision making with respect to socio economic status was as follows; in category I, 9.09% woman made their own decision, 90.90% women consulted their husbands, and no women consulted their in laws. In category II group, 12.55% women made their own decision, 82.5% women consulted their husbands, and 5% women consulted their in laws. In Category III group, 23.33% women made their own decision, 76.66% women consulted their husbands, and no women consulted their in laws. In Category IV group, 22.22% women made their own

decision, 74.74% women consulted their husbands, and 3.03% women consulted their in laws. In Category V group, 21.83% woman made their own decision, 74.90% consulted their husbands, and 3.25% women consulted their in laws for treatment of gynecological health problems.

Table: 42: Decision making with respect to socio economic status of family for family planning

Socio economic status of family	Own	Husband	In laws	Total
Category I	1 (9.09)	10 (90.90)	0 (0)	11 (100)
Category II	5 (12.5)	33 (82.5)	2 (5)	40 (100)
Category III	14 (23.33)	46 (76.66)	0 (0)	60 (100)
Category IV	22 (22.22)	74 (74.74)	3 (3.03)	99 (100)
Category V	114 (21.83)	391 (74.90)	17 (3.25)	522 (100)
Total	**156 (21.31)**	**554 (75.68)**	**22 (3.0)**	**732 (100.0)**

X^2= 5.87 DF= 8 P= 0.6618

* (Figures in parentheses indicate row percentages)

In this study decision making with respect to socio economic status was as follows; in category I group, 9.09% woman made their own decision, 90.90% women consulted their husbands, and no women consulted their in laws. In category II group,

12.5% women made their own decision, 82.5% women consulted their husbands, and 5% women consulted their in laws. In Category III group, 23.33% women made their own decision, 76.66% women consulted their husbands, and no women consulted their in laws. In Category IV group, 22.22% women made their own decision 74.74% women consulted their husbands, and 3.03% women consulted their in laws. In Category V group, 21.83% woman made their own decision, 74.90% consulted their husbands, and 3.25% women consulted their in laws for family planning methods.

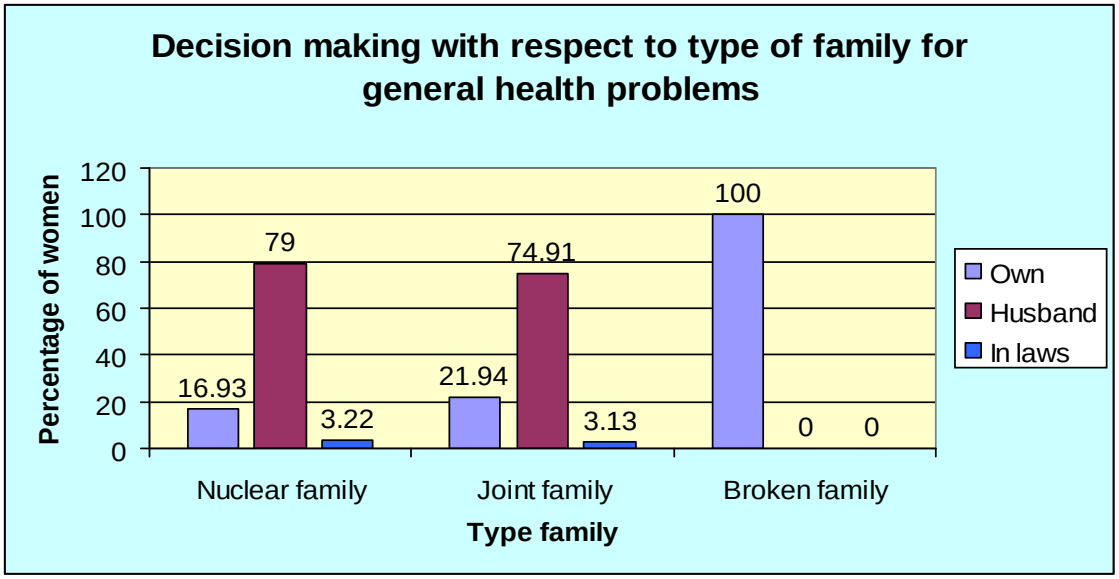
Table: 43: Decision making with respect to type of family for general health problems

Type of family	Own	Husband	In laws	Total
Nuclear family	21 (16.93)	99 (79.83)	4 (3.22)	124 (100)
Joint family	133 (21.94)	454 (74.91)	19 (3.13)	606 (100)
Broken family	2 (100)	0 (0)	0 (0)	2 (100)
Total	**156 (21.31)**	**553 (75.54)**	**23 (3.14)**	**732 (100.0)**

X^2= 68.4 DF= 4 P= <.0001

* (Figures in parentheses indicate row percentages)

Figure no 20.



In this study decision making with respect to the type of family was as follows; 16.93% women who belonged to the nuclear family made their own decision, 79.83% women consulted their husbands, and 3.22% women consulted their in laws. In women belonging to joint family, 21.94% women made their own decision, 74.91% women consulted their husbands, and 3.13% women consulted their in laws. And in broken family 100% women took their own decision for taking treatment for general health problems.

