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AWARENESS AND ATTITUDE TOWARDS REPRODUCTIVE HEALTH AMONG RURAL WOMEN IN THANJAVUR DISTRICT WITH SPECIAL REFERENCE TO PRACTICE OF CONTRACEPTION

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ABSTRACT

Background:

According to Family Planning 2020 Report, in 2017 there were 136,569,000 women using modern method contraception which prevented: 39,170,000 unintended pregnancies, 11,966,000 unsafe abortions, and 42,000 maternal deaths due to family planning. In 2012, India's modern contraception prevalence rate among all women was 39.2, in 2017 it was 39.57, and in 2020 is predicted to rise to 40.87. In the following passages, the awareness and attitude towards Reproductive Health and perception and practice of contraception among rural women of Thanjavur District are analyzed

Objectives:

The objective of this study is to assess the awareness and attitude towards the various contraception methods among rural women in order to improve their reproductive health.

Methodology:

The Thanjavur District primarily comprised of eight revenue Taluks. Thousand respondents were selected by equal numbers of respondents from each Taluk in Thanjavur District. Thus this is a descriptive-analytical study which was conducted during January to April 2018 among rural women in Thanjavur District who were selected by purposive random sampling method.

Results:

A statistical analysis into whether a reasonable relationship remains between a few select socio economic factors and the usage of contraceptives was made : As the calculated chi-square p value is less than the value of level of significance there exists a significant relationship between the religion and education with the usage of contraceptives and there is no significant relationship between the caste and type of family with usage of contraceptives are found.

KEYWORDS: *Reproductive Health, Contraception, Pregnancy, Miscarriage, Abortions,female specific diseases.*

JEL Classification: I 12, B 54,

INTRODUCTION

Gender is one of many social determinants of health—which include Social, Economic, and Political factors—that play a major role in the health outcomes of women in India (*Balarajan, Y; Selvaraj, S; et al., 2011).* Therefore, the high level of gender inequality in India negatively impacts the health of women.

Amartya Sen's cooperative conflicts approach to gender biases frames women's gender disadvantage through three different responses: breakdown wellbeing, perceived interest and perceived contribution responses.

The breakdown well-being response which is derived from the Nash equilibrium, describes breakdown positions between individuals during cooperative decisions. When the breakdown position of one individual is less than the other person, the solution to any conflict will ultimately result in less favourable conditions for the first individual. In terms of women's health in India, the overall gender disadvantage facing women negatively impacts their ability to make decisions while they seek healthcare.

The perceived interest response describes the outcome of a bargained decision when one individual attaches less value to his or her well-being. Any bargaining solution derived between the aforementioned individual and another individual will always result in a less favourable outcome for the person who attaches less value to their well-being. The health status of women in India relates to the perceived interest response because of the societal and cultural practices that create an environment where the self-worth of women is marginalised compared to men. Therefore, outcomes relating to healthcare decisions within households will favour the men, due to greater self-worth.

The perceived contribution response describes the more favourable position of an individual when the individual's contribution is perceived as contributing more to a group than other individuals. The more favourable perception gives the individual a better outcome in a bargaining solution. In terms of women's health in India, males' perceived contribution to household productivity is higher than that of women, which ultimately affects the bargaining power that women have with regards to accessing healthcare.

OBJECTIVES

1. To study the Pregnancy History of rural women especially the distribution of type of births, Miscarriages, Abortions and IMR.
2. To study the level of awareness among the rural women about the anatomy of a female reproductive organ and to document their responses to pregnancy related questions.
3. To study the usage of Contraception and various methods adopted by rural women and to find out the reasons for non usage.
4. To find out the relationship between the usage of contraception with their socioeconomic variables like Reigion, Type of family and Education of the respondents.
5. To trace and List down the reasons for not seeking gynaecological healthcare in time and suggestions to solve the issue.

METHODOLOGY OF THE STUDY

The fair sex is yet to get the fair treatment especially for the female specific problems, at times of needs either because of lack of awareness, or of the unwillingness. So, the present study is intended to analyse the awareness of, attitude about and experience with the reproductive health, among rural women in Thanjavur District.

Sources of Data: The primary data were collected from the field surveys through interview schedules as well as observation.

Sampling Method: Thanjavur District of Tamil Nadu is the study area chosen for the present research. The primary data is collected among the women respondents. The sample size is limited to 1000 which is nearly 0.12 % of the rural female population size (789354) as per 2011 census. The sampling method presently adopted is stratified random sampling choosing 125 samples from each of the eight taluks of Thanjavur District. Out of the 789 inhabited villages in Thanjavur district there are 7 villages in which the sex ratio is 899 or less and 54 villages in which the child sex ratio is less than 699 or less. While choosing the samples due care is given to include women respondents from all these villages.

Tools For Data Collection: As the research is revolving around rural women, for their better understanding and answering a well planned structured interview schedule in their mother tongue, Tamil, was prepared in consultation with experts working in this field. The Pregnancy history of the respondents, observation and awareness about the contraception, the health seeking behavior for female specific diseases, reasons for not seeking health care are enquired with a structured questionnaire.

Data Analysis: For analysing the data, frequency distribution, percentages, simple averages, were used. The analysis was mainly qualitative and descriptive in nature. So, non-parametric tests like Chi-Square are used.

Study Period: The primary data was collected during the two year period 2017 and 2018.

