

## Chapter V

# Knowledge and Practice of Reproductive Health

### 5.1. Introduction

This chapter furnishes young women's knowledge and practices about different reproductive health components like Antenatal care (ANC), Delivery care, Post-natal care (PNC), Family planning and RTI/STI. Here detailed analysis has been carried out for each component to understand its prevalence and association with different socio-demographic variables. Specifically, under ANC, the analysis highlights the number, timing and place of obtaining ANC, experience of health problems during pregnancy and treatment seeking behaviour. Subsequently, association of these factors with selected socio-demographic characteristics of women have been examined. Logistic regression analysis was done to understand the determinants of women's acceptance of three ANC and treatment seeking behaviour for the health problems faced during the last pregnancy. Similarly, under delivery care analysis was carried out on the place of delivery and its association with socio-demographic characteristics of women, preparedness of women for birth and experience of health problems during delivery. Logistic regression analysis has also been conducted to understand the factors influencing institutional delivery. Subsequently, timing of postnatal check-up, experience of health problems during postnatal period, treatment seeking behaviour and its association with socio-demographic characteristics of women have been explored. The chapter also explains the young women's knowledge and use of different family planning methods and the factors influencing it. Likewise, experience of RTI/STI in past six months and its treatment seeking behaviour is analysed in association with the socio-demographic characteristics of women.

### 5.2. Knowledge and practice about antenatal care

Under antenatal care, this chapter explains the knowledge of young women about the number of times a woman should receive ANC and also timing of receiving first ANC. Similarly, it describes the number and timing of ANC received by women, their knowledge about the place of receiving it and its actual place during previous pregnancies. Subsequently, knowledge and practice of ANC is analysed by different background characteristics of the respondents to understand variations in behaviour. Here ANC services for women are classified in two categories, viz., ANC care and ANC check-up.

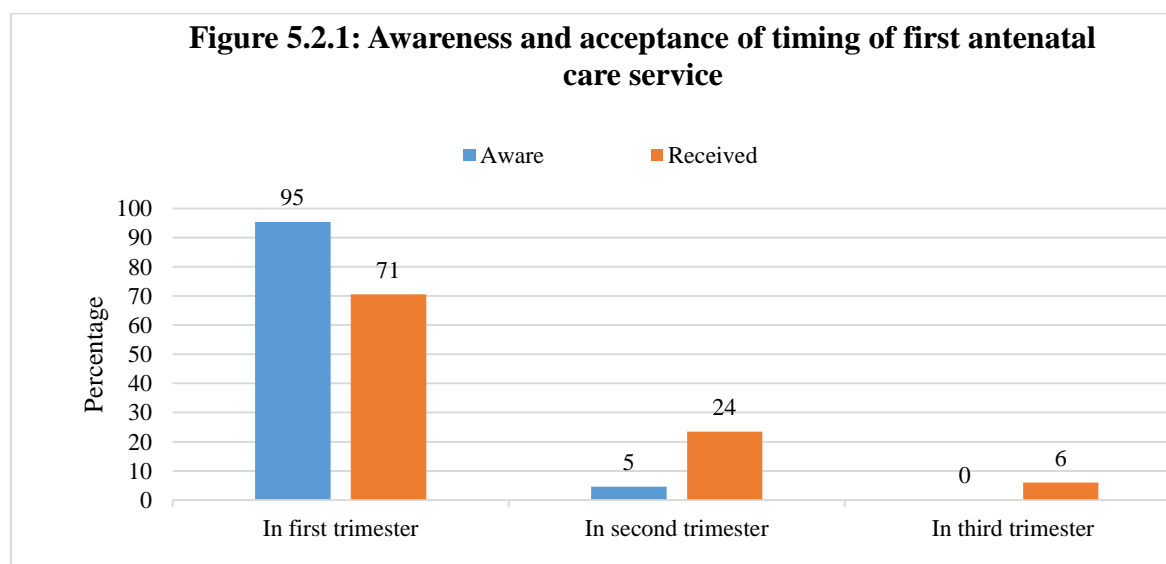
Services included in ANC care are tetanus toxoid (TT) injection and iron and folic acid (IFA) tablets, while in ANC check-up services like haemoglobin (HB), blood pressure (BP), protein urea test and abdomen examination are included.