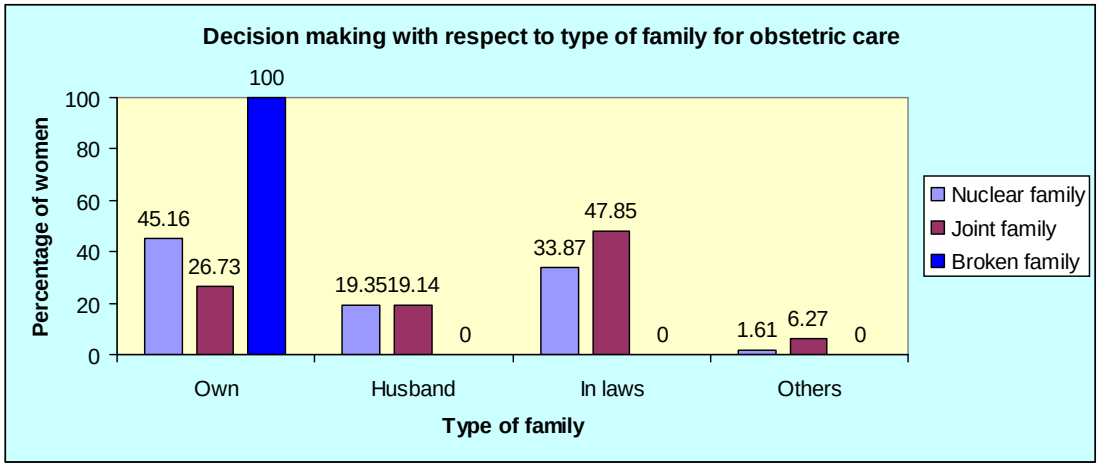
Table: 44: Decision making with respect to type of family for obstetric care

Type of family	Own	Husband	In laws	Others	Total
Nuclear family	56 (45.16)	24 (19.35)	42 (33.87)	2 (1.61)	124 (100)
Joint family	162 (26.73)	116 (19.14)	290 (47.85)	38 (6.27)	606 (100)
Broken family	2 (100)	0 (0)	0 (0)	0 (0)	2 (100)
Total	**220 (30.05)**	**140 (19.12)**	**332 (45.35)**	**40 (5.46)**	**732 (100.0)**

X^2= 24.83 DF= 6 P= 0.0004

* (Figures in parentheses indicate row percentages)

Figure no 21.



In this study decision making with respect to the type of family was as follows; 45.16% women who belonged to the nuclear family made their own decision, 19.35% women consulted their husbands, 33.87% women consulted their in laws and

1.61% women consulted others. In joint family women, 26.73% women made their own decision, 19.14% women consulted their husbands, 47.85% women consulted their in laws and 6.27% women consulted others. And in broken family 100% women took their own decision for obstetric care.

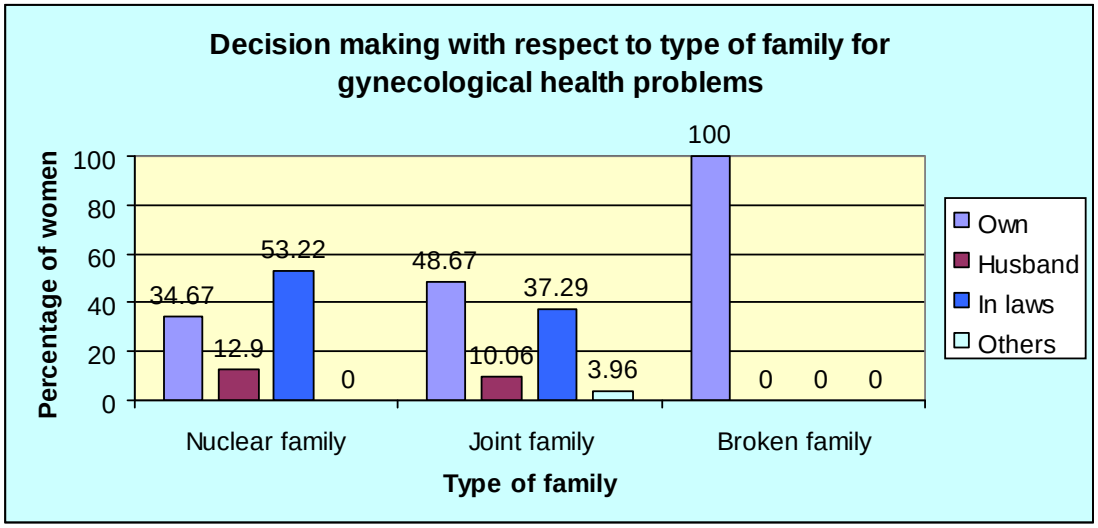
Table: 45: Decision making with respect to type of family for gynecological health problems

Type of family	Own	Husband	In laws	Others	Total
Nuclear family	43 (34.67)	15 (12.09)	66 (53.22)	0 (0)	124 (100)
Joint family	295 (48.67)	61 (10.06)	226 (37.29)	24 (3.96)	606 (100)
Broken family	2 (100)	0 (0)	0 (0)	0 (0)	2 (100)
Total	**340 (46.44)**	**76 (10.38)**	**292 (39.89)**	**24 (3.27)**	**732 (100.0)**

X^2= 18.54 DF= 6 P= 0.005

* (Figures in parentheses indicate row percentages)

Figure no 22.