Study Area: The Thanjavur District , one of the 32 Districts in the State of Tamil Nadu, is taken as the area for the present study. It is one of the biggest districts in Tamil Nadu State with an area of 3,396.57

Square km. It lies on the east coast of Tamil Nadu. Basically, it is an agricultural district and is considered to be the treasury of grains. About 75 percent of the workforce in the district depends on agriculture.

Limitations:

The study is confined to Thanjavur district only. The results may be generalised for the whole of Delta Districts of Tamil Nadu. But the socio-economic conditions cannot be generalized to the entire country. As it is dealt with female specific issues the respondents were very reluctant to share their reproductive health.

REVIEW OF LITERATURE

As women mature into adulthood, many of the barriers preventing them from achieving equitable levels of health stem from the low status of women and girls in Indian society, particularly in the rural and poverty-affected areas (*Raj, Anita 2011).* The low status of women in India can be attributed to many cultural norms. Societal forces of patriarchy, hierarchy and multigenerational families contribute to Indian gender roles. Men use greater privileges and superior rights to create an unequal society that leaves women with little to no power. Gender inequalities, in turn, are directly related to poor health outcomes for women. Numerous studies have found that the rates of admission to hospitals vary dramatically with gender, with men visiting hospitals more frequently than women *(Balarajan, Y; Selvaraj, S; et al. 2011).* A study by Choi in 2006 found that boys are more likely to receive immunisations than girls in rural areas. This finding has led researchers to believe that the sex of a child leads to different levels of health care being administered in rural areas *(Choi, Jin; Lee, Sang-Hyop,2006).* Differential access to healthcare occurs because women typically are entitled to a lower share of household resources and thus utilise healthcare resources to a lesser degree than men. Indian women frequently underreport illnesses. The underreporting of illness may be contributed to these cultural norms and gender expectations within the household. Gender also dramatically influences the use of antenatal care and utilisation of immunizations (*Balarajan, Y; Selvaraj, S; et al.,2011).* There is also a gender component associated with mobility. Indian women are more likely to have difficulty traveling in public spaces than men, resulting in greater difficulty to access services. *(Mechakra-Tahiri, Samia; Freeman, Ellen; et al. ,2012).*

SOCIO-ECONOMIC PROFILE OF RESPONDENTS

The Thanjavur District primarily comprised of eight revenue Taluks namely, Kumbakonam, Orathanadu, Papanasam, Pattukkottai, peravurani, Thanjavur, Thiruvaiyaru and Thiruvidaimaruthur. Equal numbers of respondents were randomly selected from each Taluk in Thanjavur District. The primary data collected from these respondents regarding their socio Economic life are discussed in the following passages in detail.

Age Composition:

Among the thousand respondents surveyed, a majority of 346 (35%) are between the age group of 21 to 30 years and only 124 (12%) respondents are of the age group of 20 Years or below. Among the other female respondents, 224 are between the age group of 31 to 40 years, 147 are between the age group of 41 and 50 years, 159 are of above 50 years of age.

Age-at-Marriage Composition:

Among the respondents surveyed, a majority of 462 (46%) got married between the age group of 18 to 23 years and only 51 (5%) respondents got married after 30 years of age. Around 25% of the respondents were found married even before their attaining 18 years of marriage and almost majority of them are found to be in the present age group of above 50 years evidencing the fact that the early marriages were more prevalent in the 1960's and 70's. Around 5% of the respondents got married only after the age of 30 years due to many reasons including family commitments, religious beliefs, Dowry system, etc.

Marital Status Composition:

While 89% of the respondents found married nearly 11% (114 respondents) are unmarried due to age, education, seeking employment, etc. It is further tested whether there is any relationship between the Taluk area they reside in.Similarly, of the 886 respondents married, 78 are found widowed or separated and only the remaining are living with their husband

Composition of Age at First Delivery:

Of all the thousand respondents, 886 respondents are married ones and of the married 22 bore no children, on account of infertility, postponement of child birth, or just–now-married ones. Around one-fourth of the total respondents had their first delivery at their age of 20 years or below. It is to be noted here that nearly the same number of respondents had their marriage before 18 years of age. A majority of 321 respondents had their first child in the age group of 21- 30 years and 186respondents bore their first baby in the age group of 31-40 years only. Strangely 11 % of the respondents had their first delivery only after 40 years and all were found to be under infertility treatments for them or for their husbands.

Composition of Type of family:

Nowadays the Joint Family system is getting collapsed for the well known reasons which do not leave the rural households also. Among the surveyed respondents, 711 (71%) belong to the Nuclear family set up and only the rest 289 (29%) hail from the extended family households.

Composition regarding Religion and Caste:

Among the respondents surveyed, 684 (90%) household respondents follow Hindu Religion, 189 (2%) of the respondents follow Islam, 120 (8%) respondents follow Christianity and the rest follow other religions. From the below found table it is interpreted that the female respondents in Thanjavur District are dominantly from the Hindu religion.Among the Thousand respondents, 792 (79%) belong to Backward Caste and Most Backward Caste, 190 (19%) households belong to Scheduled Caste/Scheduled Tribe community and the rest either belong to other communities or do not like to reveal..

Composition of Educational Qualification:

The below-found table shows the educational qualification of the interviewed respondents. Of the respondents surveyed, only 154 were found illiterates, having no formal schoolings; 165 respondents having elementary education and a majority of 387 undergoing secondary level education. While one fourth of the respondents completed the higher secondary education and 40 respondents underwent still higher education like Diploma, Degree, etc.

