UTILISATION OF HEALTH SERVICES BY RURAL WOMEN IN COIMBATORE DISTRICT

By

JANSI RANI, R.

A THESIS SUBMITTED TO THE AVINASHILINGAM INSTITUTE FOR HOME SCIENCE AND HIGHER EDUCATION FOR WOMEN (DEEMED UNIVERSITY) COIMBATORE-641 043, IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF SCIENCE

IN HOME SCIENCE EXTENSION EDUCATION

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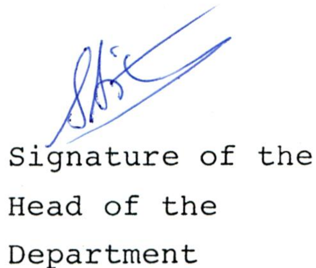
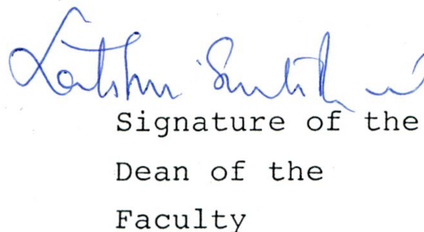
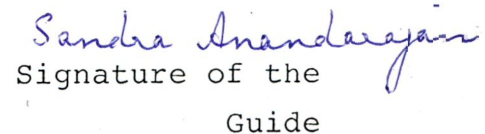
CERTIFIED AS BONAFIDE RESEARCH WORK







Signature of the Head of the Department	Signature of the Dean of the Faculty	Signature of the Guide

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APPENDIX

AN INTERVIEW SCHEDULE TO ELICIT INFORMATION ON "UTILISATION OF HEALTH SERVICES BY RURAL WOMEN" IN COIMBATORE DISTRICT

INTRODUCTION

I INTRODUCTION

> Health is not luck or chance but must be worked for every day of one's life
>
> - Smt. Indira Gandhi

The word 'Health' as a means of referring to the quality of soundness and wholeness of body in a very broad sense. 'Health' was a condition of being hale, that is safe and sound. A physician defines "Health as normal functioning of the body organs and systems". "Health is that state in which the individual is able to mobilize at his intellectual, emotional and physical - for optimum daily living".

India became Independent in 1947 and adopted the new concept of 'Welfare State' with the cherished goal of improvement of the quality of life of its people. Without the development of the health of the people, this dream shall remain unfulfilled (Singh and Kundu 1988)

The constitution of India envisages the establishment of a new social order based on equality, freedom, justice and the dignity of the individual. Hence the significance is attached to promoting the medical health care facilities in the cities, slums, the villages and

remote tribal areas. The health of the mother and the children has been receiving our special attention (Rohatgi, 1983)

The directive principles of State policy of the Indian Constitution mentions "the state shall regard the raising of the level of nutrition and the standard of living of its people and improvement of public health as among its primary duties (Partharasarathy, 1992). The constitution of the World Health Organisation says "enjoyment of the highest of health is one of the fundamental rights of every human beings without distinction of race, religion, political belief, economic and social condition (Rao, 1986).

The vital aspect of health did not receive proper care and attention during the pre-independence period as the British Rulers were concerned more with the expansion, consolidation and concentration of their rule, rather than to attend to the alarming, awful and pressing insanitary, unhygienic and unhealthy conditions rampant in the country as a whole. Negligence of these (susceptible) areas, absence of medical and health services, and large-scale prevalence of poverty and ignorance, created conditions conducive for breeding and spreading of all types of diseases among the Indian masses (Rameshwaram, 1989).

As soon as the country became independent in 1947, Ministry of Health were established at the centre and in the

States. The Government was immediately confronted with the bur-den of improving health of the people. At the time of independence in 1947, health services in India were rudimentary, comprising a few dispensaries in rural and urban areas supposed by sub-divisional and district hospital. Even the latter were ill-equipped and poorly staffed. Communicable diseases like smallpox, cholera, plague, malaria used to occur in epidemic form taking a heavy toll of life and bringing untold misery (Tiwari, 1992).

It is noteworthy that is those days the committee emphasized that, "The provision of adequate protection to all, covering both its curative and preventive aspects, irrespective of their ability to pay for it, the improvement of nutritional standards qualitatively and quantitatively, the elimination of unemployment, the provision of living minimum wage for all workers and improvement in agricultural and industrial production and in means of communication, particularly in the rural areas, are all facts of a single problem and call for urgent attention. In the meantime in 1948, India joined World Health Organization as a member state and employees State Insurance (ESI) Act was passed.

In 1950, as soon as the constitution of India came into force, the Planning Commission was setup which started drafting country's First Five Year Plan. Wherein Health Planning was an integral part of overall socio-economic developmental planning for the whole country.

Health is the most basic and primary need of an individual which makes the nation progress in socio-economic, scientific, literacy and cultural spheres. Health is both an input and output and is linked with development and therefore it should not be viewed in isolation from the overall goals of development. In assessing the country's resources for economic development, the health of the people is reckoned as an important factor. A healthy individual is an asset to a community, while a sick person is a liability (Rameswaram, 1989).

The chief focus is an achievement of the goal of 'Health for all by 2000 A.D' through the universal provision of primary health care and through the implementation of the National population policy, the National Health Policy and the National medical and Health Education Policy. The objective of Health services is to attain the goal of available resources and with the active participation of community. Health care delivery helps to provide health care services (WHO, 1987).

Health services should combat maternal mortality and morbidity by providing primary care in the village, dispensary and health centre, together with essential obstetric functions at the first referral level. Primary care in the family and community involves: pre-natal screening, screening for high risk; primary and secondary prevention of certain conditions, treating such conditions as anaemia before they become so

serious as to threaten safe childbirth, health education; couns-elling; and domiciliary delivery by trained persons for women who desire it and who are not at high risk (Kwast, 1991).

Primary health care has been defined as an essential health care, based on practical, scientifically sound and socially acceptable methods and technology made universally available to families and individuals in the community, through their full participation and at a cost that the community and country can offord to maintain at every stage of their development, in the spirit of self-reliance and self-determination.

Health services should be accessible to all sections of the society with special attention to the needy and vulnerable groups. In 1977, the government of India launched a Rural Health Scheme, based on the principle of "placing people's health in people's hand". Health services should be comprehensive, accessible, acceptable and provide scope for community participation. The health planners in India have visualised the complex of primary health centre and the sub-centres as the proper infrastructure to provide basic health services to the rural population (Park and Park, 1987).

The term "Maternal and child health", refers to the promotive, preventive, curative, family planning, immunization, nutrition, health education and rehabilitative health care for

mothers and children. It is the integrated health care given from the time of conception till the child reaches 15 years or attains adolescence. The overall aim of integrated maternal and child health services is to reduce the morbidity and mortality among pregnant women, infants and pre-school children (Rural Health and Family Welfare Trust and Bhasin, 1985).

Health depends upon the health consciousness of the people, economic conditions, availability of health services and the way of living. If people do not make use of available health services, they have to face the problems of diseases, resulting to higher morbidity and mortality rates (Arasu, 1988).

Health for All-All for Health means giving people a positive sense of health so that they can make full use of their physical, mental and emotional capacities. This is well understood in India by the planners, administrators, and programme implementers. The theme highlights the goal of 'Health for all by the year 2000' on the one hand and emphasises the fact that we all have individual and collective responsibilities for maintaining health through healthy lifestyle, personal hygiene and maintenance of healthy clean environment and the judicious use of appropriate health technologies locally available (Bhasin, 1988).

In 1952, under the Community Development Programme, one Primary Health Centre with three-sub-centres were planned to be established in one community development block. They were responsible for the medical care, control of communicable diseases, maternal and child health, nutrition, school health, environmental sanitation, health education and collection of vital statistics.

Primary health care is being provided to rural population in the country through a network of 20,531 primary health centres, 1,30,390 sub-centres and over a thousand community health centres by 5.86 lakh trained dais and 4.10 lakh health guides besides a large number of rural dispensaries working under State Governments/Union territory administrations (India, 1991).

Recognising the importance of research in the field of health care, this study was undertaken to find out the "Utilisation of Health Services by Rural Women in Coimbatore District". The objectives of the study are: To

1. Elicit information about the health services available for rural women.
2. Extent of awareness and utilisation of these health services by the rural women.
3. Problems faced in the utilization of these services.

REVIEW OF LITERATURE

II. REVIEW OF LITERATURE

The literature pertaining to this study are reviewed under the following heads:

A. Health Programmes in India

B. National Health Policy

C. Health and Nutrition and

D. Research studies on Health Services in India and abroad

A. HEALTH PROGRAMMES IN INDIA:

India became free and several measures have been undertaken by the Government to improve the health of the people. Prominent among these measures are the National Health Programmes like control/eradication of communicable diseases, improvement of environmental sanitation, nutrition, control of population and rural health. Various International Agencies like World Health Organisation (WHO), United Nations International Children's Fund (UNICEF), World Bank, and also a number of foreign agencies like Swedish International Development Agency (SIDA), Danish International Development Agency (DANIDA), Norwegian Agency for Development (NORAD), and United States Agency for International Development (USAID) have been providing

technical and material assistance in the implementation of these programmes. A brief account of these programmes which are currently in operation is given below:

1. National Malaria Eradication Programme:

In the 1950's Malaria was India's number one health problem. The National Government launched a programme known as the National Malaria Control Programme in 1953 with a view to reduce the incidence of malaria in the country. The programme was upgraded to National Malaria Eradication Programme in 1958.

Malaria can be prevented. People have to take active measures to curtail mosquito breeding, report fever cases and take the full course of treatment (Parthasarathy, 1992).

2. Diarrhoeal Diseases Control Programme:

Diarrhoeal diseases constitute a major cause of mortality and morbidity, especially in children below the age of 5 years. The Government of India in the Ministry of Health and Family Welfare have formulated a National Plan of action to control diarrhoeal diseases under Primary Health Centres. This also includes control of cholera. A key activity in this programme is oral rehydration supplemented by

health education. Every village guide is supplied with 60 packets of oral rehydration salts. They are being utilized at the community level to control dehydration and death in diarrhoea cases. This strategy has proved effective not only in the treatment of cholera, but all diarrhoeal diseases. Health education material like "Home Treatment of Diarrhoea" in regional languages is supplied to all Primary Health Centres for free distribution (Park and Park, 1987).

3. National Filaria Control Programme:

National Filaria Control Programme was launched during 1955. Since June 1978, the operational component of the National Filaria Control Programme has been merged with the urban malaria scheme for maximum utilization of available resources (Kundu, 1988).

4. National Tuberculosis Control Programme:

National Tuberculosis Control Programme has been in operation since 1962. Its Primary objective is to provide tuberculosis case-finding and treatement activities on domiciliary basis through an organised District Tuberculosis Control Programme. Avoiding spitting indiscriminately and seeking medical

assistance if there is persistant cough for a long period, covering the mouth and nose while coughing and sneezing, are some of the preventive steps against the spread of the disease (Parthasarathy, 1992).

5. National Leprosy Control Programme:

National Leprosy Control Programme has been in operation since 1955. It is only after 1980 it has received high priority. The control programme has been redesigned in 1983 as the National Leprosy Eradication Programme (NLEP) with the objective of arresting disease in all the known cases by the turn of the century. One leprosy control unit for every 4.5 lakh population and one urban leprosy centre for every 50,000 population have been established in a phased manner since the inception of control programme in endemic areas (Mittal and Dharmshaktu, 1988).

The old fatalistic slogan "Once a leper always a leper" is being replaced by the promising guiding principle "Leprosy is curable" in the present time (Drabik and Drabik, 1992).

6. National Sexually Transmitted Diseases Control Programme:

The National Sexually Transmitted Diseases Control Programme during the current plan period (i.e.

The Seventh Five Year Plan) operates as a purely central sector scheme with 100% central assistance with an approved outlay of Rs.100.00 lakhs. The strategy has now been focussed on training and teaching, Research, Community education, and epidemiology in the various aspects of Sexually Transmitted Diseases (Bhargava, 1987).