**Table 5.2.1: Awareness and acceptance of antenatal care services**

Number of ANC services	Aware of ANC	Received ANC	Number of women
Don't know / Not received	1.5	1.5	5
1 to 2 times	5.6	21.9	71
3 times and more	92.9	76.5	248
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>324</b>

Note: "Don't know" is applicable for "Aware of ANC" and "Not received" is applicable for "Received ANC".

Results show that most of young women (93 per cent) were aware that women should receive at least three ANC services during pregnancy. But it was found that 77 per cent women received three ANC services during their last pregnancy which is lower by 16 per cent points than awareness.



Women were further asked about the time of receiving first ANC. More than 95 per cent of them said that they should receive their first ANC during initial three months of pregnancy, but 71 per cent of them received it in the first trimester. Though all the maternal and child health programmes emphasized first ANC during the first trimester, 24 per cent women received it in the second trimester (4-6 months of pregnancy) and 6 per cent received it in the third trimester (7-9 months) of pregnancy.

**Table 5.2.2: Awareness and acceptance of antenatal care service in different places**

Place	Aware about place of ANC	Number of women	Place of Receiving ANC	Number of women <sup>2</sup>
Anganwadi centre	55.2	179	52.4	167
Govt. Hospital (SC/PHC/CHC)	93.2	302	71.5	228
Private hospital/clinic	42.9	139	31.3	100
Others <sup>1</sup>	0.3	1	0.9	3
<b>Total (N)</b>	--	<b>324</b>	--	<b>319</b>

Note: Total percentage exceeds hundred due to multiple responses.

<sup>1</sup>Others include quacks and faith healers.

<sup>2</sup> Five women did not receive any ANC.

Subsequently, women were asked about different places where a woman can receive ANC services. About 93 per cent of them said that a woman can receive ANC services in Government hospitals, 55 per cent said in anganwadi centres, and 43 per cent said in private hospitals. Similarly, the actual receiving of ANC services is high in Government hospitals (72 per cent), followed by anganwadi centres (52 per cent) and private hospitals (31 per cent). More than half of the women reported receiving ANC services in a non-medical platform like anganwadi centre and the reason for it is evident from the FGDs conducted with young married women. They said that the Village Health and Nutrition Day (VHND) conducted at the anganwadi centre is best for them where ANM provides ANC services.

One of the FGD participants said,

*“ANM didi comes to our anganwadi every month and gives injection (meaning TT) and tablets (meaning IFA) to pregnant women. If anyone tells about any problem, she asks her to come to hospital (meaning sub-centre)”*

Another woman said,

*“Sometime ANM didi asks us to go to higher health facilities (PHC or CHC) for check-up, but at other times we go there or to the nearby private hospital. Treatment in private hospital is good”.*

Awareness and acceptance of antenatal care services were further analysed by the background characteristics of women. Table 5.2.3 illustrates awareness and acceptance of three ANC services among all young women by their socio-demographic characteristics.

**Table 5.2.3: Awareness and acceptance of at least three antenatal care services during last pregnancy by socio-demographic characteristics**

