

**UTILIZATION OF REPRODUCTIVE HEALTH SERVICES  
ACROSS DIFFERENT SOCIAL SETTINGS OF RURAL  
HARYANA**

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**Abstract**

Reproductive health has become a matter of paramount importance today, both for population control as well as for ensuring survival and good health for women and their offspring. Sociological and Anthropological research on women suggest that, generally, Indian women enjoy little autonomy. Family decisions relating to finances etc. even selection of mates are generally made by men (Jeffrey et al., 1989) Method. To have a comprehensive understanding of the Reproductive and Child Health care a comparative study of two villages in district Rohtak in Haryana, one with relatively high female literacy i.e., village Bainsi and another village with relatively low female literacy rate i.e., Kharak Jatain have been chosen. Married women (total 250) up to the age of 45 years were interviewed as units of investigation.

*Key words: Reproductive Health, Utilization, Rural Health.*

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## **Introduction**

Women in India, and especially those in rural areas, given their general living conditions and the double burden on their shoulders, have never publicly voiced their concern over their reproductive sexual and gynaecological health needs. Women more than men have a raw deal with in each socio-economic stratum because they are discriminated against right from birth. Unequal access to nutrition, health care and education, early marriage, low autonomy in most areas of operation, the social responsibility for bearing or rearing of children, maintaining the household and ensuring family survival, combine with a heavy workload to generate a state of anaemia and poor health for the majority. Another indicator of women's low status and gender inequality is the number of desired children mainly male. There is evidence that son preference and family size are negatively related to women's status (Malhi & Singh, 1995; Mutharayappa et al., 1997; Bhat and Zavier, 2003; Das Gupta et al., 2003; Pande & Astone, 2007).

Reproductive health play a key role in reducing infant and child mortality and morbidity, to lower the fertility rate and to improve the quality of life of people and improvements in the quality of life lead to fertility reduction. Reproductive health has by and large, been equated with family planning. The scope of these programmes should be expanded to include all aspects of women's health. Reproductive Tract Infections are an important reason for the poor acceptance and low continuation rates of contraceptive methods such as IUD. Bhatia and Cleland (1995) found a higher incidence of gynaecological symptoms among women who had undergone tubectomy and yet there is no provision for their management in the family planning programme.

## **Reproductive and Child Health: An Overview**

Reproductive health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its function and processes. Reproductive health care is defined as the consultation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems (United Nations International Conference on Population and Development Programme of Action, Cairo, Sept. 23, 1994).

### **A Reproductive and Child Health Programme Means That:**

- (i) People have the ability to reproduce and regulate their fertility.

- (ii) Women are able to go through pregnancy and child birth safely.
- (iii) The outcome of pregnancy is successful in terms of maternal and infant survival and well being and
- (iv) Couples are able to have sexual relations free from the fear of pregnancy and of contracting disease (Pachauri, 1996).

Safe motherhood and family planning are two vital components of reproductive health. Reproductive Tract Infections (RTIs), Urinary Tract Infections (UTIs), Sexually Transmitted Diseases (STDs), unsafe abortion, genital mutilation are most underlying causes of reproductive ill health of women.

### OBJECTIVES OF THE STUDY

1. To study the reproductive health care of women in terms of prenatal and post-natal care, institutional delivery, immunization across different social settings.
2. To examine the impact of literacy levels of women on the utilization of reproductive health services available in their area.
3. To study the contraceptive awareness and practice level among women.

### METHODOLOGY

In order to have a comprehensive understanding of the Reproductive and Child Health care a comparative study of two villages in district Rohtak in Haryana, one with relatively high female literacy i.e., village Bainsi and another village with relatively low female literacy rate i.e., Kharak Jatain have been chosen.

In order to collect information, interview schedule was prepared and questions were framed in both open ended and close ended. Qualitative and quantitative data was also taken. The questions were framed in such a way that the respondents could easily understand them. Besides, interview schedule, information was also collected through observation method to make the study more comprehensive. Married women upto the age of 45 years were interviewed as units of investigation. The questions were arranged relating to the ante natal care, post-natal care, delivery, immunization, ideal diet after delivery, gynaecological problems etc. Alongwith

primary information, data was also collected through secondary sources such as anganwadi centers, sub centers, census reports, NFHS surveys reports, Human Development reports, Patwari record, information from block development office, district family welfare department etc.