7. National Programme for Prevention of Visual Impairment and Control of Blindness:

The Government of India launched this programme in 1976. In 1982, it was included in the new 20 - Point Programme. The Seventh Five Year Plan's objective is to reduce the overall incidence of blindness to 10 per 1000 by 1990 with potential for future reduction to 5 per 1000 by 2000 A.D. (Park and Park, 1987).

8. National Goitre Control Programme:

National Goitre Control Programme was launched towards the end of the Second Five Year Plan. The National Goitre Control Programme envisages the replacement of edible common salt with iodised salt throughout the country by 1992 as the disease is caused by iodine deficiency (Bhisham Pal, 1992).

9. Expanded Programme on Immunization:

The Expanded Programme on Immunization (EPI) was started by the Government of India in 1978 with the objective of reducing the morbidity and mortality and disabilities due to diphtheria, pertussis, tetanus, poliomyelitis, tuberculosis and typhoid fever by making free vaccination services easily available to all eligible children and pregnant women by 1990. Measles was included in the programme in 1985-86. It was also aimed at achieving self sufficiency in the production of vaccines required for the programme. The programme renamed Universal Immunization Programme in 1985 with more inputs (Srivastava, 1988).

10. National Family Welfare Programme:

The National Family Planning Programme which started in 1951 with a clinical approach was subsequently expanded into a community oriented service programme which provided family planning services as part and parcel of the overall health package of services including maternity, child health and nutrition. By 2000 A.D. the number of eligible couples would rise to 170 millions out of which 60 per cent is proposed to be covered by the programme (Dharia, 1989).

11. National Water Supply and Sanitation Programme:

The National Water Supply and Sanitation Programme occupies a key position in the health programmes of India. It was initiated in 1954 with the object of providing safe water supply and adequate sanitation arrangements for the entire urban and rural population of the country.

India is committed to the goal of the International Drinking Water Supply and Sanitation Decade 1981-1990 i.e. to provide safe drinking water and adequate sanitation for all by 1990 (Park and Park, 1987).

12. Minimum Needs Programme:

The Minimum Needs Programme was first introduced in 1974 to combat poverty and now there are nine components under the revised minimum needs programme, namely elementary education, adult education, rural health, rural water supply, rural roads, rural electrification, housing for landless households, environment and improvement of slums and nutrition programmes (Dak, 1991).

13. Maternal and Child Health Care Programme:

The safe motherhood and child survival programme plays the most important part in family

welfare programmes. The programme ensures effective ante-natal care, safe and asceptic delivery, care of mother and infants for immunization, control of diarrhoeal diseases and acute respiratory infections, nutrition education, and provision of basic medical care.

The integrated programme of mother and child health aims at the welfare of both mother and child. It has also been extended to homes providing special care to pregnant mothers and children requiring immunization (India, 1990).

14. School Health Programme:

School Health Programme of the Primary Health Centre is concerned with child's growth and development of physical, emotional, intellectual and social. A complete health examination must be carried out to every child at the time of admission and reported after five years and before leaving the school (Mehta, 1988).

15. National Mental Health Programme:

The Government of India had launched this programme during the 7th Five Year Plan period (Srivastava, 1988). Mental health care is a part but

not apart from the total health care programme. The increasing complexity of modern life has added a new dimension to this problem.

During the last four decades, the role of mental hospitals which were so far providing custodial care to psychiatric patients, has changed. There is a need that these mental hospitals should now become centres of cure and care through regular out-patient and community extension (Sharma, 1990).

16. National AIDS Control Programme:

To face the emerging threat of AIDS in India, a new programme for control of AIDS with its three major components, namely surveillance, education and information and screening of blood donors was launched in 1989. There are at present 40 surveillance centres for screening persons in the high risk groups. In addition, 28 zonal blood testing centres have been established in metropolitan cities for screening blood donors. AIDS spread can only be stemmed by change in the behaviour of the people, health education is the only vaccine against AIDS spread (Bhisham Pal, 1992).

B. NATIONAL HEALTH POLICY:

The National Health Policy "Attainment of health for all by 2000 A.D." was evolved by the Government of India in the year 1983.

The Policy stressed the need for a decentralised system of health-care delivery with maximum community and individual self-reliance and participation, ensuring adequate nutrition, safe drinking water supply and improving sanitation for all segments of the population. Emphasis is also placed on health education (Issar, 1984).

Provision of health services at the door steps of the people and ensuring the fuller participation of the community in the health development process, co-ordinated approach to tackle the problems related to health such as protected water supply, environmental sanitation and hygiene, nutrition, housing and education have been given adequate attention and top priority (Rameshwaram, 1989).

The following should therefore, be the short-term and long-term goals of the National Health Policy.

Short-Term Goals:

- To eradicate/control communicable diseases in the country;
- To provide adequate infrastructure for primary health care in the rural areas and in urban slums;
- To utilise all available methods for health education and family welfare;
- To utilise knowledge from different systems for providing quick and safe relief from sickness and debility at the cheapest possible cost;
- To reorient medical education in tune with the needs of the community;
- To provide increasing maternal and child health coverage.

Long-Term Goals:

- To improve public health services by setting up a chain of sanitary-cum epidemiological stations;
- To ensure 100 percent coverage of all segments of population with preventive service;
- To create a self-sustaining system of health security so that earnings of the individuals are not affected adversely during periods of illness;
- To impart medical education in a medium which is an integral part of our culture and life-style and thus remove the foreign concepts associated with foreign languages which are major factors inhibiting people from understanding the true and proper roles which medicine plays in the development of a healthy community;

- To utilise available knowledge from the ancient and modern system of medicine in an effort to develop a composite system of medicine, thus obliterating the caste system prevailing in the field of medicine;
- To inculcate a sense of self-reliance and discipline in all segments of population so that all four sides of the health square, namely prevention, promotion, cure and rehabilitation are effectively handled at the local level consistent with the developments in the fields of medicine (Goel, 1981).

TABLE - I

INDIA'S NATIONAL HEALTH POLICY/INDICATORS AND TARGETS TO BE ACHIEVED

S.No.	Indicator		Current Level	Targets		
				1985	1990	2000
(1)	(2)		(3)	(4)	(5)	(6)
1.	Infant mortality rate	Rural	136 1978	122	--	--
		Urban	70 1978	60		
		Total	125 1978	106	87	below 60
	Pre-natal mortality		67 1976			30.35
2.	Crude death rate	Around	14	12	10.4	9.0
3.	Pre-school child (1-5 years) Mortality		24 (76-77)	20-24	15-20	10
4.	Maternal mortality rate		4-5 1976	3-4	2-3	below 2
5.	Life expectancy at birth (Years)	Male	52.6 (76-81)	55.1	57.6	64
		Female	52.6 (76-81)	54.3	57.1	64
6.	Babies with birth weight below 2500 Grams (% age)		50	25	18	10
7.	Crude birth rate	Around	35	31	27.0	21
8.	Effective couple protection (percentage)		23.6 (Mar.'82)	27.0	42.0	60.0
9.	Net reproduction rate (NRR)		1.48 1981	1.34	1.17	1.0
10.	Growth rate (Annual)		2.24 (71-81)	1.90	1.66	1.20
11.	Family size		4.4 1975	3.8	--	2.3
12.	Pregnant mothers receiving ante-natal care (%)		40.50	50.60	60.75	100

-continued

S.No. (1)	Indicator (2)	Current Level (3)	Targets 1985 (4)	Targets 1990 (5)	Targets 2000 (6)
13.	Deliveries by trained birth attendents(%)	30.35	50	80	100
14.	Immunization status (%) coverage				
	TT (for pregnant women)	20	60	100	100
	TT (for school children 10 Years)		40	100	100
	DPT (children below 3 years)	25	70	85	85
	Polio (infants)	85	50	70	85
	BCG (infants)	65	70	80	85
	DT (New school entrants 5-6 years)	20	80	85	85
	Typhoid (New school entrants 5-6 years)	2	70	85	85
15.	Leprosy-percentage of disease arrested cases out of those detected	20	40	60	80
16.	TB percentage of diseases arrested cases out of those detected	50	60	75	90

Source: Statement of National Health Policy,Government of India, Ministry of Health and Family Welfare, New Delhi, (1983).

In order to provide minimum basic health facilities, it was decided by the Health Assembly of the WHO to launch a movement known as 'Health for All by the year 2000 A.D.'.

Ministry of Health and Family Welfare, Government of India convened a National conference to discuss national strategies and action plans and also appointed a working committee which recommended the following:

1. Reduction of infant mortality from the present level of 125 to below 60 by 2000 A.D.
2. To raise the expectation of life at birth from the present level of 52 years to 64 by 2000 A.D.
3. To reduce the crude birth rate from the present level 33 per 1000 population to 21 by 2000 A.D.
4. To reduce crude death rate from the present level of 14 per 1000 population to 9 per 1000 by 2000 A.D.
5. To achieve a net reproduction rate of one by 2000 A.D.
6. To provide potable water to the entire rural population by 1990 (Nagla and Nagla, 1991).

C. HEALTH AND NUTRITION:

The subject of nutrition concerns every human beings and optimal nutrition for all is the corner stone of good health (Krishnaswamy, 1991).

A nutritious diet is the basic component of health. It is of prime importance in the normal growth and development of the body, and also in the maintenance of good health throughout life (Jeelani, 1992).

In the field of nutrition today more emphasis is laid not only on prevention of deficiency diseases but also on prevention of chronic diseases which appear to be related to excesses and imbalances of nutrients in the diet (Raman, 1991).

Healthy people are less likely to become victims of disease than those already weakened by malnutrition. Therefore, first key to good health is better nutrition. Healthy communities and strong nations have always been based on strong and healthy homes, where special attention is paid towards nutrition.

A balanced diet is one which contains the different foods in such quantities and proportions that

our body needs for carbohydrates, proteins, minerals, vitamins and other nutrients are adequately met and small provision is made for extra nutrients to withstand short duration of illness and extra exertion. These nutrients are essential for health and protection of body against diseases. These also provide the body with energy and help build tissues (Srivastava, 1986).

E. RESEARCH STUDIES ON HEALTH SERVICES IN INDIA AND ABROAD:

Malkit Kaur *et al* ., (1991) study on "Utilisation of Health and Family Planning Services Among Rural Women". Where two districts were selected from the state of Haryana, one advanced (Karnal) and the other not so advanced (Bhiwani) in respect of agricultural and socio-economic developemnt. On the whole, 401 respondents were selected for the study. It was found that only 25.7 per cent of the respondents were making use of the modern health services either for pre-natal care or at the time of delivery. All the others (74.3 per cent) were availing the services of the villages midwife at the time of delivery and none of them were consulted in pre-natal period, unless there was a problem. Only 17.7 per cent of the respondents had a high access to modern health

facilities, as they were regularly using these services in the pre-natal period and also unfortunately the health programmes have not benefited them.

Pokarna (1991) conducted a study entitled "Health and Disease: Socio-cultural Dimensions". The study was carried out in Jaipur district of Rajasthan. The study revealed that most of the respondents were of the opinion (68.8 and 68.6 per cent) that good health means absence of illness/sickness/or injury. And also they believed that a healthy person is one who has an ability to perform all the hard physical labour demanded of him.

Kapoor's (1991) study on "Female Literacy and Acceptance of Family Planning" showed that 85 per cent of the female respondents were aware of vasectomy, 95 per cent of tubectomy, 56 per cent of Intra-Uterine Device, 56 per cent of condoms and 59 per cent of oral pills. It was, however, observed that a considerable number of respondents were aware of individual family planning methods improved with the increase in the educational status of wives.