In this study decision making with respect to the type of family was as follows, 34.67% women who belonged to the nuclear family made their own decision, 12.09% women consulted their husbands, 53.22% women consulted their in laws and no women consulted others. In joint family women, 48.67% women made their own decision, 10.06% women consulted their husbands, 37.29% women consulted their in laws and 3.96% women consulted others. And in broken family, 100% women took their own decision for taking treatment for gynecological health problems.

Table: 46: Decision making with respect to type of family for family planning

Type of family	Own	Husband	In laws	Others	Total
Nuclear family	41 (35.96)	63 (55.26)	3 (0.87)	7 (6.14)	114 (100)
Joint family	218 (39.49)	260 (47.10)	25 (4.52)	49 (8.87)	552 (100)
Broken family	2 (100)	0 (0)	0 (0)	0 (0)	2 (100)
Total	**261 (39.07)**	**323 (48.35)**	**28 (4.19)**	**56 (8.38)**	**668 (100.0)**

X^2= 6.39 DF= 6 P= 0.3809

* (Figures in parentheses indicate row percentages)

In this study decision making with respect to the type of family was as follows; 35.96% women who belonged to the nuclear family made their own decision, 55.26% women consulted their husbands, 0.87% women consulted their in laws and 6.14% women consulted others. In joint family women, 39.49% women made their own decision, 47.10% women consulted their husbands, 4.25% women consulted their in laws and 8.87% women consulted others. And in broken family 100% women took their own decision for taking using of family planning methods.

DISCUSSION

I. DEMOGRAPHIC PROFILE OF THE STUDY POPULATION

Table No I: Percentage wise distribution of study population by age

In the present study the distribution of women population by various age groups show that the largest share 50% was in the age group category of 25 – 39 years, and the lowest share of 23% was in the age group category of 15 – 24 years.

Table No II: Literacy status of the husbands of the women participants

In the present study the majority 60% of the husbands were literate and only 17% were illiterates. According to the census data 2001, the literacy rate of Belgaum district is found to be 64%.[27] this rate in the present study could be due to the awareness regarding the importance of education among the rural areas.

Table No III: Literacy status of the women

In the present study, 74.3% of the women were literates and only 25.5% were illiterate, Awareness to education was found more among women than men. According to the census data the literacy of females is 52% so being significant.[27]

Table No IV: Types of family

Among 732 study participants 81.55% (595) of women belonged to joint family and 18.44% belonged to the nuclear family.

Table No V: Village wise distribution of the women

In the present study 48.8% of the women belonged to village Handignur, 27.45% belonged to Village Kuriharl, and 24.43% belonged to village Borkanatti.

Table No VI: Distribution of women according to socio economic status

In the present study 71.3% of the women in the present study were of category V, 13.5% belong to category IV and the remaining 15.2% belong to category I, II and III.

II. AVAILIBLITY OF HEALTH CARE SERVICES

Table No VII: Awareness of health care services available

In the present study, all 732 respondents had the knowledge regarding the availability of health care services.

III. UTILIZATION OF HEALTH FACILITY FOR GENERAL HEALTH PROBLEMS

Table No (IX – XII): General health problems

79% women utilized the PHC/ sub center, 99.59% of women said it was near to the house. And 92.48% of women said they were satisfied with the health facility. The decision for using the facility for general health problems 75.18% women said that their husband would decide.

IV: UTILIZATION OF HEALTH FACILITY FOR OBSTETRICS CARE

Table No (XIII – XXII): Obstetrics care

99.59% of women said that the reasons they used this facility was because it was near to the house. 39.34% of women visited once, 24.59% of women gave 3 visits, whereas 21.03% of women did not visit at all. 78.96% of women during these ANC checkups did receive iron and folic acid tablets. For the provider of iron and folic acid tablets 54.78% women said the doctor provided them. 78.96% of women

said they did receive injection tetanus toxoid and 54.78% of women said the doctor provided it to them. Along with this 78.96% of women said they had other checkups during ANC. 66.12% of women said they preferred PHC/ sub center. And the person preferred for conducting the delivery 47% of the women said they would prefer the doctor. The decision maker for using this health facility for obstetrics care, 75.82% of women said their husband would decide.

In a study conducted by the Center for Development Studies, Thiruvananthapuram, India in 2000, it was revealed that institutional delivery reduces the risk of maternal and child mortality. As regards the place of delivery, over 60 % of the deliveries were at home in both Andhra Pradesh and Karnataka. This percentage was only 36 in Tamil Nadu. About three quarters of the deliveries were assisted by medical personnel (doctor, nurse or midwife, ANM/LHV, trained birth attendant) in Tamil Nadu, but in Karnataka and Andhra Pradesh the proportion was only one-half.[30]

In another study conducted at 90 districts, and nineteen thousand pregnant women it was found that about 89% 0f the pregnant women had antenatal visits and 62% had made three or more ANC visits. There were about 11% pregnant women who had no ANC visits at all during their pregnancy.[31]

V: UTILIZATION OF HEALTH FACILITY FOR GYNECOLOGICAL PROBLEMS

Table No (XXIII - XVI): Gynecological Problem

43.85% of the women complained of dysmenorrhoea. The choice for using this health facility for gynecological problems 81.42% of women opted for PHC/sub center. And the reasons that they gave 81.42% of women said that it was because of the center was near the house, all drugs were available and all facilities were

provided. The decision maker for using this health facility for gynecological health problems 46.17% of women said they would make their own decision.