## FINDINGS AND CONCLUSION

The study was an attempt to examine the socio-economic background of the respondents, reproductive health care in terms of ante-natal, post-natal care, and institutional/home delivery. Impact of literacy levels of women on the utilization of reproductive health services as well as contraceptive awareness and practice level among women have also been studied.

The data revealed that majority of the respondents belonged to upper castes in both the villages. Regarding the land holding in village Bainsi nearly half (48.8 percent) of the respondents were landless whereas in village Kharak Jatain one fifth (20.8 percent) of the respondents were landless. There is a distinctive difference and distressing figure that in village Bainsi the numbers of landless respondents were more than double of the respondents from village Kharak Jatain. Majority of the respondents i.e. 48.8 percent had 1 to 2 children in village Bainsi whereas in village Kharak Jatain more than half (61.6 percent) of the respondents had 3 to 4 children.

Regarding family structure in village Kharak Jatain joint families were more than double (54.4 percent) of the number of joint families in village Bainsi. There was a sharp contrast in terms of educational levels of the respondents. In village Bainsi the educational levels of the respondents were quite high as compared to educational levels of the respondents of village Kharak Jatain. In village Kharak Jatain more than half (55.2 percent) of the respondents were illiterate. Majority (37.6 percent) of the husbands of the respondents in village Bainsi had studied either primary or middle level whereas in village Kharak Jatain who had studied upto middle level were 35.2 percent.

It is interesting to note that in agricultural work the number of respondents in village Kharak Jatain were more than double (46.4 percent) of the respondents from village Bainsi while a significant number (13.6 percent) in village Bainsi and 6.4 percent of the respondents in village Kharak Jatain were teachers and self employed. As regards the respondents husband's

occupation more than one fourth (25.6 percent) in village Bainsi and more than half (54.4 percent) in village Kharak Jatain were engaged in agriculture.

Regarding the monthly income of the households of the respondents, a large majority (76 percent) of the respondents were found in the income category of Rs.5001 to 10000 and above, whereas those respondents who had monthly income between Rs.5001 to 10000 and above were 61.6 percent in village Kharak Jatain sector or self employed.

As regards age intervals, majority of the respondents in village Bainsi were in the age group of 25 to 29 years whereas in village Kharak Jatain majority of the respondents were in the age group of 20 to 24 years. Regarding, age at marriage majority of the respondents i.e. 44.8 percent were married between the age of 18 to 20 years in village Bainsi, whereas in village Kharak Jatain the percentage was 59.2 percent who got married between the age of 18 to 20 years. It is disturbing to note that in village Kharak Jatain 17.6 percent of women got married below 18 years of age and the corresponding percentage for village Bainsi is 12.8 percent. It is also revealed that the number of respondents married above 23 years of age was higher (17.6 percent) in village Bainsi than the number (7.2 percent) of women respondents who married above 23 years of age in village Kharak Jatain.

Regarding the ante-natal check-ups of respondents during their last pregnancy, it was found that in village Bainsi respondents had 3 or more ante-natal check-ups, nearly double (38.4 percent) than their counterparts in village Kharak Jatain (20 percent). Similarly, in the category of 'no. ante-natal check-ups' the percentage of respondents in village Kharak Jatain was much higher than that of village Bainsi. Respondents who received first ante-natal check-up during the first trimester of their pregnancy was quite high i.e. 60 percent in village Bainsi which is significant. On the other hand the percentage of respondents who received the very first ante-natal check-up during the 3<sup>rd</sup> trimester was double in village Kharak Jatain to the percentage in village Bainsi. There are different sources of ante-natal check-up services with respect to respondent's last pregnancy. Majority of the respondents i.e. 58.8 percent from village Bainsi and 76.2 percent from village Kharak Jatain received ante-natal check-up services from sub-center in the respective villages. The percentage of respondents from village Bainsi who took ante-natal check-up services from government/private nursing homes was significantly higher than that of village Kharak Jatain. The majority of the respondents i.e. 73.3 percent from village Bainsi and 72.4 percent from village Kharak Jatain did not consider it necessary. It is surprising



that 8.9 percent of the respondents in village Bainsi and 12.1 percent of the respondents in village Kharak Jatain had no knowledge about ante-natal check-ups. Only those women respondents, who went for ante-natal check-ups were vaccinated against tetanus toxoid and were given iron folic acid tablets. However, the intake of supplements was found to be poor in both the villages. Some women believed that tablets might harm the foetus while others discontinued the consumption after facing side effects.