Tamang *et al*., (1990) in their study on "Utilisation of Ante-natal Services" confined to a comparison of the utilisation of health care services particularly during pregnancy by the two groups of women (working and house wives). The findings indicate that a higher proportion of women receiving ante-natal care, particularly a medical check-up, vitamin tablets or two doses of tetanus toxoid were working rather than non-working. Some marginal difference was also observed in case of routine examinations (Urine and blood tests). The two groups differed significantly with respect to ante-natal check-up and in receiving iron and folic acid tablets, but not in case of other ante-natal services. Considering all the parameters of ante-natal care, working women appeared to utilise more ante-natal servics than housewives.

Indian Council of Medical Research (1988) conducted a study entitled "Rural Health Care under-utilised " aimed at analysing the functioning of the primary health centres, was carried out in seven states. An analysis of the findings revealed that a majority of the respondents preferred home for child birth. Thus the access of women to modern health services is very low, reflecting the low status of women.

Ramalingaswami (1987) conducted a study on "Tribal Women and their health problems". The sample consisted of 372 tribal women in 15-45 age group living in Paderu Block of Visakhapatnam district in Andhra Pradesh. Although these women were illiterate and were living in a remote place away from urban influence, they showed awareness about these health programmes. About 50 per cent of the women have liked to have their babies delivered by Auxillairy Nurse midwives and trained dais. However, it was approximately 17 per cent of women who could avail the services of the dais and Auxillary nurse midwives for purposes of delivery, while 40 to 77 per cent were of the opinion that the delivery should be conducted by a dai (mid wife). An important reason for under-utilisation of health services was the lack of inter-personal communication and contacts, between the health functionaries and the health beneficiaries, the study noted.

Gangrade (1987) conducted a study on "Knowledge, attitude and practice of family planning". The sample consisted of 130 heads of families living in joint and nuclear families. This study was undertaken in the village Chhatera of Haryana State. As regards knowledge about family planning programme, it has been

found that 93.8 per cent and 98.4 per cent respondents belonging to joint and nuclear families respectively had some knowledge and ideas about family planning programme. All of them stated that family planning stands for smaller size family and also for happier and better family. The rest had no knowledge about family planning though they had heard about it. It is significant to point out that respondents from younger age groups who have greater education, have more knowledge about family planning than the respondents from higher age groups.

Singh et al., (1987) conducted a study on "Family Planning and Child care in rural tribals of Chotanagpur". The sample comprised of 498 males and 493 females in two tribal rural blocks in Ranchi District. Data on information, attitudes and behaviour in relation to family planning, child care, and breast feeding were collected through personal interviews. The data revealed that there was wide spread ignorance and misconception about these issues. Health, population education, using audio-visual aids, had been suggested as a remedial measure.

Reddy (1986) undertook a Research study on "Accessibility of women to Health, Family Planning and

Educational Services". The data were collected from Andhra Pradesh. The study revealed that the Government does not make any discrimination against women in the provision of health, family planning and educational services. In fact, some special schemes such as Maternal and Child Health Programme and the Integrated Child Development Scheme (ICDS) are being implemented exclusively for women and children. But sometimes because of the distance between the service delivery units and people, more women than men were deprived of their use.

Srinivasan (1984) conducted a study entitled "Health care services in rural Tamil Nadu". Two primary health centre were selected for this purpose. Observation and Interview technique were employed for collection of data. Totally, 125 respondents selected at random from five sample villages, were interviewed through an interview schedule. The study revealed that 65.5 per cent of the respondents had utilised the health care services of the selected health care centres. It was significant to find that the people still preferred the traditional practice of conducting delivery at home. Majority of the respondents had immunized their children. It also revealed that majority of the respondents were not in favour of family welfare programme.

Maine (1982) in their study on "Family Planning Reduces Childbirth Risks". The study carried out in the centre for population and family health, Columbia Unversity, New York. According to estimates, between 40 and 180 women died due to pregnancy or childbirth for every 100,000 children born in most developing countries in the mid-1970s. Most parts of Europe, in comparison, had less than 20 maternal deaths per 100,000 live births. Further estimates reveal that 25 million women in developed countries have complications from third or later births every year.

Khan *et al*., (1981) study on "Health Practices in two states of India", namely Andhra Pradesh and Bihar, to find out perception of people about family planning. The data for the study was gathered by interviewing 797 currently married people randomly selected from the two states. Out of these 797 respondents 397 were taken from Andhra Pradesh and 400 from Bihar. It is surprising to note that as high as 58 per cent of the respondents from Andhra Pradesh and 66 per cent from Bihar said that they generally went to private Allopathic doctors or private hospitals for treatment. Only 32 per cent of the respondents from Andhra Pradesh and 27 per cent from Bihar said that they sought help from government hospital or dispensary.

Malison *et al*., (1987) in their study on "Estimating health services utilisation, immunization coverage and child-hood mortality" attempted to estimate childhood mortality and morbidity and the utilization of health services in Mbale district, Uganda. Interviews were conducted in the 75 households through random cluster survey method nearest to each of 36 existing rural health facilities. High rates of mortality and low levels of utilisation of primary health care services were found despite easy access to the health facilities. The basic primary health care services like immunization and treatment of diarrhoea were poorly utilized even in the homes very close to the health facility available in this district.

METHODOLOGY

III METHODOLOGY

The procedure of the study involves the following aspects:

A. Selection of the Area

B. Selection of the Sample

C. Selection of the Method

D. Collection of the Data

E. Analysis and Interpretation of the Data

A. Selection of the Area:

Coimbatore is situated in the North-Western part of Tamil Nadu, and comprises of 7 Taluks and 21 Blocks. There are 70 primary Health Centres and 468 Health sub-centres catering to the health needs of the rural population. The required data for the study was collected from one Block namely Periyanaickenpalayam. Ten villages of the block were selected based on the distance from the primary Health Centre. Accordingly three villages situated near to the centre (5 KM), four villages located faraway from Primary Health Centre (15 KM) and three villages of an average distance (8 KM) was selected. (Figure-1)

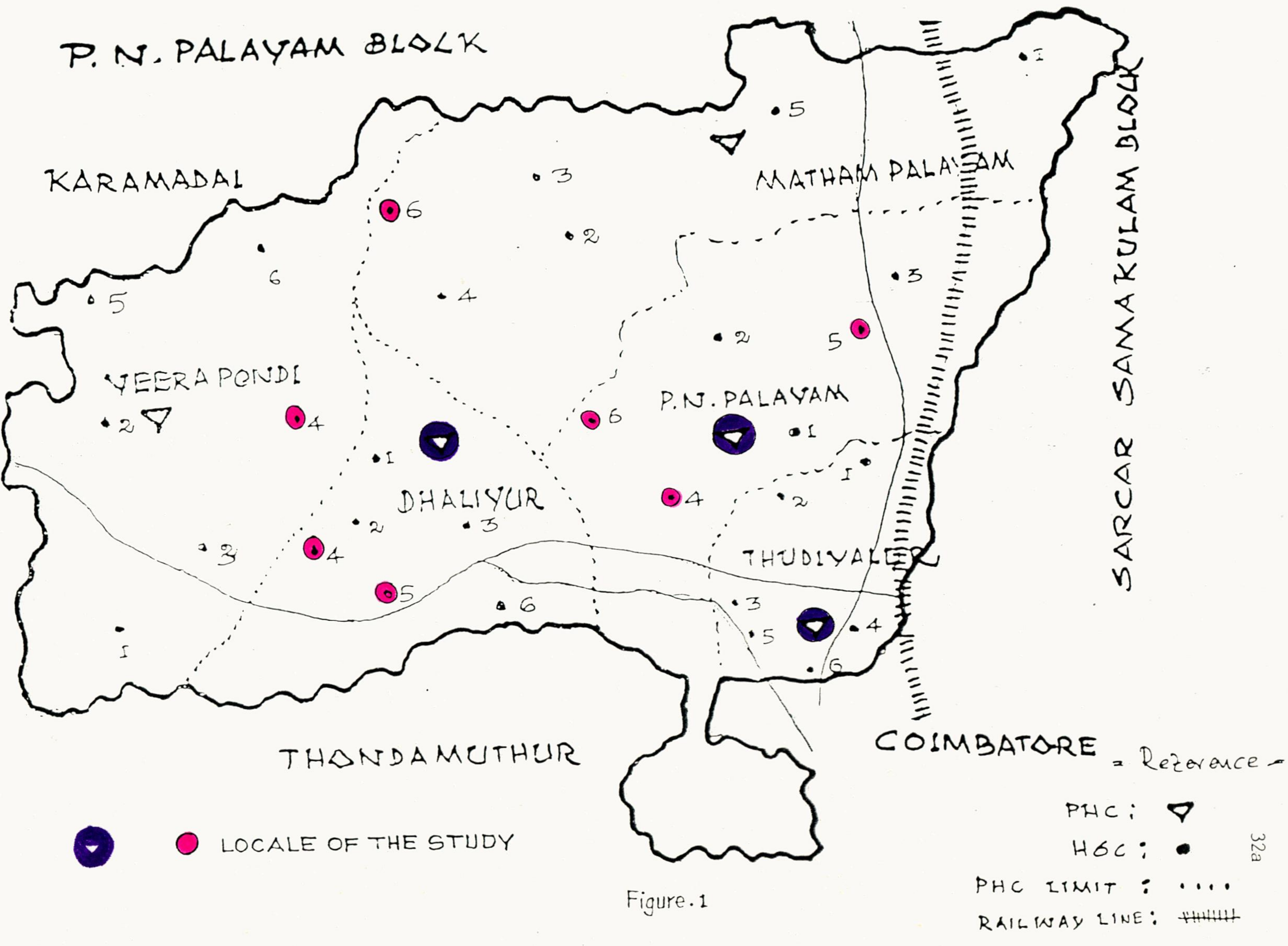


Figure.1

The following are the villages selected for the study:-

Villages Covered

A. Nearer to the Primary Health Centre

1. Periyanaickenpalayam
2. Thudiyalur
3. Narasimmanaickenpalayam

B. Faraway from Primary Health Centre

1. Dhaliyur
2. Chinnathadagam
3. Poochiyur
4. Govanur

C. Average Distance from the Primary Health Centre

1. Samichettipalayam
2. Thirumalainaickenpalayam
3. 4-Veerapandi

B. Selection of the Sample:-

The success of any study depends on the careful selection of the sample.

Sample is that part of the universe which is selected for the purpose of investigation (Gupta, 1988).

A Random Sample is one where every item of the universe has an equal opportunity of being selected in the sample (Gupta, 1991).

For selecting the sample units a source list was collected to compile information about the number of households and total population of the selected villages in Coimbatore, Periyanaickenpalayam block.

Based on the preliminary information 100 samples were randomly selected for this study. The sample belonged to the age group of 20-35 years having one, two and three children. (Figure 2)

C. Selection of the Method:-

The interview method of collecting data involves presentation of oral-verbal stimuli and replay in terms of oral-verbal responses (Kothari, 1990).

A schedule refers to a set of statements and/or questions to be answered by the respondent in a face to face interview, and filled in by the interviewer, or by the respondent in writing (Chaudhari, 1991).

Accordingly an interview schedule was prepared and administered to the selected sample.

FIGURE-2 INTERVIEW IN PROGRESS

A pilot study was carried out in these areas having a sample of 10 respondents. Based on the pilot study the schedule was restructured (Appendix I).

D. <u>Collection of the data:-</u>

Since the investigator was particular on households with one, two and three children, she surveyed the areas and selected the samples accordingly. After establishing rapport the investigator met the respondents and collected the required information.

E. <u>Analysis and Interpretation of the data:-</u>

The collected data were analysed and interpreted under the following heads:

1. Background information of the sample
2. Types of Health Services rendered by the various agencies.
3. Awareness and utilisation about Health Services by the rural women.
4. Problems faced in the utilisation of these services.