In a similar study conducted at AIIMS, New Delhi in 1997, it was observed that major gynecological problems among the rural women was of vaginal discharge was variously referred to as leucorrhea.[28]

VI: UTILIZATION OF HEALTH FACILITY FOR FAMILY PLANNING SERVICES

Table No (XXVII - XXX): Family planning services

91.25% of the women accepted that they were utilizing family planning methods. 67.06% of women said they were using copper –T as the type of family planning methods and 61.07% of females said the doctor provided them family planning care. 48.35% of the women said that their husbands would decide for utilization of family planning methods.

VII: DECISION MAKING WITH RESPECT TO AGE FOR GENERAL HEALTH PROBLEMS

Table No (XXXI): Decision makers for general health problems

In the present study decision making with respect to age was as follows, 15-19 years 19.7% women made their own decisions, 28.16% women consulted their husbands, 2.1% women consulted their in laws, In 20-24 years group women 6.6% women made their own decisions, 68.3% women consulted their husbands, and non consulted their in laws, In 25-29 years group women 36.6% women made their own decisions, 51.6% women consulted their husbands, 11.6% women consulted their in laws, In 30-34 years group women 12.1% women made their own decision 87.8%

women consulted their husbands, and none of the women consulted their in laws, In 35-39 years group of women, 0.61% women made their own decision, 98.7% women consulted their husbands and 0.61% women consulted in laws, In 40-44 years group women, 19.6% women made their own decision, 77.27% women consulted their husbands and 3.03% women consulted their in laws, In 45-49 years group women, 40.32% women made their own decisions, 58.06% women consulted their husbands and 1.61% women consulted in laws for decision to take treatment for general health problems.

In a study conducted in Agra in 2002 advice was first sought mainly from the peer group by majority and not with other people of the village, unless the condition is considered serious enough to seek better advice. It was almost universally revealed that elder male members of the family like grand father or father are the decision-makers most of the times, for the health problems of women, female family members were not found to be empowered to take decision as to when and where to seek treatment, and they had to depend and follow the decisions of their mother in laws, husbands or elder family members. It was observed that as the age increased the husband's decision was taken into consideration.[5]

VIII: DECISION MAKING WITH RESPECT TO AGE FOR OBSTETRICS CARE

Table No (XXXII): Decision makers for obstetrics care

In the present study decision making with respect to age, it was observed that in, 15-19 years 100% women consulted their in laws, In (20-24) years group women (100%)women consulted their in laws, In (25-29) years group women 100% women consulted their in laws, In (30-34) years group women 52.4% women made their own decision, and 47.5% of the women consulted their in laws, In 35-39 years group of women, 100% women made their own decision, In 40-44 years group women, 10.16% women made their own decision, 89.3% women consulted their husbands, In 45-49 years group women, 35.48% women consulted their husbands, and 64.51% women consulted others for decision to take treatment for obstetric care.

In a study conducted in Aligarah in 2000, it was observed that only 57.2% of the Antenatal cases were registered, 78% at the rural health training centre 15% at the community health centre and the remaining 6.8% by private practitioners. Of all ANC registrations, 66.1% got themselves registered in second trimester, while 18.6% and 15.2% women were registered in third and first trimester respectively. 62% of the registered cases had 3 or more ANC visits, while over 37% had 1 or 2 visits. 78% of cases registered with the rural health training centre had 3 or more ANC visits, while only case registered at a source other than RHTC, completed at mandatory 3 ANC visits. All the registered 59 ANC cases were protected with at least one dose of Tetanus toxoid (TT), while only 55 cases were given a second dose or booster. The drop-out rate was nearly 7%. The iron and folic acid consumption was even quite low

being 1.7%, 16.9% and 81.3% for more than 100 tablets, 51 to 100 tablets and 1 to 50 tablets respectively.[22]

IX: DECISION MAKING WITH RESPECT TO AGE FOR GYNECOLOGICAL PROBLEMS

Table No (XXXIII): Decision makers for gynecological problems

In the present study decision making with respect to age for gynecological problems was as follows, (15-19) years, 66.19% women consulted their husbands, and 71.56% women consulted others. In (20-24) years group women, (28.43%) women consulted their husbands, and 71.56% women consulted their in laws, In (25-29) years group women 100%women consulted their in laws, In (30-34) years group women 100% women consulted their in laws, In (35-39) years group of women, 88.34% women made her own decision, and 11.56% women consulted her in law, In (40-44) years group women, 132 women made their own decision, no women consulted their husbands and no women consulted their in laws, In (45-49) years group women, 100% women made their own decisions, for decision to take treatment for gynecological health problems.

In this study it was observed that as the age grows women taking their own decisions for gynecological problems.

X: DECISION MAKING WITH RESPECT TO AGE FOR FAMILY PLANNING

Table No (XXXIV): Decision makers for family planning

In the present study decision making with respect to age was as follows, (15-19) years 9.52% women made their own decisions, 28.57% women consulted their

husbands, 33.33% women consulted their in laws, and 28.57% women consulted others. In (20-24) years group women 20.45% women made their own decisions, 37.5% women consulted their husbands, 19.31% women consulted their in laws and 22.72% women consulted others, In (25-29) years group women 44.16 women made their own decisions, 30.38% women consulted their husbands, and 25.0% women consulted others, In (30-34) years group women 13.41% women made their own decision and 86.58% women consulted their husbands, In (35-39) years group of women, 62.57% women made her own decision, and 37.42% women consulted their husbands, In (40-44) years group women, 50% women made their own decision, (48.48%) women consulted their husbands and only 1.51% women consulted their in laws, In (45-49) years group women, 4.51% women made their own decisions, 82.25% women consulted their husbands, and only 3.22% women consulted her in laws, for decision to take for family planning.