Regarding health problems faced by respondents during their last pregnancy, it was found that as high as 56 percent of the respondents from village Bainsi and 68.8 percent from village Kharak Jatain suffered from one or the other health problems during their last pregnancy. With regard to the nature of health problems majority of them suffered from weakness i.e. 49.6 percent in village Bainsi and 58.4 percent in village Kharak Jatain. Comparative analysis of the two villages showed that health problems faced by respondents during their last pregnancy was found more severe among the respondents of village Kharak Jatain in comparison to village Bainsi. Among the women who suffered from one or the other health problem during their last pregnancy 27.2 percent of the respondents from village Bainsi and 26.8 percent from village Kharak Jatain did not seek any treatment. The number of respondents who took treatment from government/private doctors were almost double in village Bainsi than village Kharak Jatain.

The study revealed that the percentage of institutional deliveries were found to be very low, just above 30 percent in village Bainsi and 21.6 percent in village Kharak Jatain. Majority of the births i.e. 69.6 percent in village Bainsi and 78.4 percent in village Kharak Jatain took place at home. This has serious implications for the reproductive health of women. Among the births that took place in medical set ups the preference had been shown for government hospitals by respondents of both the villages. There were limited health facilities in villages for institutional deliveries. The government hospitals are far off and private services unaffordable. Therefore, women, prefer to deliver at home. As regards the assistance during last pregnancy, majority of the respondents i.e. 64.8 percent from village Bainsi and 76 percent from village Kharak Jatain got assistance from dai. The percentage of the respondents who sought the assistance of dais was much higher in village Kharak Jatain. In village Bainsi significant number of deliveries were attended by gynaecologist.

Regarding taking rest after delivery, it was found that majority of the respondents from both the villages took rest for 11 to 20 days after their last delivery. Some respondents took rest only for 10 days due to pressing domestic needs.

It was observed that prevalence of gynaecological health problems among women were as many as 65.6 percent of the respondents from village Bainsi and 70.4 percent from village Kharak Jatain reported having suffered from at least one or more gynaecological health problems. Treatment seeking with regard to gynaecological health problem was found to be very poor in both the villages. There was a tendency among women to bear the problem silently without seeking advice or treatment. They tend to consider these problems as normal unless the problem becomes acute. Sense of shame and fear also prevented them from seeking timely medication. As a result it was found that 35.4 percent of the respondents from village Bainsi and 53.4 percent from village Kharak Jatain did not seek treatment. The treatment seeking behaviour was found among 64.6 percent of respondents in village Bainsi which was comparatively higher than 46.6 percent in village Kharak Jatain who received treatment from different sources. The majority of the respondents from both the villages received treatment from ANM working in the local health centre.

Regarding knowledge and practice of family planning methods, it was found that in both the villages all the women respondents were aware about the various methods of family planning. In both the villages, 90 percent of the respondents were using one or the other family planning method and 10 percent were not using any method at all. Regarding ideal number of children in the family majority of the respondents i.e. 41.6 percent from village Bainsi and 47.2 percent from village Kharak Jatain were in favour of two sons and one daughter to make ideal size of the family. None of the respondents was of the opinion that family is complete with daughter only. All the respondents from both the villages desired to have at least one male child in the family. It is evident that no one plans or limits the family with daughter. On being questioned why sons are preferred in the family, almost all of them had firm belief that sons propagate one's lineage. It was also felt that sons in the family contribute to the family income.