RESULTS AND DISCUSSION

IV RESULTS AND DISCUSSION

The results of the study are discussed under the following heads:

A) Background information of the sample

B) Types of health services rendered by the various agencies

C) Awareness and utilisation of health services by the rural women, and

D) Problems faced in the utilisation of these services

A. BACKGROUND INFORMATION OF THE SAMPLE

Background information of the sample is discussed under the following heads: (Figure- 3)

1. Age wise Distribution of the selected sample
2. Educational level of the sample
3. Type of family
4. Religion wise distribution of the sample
5. Income distribution of the family
6. Age at marriage of the selected sample
7. Details about the children born to the selected women

1. Age wise distribution of the selected sample:

Table II indicates the age wise distribution of the selected women.

TABLE - II

AGE WISE DISTRIBUTION OF THE SELECTED SAMPLE

S.No.	Present age	Number	Percentage
1.	20 - 25	47	47
2.	26 - 30	31	31
3.	31 - 35	22	22

It is clear from the above table that majority of the women (47 per cent) belonged to the age group of 20-25 years and 31 per cent belonged to the age group of 26-30 years and 22 per cent belonged to the age group of 31-35 years.

2. Educational level of the sample:

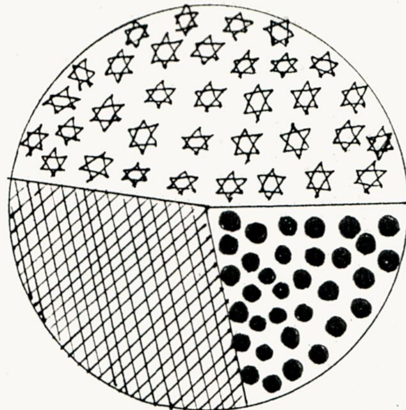
Table II gives the Educational level of the selected women.

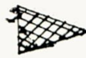
TABLE III

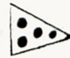
EDUCATIONAL LEVEL OF THE SAMPLE

S.No.	Educational level	Number	Percentage
1.	Illiterate	51	51
2.	Elementary Education	35	35
3.	High School Education	14	14

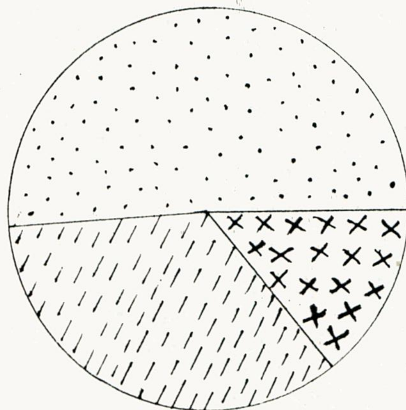
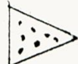
It is disheartening to note that 51 per cent of the selected women were illiterate. Thiry five of them had studied

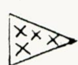


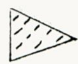




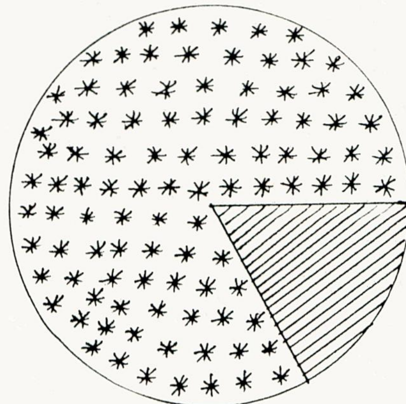
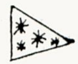
AGE DISTRIBUTION OF THE WOMEN

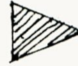







EDUCATIONAL LEVEL OF THE WOMEN.



TYPE OF FAMILY.

Figure·3 . FAMILY BACKGROUND OF THE SAMPLE.

only upto elementary school and the rest (14 per cent) had studied upto high school.

3. Type of Family:

Table IV gives the type of family of the women.

TABLE IV

TYPE OF FAMILY

S.No.	Type of family	Number	Percentage
1.	Joint	17	17
2.	Nuclear	83	83

The modern trend of adopting the nuclear family has sweeped the villages is obvious from the above picture. Only 17 per cent belonged to the traditional joint family, whereas 83 per cent were members of the nuclear family.

4. Religion wise distribution of the sample:

Table V reveals the picture of Religion wise distribution of the selected women.

TABLE V

RELIGION WISE DISTRIBUTION OF THE SAMPLE

S.No.	Religion	Number	Percentage
1.	Hindu	96	96
2.	Christian	2	2
3.	Muslim	2	2

It is very clear from the above table that majority of the women (96 per cent) were Hindus, Christians were only 2 per cent and so also Muslims 2 per cent.

5. Income Distribution of the family:

Table VI illustrates the details about income of the family.

TABLE VI

INCOME DISTRIBUTION

S.No.	Monthly Income	Number	Percentage
1.	100 - 500	20	20
2.	501 - 1000	68	68
3.	1001 - 1500	12	12

It is disheartening to note that only 12 per cent of the families had a monthly income of above Rs.1000/- whereas the majority of them (68 per cent) were within the income range Rs.501/- Rs.1000/-. Twenty of them had a monthly income less than Rs.500/-. This is due to the fact that most of their family members were only agricultural labourers or coolies who had worked on daily wages.

6. Age at marriage of the selected women:

Table VII gives the information of age at marriage of the selected women.

TABLE VII

AGE AT MARRIAGE OF THE SELECTED WOMEN

S.No.	Age at marriage	Number	Percentage
1.	16 - 17	16	16
2.	18 - 19	61	61
3.	20 - 21	23	23

Out of the 100 selected women 61 per cent of them had married at the age range of 18-19 years. It is surprising to note that 16 per cent of them had got married even earlier (16-17). Only 23 of them had married after 20 years of age.

All the respondents were married. Out of which 2 of them were widows whereas the rest 98 per cent were living with their husbands.

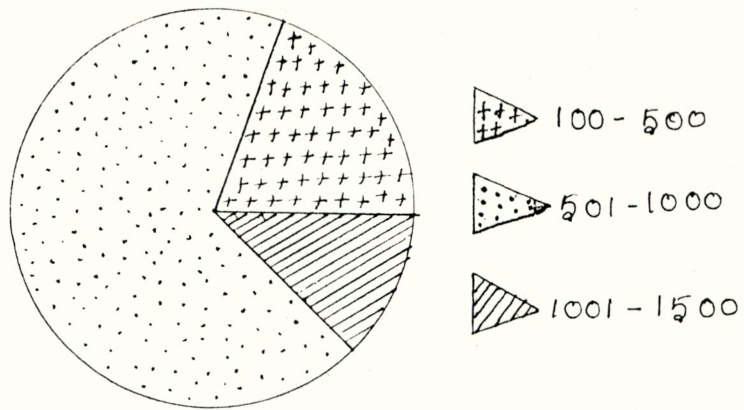
7. Details about the children born to the selected women:

Table VIII indicates the details about the children born to the selected women.

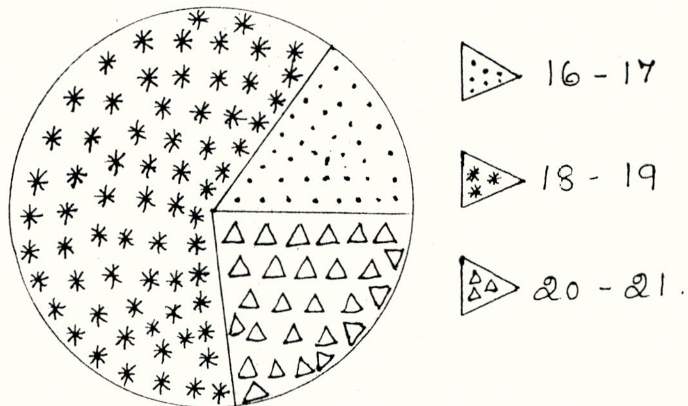
TABLE VIII

DETAILS ABOUT THE CHILDREN BORN TO THE SELECTED WOMEN

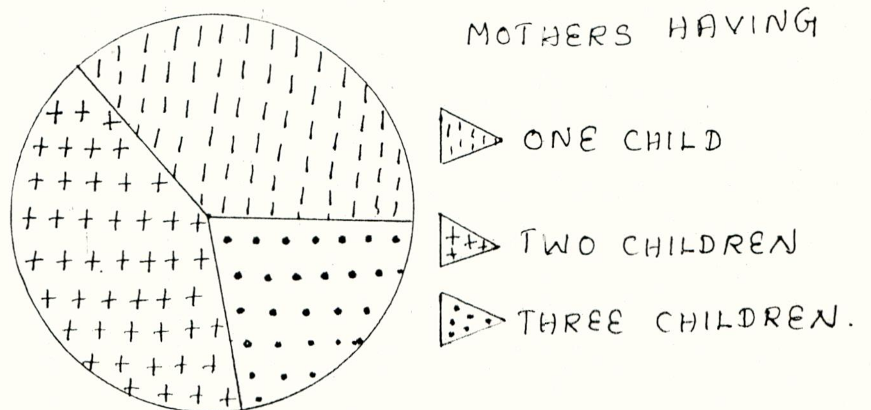
S.No.	Particular	Number	Percentage
	Mothers having		
1.	One child	37	37
2.	Two children	41	41
3.	Three children	22	22



INCOME DISTRIBUTION OF THE FAMILY.



AGE AT MARRIAGE OF THE WOMEN.



CHILDREN BORN TO SELECTED WOMEN.

Figure 3 . FAMILY BACKGROUND OF THE SAMPLE.

This table reveals that out of 100 respondents 37 per cent of women are having only one child, and 41 per cent were having two children and the remaining 22 per cent were having three children.

B. TYPES OF HEALTH SERVICES RENDERED BY THE VARIOUS AGENCIES

Types of health services rendered by the various agencies are discussed on the following lines.

1. Institutions that provide health services in the selected villages
2. Health services rendered by the various agencies

1. Institutions that provide health services in the selected villages:

Table IX illustrates the institutions that provide health services in the selected villages.

TABLE IX

INSTITUTIONS THAT PROVIDE HEALTH SERVICES IN THE SELECTED VILLAGES

S. No.	Village	PHC	Additional PHC	H.SC	Private Hospital (Allopathy)	Private doctor	Ayurvedic (Siddha)	ESI dispensaries
1.	Nearer to the PHC							
	a. Periyanaickenpalayam	1	-	3	7	12	1	1
	b. Thudiyalur	-	1	-	6	8	1	1
	c. Narasimmanaicken palayam	-	-	1	-	1	-	-
2.	Far away from the PHC							
	a. Dhaliyur	-	1	-	-	-	-	-
	b. Chinnathadagam	-	-	1	2	3	-	-
	c. Poochiur	-	-	1	-	1	-	-
	d. Govanur	-	-	1	-	2	-	-
3.	Average distance from the PHC							
	a. Samychettipalayam	-	-	1	-	4	-	-
	b. Thirumalainaicken palayam	-	-	1	1	3	-	-
	c. 4-Veerapandi	-	-	1	-	2	-	-

Out of the ten villages selected for the study, there was only one PHC situated at Periyanaickenpalayam. Two villages namely Thudiyalur and Dhaliyur had additional Primary Health Centre. Rest of the seven villages had only Health Sub-centre. There were sixteen private hospitals out of which 12 were located at Periyanaickenpalayam, 6 at Thudiyalur, 2 at Chinnathadagam, and one at Thirumalainaickenpalayam. There were only 2 Ayurvedic centres and two ESI dispensaries. So all the 10 villages had access to Health centres for their immediate need.

2. HEALTH SERVICES RENDERED BY THE VARIOUS AGENCIES:

Table X explains the Health services rendered by the various agencies.