In the present study it was observed that mostly it would be the husbands who would be the decision makers for family planning. And as the age increased the women would also make decisions.

XI: IMPACT OF LITERACY ON UTILIZATION OF GENERAL HEALTH PROBLEMS

Table No (XXXV): Decision makers for general health problems

In the present study decision making with respect to education was as follows, in illiterates 7.1% women made their own decisions, 17% women consulted their husbands, 1.5% women consulted their in laws, and no women consulted others. In primary school educated group women 9% women made their own decisions, 33.7% women consulted their husbands, and 1% women consulted their in laws, In high

school educated group women 4.5% women made their own decisions, 22.5% women consulted their husbands, and .5% women consulted their in laws, In higher secondary educated group women 0.4% women made their own decision 2.5% women consulted their husbands, and 1 women consulted their in laws, and no women consulted others for decision to take treatment for general health problems.

XII IMPACT OF LITERACY ON UTILIZATION OF OBSTETRICS CARE

Table No (XXXVI): Decision makers for obstetrics care

In the present study decision making with respect to education was as follows, in illiterates 23.4% women made their own decisions, 1.7% women consulted their husbands, 0.1% women consulted their in laws, and 0.1% women consulted others. In primary school educated group women 17% women made their own decisions, 22% women consulted their husbands, 2.7% women consulted their in laws and 1.7% women consulted others, In high school educated group women 9.6% women made their own decisions, 17% women consulted their husbands, 0.25% women consulted their in laws and 0.4% women consulted others, In higher secondary educated group women 1.4% women made their own decision 1.7% women consulted their husbands, and no women consulted their in laws, and no women consulted others for decision to take treatment for obstetrics care.

In a similar study conducted by the Center for Development Studies, Thiruvananthapuram, India in 2000, it was found that women's literacy is an important predictor for the use of maternal health care services in all three states of Kerala, Karnataka and Andhra Pradesh. Illiterate women are less likely to use maternal health care services for delivery assistance and place of delivery compared to literate women in all the three states.[30]

XIII: IMPACT OF LITERACY ON UTILIZATION OF GYNECOLOGICAL PROBLEMS

Table No (XXXVII): Decision makers for gynecological problems

In the present study decision making with respect to education was as follows, in illiterates 23.5% women made their own decisions, 0.13% woman consulted their husbands, 1.8% women consulted their in laws, and 0.13% woman consulted others. In primary school educated group women 13.5% women made their own decisions, 7.25% women consulted their husbands, and 20% women consulted their in laws, and 2.9% women consulted others. In high school educated group women 8% women made their own decisions, 2.5% women consulted their husbands, 16.5% women consulted their in laws, and 0.27% women consulted others. In higher secondary educated group women 1.1% women made their own decision 0.4% women consulted their husbands, and 1.64% women consulted their in laws, and no women consulted others. In degree group women only 0.13% woman made her own decision for treatment of general health problems.

XIV: IMPACT OF LITERACY ON UTILIZATION OF FAMILY PLANNING

Table No (XXXVIII): Decision makers for family planning

In the present study decision making with respect to education was as follows, in illiterates 11.6% women made their own decisions, 13.5% woman consulted their husbands, 0.13% women consulted their in laws, and 0.13% woman consulted others.

In primary school educated group women 14% women made their own decisions, 15.8% women consulted their husbands, 3% women consulted their in laws and 4% women consulted others. In high school educated group women 9% women made their own decisions, 13% women consulted their husbands, 0.7% women consulted their in laws and 3.3% women consulted others. In higher secondary educated group women 0.9% women made their own decision 1.6% women consulted their husbands, and no women consulted their in laws, and 0.13% woman consulted others. In degree group women only 0.13% woman consulted her husband for using of family planning methods.

XV: DECISION MAKING WITH RESPECT TO SOCIO ECONOMIC STATUS FOR GENERAL HEALTH PROBLEMS

Table No (XXXIX): Decision makers for general health problems

In the present study decision making with respect to socio economic status was as follows, in category I, 0.13% woman made her own decisions, 1.3% women consulted their husbands, 0.13% woman consulted her in laws, and no woman consulted others. In category II group women 0.6% women made their own decisions, 4.5% women consulted their husbands, 0.23% women consulted their in laws, and no women consulted others. In Category III group women 1.9% women made their own decisions, 6.3% women consulted their husbands, no women consulted their in laws, and no women consulted others. In Category IV group women 2.7% women made their own decision 10.3% women consulted their husbands, 0.4% women consulted their in laws, and no women consulted others. In Category V group women 15.5% woman made their own decision, 53.5% consulted their husbands, 2.3% women

consulted their in laws and none consulted others for treatment of general health problems.