Composition of Educational Qualification of the Husband:

Educational Qualification of the Husband also makes a considerable impact on the wife's health seeking behaviour. Of the respondents surveyed, spouses of only 39 respondents were found illiterates, having no formal schoolings; spouses of 99 respondents having elementary education, spouses of 264 respondents having secondary level education, and a majority of 328 undergoing higher secondary level education. Around spouses of 16% of the respondents underwent still higher education like Diploma, Degree, etc. The figures reveal the fact that the male literacy is comparatively better than the female one.

Composition of Occupation:

Occupational structure of the respondents plays a vital role in their decision making abilities especially regarding the health. Of the respondents surveyed, a majority of 40 % respondents remain as homemakers, and 114 more also found dependents/ students not doing any external employment. Thus more than half of the female respondents fetch no formal income earnings. On the other hand 126 respondents contribute their labour for the agricultural work in the own lands; 69 for the agricultural work in the leased lands and 190 respondents work as agriculture coolie workers. Thirty three respondents are found self employed running petty shops, practicing as tailors or other micro level businesses; 38 respondents are employed in private concerns like Textile shops, Super markets, Hotels, etc.; and only 29 respondents are employed in government service.

TableNo.1 Socio-Demographic Factors of the Respondents

Socio-Demographic Factors		Total	Kumbakonam	Orathanadu	Papanasam	Pattukkottai	Peravurani	Thanjavur	Thiruvaiyaru	Thiruvidaimaruthur
Age (Years)	1. 20 and Below	124	16	15	15	18	21	12	13	14
	2. 21-30	346	50	45	47	48	31	42	41	43
	3. 31-40	224	31	28	29	30	22	26	37	19
	4. 41-50	147	18	15	14	17	16	22	21	24
	5.Above 50	159	10	22	20	12	35	23	13	25
	Total	**1000**	**125**	**125**	**125**	**125**	**125**	**125**	**125**	**125**
Age at menarche (in years)	1. Below 12 years	184	27	23	21	17	17	29	25	25
	2. 12-16	795	96	99	104	108	106	95	96	91
	3.Above 16	21	2	3	0	0	2	1	4	9
	Total	**1000**	**125**	**125**	**125**	**125**	**125**	**125**	**125**	**125**
Age at Marriage (in years)	1.Below 18	261	33	36	35	33	34	33	30	27
	2. 18-23	462	55	61	56	59	59	60	60	52
	3.24-29	112	10	19	17	16	21	0	18	11
	4.Above 30	51	6	3	5	8	3	7	6	13
	Unmarried	114	21	6	12	9	8	25	11	22
	Total	**1000**	**125**	**125**	**125**	**125**	**125**	**125**	**125**	**125**
Marital Status	Married	886	104	119	113	116	117	100	114	103
	Unmarried	114	21	6	12	9	8	25	11	22
	In married life	808	99	106	105	105	102	91	107	93
	Widowed/Separated	78	5	13	8	11	15	9	7	10

Age at first delivery (in Years)	1. 20& Below	245	28	36	31	39	37	19	33	22
	2. 21-30	321	41	41	38	43	44	41	42	31
	3. 31-40	186	21	24	29	21	18	25	23	25
	4.Above 40	112	13	15	11	10	15	11	13	24
	5. No child	22	1	3	4	3	3	2	3	3
	6. Unmarried	114	21	6	12	9	8	28	11	19
	Total	245	28	36	31	39	37	19	33	22
Type of Family	1. Nuclear	711	92	88	85	80	78	106	91	91
	2.Extended	289	33	37	40	45	47	19	34	34
	Total	**1000**	**125**	**125**	**125**	**125**	**125**	**125**	**125**	**125**
Educational Qln of the Respondent	1.No formal schooling	154	21	19	17	18	20	17	21	21
	2.Elementary Education	165	23	23	22	19	21	18	19	20
	3.Secondary	387	45	47	48	42	48	48	47	62
	4. Higher Secondary	254	32	33	36	38	32	34	29	20
	5. Degree/ Diploma/any other higher education	40	4	3	2	8	4	8	9	2
	Total	**1000**	**125**	**125**	**125**	**125**	**125**	**125**	**125**	**125**
Educational Qln of the Husband	1.No formal schooling	39	5	7	4	4	5	7	3	4
	2.Elementary Education	99	15	14	13	10	13	11	12	11
	3.Secondary	264	31	32	33	28	33	33	40	34
	4. Higher Secondary	328	46	38	43	56	48	35	30	32
	5. Degree/ Diploma/any other higher education	156	14	20	19	10	12	26	27	28
	Total	**886**	**111**	**111**	**112**	**110**	**111**	**111**	**112**	**108**
Occupation of the Respondent	1. Homemaker	401	50	51	53	50	47	44	51	55
	2. Student /unmarried/dependent	114	14	14	13	15	14	14	13	17
	3.Agriculture in own land	126	16	17	15	15	16	20	14	13
	4. Agriculture in Lease land	69	9	12	8	8	7	7	9	9
	5. Daily wager in Agriculture	190	24	21	22	22	24	29	25	23
	6.Private job	38	5	4	5	6	6	4	4	4
	7. Self Employed	33	4	4	5	6	5	5	3	1
	8.Govt. Employed	29	3	2	4	3	6	2	6	3
	Total	**1000**	**125**	**125**	**125**	**125**	**125**	**125**	**125**	**125**

Source: Primary Data

Relationship between Age at Marriage and Education Level:

The relationship between the age at marriage and the education level of the respondents are measured in the below found table. As already noted in the earlier paragraphs the respondents of the age of more than 50 years do not have a formal schooling and in this table it is further revealed that 80% of those who had no formal school education got married before the age of 18 years. The age at marriage gets linearly increased as the

education improves. Only 36% of the respondents with mere elementary education, 13% of those with secondary education and 21% of those with higher secondary education got married in their younger years. A majority of those who are with secondary education/ higher secondary education / still higher education were found married only in their age between 18 to 23 years only. As marriages at early ages affect the higher studies normally, pursuit of higher education also postpones the marriages.