TABLE X

HEALTH SERVICES RENDERED BY THE VARIOUS AGENCIES

S.No.	Agencies involved		Type of health services	
1.	Primary Health Centre	i.	Ante-natal services	
		ii.	Natal services	
		iii.	Post-natal services	
		iv.	Immunization	
		v.	Family Welfare Services	
		vi.	Other services	
2.	Health sub-centre	i.	Ante-natal services	
		ii.	Natal services	
		iii.	Post-natal services	
		iv.	Immunization	
		v.	Family welfare services	
		vi.	Other services	
3.	Private Hospital	i.	Ante-natal services	
		ii.	Natal-services	
		iii.	Post-natal services	
		iv.	Immunization	
		v.	Family welfare services	
		vi.	Nursing homes	
		vii.	Treatment including surgery	
		viii.	Other services	
4.	Ayurvedic	i.	Preventive measures	
		ii.	Curative measures	for all health problems
		iii.	Treatment	
5.	ESI-Dispensaries	i.	Ante-natal services	
		ii.	Natal-services	
		iii.	Post-natal services	
		iv.	Immunization	
		v.	Family welfare services	Working labourers
		vi.	Other services	

The above table gives a clear picture of the various agencies present in the selected villages and also explains the type of health services provided by the agencies.

C. AWARENESS AND UTILIZATION ABOUT HEALTH SERVICES BY THE RURAL WOMEN:

i) Awareness of Health Services by women

Awareness of health services by the rural women is discussed under the following heads.

1. Awareness of health services
2. Awareness of the various programmes of Ante-natal care
3. Knowledge of women about immunization programme for children
4. Awareness of family welfare services
5. Awareness of health education programmes

1. Awareness of health services:

Table XI illustrates awareness of health services with reference to number of children.

TABLE XI
AWARENESS OF HEALTH SERVICES

S. No.	Aspects	Number of women having one child N:37		Number of women having two children N:41		Number of women having three childre N:22	
		Aware	not aware	Aware	not aware	Aware	not aware
1.	Ante-natal services	37	--	30	11	8	14
2.	Natal services	37	--	41	--	22	--
3.	Post-natal services	37	--	38	3	9	13
4.	Child health services	37	--	35	6	10	11
5.	Family welfare servies	37	--	40	1	20	2

It is remarkable to note from the above table that women having only one child, that is, women who were recently married were well aware of all the health services provided by the Primary Health Centre. The older the women, the lesser knowledge she had about health services. Some of them expressed that during the delivery of their first two children, they were not aware of any health services. During the third pregnancy only the women became aware of the health services. So also women having two children had expressed that they had gained more knowledge during their second pregnancy. Hence women at present were more aware of the health services due to media and also because of the regular visits of the Village Health Nurse (VHN).

The Village Health Nurse and mass media plays a significant role in creating an awareness about the health services available to the mothers and the children.

2. Awareness of the various programmes of ante-natal care:

Table XII indicates awareness in the various Antenatal programmes by women.

TABLE XII

AWARENESS OF VARIOUS ANTENATAL PROGRAMMES

S. No.	Aspects	number of women having one child N:37		number of women having two children N:41		number of women having three children N:22	
		Aware	not aware	Aware	not aware	Aware	not aware
1.	Antenatal registration	37	--	40	1	10	12
2.	Antenatal advice, tests and treatment	37	--	30	11	8	14
3.	Tetanus toxoid and ferrous sulphate tablets	37	--	20	21	0	22
4.	Weight, blood pressure, urine and sugar test	37	--	20	21	0	22

The women who were having only one child were young mothers and were aware of the various programmes of ante-natal care. They had also benefited out of these programmes. 40 per cent of the women having two children were aware of the ante-natal registration, only 30 per cent were aware of ante-natal advice, tests and treatment whereas 11 per cent knew nothing of it.

It was disheartening to note that none of the women having 3 children were aware of the doses of Tetanus Toxoid and intake of ferrous sulphate tablets. None of them were aware of the various tests to be conducted during pregnancy.

3. Knowledge of women about immunization progrmmes for children:

Table XIII depicts the knowledge of women about immunization programme for children.

TABLE XIII

IMMUNIZATION KNOWLEDGE OF WOMEN

S. No.	Aspects	Number of women having one child N:37		Number of women having two children N:41		Number of women having three children N:22	
		Aware	not aware	Aware	not aware	Aware	not aware
1.	Immunization for children	37	--	35	6	10	12
2.	Type of vaccine	37	--	30	11	8	14
3.	Immunization for Children	37	--	20	21	10	12

It is obvious from the above table that the younger the mother, the greater the knowledge, she had on immunization programmes. Women who had delivered the first child were well aware of the programmes. Women who were having two children had gained knowledge during the second pregnancy. Among the mothers who were having three children half of them were aware of the programmes.

4. Awareness of family welfare services:

Table XIV reveals awareness of family welfare services by the selected women.

TABLE XIV

AWARENESS OF FAMILY WELFARE SERVICES

S. No.	Knowledge	Number of women having one child N:37		Number of women having two children N:41		Number Of women having three children N:22	
		Aware	not aware	Aware	not aware	Aware	not aware
1.	Temporary methods	16	21	20	21	--	22
2.	Permanent methods	12	25	20	21	20	2
3.	Spacing methods	--	37	--	41	--	22

It was heartwarming to note that more than half of the selected women (52 per cent) were aware of the permanent methods of population control and 36 per cent were aware of the temporary methods of contraception. But it was discouraging to note that all the women (100 per cent) were not aware of the spacing methods.

5. Awareness of health education classes

Table XV shows the awareness of health education classes by selected women.

TABLE XV
AWARENESS OF HEALTH EDUCATION CLASSES

S.No.	Aspects	Aware	Not aware
1.	Health Education	80	20
	Classes conducted on:		
	i. Nutrition	70	30
	ii. Sanitation	55	45
	iii. Immunization	80	20
	iv. Importance of breast feeding	80	20
	v. Personal hygiene	65	35
	vi. Pre-natal, Natal and Post-natal care	75	25
	vii. Family welfare programme	80	20

It is heartening to note that majority of the women (80 per cent) were aware of the health education classes conducted for them by the Village Health Nurse. The trend was clear that as the years advance, the mothers were becoming aware of nutrition, immunization, importance of breast feeding and per -sonal hygiene. It had been due to the communication dissemination of the various mass media like radio, television, newspaper, magazines and also health infrastructure.

ii) UTILISATION OF HEALTH SERVICES BY WOMEN

Utilisation of Health Services is discussed under the following heads:

1. Utilisation of Ante-natal services
2. Utilisation of Natal services
3. Utilisation of Post-natal services
4. Post-Natal care
5. Utilisation of Immunization programmes for their children
6. Adoption of Family Planning methods
7. Utilisation of other services
8. Utilisation of Health Education Programmes

1. Utilisation of ante-natal services:

Table XVI illustrates the utilisation of ante-natal services by women.

TABLE XVI

UTILISATION OF ANTE-NATAL SERVICES

S. No.	Aspects	Position of the child	Utilisation of services at various Agencies					
			PHC	HSC	Private Hospital	Government Hospital	ESI	Not Utilised
1.	Place of Health Check up during pregnancy	One Child	7	19	6	4	1	--
		Two children	4	21	10	5	0	1
		Three children	2	2	1	4	1	12
2.	Ante-Natal Registration	One Child	7	19	6	4	1	--
		two children	4	21	10	5	0	1
		Three children	2	2	1	4	1	12
3.	Ante-Natal advice, tests and treatment given by	One child	7	19	6	4	1	--
		Two children	4	11	10	5	0	11
		Three children	2	2	1	2	1	14
4.	Tetanus Toxoid and ferrous sulphate tablets given by	One child	7	19	6	4	1	--
		Two children	2	9	6	3	--	21
		Three children	--	--	--	--	--	22
5.	Weight, Blood pressure, Urine and Sugar check-up	One child	7	19	6	4	1	--
		Two children	2	9	6	3	--	21
		Three children	--	--	--	--	--	22

Ante-natal care is the care of the women during pregnancy. The primary aim of ante-natal care is to achieve a healthy mother and a healthy baby.

Out of the 100 mothers chosen for the study only 88 per cent had utilised the services of Primary Health Centre, Health Sub-centre, Private Hospitals, Government Hospitals, ESI for ante-natal care.

The rest 12 per cent had not gone for any ante-natal check-up and registration.

It is clear from the above table that out of 41 mothers who had two children, 73 per cent alone could avail the services and only 27 per cent had not utilised the same. Out of the 22 mothers who had three children, majority (12) of them had not gone to any agency for check-up. 8 of them who had three children had obtained ante-natal services only for the third child, which is a welcoming trend.

All the mothers who had only one child were aware of the importance of taking the 100 tablets of ferrous sulphate and had taken. Whereas only 50 per cent mothers who had two children had taken the iron tablets. Mothers who had three children had not taken due to forgetfulness or vomitting sensation.

The 37 mothers having one child and 41 mothers having two children availed the health check up and 22 mothers who had three children had not availed this facility.(Figure-4)

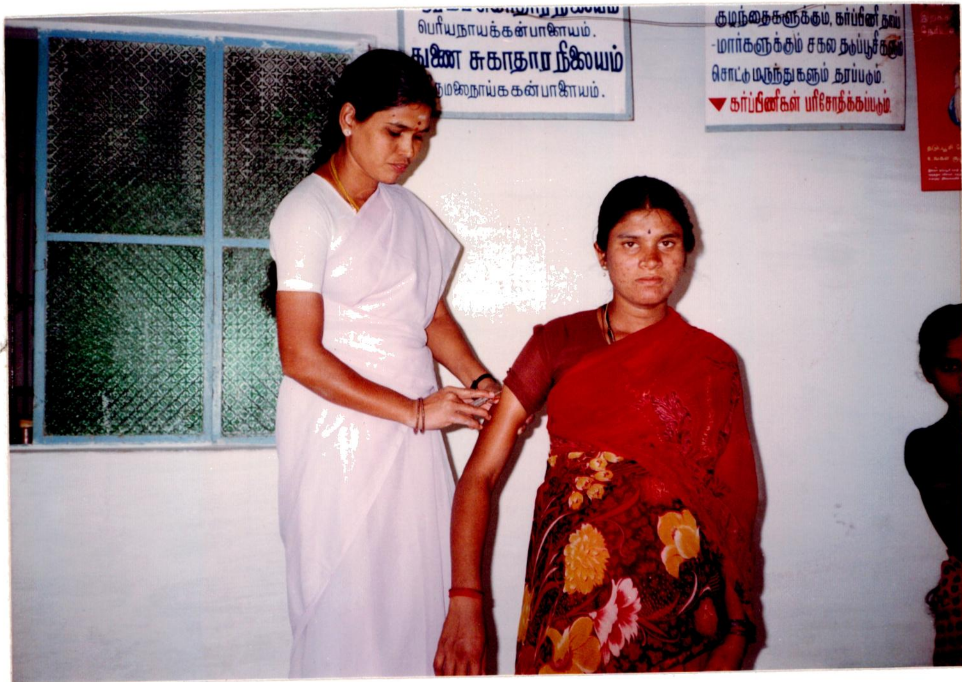


FIGURE-4 UTILISATION OF ANTE-NATAL SERVICES

2. Utilisation of natal services:

Table XVII indicates utilisation of Natal services by women.

TABLE XVII

UTILISATION OF NATAL SERVICES

S. No.	Aspects	Mothers having: One Child N:37		Two Children N:41		Three Children N:22	
		Number	Percentage	Number	Percentage	Number	Percentage
1.	Place of delivery						
	i. Private Hospital	13	35	10	24	5	23
	ii. Government Hospital	11	30	14	34	3	14
	iii. Maternity centre	3	8	3	7	--	--
	iv. Home	9	24	13	32	13	59
	v. ESI	1	3	1	3	1	4
2.	Attended by						
	i. Doctors	25	68	25	61	9	41
	ii. Village Health Nurse	10	27	15	37	10	45
	iii. Trained dais	--	--	1	2	--	--
	iv. Untrained dais	2	5	--	--	3	14
3.	Nature of delivery						
	i. Normal	34	92	38	93	22	100
	ii. Complicated	3	8	3	7	--	--

Out of the 100 selected women, 35 of them had delivered their children in their homes, either nursed by the Village

Health Nurse or untrained or trained dais. 28 of them had preferred the Government Hospital because they had felt that there were more facilities and amenities. It was surprising to note that 28 per cent had opted the Private Hospital for luxury and comfort. It was interesting to note that 59 per cent of the deliveries were attended by doctors, 35 per cent by the Village Health Nurse, 5 per cent by untrained dais and only one per cent by trained dais.