XVI: DECISION MAKING WITH RESPECT TO SOCIO ECONOMIC STATUS FOR OBSTETRICS CARE

Table No (XXXX): Decision makers for obstetrics care

In the present study decision making with respect to socio economic status was as follows, in category I, 0.5% women made her own decisions, 0.6% women consulted their husbands, 0.27% women consulted her in laws, and no woman consulted others. In category II group women 1.9% women made their own decisions, 1.4% women consulted their husbands, 1.4% women consulted their in laws, and 0.8% women consulted others. In Category III group women 3.3% women made their own decisions, 1.6% women consulted their husbands, 2.9% women consulted their in laws, and 0.4% women consulted others. In Category IV group women 4.3% women made their own decision 2.5% women consulted their husbands, 6% women consulted their in laws, and 0.7% women consulted others. In Category V group women 20% woman made their own decision, 13% consulted their husbands, 34.8% women consulted their in laws and none consulted others for treatment of obstetric care.

XVII: DECISION MAKING WITH RESPECT TO SOCIO ECONOMIC STATUS FOR GYNECOLOGICAL PROBLEMS

Table No (XXXXI): Decision makers for gynecological problems

In the present study decision making with respect to socio economic status was as follows, in category I, 0.13% woman made her own decisions, 1.3% women consulted their husbands, and no women consulted her in laws. In category II group

women 0.62% women made their own decisions, 4.5% women consulted their husbands, and 0.27% women consulted their in laws. In Category III group women 1.9% women made their own decisions, 6.3% women consulted their husbands, and no women consulted their in laws. In Category IV group women 3% women made their own decision 10% women consulted their husbands, and 0.4% women consulted their in laws. In Category V group women 15.5% woman made their own decision, 53.4% consulted their husbands, and 2.3% women consulted their in laws for treatment of gynecological health problems.

XVIII: DECISION MAKING WITH RESPECT TO SOCIO ECONOMIC STATUS FOR FAMILY PLANNING

Table No (XXXXII): Decision makers for family planning problems

In the present study decision making with respect to socio economic status was as follows, in category I, 0.13% woman made her own decisions, 1.3% women consulted their husbands, and no women consulted her in laws. In category II group women 0.7% women made their own decisions, 4.5% women consulted their husbands, and 0.27% women consulted their in laws. In Category III group women 1.9% women made their own decisions, 6.2% women consulted their husbands, and no women consulted their in laws. In Category IV group women 3% women made their own decision 10% women consulted their husbands, and 0.4% women consulted their in laws. In Category V group women 15.5% woman made their own decision, 53.4% consulted their husbands, and 2.3% women consulted their in laws for treatment of gynecological health problems.

XIX: DECISION MAKING WITH RESPECT TO TYPE OF FAMILY FOR GENERAL HEALTH PROBLEMS

Table No (XXXXIII): Decision makers for general health problems

In the present study decision making with respect to the type of family was as follows, 3% women who belonged to the nuclear family made their own decisions, 13.5% women consulted their husbands, and 0.54% women consulted their in laws. In joint family, 18.1% women made their own decisions, 62% women consulted their husbands, and 2.6% women consulted their in laws. And in broken family only 0.27% women took their own decisions for taking treatment for general health problems.

XX: DECISION MAKING WITH RESPECT TO TYPE OF FAMILY FOR OBSTETRICS CARE

Table No (XXXXIV): Decision makers for obstetrics care

In the present study decision making with respect to the type of family was as follows, 7.6% women who belonged to the nuclear family made their own decisions, 3.2% women consulted their husbands, 5.7% women consulted their in laws and 0.27% women consulted others. In joint family women, 22% women made their own decisions, 15.8% women consulted their husbands, 39.6% women consulted their in laws and 5% women consulted others. And in broken family only 0.27% women took their own decisions for taking treatment for obstetrics care.

XXI: DECISION MAKING WITH RESPECT TO TYPE OF FAMILY FOR GYNAECOLOGICAL HEALTH PROBLEMS.

Table No (XXXXV): Decision makers for gynecological health problems.

In the present study decision making with respect to the type of family was as follows, 5.8% women who belonged to the nuclear family made their own decisions, 2% women consulted their husbands, 9% women consulted their in laws and no women consulted others. In joint family women, 40.4% women made their own decisions, 8.3% women consulted their husbands, 30.8% women consulted their in laws and 3.2% women consulted others. And in broken family only 0.27% women took their own decisions for taking treatment for gynecological health problems.

XXII: DECISION MAKING WITH RESPECT TO TYPE OF FAMILY FOR FAMILY PLANNING.

Table No (XXXXVI): Decision makers for family planning.

In the present study decision making with respect to the type of family was as follows, 5.6% women who belonged to the nuclear family made their own decisions, 8.6% women consulted their husbands, 0.4% women consulted their in laws and 2.75% women consulted others. In joint family women, 29.7% women made their own decisions, 35.5% women consulted their husbands, 3.4% women consulted their in laws and 6.7% women consulted others. And in broken family only 0.27% women took their own decisions for taking using of family planning methods.

CONCLUSION

In the present study, the women of reproductive age group residing in PHC/sub center Handignur had a fair knowledge regarding treatment seeking, the availability of health care services and the types of services offered by them.

Most of the women preferred the PHC/ sub center for mostly obstetric care as the new generation was more aware of the health care system. However it was observed that they utilized much of the services offered by the PHC/ sub center for preventive services as it was adequate and free of cost.