**Distribution of the respondents according to their education and ante-natal check-ups during their last pregnancy**

| Educational Level                                | Number of Ante-Natal Check-ups |              |              |              |                       |              |              |              |
|--|--------------------------------|--------------|--------------|--------------|-----------------------|--------------|--------------|--------------|
|  | Village Bainsi                 |              |              |              | Village Kharak Jatain |              |              |              |
|  | 0                              | 1-2          | 3 & above    | Total        | 0                     | 1-2          | 3 & above    | Total        |
| Illiterate                                       | 17<br>(37.8)                   | 2<br>(6.25)  | 1<br>(2.1)   | 20<br>(16.0) | 43<br>(74.1)          | 24<br>(57.1) | 2<br>(8.0)   | 69<br>(55.2) |
| Primary  | 11<br>(24.5)                   | 8<br>(25.0)  | 5<br>(10.4)  | 24<br>(19.2) | 9<br>(15.6)           | 17<br>(16.7) | 2<br>(8.0)   | 18<br>(14.4) |
| Middle   | 9<br>(20.0)                    | 6<br>(18.75) | 11<br>(22.9) | 26<br>(20.8) | 2<br>(3.4)            | 3<br>(7.1)   | 4<br>(16.0)  | 9<br>(7.2)   |
| Matric/10+2                                      | 6<br>(13.3)                    | 12<br>(37.5) | 17<br>(35.5) | 35<br>(28.0) | 3<br>(5.1)            | 6<br>(14.3)  | 11<br>(44.0) | 20<br>(16.0) |
| Graduate, Post-Graduate and Professional Courses | 2<br>(4.4)                     | 4<br>(12.5)  | 14<br>(29.1) | 20<br>(16.0) | 1<br>(1.8)            | 2<br>(4.8)   | 6<br>(24.0)  | 9<br>(7.2)   |
| Total  | 45<br>(100)                    | 32<br>(100)  | 48<br>(100)  | 125<br>(100) | 58<br>(100)           | 42<br>(100)  | 25<br>(100)  | 125<br>(100) |

Brackets indicate percentage

**Distribution of the respondents according to their caste and receiving ante-natal check-up during their last pregnancy**

| Castes           | Number of Ante-Natal check-ups |               |              |              |                       |              |              |              |
|------------------|--------------------------------|---------------|--------------|--------------|-----------------------|--------------|--------------|--------------|
|                  | Village Bainsi                 |               |              |              | Village Kharak Jatain |              |              |              |
|                  | 0                              | 1-2           | 3 & above    | Total        | 0                     | 1-2          | 3 & above    | Total        |
| Upper Castes     | 16<br>(35.5)                   | 12<br>(37.5)  | 28<br>(58.3) | 56<br>(44.8) | 29<br>(50.0)          | 31<br>(66.7) | 19<br>(76.0) | 79<br>(63.2) |
| Backward Castes  | 7<br>(15.6)                    | 10<br>(31.25) | 13<br>(27.1) | 30<br>(24.0) | 7<br>(12.1)           | 8<br>(19.1)  | 4<br>(16.0)  | 19<br>(15.2) |
| Scheduled Castes | 22<br>(48.9)                   | 10<br>(31.25) | 7<br>(14.6)  | 39<br>(31.2) | 22<br>(37.9)          | 3<br>(7.14)  | 2<br>(8.0)   | 27<br>(21.6) |
| Total            | 45<br>(100)                    | 32<br>(100)   | 48<br>(100)  | 125<br>(100) | 58<br>(100)           | 42<br>(100)  | 25<br>(100)  | 125<br>(100) |