It was heartening to note that 94 per cent had normal deliveries and only 6 per cent had complicated deliveries.

3. Utilisation of Post-Natal services:

Table XVIII shows utilisation of post-natal services by women.

TABLE XVIII

UTILISATION OF POST-NATAL SERVICES

S. No.	Aspects	Mothers having					
		One child N:37		Two chidren N:41		Three children N:22	
		Avail -ed	not availed	Avail -ed	not availed	Avail -ed	not availed
1.	Health Check-up (within 3 months)	37	--	38	3	9	13
2.	Frequency of Check-up						
	i. Once in a month	37	--	38	--	9	--
	ii. Twice in a month	--	--	--	--	--	--
3.	Weighing of the child	35	2	35	6	9	13

It is interesting to note that all the 37 mothers who were having one child had availed the post-natal services which included health check-up, frequency of check-up and weighing of the child. Even mothers with two children (38 per cent) had availed the services. But mothers having 3 children were reluctant due to their experience and negligence. Even 9 mothers who had availed it only for the third child.

4. Post-Natal Care:

Table XIX illustrates Post-Natal care by women.

TABLE XIX

POST - NATAL CARE

S. No.	Aspect	Mothers having					
		One child N:37		Two children N:41		Three children N:22	
		Breast fed	Did not	Breast fed	Did not	Breast fed	Did not
1.	Breast feeding	36	1	40	1	20	2
2.	Period of Breast feeding						
	i. 0-12 months	25	--	20	--	5	--
	ii. 12-24 months	9	--	18	--	12	--
	iii. 24 and above	2	--	2	--	3	--
3.	Reasons for not Breast feeding						
	i. No Breast milk	--	1	--	--	--	1
	ii. Breast milk inadequate	--	--	1	1	--	1

It is highly appreciative that 96 out of 100 mothers had breast fed their babies and 45 of them had done it for one year. 39 of the mothers had breast fed their children upto 2 years and it was interesting to note that 7 of them had even breast fed after 2 years.

The 4 women who did not breast feed had genuine reasons saying that there was inadequacy of breast milk or no secretion of milk.

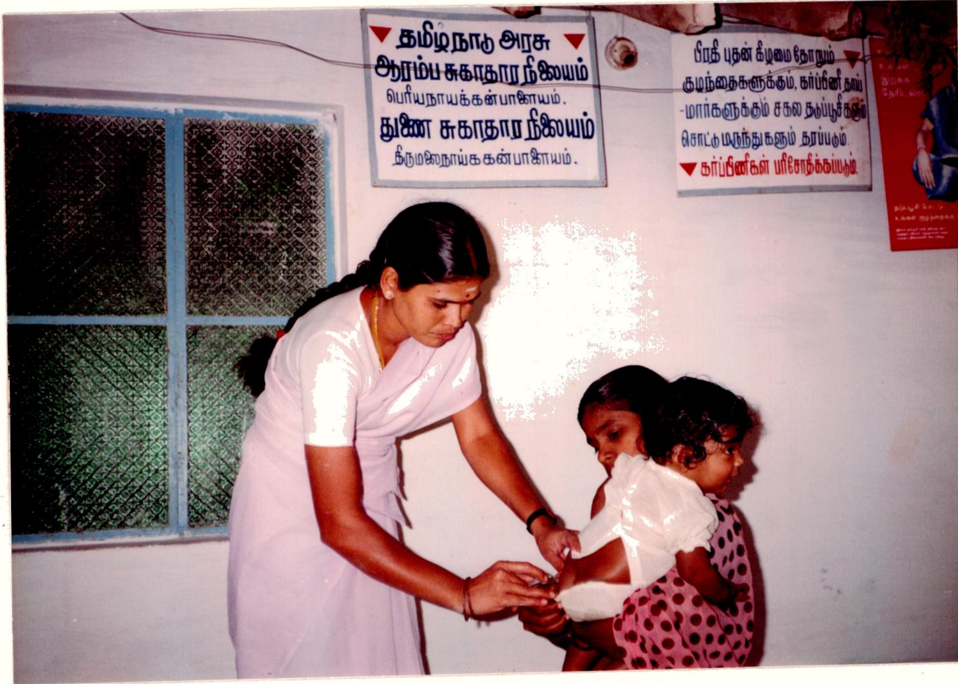
5. Utilisation of Immunization Programmes for their children:

Table XX gives utilisation of immunization programmes for their children.

TABLE XX

UTILISATION OF IMMUNIZATION PROGRAMMES FOR THEIR CHILDREN

S. No.	Aspects	Mothers having					
		One child N:37		Two children N:41		Three children N:22	
		Utilised	not Utilised	Utilised	not Utilised	Utilised	not Utilised
1.	Types of vaccine						
	i. D.P.T.	37	--	35	6	9	13
	ii. Polio	37	--	35	6	9	13
	iii. B.C.G.	37	--	35	6	9	13
	iv. Measles	37	--	35	6	9	13
	v. D.T.	20	17	25	16	0	22
	vi. Vitamin A solution	37	--	25	16	0	22
2.	Source						
	i. Private Hospital	1	--	1	--	--	--
	ii. Government Hospital	4	--	1	--	1	--
	iii. PHC	8	--	4	--	1	--
	iv. HSC	24	--	29	--	7	--
	v. ESI	--	--	--	--	--	--



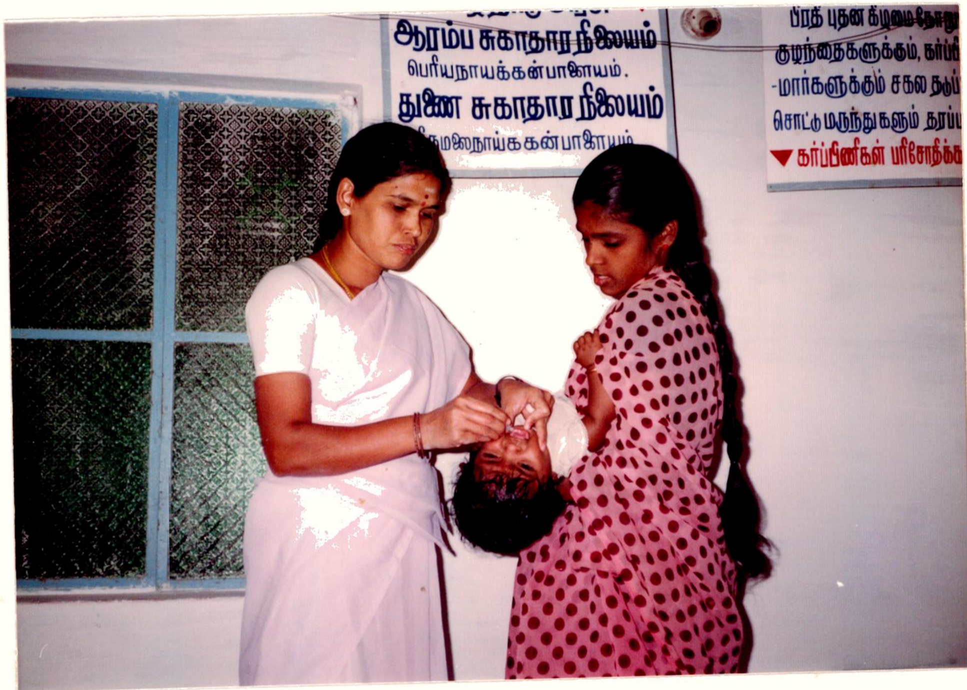


FIGURE-5 UTILISATION OF IMMUNIZATION PROGRAMMES
FOR THEIR CHILDREN

It is heartwarming to note that all the mothers who had one child had immunized their children and so also 35 mothers who had 2 children. It is disheartening to note that out of 22 women who had 3 children only nine women had utilized the Immunization programmes. Even, these nine women had immunized only their third child. They had remarked that they were not aware of the programmes earlier.

Majority (60 per cent) who had fully immunized their children had utilized the service at the Health sub-centre. The success could be attributed to the untiring efforts of the sub-centre. (Figure - 5)

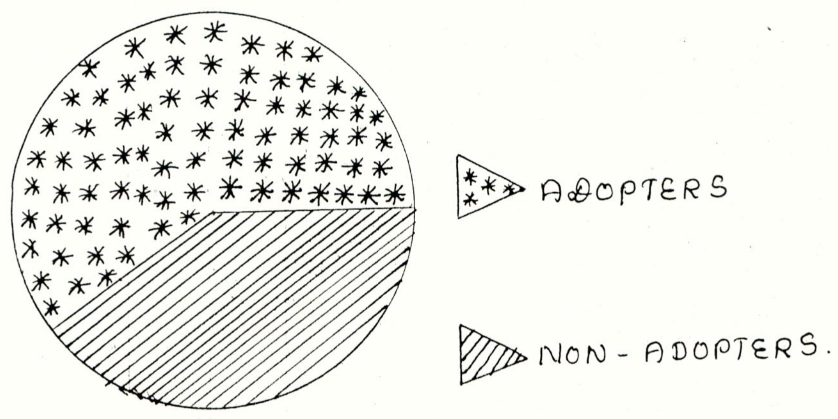
6. Adoption of family planning methods by the selected women:

Table XXI depicts the adoption of family planning methods by selected women.

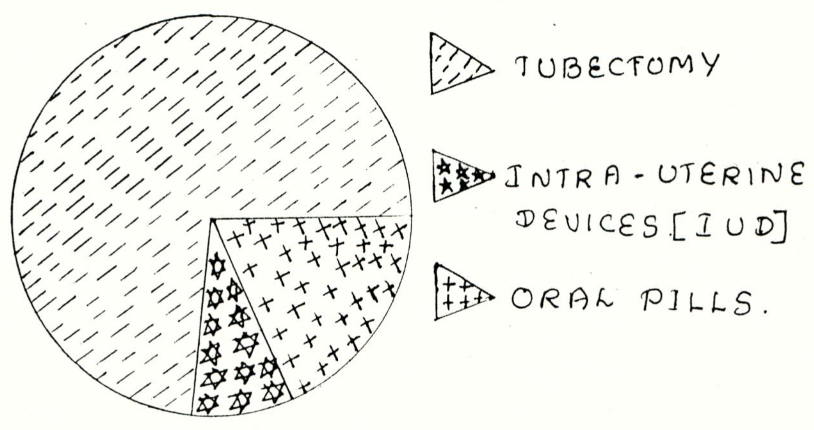
TABLE XXI

ADOPTION OF FAMILY PLANNING METHODS

S. No.	Methods	No.of mothers with One child N:37		No.of mothres with Two children N:41		No.of mothers with Three children N:22	
		Adopted	not Adopted	Adopted	not Adopted	Adopted	not Adopted
1.	Family Planning	7	30	33	8	20	2
2.	Methods						
	i.Vasectomy	--	--	--	--	--	--
	ii.Tubectomy	3	--	22	--	19	--
	iii.Laparoscopy	--	--	--	--	--	--
	iv.Intra Uterine Device (IUD)	1	--	3	--	1	--
	v.Oral pills	3	--	8	--	--	--
	vi.Condoms	--	--	--	--	--	--



METHODS OF FAMILY PLANNING
ADOPTERS AND NON-ADOPTERS.



METHODS OF FAMILY PLANNING
ADOPTERS

Figure - 6

It is interesting to note that out of 100 mothers,60had adopted family planning methods and had welcomed the idea of a small family norm. Out of the 60 adopters, 44 of them had adopted Tubectomy, 5 of them Intra Uterine Device and 11 had taken Oral pills. Inspite of the widespread propaganda on family planning there were still 40 of them who had not come forward to undergo the same.