Table No.2 Relationship between the Age at Marriage and the Education level of the Respondent

Age at Marriage /Education	No formal schooling	Elementary Education	Secondary	Higher Secondary	Degree/ Diploma/any	Total	No formal schooling	Elementary Education	Secondary	Higher Secondary	Degree/ Diploma/any other higher	P value	Result
1.Below 18	114	55	45	47	0	261	80%	36%	13%	21%	0%	2.74E-72	Related
2. 18-23	19	41	241	142	19	462	13%	27%	71%	64%	58%		
3.24-29	9	48	15	29	11	112	6%	32%	4%	13%	33%		
4.Above 30	0	7	38	3	3	51	0%	5%	11%	1%	9%		
Total Married	142	151	339	221	33	886	100%	100%	100%	100%	100%		

Source: Primary Data

It is further tested whether there is any statistically significant relationship between the age at marriage of the respondent and the education level of the respondent framing a hypothesis as follows.

H_0: There is no significant relationship between the age at marriage of the respondent and the education level of the respondent

H_1: There exists a significant relationship between age at marriage of the respondent and the education level of the respondent

Inference: As the calculated chi-square p value 0.00 is less than the value of level of significance i.e. 0.05, H_0 is rejected i.e., there exists a significant relationship between age at marriage of the respondent and the education level of the respondent.

II ANALYSIS REGARDING REPRODUCTIVE HEALTH

Distribution of type of Births:

As described earlier, of all the thousand respondents, 886 respondents are married ones and of the married 22 bore no children, on account of infertility, postponement of child birth, or just–now-married ones. Of the 864 mother respondents, 58 had only single child and a majority of 478 respondents have two children. While 247 respondents have three deliveries, 64 had four and 12 had five deliveries. There are five respondents who bore more than six children and almost all of them were observed in the age group of fifty plus years. Thus, in toto, 2110 total births were given by the respondents surveyed. Of these total births 24% happened to be the caesarean births while the rest were normal ones. The occurrence of caesarean births is more when the frequency of birth is less. For instance, of the 58 respondents (78%) who gave birth to single child only, 45 underwent caesarean surgery. Nearly half of the births by the respondents who bore two children gave caesarean births only.

Table No.3 Distribution of births among the Respondents

No. of Births	No. of Respondents	Total Births	Caesarean Births	Vaginal Births	Caesarean Births In %	Vaginal Births In %
1	58	58	45	13	78%	22%
2	478	956	465	491	49%	51%
3	247	741	1	740	0%	100%
4	64	256	0	256	0%	100%
5	12	60	0	60	0%	100%
6 or more	5	39	0	39	0%	100%
Total	864*	2110	511	1599	24%	76%

Source: Primary Data

Miscarriages, Abortions and IMR:

Miscarriage, also known as spontaneous abortion and pregnancy loss, is the natural death of an embryo or foetus before it is able to survive independently. Some use the cut off of 20 weeks of gestation, after which foetal death is known as a stillbirth. The most common symptom of a miscarriage is vaginal bleeding with or without pain. Sadness, anxiety and guilt often occur afterwards. Tissue and clot-like material may leave the uterus and pass through and out of the vagina.

Abortion is the ending of pregnancy due to removing an embryo or foetus before it can survive outside the uterus. An abortion that occurs spontaneously is also known as a miscarriage. When deliberate steps are taken to end a pregnancy, it is called an induced abortion, or less frequently as an "induced miscarriage".

In 2015, the total fertility rate of India was 2.40 births per women and 15.6 million abortions performed, with an abortion rate of 47.0 abortions per 1000 women aged between 15–49 years. With high abortions rates follows a high number of unintended pregnancies, with a rate of 70.1 unintended pregnancies per 1000 women aged 15–49 years. Overall, the abortions occurring in India make up for one third of pregnancies and out of all pregnancies occurring, almost half were not planned(*Singh, 2015)*. The word abortion is often used to mean only induced abortions. Of all the thousand respondents, 886 respondents are married ones, of whom 121 respondents had miscarriages at least once. While 112 respondents had the miscarriages once, 9 respondents had the same more than once in their pregnant life.

Of all the 886 married respondents, 864 respondents gave birth to at least one child, of whom 152 respondents underwent abortions at least once. While 149 respondents had the abortion once, 3 respondents had the same more than once to avoid unwanted pregnancy.

Infant mortality is the death of young children under the age of 1.This death toll is measured by the infant mortality rate, which is the number of deaths of children below one year of age per 1000 live births. Premature birth is the biggest contributor to the IMR. Of all the 864 mother-respondents, 24 lost their child within a year of birth and 3 respondents had this agony more than once. Thus IMR is 30 per thousand live births, which seems to be so high as it is not the current IMR, but taken from samples who had pregnancies during a span of more than thirty years.

Table No.4 Miscarriages, abortions and IMR among the respondents

No. of Births	Miscarriages	Abortions	Lost any children under the age of 1 year	Miscarriages in %	Abortions in %	Lost any children under the age of 1 year in %
Nil	765	712	838	86%	82%	97%
Once	112	149	24	13%	17%	3%
Twice Or More	9	3	2	1%	0%	0%
Married*/ Delivered**	886*	864**	864**	100%	100%	100%

Source: Primary Data

Pregnancy Related Issues:

There are six pregnancy and post birth related questions posed to the respondents, the responses of which are tabulated below.