<b>Socio-demographic characteristics</b>	<b>Aware of need for three ANCs</b>	<b>Received three ANCs</b>	<b>Number of women</b>
<b>Educational level of women</b>			
No education	89.5	60.5	114
Class 1-5	91.4	81.0	58
Class 6-8	92.0	85.3	75
Class 9 and above	100.0	88.3	77
<b>Educational level of husbands</b>			
No education	84.3	57.1	70
Class 1-5	91.7	69.4	36
Class 6-8	91.8	74.0	73
Class 9 and above	97.9	89.0	145
<b>Age of women</b>			
15-19 years	91.7	78.1	96
20-24 years	93.4	75.9	228
<b>Caste</b>			
General	95.7	78.3	46
SC	91.3	71.7	127
ST	88.2	60.8	51
OBC	96.0	90.0	100
<b>Duration of marital life</b>			
0-1 year	91.2	78.8	80
2-4 years	94.2	80.2	121
5 years and above	92.7	71.5	123
<b>Number of living children</b>			
No child or one child	91.1	72.6	157
Two children	95.8	84.7	118
Three or more children	91.8	69.4	49
<b>Ever experienced infant mortality</b>			
Yes	96.7	78.7	61
No	92.0	76.0	263
<b>Had discussion about need for ANC</b>			
Yes	92.2	77.8	293
No	100.0	64.5	31
<b>Women's autonomy</b>			
High autonomy	97.1	91.2	34
Moderate autonomy	94.7	74.7	75
Low autonomy	91.6	74.9	215
<b>Gender attitude of women</b>			
High equitable attitude	94.3	79.2	53
Moderate equitable attitude	91.0	75.8	223
Low equitable attitude	100.0	77.1	48
<b>Exposure to mass media</b>			
High exposure	95.0	85.0	40
Medium exposure	95.0	82.2	202
Low exposure	86.6	58.5	82
<b>Standard of living</b>			
High standard of living	100.0	85.2	27
Medium standard of living	94.4	83.7	196
Low standard of living	88.1	60.4	101
<b>Total</b>	<b>92.9</b>	<b>76.5</b>	<b>324</b>

Awareness and receiving of three ANC services were found better with higher education of a woman and her husband. Data revealed that a majority of the young women (90 per cent) with no education were also aware that at least three ANC services are required, but only 61 per cent of similar women received three ANC services for their last pregnancy. Sixty one per cent of women having no education receiving three ANC services could be because of the provision of ANC services at the doorstep. It is also found that all the women who studied Class IX and above were aware that at least three ANC services are required for a pregnant woman. Similarly, more than 88 per cent women who studied higher than Class IX received at least three ANC services for their last pregnancy. Education of husbands also played an important role in the use of ANC services. Eighty-four per cent of women whose husbands have not studied at all and 98 per cent of women whose husbands completed Class IX and above were aware of receiving at least three ANC services. Likewise, 57 per cent of women whose husbands have not studied and 89 per cent of women whose husbands completed Class IX and above have received at least three ANC services.

One of the women during an FGD said,

*“We don’t know how many and which ANC services are required for a pregnant women. Whenever our ASHA didi asks or takes us to the anganwadi centre or hospital we go. She does everything for us.”*

Another woman said,

*“I came to know about the care to be taken during pregnancy from my mother and mother-in-law who told me everything. My sister-in-law also told me many things”.*

Compared with 15-19 year old women, 20-24 year old women were slightly better aware of the requirement of three ANC services, while about 2 per cent more women in the age group of 15-19 years received three ANC services compared with the women of 20-24 years. About 60 per cent of ST young women received three ANC services during the last pregnancy and the same was 72 per cent for the women belonging to SC, 78 per cent for general and 90 per cent for other backward class women. Duration of marital life and number of living children do not seem to have a prominent association with awareness and receiving of three ANC services. Young women who ever experienced infant mortality were better aware (97 per cent) as well as receptors (79 per cent) of three ANC services, whereas this was 92 per cent and 76 per cent respectively for the women who did not experience infant mortality. It was found

that 78 per cent of the women (with whom someone like front line health service provider or household member discussed the need for ANC) received three ANC services, where as this was low (65 per cent) for the women who did not have any discussion about the need for ANC. Women with higher autonomy were better aware (97 per cent) as well as accepters (91 per cent) of three ANCs compared with women of moderate and low autonomy, where 92 and 75 per cent of women having low autonomy were aware and received three ANC services respectively.