The reason being that most of them were mothers with only one child and wanted to have another to complete the family. (Figure - 6)

It was also noted that 73 per cent of mothers had their first child only after one year of marriage, and 22 percent had their first child only after 2 years of marriage and surprisingly 5 of them had their first child only after 3 years of marriage.

7. Utilisation of other services:

Table XXII illustrates utilisation of other services by selected women.

TABLE XXII

UTILISATION OF OTHER SERVICES

S.No.	Aspects	Number	Percentage
1.	Source		
	i.Private Hospital	13	13
	ii.Government Hospital	14	14
	iii.PHC	17	17
	iv.HSC	54	54
	v.ESI	2	2
2.	Type of illness/disease		
	i.Fever	100	100
	ii.Dysentry	9	9
	iii.Diarrhoea	6	6
	iv.Vomitting	3	3
	v.Chicken pox	--	--
	vi.Typhoid	13	13
	vii.Mumps	--	--
	viii.Measles	--	--
	ix.Cholera	--	--
	x.Leprosy	--	--
	xi.Tuberculosis	2	2
	xii.Cold	8	8

The above table shows that the women had approached the Primary Health Centre, Health sub-centre, Private Hospital,

Government Hospital and ESI for even other services apart from maternal and child health services. It is surprising to note 100 per cent of the women had referred the above agents for treatment of fever either for their child or for themselves. 15 of them had approached for treatment of Diarrhoea or Dysentry. Even common cold they had consulted the agencies. Majority (54 per cent) of them had availed the services at Health Sub-centre only proving their confidence which they have built-up with the sub-centre staff.

8. Utilisation of health education programmes:

Table XXIII illustrates Utilisation of health education programmes.

TABLE XXIII

UTILISATION OF HEALTH EDUCATION PROGRAMMES

S.No.	Items taught	Utilised	Not utilised
1.	Nutrition	70	30
2.	Sanitation	50	50
3.	Immunization	80	20
4.	Importance of breast feeding	80	20
5.	Personal Hygiene	55	45
6.	Pre-natal, natal and Post-natal care	75	25
7.	Family Welfare Progamme	80	20

Majority (80 per cent) had attended the health education classes and benefited from them. Their view on sanitation and hygiene had still to be changed and more emphasis to be given on environment cleanliness and keeping their homes and surroundings clean.(Figure-7)

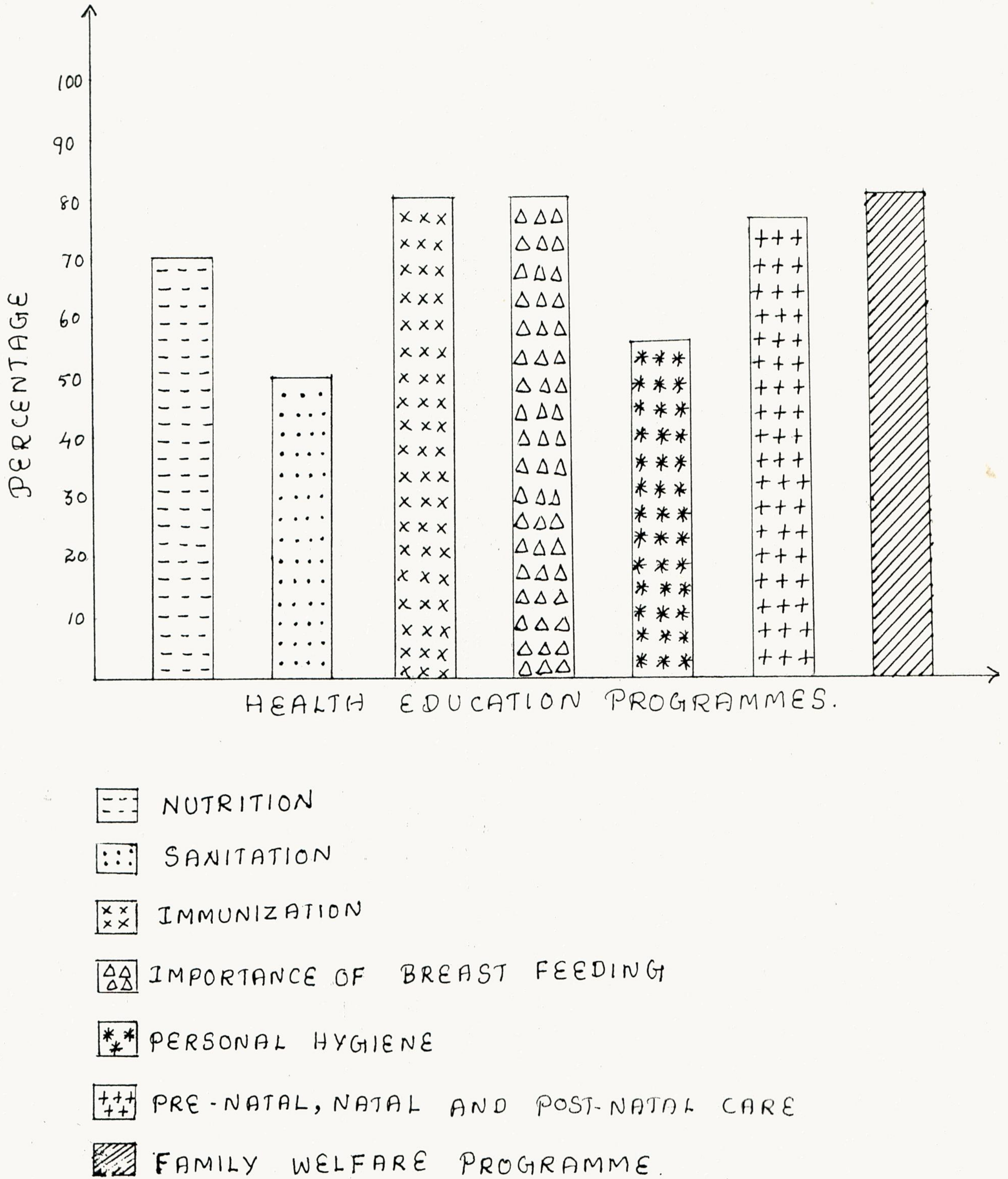


Figure-7. UTILISATION OF HEALTH EDUCATION PROGRAMMES.

IV PROBLEMS FACED IN THE UTILISATION OF THESE SERVICES:

Problems faced in the utilisation of these services are as follows:

1. Maternity Health Centre was not hygienically kept
2. There was no adequate space in the maternity centre and not convenient
3. The trained dais had not conducted the delivery properly.
   Since they did not have proper knowledge and were not trained properly. The chance for most of the women being treated by a doctor was more remote.
4. Tubectomy was done haphazardly. There were three women who had become pregnant again. Mothers who had adopted Family Planning had complained that they could not eat properly and could not work as before. They were not satisfied with the adoption.
5. They had not used disposable syringes for the children. They did not sterilise the syringes and other equipments properly and did not keep it clean. Hence when they were injected, their hands got swollen up etc.
6. Since Primary Health Centre and Health Sub-centre did not provide facilities for blood or Urine test during Ante-natal care they had to resort to other places, which are prohibitively expensive. Hence they had avoided coming for their second check-up.
7. Poor supervision
8. Lack of continuing education
9. Shortage of water at health units
10. Poor feed back.

SUMMARY AND CONCLUSION

V. SUMMARY AND CONCLUSION

This study was undertaken to elicit information on the "Utilisation of Health Services By Rural Women" in Coimbatore District. The required data for the study was collected from one Block namely Periyanaickenpalayam. Ten villages of the block were selected. The major findings of the study are presented below:

1. Among the selected hundred women, 37 per cent of them were having one child, 41 per cent of them were having two children and 22 per cent of them had three children.

2. Out of the ten villages selected for the study, there was only one Primary Health Centre, two additional Primary Health Centres, ten Health Sub-Centres, Sixteen Private hospitals, two Ayurvedic and two ESI dispensaries. So all the 10 villages had access to Health Centres for their immediate need.

3. These health centres rendered the health services like ante-natal, natal, post-natal services, Immunization, Family welfare services and other services (Diseases/illness).

4. Mothers having only one child, that is, women who were, recently married were well aware of all the health services. The older the women, the lesser knowledge she had about health services. Some of them expressed that during the delivery of their first two children, they were not aware of any health services. During the third pregnancy only the women became aware of the

health services. So also women having two children had expressed that they had gained more knowledge during their second pregnancy. Hence women at present were more aware of the health services due to mass media and also because of the regular visits of the Village Health Nurse.

5. The Village Health Nurse and mass media, play a significant role in creating an awareness about the health services available to the mothers and the children.

6. Majority of the women (80 per cent) were aware of the health education classes conducted for them bythe Village Health Nurse. The trend was clear that as the years advanced, the mothers were becoming aware of nutrition, immunization, importance of breast feeding and personal hygiene. It had been due to the communication dissemination of the various mass media like Radio, Television, Newspaper, Magazines and also health infrastructure.

7. Out of the 100 mothers chosen for the study, only 88 per cent had utilised the services of Primary Health Centre, Health Sub-Centre, Private Hospitals, Government Hospitals, ESI for ante-natal care. The rest 12 per cent had not gone for any ante-natal check-up and registration.

8. Out of the 100 selected women, 35 of them had delivered their children in thier homes, either nursed by the Village Health Nurse or untrained or trianed dais. 28 of them had preferred the Government Hospitals because they had felt that there were more facilities and amenities. It was surprising to note that 28 per cent had opted the private hospitals for luxury and comfort. It was interesting to note that 59 per cent of the deliveries were attended by doctors, 35 per cent by

the Village Health Nurse, 5 per cent by untrained dais and only one per cent by trained dais.

9. It was heartening to note that 94 per cent had normal deliveries and only 6 per cent had complicated deliveries.

10. All the 37 mothers who were having one child, had availed the post-natal services which included health check-up, frequency of check-up and weighing of the child. Even mothers with two children had availed the services except for nine women. But mothers having three children were reluctant due to their experience and negligence. Even the nine mothers who had utilised it only for the third child.

11. It is highly appreciative that 96 out of 100 of the mothers had breast fed their babies and 45 of them had done it for one year. 39 of the mothers had breast fed their children upto 2 years and it was interesting to note that 7 of them had even breast fed after two years.

12. It is heartwarming to note that all the mothers who had one child had immunised their children and so also 35 mothers who had 2 children. It is disheartening to note that out of 22 women who had three children only 9 women had utilised the immunization programme. Even these nine women had immunized only their third child. They had remarked that they were not aware of the programmes earlier.

13. Majority (60 per cent) who had fully immunized their children had utilized the service at the Health Sub-Centre. The success could be attributed to the untiring efforts of the Sub-centre.

14. It is heartwarming to note that out of 100, 60 of the mothers had adopted family planning methods and had welcomed the idea of small family norm. Out of the 60, 44 of them had adopted tubectomy, 5 of them Intra Uterine Devices and 11 had taken Oral pills. Inspite of the widespread propaganda on family planning, there were still 40 of them who had not come forward to undergo the same.

15. 100 women taken for the study had stated that they had approached the Primary Health Centre, Health Sub-Centre, Private Hospital, Government Hospital and ESI for even other medical and health services apart from maternal and child health services.

16. Majority (80 per cent) had attended the health education classes and benefited from them. Their view on sanitation and hygiene had still to be changed and more emphasis to be given on environment cleanliness and keeping their homes and surroundings clean.

Recommendations:

Since Primary Health Care Services, with their emphasis on community-based, low cost health measures offer the best hope of an improved standard of health for all, the following recommendations are made:

1. The Health Sub-centre be adequately staffed and the buildings be bigger and kept clean.
2. More care to be taken during the conduct of sterilisation, tubectomy etc.
3. Provision of facilities at Health Sub-Centre to carry out urine test, blood tests etc.
4. Well-trained staff to be posted at Health Sub-Centre for more utilisation of services.
5. Effective Mass Media Network could be established to propogate health schemes and Family Planning methods.