An ectopic pregnancy occurs when a fertilized egg implants somewhere other than the main cavity of the uterus. It most often occurs in the fallopian tube, causing a **"tubal pregnancy."** It can also occur in the ovary, cervix or abdomen. It is important to find the ectopic pregnancy in its early stages. An ectopic pregnancy can rupture or damage the pelvic organs that it is implanted in, which leads to multiplication of complexities including death. Nearly 2% of the married respondents at least once had the ectopic pregnancy i.e., of all the 886 married respondents, 14 respondents had such pregnancy.

Gestational diabetes is a condition in which a woman without diabetes develops high blood sugar levels during pregnancy. Gestational diabetes generally results in few symptoms; however, it does increase the risk of pre-eclampsia, depression, and requiring a Caesarean section. Babies born to mothers with poorly treated gestational diabetes are at increased risk of being too large, having low blood sugar after birth, and jaundice. If untreated, it can also result in a stillbirth. Nearly 5% of the married respondents had the gestational diabetes i.e., of all the 864 married respondents, 46 respondents had such diabetes.

Of the 864 mother respondents, 58 had only single child and rest had two or more children. Enquiring about the gap between the last two children the respondents had, half of the 806 eligible respondents, replied that they had their second child immediately after the first birth, within a year. While 43% of the eligible respondents admit that there is a gap of 2 years between their last two children 7% only said that the gap between the two children was three years or more.

Dilation and curettage (D&C) is the dilation of the cervix and surgical removal of part of the lining of the uterus and/or contents of the uterus by scraping and scooping. In a D&C, dilation refers to opening the cervix; curettage refers to removing the contents of the uterus. Curettage may be performed by scraping the uterine wall with a curette instrument or by a suction curettage (also called vacuum aspiration).It is a therapeutic gynaecological procedure as well as the most often used method of first trimester miscarriage or abortion. Enquired about whether the respondents had a D&C, 102(12%) respondents said that they had it at least once in their life, especially after the miscarriages. It is to be noted here that the miscarriages among the sample respondents, 121 had miscarriages.

Doctors call it infertility when one doesn't get pregnant after a year of regular sex without using birth control. Different treatments for a poor response to ovarian stimulation include altering the pituitary down regulation protocols, modifying stimulation cycle medications, use of adjuvant therapy (such as, growth hormone or androgen pretreatment), etc. Nearly 7% of the married respondents acknowledged that they have undergone infertility treatments for them or their husbands undertaken the same.

For how long the rural women breast fed their last child was enquired and found that a maximum of 92% breastfed their last child from 3 to 6 months and only 5% fed for less than 3 months. Twenty respondents breastfed even for the extended period and all the respondents were in the fifty plus age. It shows that the practice feeding breast milk for more months was prevailing in the past and the same is coming down in the present days.

Table No. 5 Awareness about Pregnancy related questions

Pregnancy related questions	Responses	No	In %
	1.Yes	14	2%
	2.No	872	98%
Have you ever had ectopic pregnancy?	Married Respondents	886	100%
	1.Yes	46	5%
	2.No	799	92%
	3.Dont Know	19	2%
Have you ever had gestational diabetes	Mother Respondents	864	100%
	1. One year	401	50%
	2. One to two years	345	43%
	3. More than 2 years	60	7%
Gap between the last two children	Total no of respondents having 2 or more children	806	100%
	1.Yes	59	7%
	2.No	827	93%
Have you had any infertility treatments?	Married Respondents	886	100%
	1.Yes	102	12%
	2.No	784	88%
Have you had a D& C	Married Respondents	886	100%
	Less than 3 months	46	5%
	3 to 6 months	798	92%
	6 months to 1 year	19	2%
	Above 1 year	1	0%
Average duration of Breastfeeding	Mother Respondents	864	100%

Source: Primary Data

Awareness about Reproductive Organ:

The female reproductive system is made up of the internal and external sex organs that function in reproduction of new offspring. In the human, the female reproductive system is immature at birth and develops to maturity at puberty to be able to produce gametes, and to carry a foetus to full term. The internal sex organs are the uterus, Fallopian tubes, and ovaries. The uterus or womb accommodates the embryo which develops into the foetus. The uterus also produces vaginal and uterine secretions which help the transit of sperm to the Fallopian tubes. The ovaries produce the ova i.e., egg cells. The external sex organs are also known as the genitals and these are the organs of the vulva including the labia, clitoris, and vaginal opening. The vagina is connected to the uterus at the cervix *(Mahadevan, Harold Ellis, Vishy 2013).*

As a part of the present research the anatomy of a female reproductive organ and its functions were explained to the respondents with the help of pictorial charts and models and asked whether the respondents were already aware of the anatomy of a female reproductive organ. Of the total respondents 38% are found fully aware of the anatomy and its functions while 45% respondents accepted that they knew the same partly. But 17% respondents said that they were either unaware or were not even interested to know and discuss about the same.