Gender attitude of women did not seem to have a substantial association with ANC services. All the women belonging to low equitable gender attitude were aware that a pregnant woman should receive three ANCs, while it was 94 per cent for the women of high equitable gender attitude. Contrary to this, 77 per cent women in the low equitable attitude received three ANCs and the same was 76 per cent for the women of moderate and 79 per cent for the women of high equitable gender attitude. Women who had lower levels of mass media exposure had low awareness about three ANCs and only 59 per cent of them had received three ANCs during the last pregnancy. This was found to be better among the women who were highly exposed to mass media, where 95 per cent of them were aware and 85 per cent received three ANCs. Women having high standard of living were more knowledgeable and receptors of three ANCs compared with women of medium and low standard of living. Eighty-eight per cent of women having low standard of living and all the women having high standard of living were aware that three ANCs are required for a pregnant woman. Similarly, 60 per cent women of the low standard of living and 85 per cent women of high standard of living received three ANCs during their previous pregnancy.

**Table 5.2.4: Logistic regression results for women’s acceptance of at least three antenatal care services during last pregnancy**

Independent or predictor variables	Odds of receiving three ANC			N (324)
	Model-1	Model-2	Model-3	
<b>Age of women</b>				
15-19 years®	1.00	1.00	1.00	96
20-24 years	0.92	0.83	0.82	228
<b>Education level of women</b>				
No education®	1.00	1.00	1.00	114
Any education	2.51**	2.54**	2.57**	210
<b>Caste</b>				
SC and ST®	1.00	1.00	1.00	178
General and OBC	2.21**	2.32**	2.35**	146
<b>Type of family</b>				
Nuclear®	1.00	1.00	1.00	113
Non-nuclear	1.14	1.24	1.22	211
<b>Number of living children</b>				
No or one child®	1.00	1.00	1.00	157
Two or more children	3.13***	2.88**	2.90**	167
<b>Exposure of women to mass media</b>				
Low exposure®	1.00	1.00	1.00	82
High to medium exposure	1.55	1.59	1.65	242
<b>Standard of living</b>				
Low SLI®	1.00	1.00	1.00	101
High to medium SLI	2.37**	2.39**	2.30**	223
<b>Distance to nearest health facility</b>				
More than 5 km®	1.00	1.00	1.00	80
Within 5 km	1.34	1.33	1.27	244
<b>Had discussion about need for ANC</b>				
No®	1.00	1.00	1.00	31
Yes	1.47*	1.50*	1.49*	293
<b>Women’s autonomy</b>				
Low autonomy®	1.00	1.00	1.00	215
High to moderate autonomy	1.73*	1.63*	1.86*	109
<b>Decision-making power</b>				
Low DMP®	--	1.00	1.00	196
High to moderate DMP	--	1.41	1.36	128
<b>Gender attitude of women</b>				
Low equitable attitude®	--	--	1.00	48
High to moderate equitable attitude	--	--	1.44	276

Note: ® Reference category; Level of significance: \* p≤0.100; \*\* p≤0.050; \*\*\* p≤0.001

Logistic regression analysis for women’s acceptance of three antenatal care services during the last pregnancy was carried out and three different models were tested. It was found that the likelihood of receiving three ANCs was 2.5 times significantly high for women with education compared with those who have not studied at all. Similarly, compared with the SC-ST women, general and other backward class women were significantly more likely (OR 2.3) to receive three ANCs. The odds of receiving three ANCs were significantly high (Model-1 OR 3.1, Model-2,3 OR 2.9) among the women with two or more children,

compared with those having no or one child. Though the likelihood of receiving three ANC services was better among the women of non-nuclear families, for women with higher to medium exposure to mass media and those residing within five kms of distance to a health facility, this did not show any significant relationship. However, women having higher standard of living, those who had discussions with health service providers or family members about the need for ANC and those with high to moderate autonomy were found to have significant impact on accepting three ANC services. Compared especially with women of low standard of living, models-1 and 2 showed that women of moderate to high standard of living were 2.4 times more likely to receive three ANCs, while according to model-3 the odds ratio was 2.3. Women who had a discussion with front line health service providers like ASHA, ANM, anganwadi worker or any household member about the need for ANC were 1.5 times more likely to receive three ANCs as compared with those who did not do it. Similarly, the odds of receiving three ANCs were 1.6 to 1.9 times more (Model-1 OR 1.7, Model-2 OR 1.6, Model-3 OR 1.9) for the women with high to moderate autonomy, as compared with women with low autonomy. Subsequently “decision-making power” variable was included in models 2 and 3 and “gender attitude of women” variable was included only in model3. It was found that women having high to moderate decision-making power and those having high to moderate equitable gender attitude were 1.4 times more likely to receive three ANCs compared with their counterparts. But this association is insignificant.