Health is fundamental to human progress. People in sound health can accelerate the pace of economic, industrial and social development. Health care remains one of the most important human endeavour to improve the quality of life. The primary health centre in Independent India has been accepted as an instrument for the delivery of comprehensive health care. It is envisaged as the minimum infrastructure for the delivery of health care to the rural people. The findings of the study call for the spread of better and well equipped medical facilities where these are not available and the expansion of education and development of scientific attitudes and beliefs to counter the religious interpretation of health and disease.

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APPENDIX

APPENDIX - I

AVINASHILINGAM INSTITUTE FOR HOME SCIENCE AND HIGHER EDUCATION
FOR WOMEN, COIMBATORE - 641 043.

An interview schedule to elicit information from women on "Utilisation of Health Services by Rural Women in Coimbatore District".

I. General Information: Date:

1. Name of the Interviewer :
2. Name of the Interviewee :
3. Address :

4. Name of the village :
5. Name of the Panchayat Union:
6. Present Age :
7. Age at Marriage :
8. Educational Qualification :

9. Type of Family : Joint ( ) Nuclear ( )
10. Religion : Hindu ( ) Christian ( )
Muslim ( ) Others ( )

11. Income :

12. Present status of women :

Married with Husband : ( )

Divorced : ( )

Widowed : ( )

Deserted : ( )

Any other (specify) : ( )

II Awareness about maternal health services:

1. Are you aware of health services:

Yes ( ) No ( )

If Yes, what are the types of health services you are aware?

i) Ante - natal services

ii) Natal services

iii) Post - natal services

iv) Child health services

v) Family Welfare Services

A. ANTE - NATAL SERVICES:

1. Place of Health Check up, during pregnancy:-

S.No.	Aspects	Private Hospital	Government Hospital	PHC	HSC	Others
1.	Ist Delivery					
2.	IInd Delivery					
3.	IIIrd Delivery and above					

2. Frequency of health check-up

i) Once in a Month

ii) Twice in a Month

iii) Three times in a Month

iv) Four or more times in a Month

3. Details of Ante-Natal care:

A.

S.No.	Aspects	Yes	No
1.	Ante-natal care		
2.	Ante-natal Registration		
3.	FST Given (Ferrous Sulphate tablets)		
4.	Tetanus Toxoid Given		

B.

S. No.	Aspects	Source	Advice			Tests conducted			Treatment		
			Ist Pregnancy	IInd Pregnancy	IIIrd Pregnancy	Ist Pregnancy	IInd Pregnancy	IIIrd Pregnancy	Ist Pregnancy	IInd Pregnancy	III Pregnancy
1.	Ante-natal care given by	i. Village Health Nurse									
		ii. Private Hospital									
		iii. Personnel									
		iv. Mass Media									
		v. Relatives /Neighbours									
		vi. Others									

C.

S.No.	Aspects	First Pregnancy	Second Pregnancy	Third Pregnancy
	i) Weight			
	ii) Blood Pressure			
	iii) Urine and Sugar check-up			
	Received education on			
	i) Nutrition			
	ii) Child care			
	iii) Breast Feeding			
	iv) Others			

D.

S. No.	Aspects	Source	Advice			Tests Conducted			Treatment		
			Ist Pregnancy	IInd Pregnancy	IIIrd Pregnancy	Ist Pregnancy	IInd Pregnancy	IIIrd Pregnancy	Ist Pregnancy	IInd Pregnancy	III Pregnancy
1.	FST given	i) Private Hospital									
		ii) Government Hospital									
		iii) PHC									
		iv) HSC									
		v) Others									
2.	Tetanus Toxoid given	i) Private Hospital									
		ii) government Hospital									
		iii) PHC									
		iv) HSC									
		v) Others									

4. Details of the Tablets:

S. No.	Tablets consumed		No.of tablets given			No.of tablets consumed		
	Yes	No.	Ist Preg nancy	IInd Preg nancy	IIIrd Preg nancy	Ist Preg nancy	IInd Preg nancy	IIIrd Preg nancy

5. Reasons for not consuming the tablets:

S. No.	Reasons for not consuming	Ist Pregnancy	IInd Pregnancy	IIIrd Pregnancy
1.	Forgotten			
2.	Arouses vomitting			
3.	Giddiness			
4.	Others			

6. If you have received the Ante-natal services from private hospitals or Government hospitals give the reason for it?

B. NATAL SERVICES:

1. Natal care:

S.No.	Aspects		Ist Pregnancy	IInd Pregnancy	IIIrd Pregnancy
1.	Place of Delivery	i. Private Hospital			
		ii. Government Hospital			
		iii. PHC			
		iv. Maternity Centre			
		v. Home			
		vi. Others			
2.	Attended by	i. Doctors			
		ii. Village Health Nurse			
		iii. Trained dais			
		iv. Untrained dais			
		v. Others			
3.	Nature of Delivery	i. Normal			
		ii. Complicated			
		iii. Others			

2. If you have received the natal services from Private Hospitals or Government Hospitals, give the reason for it?

3. Was it satisfactory?

   Yes (   )   No (   )

4. If No, what were the problems you faced?

   i) Not Convenient
   ii) Delivery not done properly
   iii) Not Hygienically done
   iv) Any other (specify)

C. POST - NATAL SERVICES:

1. Have you availed Post-natal Services?

Yes ( ) No ( )

If Yes, State the details of the Post-natal Services.

Details of Post-natal Care:

S.No.	Aspects		First child	Second child	Third child
1.	Health Check-up (within three months)	Yes/ No			
2.	Frequency of check-up	i. Once ii. Twice iii. Three or more times			
3.	Was your child weighed (within three months)	Yes/ No			
4.	Frequency of Check-up	i. Once ii. Twice iii. Three or more times			
5.	Breast Feeding	Yes/ No			
6.	Period of Breast Feeding	i. 0-12 months ii. 12-24 months iii. 24 and above			
7.	Reasons for not breast Feeding	i. No breast milk ii. Mother has disease iii. Breast milk is inadequate iv. Any other (Specify)			

III Details about Immunization:

1. Have you taken immunization during pregnancy stage?

Yes ( ) No ( )

If Yes, give the details:

A. Immunization during Pregnancy:

S.No.	Aspects		Ist Pregnancy	IInd Pregnancy	IIIrd Pregnancy
1.	Immunization Card	Yes:			
		No:			
		Source:			
		i. Private Hospital			
		ii. Government Hospital			
		iii. PHC			
		iv. HSC			
		v. Others			
2.	Vaccine given:	Yes:			
	a. Tetanus Toxoid-I	No:			
		Source:			
		i. Private Hospital			
		ii. Government Hospital			
		iii. PHC			
		iv. HSC			
		v. Others			
	b. Tetanus Toxoid-II	Yes:			
		No:			
		Source:			
		i. Private Hospital			
		ii. Government Hospital			
		iii. PHC			
		iv. HSC			
		v. Others			
	c. Ferrous Sulphate Tablets given	Yes:			
		No:			
		Source:			
		i. Private Hospital			
		ii. Government Hospital			
		iii. PHC			
		iv. HSC			
		v. Others			

S.No.	Aspects		Ist Pregnancy	IInd Pregnancy	IIIrd Pregnancy
3.	Immunization status	i. Fully Immunized			
		ii. Partially immunized			
		iii. Not immunized			

B. IMMUNIZATION KNOWLEDGE OF MOTHER:

1. Do you have Children?

   Yes ( ) No ( )

2. If Yes, Are you aware of Immunization for Children?

   Yes ( ) No ( )

3. Do you know what vaccine the child should receive and when?

   Yes ( ) No ( ) when

   If Yes,

   Fully ( ) Partially ( )

4. If Yes from what are the sources of information of immunization?

   i. Public Health Department Staff

   ii. Health Volunteer

   iii. Mass Media/TV/Radio/Paper/Wall Newspaper

5. Do you have immunization card for Children?

   Yes ( ) No ( )

   If yes, did you understand?

   Yes ( ) No ( )

6. Have your Children been immunized?

Yes ( ) No ( )

If Yes, the vaccine given:

S. No.	Details of the Child	Type of vaccine given	Source: Private Hospital	Source: Government Hospital	Source: PHC	Source: HSC	Source: Others
1.	First Child	a) D.P.T					
		i) First dose					
		ii) Second dose					
		iii) Third dose					
		iv) Booster dose					
		b) Polio					
		i) first dose					
		ii) Second dose					
		iii) Third dose					
		iv) Booster dose					
		c) B.C.G					
		d) Measles					
		e) D.T.					
		f) vitamin 'A' solution					
2.	Second Child	a) D.P.T					
		i) First dose					
		ii) Second dose					
		iii) Third dose					
		iv) Booster dose					
		b) Polio					
		i) First dose					
		ii) Second dose					
		iii) Third dose					
		iv) Booster dose					
		c) B.C.G.					
		d) Measles					

S. No.	Details of the Child	Type of vaccine given	Source: Private Hospital	Government Hospital	PHC	HSC	Others
		e) D.T.					
		f) Vitamin'A' solution					
3.	Third Child	a) D.P.T.					
		i) First dose					
		ii) Second dose					
		iii) Third dose					
		iv) Booster dose					
		b) Polio					
		i) First dose					
		ii) Second dose					
		iii) Third dose					
		iv) Booster dose					
		c) B.C.G.					
		d) Measles					
		e) D.T.					
		f) Vitamin 'A' solution					

IV FAMILY WELFARE METHODS:

1. When did you give birth to the First Child after marriage?

   After One year -

   Two year -

   Three year -

2. Do you know family planning methods?

   a) Spacing methods

   Yes ( ) No ( )

   b) Temporary methods

   Yes ( ) No ( )

3) Permanent methods

Yes (   ) No (   )

3. Have you adopted family planning?

Yes (   ) No (   )

If Yes,

S. No.	Methods of Family planning	Methods adopted by you	Any Problem
1.	Vasectomy		
2.	Tubectomy		
3.	Laproscopy		
4.	IUD (Intra Uterine Devices)		
5.	Oral Pills		
6.	Condoms		

4. What is your opinion about family welfare methods?

i) Satisfactory

ii) Convenient

iii) Useful

iv) Not Useful

v) Not satisfactory

vi) Not convenient

V. OTHER SERVICES:

!. Have you approached health centre for other illness/diseases within the last three years?

Yes (   ) No (   )

If Yes, Source

i) Private Hospital

ii) Government Hospital

iii) PHC

iv) HSC

v) Others

If Yes, type of illness/diseases:

i) Fever

ii) Dysentry

iii) Diarrhoea

iv) Vomitting

v) Chicken pox

vi) Typhoid

vii) Mumps

viii) Measles

ix) Cholera

x) Malaria

xi) Leprosy

xii) Tuberculosis

xiii) Others

2. Did any one from PHC visit your Village?

Yes ( ) No ( )

If Yes,

S.No.	Details of personnel	Frequency of visit	Purpose
1.	Doctor		
2.	Block Health Supervisor		
3.	Sector Health Supervisor		
4.	Village Health Nurse		
5.	Sector Health Nurse		
6.	Block Extension Officer		
7.	Others		

VI AWARENESS ON HEALTH EDUCATION CLASSES:

1. Have you attended any health education classes?

   Yes ( ) No ( )

   If Yes, give the source of information?

   i) College/University

   ii) PHC / HSC

   iii) Private Hospitals

   iv) Voluntary Agencies

   v) Mass Media

   a.Television

   b.Radio

   c.News paper

   d.Magazine

   e.Poster

   f.Relatives

   g.Friends

   h.Neighbours

   i.Others.

3. What are all the aspects you had learnt from the health education classes?

S. No.	Items taught	Yes	No	Items utilized		Benefited	
				Yes	No	Yes	No
1.	Nutrition						
2.	Personnel Hygiene						
3.	Sanitation						
4.	Immunization						
5.	Importance of Breast feeding						
6.	Pre-natal, Natal and Post-natal care						
7.	Proper caring of the child						
8.	Family Welfare programme						