Table No. 6 Level of Awareness about the anatomy of a female Reproductive organ

Awareness Level	No. of respondents	In %
1. Fully Aware	384	38%
2.Partly Aware	446	45%
3.Not interested	170	17%

Source: Primary Data

Sources of Awareness about Reproductive Organ:

Of the 830 respondents who were found partly or fully aware of the complete anatomy of the female reproductive organ, a question was raised as wherefrom they derived this awareness. The primary source of awareness was the posters depicted and pamphlets issued at the village health centres, hospitals or PHCs according to 37% of the respondents. One-fifth of the respondents said that the television was the major source of awareness followed by print media which was the prime source of awareness to 14%. While Relatives and Friends gave awareness about the anatomy of female reproduction system to 12%, Health personnel gave the same to 10% of the respondents, Teachers to 3% and Self Help Group activists to 2% of the respondents.

Table No.7 Major source of awareness about the anatomy of a female Reproductive organ

source of awareness	No. of respondents	In %
TV	174	21%
News paper/magazines/book	114	14%
Posters/slogans/pamphlets	310	37%
Doctor/ Health worker	84	10%
Teachers	28	3%
Relatives/friends & workplace	102	12%
SHG meeting & Others	18	2%
Total	830	100%

Source: Primary Data

Reproductive Health:

Questioned about whether the respondents have ever informally discussed their reproductive and sexual health with others, their responses were mixed. Out of the 886 married respondents, a majority of 84% of the respondents disclosed that they discussed at least once with their close relatives, especially maternal ones like mother, grandmother, elder sister, etc. It is followed by the acceptance by 72% of the respondents that they discussed their problems with their very close friends and one-third discussed the same with others like village health workers. But the respondents were found reluctant in discussing the sexual and reproduction related problems with their husbands as four-fifth of the respondents abstains from disclosing any such problem to them.

Table No.8 Discussion about reproductive and sexual health problems with others

Discussed with	Yes	No	Yes in %	No in %
1. Husband	172	714	19%	81%
2. Relatives	842	158	84%	16%
3. Friends	722	278	72%	28%
4. Others	355	645	36%	64%

Source: Primary Data

Contraception:

According to Family Planning 2020 Report, in 2017 there were 136,569,000 women using modern method contraception which prevented: 39,170,000 unintended pregnancies, 11,966,000 unsafe abortions, and 42,000 maternal deaths due to family planning. In 2012, India's modern contraception prevalence rate among all women was 39.2, in 2017 it was 39.57, and in 2020 is predicted to rise to 40.87. In the following passages, perception and practice of contraception among rural women are analyzed.

Discussion about Contraception:

While observing whether the respondents have ever informally discussed their contraception doubts with others, of the 886 married respondents, a majority of 40% discussed with their very close relatives preferably with an elder sister, if any, followed by 31 % with their life partners, 29% with their very close friends and 16% of the respondents discussing the same with village health workers and other health personnel.

It is notable here that though the rural women are reluctant in discussing the sexual problems with their life partners, when it comes to contraception, they are comparatively positive in discussing with them.

Table No. 9 Discussion about contraception with others

Discussed with	Yes	No	Yes in %	No in %
1. Husband	278	608	31%	69%
2. Relatives	398	602	40%	60%
3. Friends	289	711	29%	71%
4. Others	156	844	16%	84%

Source: Primary Data

Contraception usage:

Family planning in India is based on efforts largely sponsored by the Indian government. From 1965-2009, contraceptive usage has more than tripled (from 13% of married women in 1970 to 48% in 2009) and the fertility rate has more than halved (from 5.7 in 1966 to 2.4 in 2012), but the national fertility rate remains high, causing concern for long-term population

growth. India adds up to 1,000,000 people to its population every 20 day *(Rabindra Nath Pati 2003) (Marian Rengel, 2000) (G.N. Ramu, 2006) (Arjun Adlakha, April 1997).* Extensive family planning has become a priority in an effort to curb the projected population of two billion by the end of the twenty-first century.

Awareness of contraception is near-universal among married women in India. (B.M. Ramesh; S.C. Gulati; R.D. Retherford, 1996). However, the vast majority of married Indians reported significant problems in accessing a choice of contraceptive methods. About three-fourths of those using were using female sterilization which is by far the most prevalent birth-control method in India. Condoms, at a mere 3%, were the next most prevalent method (DoF&CH,2009). It is important to note that sterilization is a common practice in India. They also use camps to enforce sterilization.

Of the interviewed respondents, around one-third of the married rural women accepted that they used a contraceptive method in their marital life. Among those who used a contraceptive method, a majority of one-third respondents were using female sterilization, followed by intrauterine devices, preferred by 29% of the rural women interviewed. Hormonal pills and emergency pills were the choices of 18% and 11% rural women. Thus nearly 92% of the contraception methods followed by the rural families were women-centered only. Even the simplest barrier method like usage of condoms was in usage by the male partners of 8% respondents only and similarly, only one respondent's husband alone opted for male sterilization.

Table No. 10 Contraception usage & used methods

Primary Contraception Method	No. of respondents	In %
1. Hormonal	54	18%
2. Barrier	25	8%
3. Intrauterine devices	85	29%
4. Female Sterilization	99	33%
5. Male sterilisation	1	0%
6. Behavioural	0	0%
7. Emergency	34	11%
Total Respondents who have used any contraception method	298	34%

Source: Primary Data

Contraception Non- Usage:

Women in India are not being fully educated on contraception usage and what they are putting in their bodies. Contraceptive usage has been rising gradually in India. In 1970, 13% of married women used modern contraceptive methods, which rose to 35% by 1997 and 48% by 2009 (*Marian Rengel, 2000).* But the present study indicates that only 34% of the married rural women ever used a contraceptive method which is far below than the studies made earlier. The reason why 66% of the respondents did not use the contraception was enquired into.