For obstetric care they did not hesitate in deciding the choice of place to deliver as Handignur PHC/ sub center is providing all modern facilities, including a baby warmer and a neo natal resuscitation kit.

Door steps services were provided by the health workers uniformly at all the three villages that come under the PHC/ sub center. The frequency of the health visitor to the area was also there for health education.

Antenatal care was provided by health workers and utilized by the women of the PHC/ sub center. Younger women availed the facility more compared to the older generation, who did not have the privilege women of a health facility near their house at the time of their pregnancy.

Women's awareness towards treatment seeking for obstetric care was also found, as compared to the older generation. The importance of attending the ANC clinics, intake of iron and folic acid tablets, and the two doses of tetanus toxoid

injections was also seen. This was due to the regular health education conducted by the doctor, health visitors, ANM's and the anganwadi workers.

The decision maker for general health problems, obstetric care and for family planning was still dependent on their husbands where as for the gynecological problems the majority of women made her own decisions.

As observed the women were more comfortable and satisfied after the public private partnership with Dr Prabhakar Kore's hospital and research center. The women had this feeling that if any complications the ambulance service which was there 24x7 would shift the patient to the higher center.

SUMMARY

The present study was conducted at sub center Handignur under PHC Handignur, Belgaum district. It was a community based cross sectional study for a period of one year form January 2007 to December 2008.

The study participants were all married women of reproductive age group.

The present study revealed that, 22.03% of the women were in the age group of 35-39 years. The literacy rate of the women was found to be 74.4%. The literacy rate of their husbands was found to be 82.4%. Joint family was the commonest being 81.28%. Three-forth of the women belonged to the category V of modified B G Prasad's classification of socio-economic status. All married women of reproductive age had the knowledge of the health facilities available near their homes.

Door steps services were provided to all married women, 88.93% of the study participants said ANM's provided them these services. And all study participants said that services provided were curative, diagnostic, health education, natal services, family planning and immunization. Out of the 732 women for general health problems, 79.09% of the women preferred to go the PHC/ sub-center. The reason that they gave was easy accessibility, as agreed by 99.59%.of women. 92.49% were satisfied by the treatment given. 75.18% of women said their husband's were the decision makers for their general health problems.

For obstetrics care all 732 women preferred going to the PHC/ sub center. 39.34% said they made 1-2 visits for their ANC checkups, and it was also noticed that 21.03% of the women did not make a single visit during the time of their

pregnancy. 78.96% of women had received iron and folic acid tablets during the time of their pregnancy. More than half of study participants told doctor providing it to them. 78.96% had received injection tetanus toxoid during the time of their pregnancy. 78.96% of the women said that other check-up were also done along with it. 66.12% of women preferred the PHC / sub center as a convenient place for getting delivered. 47% preferred the doctors to conduct their deliveries. Three forth of women said their husbands took the decisions concerned to obstetrics care.

43.85% of the women had complaints of dysmenorrhoea. The choice of health facility opted by 80% of women for their gynecological problems was either PHC / sub center. 81.42% women went there because it was near to the house and all necessary and emergency drugs were available and also all facilities were provided.

More than 90% women said they were practicing either temporary or permanent methods or their husbands were using temporary methods of family planning. 61.07% women were using copper T as the method of family planning. 61.07% women said the doctors at the PHC/ sub center helped them in providing family planning services. Around 50% women said their husband’s decided about the family planning.