**Table 5.2.5: Awareness and acceptance of basic antenatal care services**

<b>ANC services</b>	<b>Percentage</b>	<b>Number of women</b>
<b>Knowledge of ANC services (N=324)</b>		
Basic ANC care	76.5	248
Basic ANC check-up	8.0	26
Both basic ANC care and check-up	6.5	21
<b>Received ANC services (N=319)</b>		
Basic ANC care	88.9	288
Basic ANC check-up	7.1	23
Both basic ANC care and check-up	6.5	21

Note: Basic ANC care includes TT and IFA.  
Basic ANC check-up includes BP, Hb, protein urea and abdomen examination.

Under ANC women receive different services like TT injection, IFA tablets, BP check-up, haemoglobin test, protein urea test, abdomen examination, weight and height measurement, etc. Generally in a typical rural setting, if a woman receives TT and IFA, she is considered as a receptor of ANC services. But other services like BP check-up, haemoglobin test, protein urea test and abdomen examination are not given a high priority



which are rated more critical for a pregnant women to identify if she is high risk or not. Thus the current analysis is done by considering TT, IFA basic ANC care and BP check-up, haemoglobin test, protein urea test and abdomen examination as basic ANC check-up. ANC care and check-up are analysed separately as well as in combination to see the differences. It was found that about 77 per cent of young women were aware of basic ANC care, while 89 per cent received the same. This is because of ANC service provision at the anganwadi centre every month and also mobilization of ASHA at the village level which is quite evident from qualitative findings. On the other hand, very less women (8 per cent) were aware of basic ANC check-up and only 7 per cent received these services. Similarly, about 7 per cent women were aware and also received both ANC care and check-up services. It seems that though provision of ANC services through VHNDs was considered as a good platform, the services were limited only to TT and IFA. Other services like BP check-up, haemoglobin test, protein urea test and abdomen examination were hardly provided to pregnant women.

**Table 5.2.6: Health problems faced during pregnancy and treatment-seeking behaviour of women**

<b>Health problems and treatment</b>	<b>Percentage</b>	<b>Number of women</b>
Aware of health problems a woman can face during pregnancy (N=324)	90.7	294
Women experienced problems during pregnancy (N=324)	54.3	176
Women sought treatment for their problems during pregnancy (N=176)	80.1	141
Major reasons for not seeking treatment for health problems (N=35)	68.6	24
<i>Did not feel the need</i>	31.4	11
<i>Cost too much</i>		

Women were asked about different health problems faced during pregnancy. A majority of them (91 per cent) were aware of some or other health problem a woman can face during pregnancy. The study reveals that more than 54 per cent women experienced some health problem during their last pregnancy and of them about 20 per cent did not seek treatment mainly because they did not feel the need.

**Table 5.2.7: Awareness and treatment-seeking behaviour of health problems faced during pregnancy by socio-demographic characteristics**