Firstly the abstinence due to age or physical problems of either of the partner was found as the reason behind non usage of contraception by 28% of the respondents and 4% more spelt the reason that the question itself does not arise since their husband is staying away. Second most important reason for non usage of contraception was the fear of side effects. Thirdly, 19% of the respondents are desirous of conception. Fourthly, opposition from husband was the reason as viewed by 16% of the respondents. No proper awareness about the right choice of contraception still lingering in the minds of 10% respondents who are willing to use but not so far tried. Inconvenience in using a contraception method was also a reason for not going for contraception according to 2% of the rural women respondents.

Table No.11 Contraception non- usage & Reasons

Particulars	No. of respondents	In %
1. Unaware of the suitable conception method	59	10%
2. Desirous for conception	111	19%
3. Worried about side effects	124	21%
4. Opposition from husband	95	16%
5. Inconvenience	10	2%
6. Husband staying away	24	4%
7. Abstinence	165	28%
Total Respondents who never used any contraceptives	588	66%

Source: Primary Data

III ANALYSIS REGARDING CONTRACEPTION AND SOCIO ECONOMIC FACTORS

A statistical analysis into whether a reasonable relationship remains between a few select socio economic factors and the usage of contraceptives was made. Firstly, an enquiry into whether a reasonable relationship exists with the religion was made. Of the 589 married respondents from Hindu religion 41% were found using a contraception method, followed by 34% of the married rural women from the Christianity. Only 8% of the respondents from the Islam tried contraception in their marital life. The chi square test was used to test whether there exists any relationship between the religion and usage of contraceptives, framing the hypotheses as follows.

H_0: There is no significant relationship between the religion and usage of contraceptives

H_1: There exists a significant relationship between the religion and usage of contraceptives

Inference: As the calculated chi-square p value i.e., 0.00 is less than the value of level of significance 0.05, H_1 is accepted. i.e., there exists a significant relationship between the religion and usage of contraceptives.

Secondly the comparison was made with the caste one belongs to. It revealed that of the respondents who belong to SC/ST castes, 38% used contraception and of the respondents who do not belong to the SC/ST castes, 34% used. A chi square test was administered to test whether there exists any relationship between the caste and usage of contraceptives framing the hypotheses as follows.

H_0: There is no significant relationship between the caste and usage of contraceptives

H_1: There exists a significant relationship between the caste and usage of contraceptives

Inference: As the calculated chi-square p value i.e., 0.18 is more than the value of level of significance 0.05, H_0 is accepted. i.e., there exists no significant relationship between the caste and usage of contraceptives.

Another common belief is that in the joint family wherein the family members are more in number, the chance is more to exchange the views on reproductive health as well as contraception techniques freely among the women members and can implement the same. While comparing the type of family with the usage of contraceptives it was found that there is no such considerable difference, since only 30% of the rural women respondents from extended family exercised the contraception whereas 35% of those from the nuclear family opted it. A chi square test was used to test whether there is any relationship between the caste and usage of contraceptives framing the hypotheses as follows.

H_0: There is no significant relationship between the type of family and usage of contraceptives.

H_1: There exists a significant relationship between the type of family and usage of contraceptives.

Inference: As the calculated chi-square p value i.e., 0.11 is more than the value of level of significance 0.05, H_0 is accepted. i.e., there exists no statistically supported significant relationship between the type of family and usage of contraceptives.

Comparative studies have indicated that increased female literacy is correlated strongly with a decline in fertility. Studies have indicated that female literacy levels are an independent strong predictor of the use of contraception, even when women do not otherwise have economic independence *(A. Dharmalingam; S. Philip Morgan 1996).* Female literacy levels in India may be the primary factor that helps in population stabilisation. Higher rates of sterilization are seen among women who hold less education than those with more education. Those with higher education further have lower rates due to the delay of getting married and childbirth *(Thulaseedharan, Jissa Vinoda, 2016).*

In the similar lines in the present study also the correlation between the education and usage of contraception is traced. Higher the education level more was the contraception usage among the rural women respondents. For instance, only 22% of the illiterates used contraception while they were in their marital life, followed by 30% usage among by the respondents with elementary education, 34% with higher secondary education, 67% with the degree or Diploma or other forms of higher education. The chi square test was also used to confirm the relationship between the educational qualification and the hygiene practice during menstruation framing the hypotheses as follows.

H_0: There is no significant relationship between the educational qualification and usage of contraceptives.

H_1: There exists a significant relationship between the educational qualification and usage of contraceptives.

Inference: As the calculated chi-square p value i.e., 0.00 is less than the value of level of significance 0.05, H_1 is accepted. i.e., there exists a statistically supported significant relationship between the educational qualification and usage of contraceptives.

Table No. 12 Relationship between the contraception usuage with the socio economic variables

Variable		Total Respondents	Unmarried	Married	Used	Never Used	Used (%)	Never Used (%)	P value	Result
Religion	1.Hindus	684	95	589	244	345	41%	59%	6.47E-16	Related
	2.Muslims	189	9	180	14	166	8%	92%		
	3. Christians &Others	127	10	117	40	77	34%	66%		
	Total	**1000**	114	886	298	588	34%	66%		
Caste	1.SC/ST	190	16	174	66	108	38%	62%	0.180827	Independent
	2.BC/MBC & Others	810	98	712	232	480	33%	67%		
	Total	**1000**	114	886	298	588	34%	66%		
Type of Family	1. Nuclear	711	84	627	221	406	35%	65%	0.113868	Independent
	2.Extended	289	30	259	77	182	30%	70%		
	Total	**1000**	114	886	298	588	34%	66%		
Educational of the Respondent	1.No formal schooling	154	12	142	31	111	22%	78%	1.68E-05	Related
	2.Elementary Education	165	14	151	45	106	30%	70%		
	3.Secondary	387	48	339	124	215	37%	63%		
	4. Higher Secondary	254	33	221	76	145	34%	66%		
	5. Degree/ Dip/any higher	40	7	33	22	11	67%	33%		
	Total	**1000**	**114**	**886**	298	588	34%	66%		