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I - Q1	I - Q2	I -Q3	I - Q4	I - Q5	I - Q6	I - Q7	I - Q8	II - Q1	II- Q2-1	II- Q2-2	II- Q2-3	II- Q2-4	II - Q3	II - Q4	III - Q1	III- Q2-1	III- Q2-2	III- Q2-3	III- Q2-4	III - Q3	III - Q4	III - Q5	III - Q6	III - Q7	III - Q8	III - Q9-1	III - Q9-2	III - Q9-3	III - Q9-4	III - Q9-5	III - Q9-6	III - Q10	III - Q11	III - Q12	IV – Q1	IV - Q2	IV- Q3	IV - Q4	IV – Q5	IV - Q6	IV - Q7	IV - 8	IV - Q9	V - Q1	V - Q2	V - Q3	V - Q4
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I - Q1	I - Q2	I -Q3	I - Q4	I - Q5	I - Q6	I - Q7	I - Q8	II - Q1	II- Q2-1	II- Q2-2	II- Q2-3	II- Q2-4	II - Q3	II - Q4	III - Q1	III- Q2-1	III- Q2-2	III- Q2-3	III- Q2-4	III - Q3	III - Q4	III - Q5	III - Q6	III - Q7	III - Q8	III - Q9-1	III - Q9-2	III - Q9-3	III - Q9-4	III - Q9-5	III - Q9-6	III - Q10	III - Q11	III - Q12	IV – Q1	IV - Q2	IV- Q3	IV - Q4	IV – Q5	IV - Q6	IV - Q7	IV - 8	IV - Q9	V - Q1	V - Q2	V - Q3	V - Q4
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I - Q1	I - Q2	I -Q3	I - Q4	I - Q5	I - Q6	I - Q7	I - Q8	II - Q1	II- Q2-1	II- Q2-2	II- Q2-3	II- Q2-4	II - Q3	II - Q4	III - Q1	III- Q2-1	III- Q2-2	III- Q2-3	III- Q2-4	III - Q3	III - Q4	III - Q5	III - Q6	III - Q7	III - Q8	III - Q9-1	III - Q9-2	III - Q9-3	III - Q9-4	III - Q9-5	III - Q9-6	III - Q10	III - Q11	III - Q12	IV – Q1	IV - Q2	IV- Q3	IV - Q4	IV – Q5	IV - Q6	IV - Q7	IV - 8	IV - Q9	V - Q1	V - Q2	V - Q3	V - Q4
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I - Q1	I - Q2	I -Q3	I - Q4	I - Q5	I - Q6	I - Q7	I - Q8	II - Q1	II- Q2-1	II- Q2-2	II- Q2-3	II- Q2-4	II - Q3	II - Q4	III - Q1	III- Q2-1	III- Q2-2	III- Q2-3	III- Q2-4	III - Q3	III - Q4	III - Q5	III - Q6	III - Q7	III - Q8	III - Q9-1	III - Q9-2	III - Q9-3	III - Q9-4	III - Q9-5	III - Q9-6	III - Q10	III - Q11	III - Q12	IV – Q1	IV - Q2	IV- Q3	IV - Q4	IV – Q5	IV - Q6	IV - Q7	IV - 8	IV - Q9	V - Q1	V - Q2	V - Q3	V - Q4
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I - Q1	I - Q2	I -Q3	I - Q4	I - Q5	I - Q6	I - Q7	I - Q8	II - Q1	II- Q2-1	II- Q2-2	II- Q2-3	II- Q2-4	II - Q3	II - Q4	III - Q1	III- Q2-1	III- Q2-2	III- Q2-3	III- Q2-4	III - Q3	III - Q4	III - Q5	III - Q6	III - Q7	III - Q8	III - Q9-1	III - Q9-2	III - Q9-3	III - Q9-4	III - Q9-5	III - Q9-6	III - Q10	III - Q11	III - Q12	IV – Q1	IV - Q2	IV- Q3	IV - Q4	IV – Q5	IV - Q6	IV - Q7	IV - 8	IV - Q9	V - Q1	V - Q2	V - Q3	V - Q4
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I - Q1	I - Q2	I -Q3	I - Q4	I - Q5	I - Q6	I - Q7	I - Q8	II - Q1	II- Q2-1	II- Q2-2	II- Q2-3	II- Q2-4	II - Q3	II - Q4	III - Q1	III- Q2-1	III- Q2-2	III- Q2-3	III- Q2-4	III - Q3	III - Q4	III - Q5	III - Q6	III - Q7	III - Q8	III - Q9-1	III - Q9-2	III - Q9-3	III - Q9-4	III - Q9-5	III - Q9-6	III - Q10	III - Q11	III - Q12	IV – Q1	IV - Q2	IV- Q3	IV - Q4	IV – Q5	IV - Q6	IV - Q7	IV - 8	IV - Q9	V - Q1	V - Q2	V - Q3	V - Q4
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I - Q1	I - Q2	I -Q3	I - Q4	I - Q5	I - Q6	I - Q7	I - Q8	II - Q1	II- Q2-1	II- Q2-2	II- Q2-3	II- Q2-4	II - Q3	II - Q4	III - Q1	III- Q2-1	III- Q2-2	III- Q2-3	III- Q2-4	III - Q3	III - Q4	III - Q5	III - Q6	III - Q7	III - Q8	III - Q9-1	III - Q9-2	III - Q9-3	III - Q9-4	III - Q9-5	III - Q9-6	III - Q10	III - Q11	III - Q12	IV – Q1	IV - Q2	IV- Q3	IV - Q4	IV – Q5	IV - Q6	IV - Q7	IV - 8	IV - Q9	V - Q1	V - Q2	V - Q3	V - Q4
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I - Q1	I - Q2	I -Q3	I - Q4	I - Q5	I - Q6	I - Q7	I - Q8	II - Q1	II- Q2-1	II- Q2-2	II- Q2-3	II- Q2-4	II - Q3	II - Q4	III - Q1	III- Q2-1	III- Q2-2	III- Q2-3	III- Q2-4	III - Q3	III - Q4	III - Q5	III - Q6	III - Q7	III - Q8	III - Q9-1	III - Q9-2	III - Q9-3	III - Q9-4	III - Q9-5	III - Q9-6	III - Q10	III - Q11	III - Q12	IV – Q1	IV - Q2	IV- Q3	IV - Q4	IV – Q5	IV - Q6	IV - Q7	IV - 8	IV - Q9	V - Q1	V - Q2	V - Q3	V - Q4
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LIMITATIONS OF THE STUDY

i. Blood test under ANC investigation included only haemoglobin percentage and other investigations like, VDRL and HIV which was done during the PPTCT (Prevention of parent to child transfer) was not included in the study.

ii. The services utilized for some of the problems like abortion and sexually transmitted diseases were not included in the study.

RECOMMENDATIONS

Based on the findings of the present study, the following recommendations are suggested for the improvement of decision making and the improvement of health care services in the rural areas.

i. Increase the frequency of household visits by health workers.

ii. Increase the number of PHC's under the Public Private Partnership so that the quality of services also improves.

iii. Involving and educating more self help groups and Mahila mandals for motivating pregnant women to utilize the health services.

iv. There is a need for imparting health education for these women regarding the RCH services.