Brackets indicate percentage



**Distribution of the respondents according to their education and adoption of different family planning methods**

| Educational level                                | Adoption of Different Family Planning Method |             |             |              |             |              |                       |              |              |             |             |              |
|--|--|-------------|-------------|--------------|-------------|--------------|-----------------------|--------------|--------------|-------------|-------------|--------------|
|  | Village Bainsi                               |             |             |              |             |              | Village Kharak Jatain |              |              |             |             |              |
|  | Tube-ctomy                                   | Cooper T.   | Oral Pills  | Condom       | None        | Total        | Tube-ctomy            | Cooper T.    | Oral Pills   | Condom      | None        | Total        |
| Illiterate                                       | 14<br>(29.8)                                 | 2<br>(10.0) | 1<br>(6.7)  | -            | 3<br>(21.5) | 20<br>(16.0) | 39<br>(66.1)          | 15<br>(46.9) | 9<br>(56.25) | 1<br>(14.2) | 5<br>(45.5) | 69<br>(55.2) |
| Primary  | 17<br>(36.1)                                 | -           | 3<br>(20.0) | -            | 4<br>(28.6) | 24<br>(19.2) | 10<br>(16.9)          | 2<br>(6.2)   | 4<br>(25.0)  | -           | 2<br>(18.1) | 18<br>(14.4) |
| Middle   | 8<br>(17.1)                                  | 7<br>(35.0) | 6<br>(40.0) | 1<br>(35.0)  | 4<br>(28.6) | 26<br>(20.8) | 2<br>(3.4)            | 3<br>(9.4)   | 2<br>(12.5)  | 1<br>(14.3) | 1<br>(9.1)  | 9<br>(7.2)   |
| Matric/10+2                                      | 6<br>(12.8)                                  | 6<br>(30.0) | 5<br>(33.3) | 16<br>(55.1) | 2<br>(14.2) | 35<br>(28.0) | 7<br>(11.9)           | 8<br>(25.0)  | -            | 2<br>(28.6) | 3<br>(27.3) | 20<br>(16.0) |
| Graduate, Post-Graduate and Professional Courses | 2<br>(4.2)                                   | 5<br>(25.0) | -           | 12<br>(41.4) | 1<br>(7.1)  | 20<br>(16.0) | 1<br>(1.7)            | 4<br>(12.5)  | 1<br>(6.25)  | 3<br>(42.9) | -           | 9<br>(7.2)   |
| Total  | 47<br>(100)                                  | 20<br>(100) | 15<br>(100) | 29<br>(100)  | 14<br>(100) | 125<br>(100) | 59<br>(100)           | 32<br>(100)  | 16<br>(100)  | 7<br>(100)  | 11<br>(100) | 125<br>(100) |

Brackets indicate percentage

There is a significant association between educational level of the respondents and the number of children. With the increase in the educational level there was decrease in the number of children. Similarly there is a strong relationship between the castes of the respondents and number of children they have. Upper caste respondent in both the villages had one or two children in the family. In backward castes and scheduled caste there were some respondents who had 5 or more children. The higher level of education of the respondents had facilitated them for more number of ante-natal check-up. Most of the respondents with high level of education adopted spacing methods of family planning whereas majority of the illiterate respondents and with education upto primary level had adopted permanent method of family planning. It was found that the upper caste respondents in both the villages had received more ante-natal check-ups in comparison to the scheduled castes.

The findings of the study thus indicate that the percentage of women receiving ante-natal check-up is higher in respect of upper castes respondents who had acquired higher education.

The study shows that most of the respondents had suffered from different health problems during their last pregnancy. The treatment-seeking-behaviour towards these problems is deplorable. Lack of awareness about health problems and the consequent seriousness for the well being of mother and foetus is common cause. Regarding the sources of treatment for health problems it was observed that ANM in the health sub centre is easily accessible. A very large majority of the respondents from both the villages had arranged delivery at home assisted by Dai. The number of institutionalized deliveries is very low which is far from satisfactory. Regarding reproductive/ gynaecological health problems the situation is very precarious where nearly 9 out of 10 respondents are facing different types of gynaecological health problems. It is a shocking observation that nearly half of the respondents did not seek any treatment. Family planning methods are mostly adopted/used by females. Women are convinced/pressurized to adopt different family planning methods. Son preference in the family is widely spread in both the villages.

On the basis of our findings, the following implications may be drawn for enhancing reproductive care service utilization. The reason behind not suckling ante-natal check-up suggest the need to inform mothers and families about the availability and benefits of ante-natal check-ups to help overcome the traditional attitudes and the other hurdles that prevent them from availing of this opportunity. Therefore, attempts should be made to reach out to the mothers through regular home visits, so that more women can utilize the benefits of ante-natal services. It is also necessary to make the women aware about the advantages of Iron folic acid tablets so that they do not discontinue them. There are limited facilities to ensure that 100 percent deliveries take place in institutions, an attempt should be made to .have trained birth attendants so that, deliveries are more safe. The health service providers should be accessible, affordable, accountable alongwith effective and reliable primary health care.

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