Source: Primary Data

IV ACCESS OF HEALTHCARE FOR FEMALE SPECIFIC DISEASES

The help seeking behaviour at times of deterioration in the gynaecological conditions was questioned and shocked to get the replies that nearly one-fourth of the total respondents surveyed used to ignore it generally, thinking that it is common and bearable and in the due course the problem may be set right. Nearly 32% of the rural women tried only home remedy for the issues that are suggested to them and 10% more, used to consult the local non allopathic rural health practitioner for the remedy. Only 34% of the rural women respondents were immediately consulting an allopathic health practitioner and were taking the remedy seriously.

Table No.13 Help- seeking behaviour in gynaecological conditions, primarily

Behaviour	No.	In %
1. Ignoring	245	25%
2. Resorting to Home Remedy	315	32%
3. Consulting a non-allopathic Rural Health Practitioner	98	10%
4. Consulting an allopathic Health Practitioner	342	34%

Source: Primary Data

As on 31.03.2016, Tamil Nadu State had 1368 Primary Health Centres out of which 54 are situated in Thanjavur District; Similarly, Tamil Nadu State had 385 Community Health Centres out of which 14 are

situated in Thanjavur District and of the 31 State Sub Divisional Hospitals out of which 12 are situated in Thanjavur District alone.

Table No.14 Type of health facility preferred

Sl.No	Health Facility	No.	In %
1	Government Sub centre/ PHC	520	52%
2	Urban Government hospital	138	14%
3	Nearby Private Hospitals	291	29%
4	Urban Specialty Hospitals	51	5%

Source: Primary Data

When the respondents were enquired about the type of health facility they prefer to take treatment for the gynaecological issues, Government PHC/ Sub Centre/ Urban Government Hospitals were in the preference list of the 66% of the rural women surveyed. Nearby private hospitals were preferred by 29% of the respondents and the rest of them preferred urban private speciality hospitals.

Table No.15 Person accompanying while seeking medical treatment for reproductive, sexual health and gynaecological problems

Sl.No.	Accompanying Person	No.	In %
1	Husband	198	20%
2	Relatives	618	62%
3	Friends & others	184	18%

Source: Primary Data

Earlier while questioned about whether the respondents have ever informally discussed their reproductive and sexual health with others, the respondents were found reluctant in discussing the same with their husbands as four-fifth of the respondents abstains from disclosing any such problem to them. *Similarly while replying to a question 'whom the rural woman wants to be accompanied while seeking medical treatment for* reproductive, sexual health and gynaecological problems' also, only one-fifth of the respondents felt comfortable being accompanied with their husbands. Close relatives are found first in the priority list as 62% of the respondents felt comfortable being accompanied with them and friends being their last option as only 18% prefer their company

Table No.16 Reasons for not seeking gynaecological health care in time

(multiple answers)

Sl. No.	Personal:	No.	In %
1	Lack of time	214	21%
2	Loss of wages	245	25%
3	Inability to go alone	156	16%
4	Family not bothered	364	36%
5	Ashamed to disclose problem	389	39%
	Inadequate health services/infrastructure		
6	PHC is too far	98	10%
7	No female doctor /attenders	519	52%
8	Lack of privacy	254	25%
9	Facilities not available	324	32%
10	Others	68	7%
	Attitude of the health providers		
11	Demand money	59	6%
12	Doctors/anms not available	145	15%
13	Doctors do not bother	332	33%
14	Staff at PHC is Rude	212	21%
15	Other Reasons	79	8%

Source: Primary Data

Those who tend to ignore and who do not approach the doctors for their gynaecological problems were questioned about the reason for the same. Listing out the personal reasons separately, a majority of 39% of the respondents opined that the shyness and feeling ashamed of disclosing the problem was the main reason behind abstaining from the treatment. It is followed by the personal reasons of the indifferent attitude of family, as opined by 36%, fear of loss of wages and financial constraints by 25%, lack of time by 21%, inability to go alone by 16% in order.

The health-centre related problems were also opined as the reasons for not seeking gynaecological treatment. For instance, unavailability of a female doctor was opined as the foremost reason by 52%, and lack of privacy and facilities by 25%, and the distance to health centres by10%.

Attitude of health providers also played a key role in seeking as well as not seeking the gynaecological health. For instance the indifferent attitude of doctors as of the opinion of 33% respondents, rude behaviour of hospital staff members (21%), unavailability of the health practitioner at times of need(15%) and charging more fees (6%) were the health provider related reasons for not preferring the consultation frequently.

CONCLUSION

"When Women move forward, the family moves, the village moves, and the nation moves". These words of Pandit Jawaharlal Nehru are often repeated because it is an accepted fact that only when women are in the main stream of progress, any economic and social development can be meaningful. Tamil Nadu is one of the glowing state with the statistics of growing literacy rate which is evidenced in the analysis of composition of the educational qualification of the respondents also. If women are trained and educated on sound lines, they become an asset in accelerating economic growth and ensuring social change in the desired direction.

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