Socio-demographic characteristics	Aware of problems faced during pregnancy	Number of women	Sought treatment of the problems	Number of women
<b>Educational level of women</b>				
No education	80.7	114	80.4	56
Class 1-5	96.6	58	76.7	30
Class 6-8	94.7	75	66.7	39
Class 9 and above	97.4	77	92.2	51
<b>Educational level of husbands</b>				
No education	91.4	70	73.5	34
Class 1-5	91.7	36	63.6	22
Class 6-8	91.8	73	85.3	34
Class 9 and above	89.7	145	84.9	86
<b>Age of women</b>				
15-19 years	88.5	96	91.1	45
20-24 years	91.7	228	76.3	131
<b>Caste</b>				
General	95.7	46	96.4	28
SC	92.9	127	64.2	67
ST	78.4	51	90.9	33
OBC	92.0	100	85.4	48
<b>Duration of marital life</b>				
0-1 year	92.5	80	86.0	50
2-4 years	90.1	121	81.4	59
5 years and above	90.2	123	74.6	67
<b>Number of living children</b>				
No child or 1 child	92.4	157	85.2	81
2 children	86.4	118	80.6	67
3 or more children	95.9	49	64.3	28
<b>Ever experienced infant mortality</b>				
Yes	83.6	61	76.0	25
No	92.4	263	80.8	151
<b>Had discussion about need for ANC</b>				
Yes	90.8	293	79.9	159
No	90.3	31	82.4	17
<b>Women's autonomy</b>				
High autonomy	91.2	34	75.0	16
Moderate autonomy	97.3	75	73.7	57
Low autonomy	88.4	215	84.5	103
<b>Gender attitude of women</b>				
High equitable attitude	83.0	53	93.3	15
Moderate equitable attitude	91.9	223	79.0	124
Low equitable attitude	93.8	48	78.4	37
<b>Exposure to mass media</b>				
High exposure	100.0	40	75.0	16
Medium exposure	90.6	202	85.5	110
Low exposure	86.9	82	70.0	50
<b>Standard of living</b>				
High standard of living	92.6	27	100.0	20
Medium standard of living	91.8	196	82.1	95
Low standard of living	88.1	101	70.5	61
<b>Total</b>	<b>90.7</b>	<b>324</b>	<b>80.1</b>	<b>176</b>

Note: "Aware of problems faced during pregnancy" includes all women; "Sought treatment of the health problems" includes women who had any problem during pregnancy.

Further analysis of awareness of women's health problems during pregnancy and treatment-seeking behaviour by different background characteristics has been carried out. It is found that more than 95 per cent women with any level of education were aware of health problems a woman can face during pregnancy, while this is slightly lower (80 per cent) for women without education. Treatment-seeking behaviour does not seem to be influenced much by the educational level of women. Eighty-nine per cent of women of 15-19 years were aware of the health problems a woman can face during pregnancy, while 91 per cent of them sought treatment for the same. Similarly, 92 per cent of women of 20-24 years were aware of the pregnancy-related health problems but only 76 per cent of them sought treatment. Women in the initial one year of marriage and those having no or one child were better in seeking treatment for pregnancy-related health problems compared with their counterparts. The knowledge level of the same does not seem to be varying much for the women having more years of marital life and larger number of children. Young women's discussion with any one about the need for ANC and their autonomy also did not influence their knowledge about pregnancy problems and treatment-seeking behaviour. However, 93 per cent women with high equitable gender attitude sought treatment for their health problems during pregnancy, while the same was 78 per cent for women with low equitable gender attitude. The standard of living of women was found to have a positive association with knowledge as well as treatment of pregnancy-related health problems. Nearly 93 per cent women having high standard of living were aware of the health problems and all of them of the same category who suffered with a problem sought treatment. As against this, 88 per cent women having low standards of living were aware of pregnancy-related health complication and only 71 per cent of them sought treatment.

It is found in our analysis that most young women (73 per cent) reported that they received information related to ANC services from the health service providers like ASHA, ANM, anganwadi worker, etc., while about 22 per cent of them came to know about it from mother, mother-in-law and electronic media and 19 per cent from friends and relatives.

**Table 5.2.8: Logistic regression results for women’s treatment-seeking behaviour of health problems faced during pregnancy**

Independent or predictor variables	Odds of seeking treatment for pregnancy-related problems			N (176)
	Model-1	Model-2	Model-3	
<b>Age of women</b>				
15-19 years®	1.00	1.00	1.00	45
20-24 years	0.30*	0.34	0.35	131
<b>Educational level of women</b>				
No education®	1.00	1.00	1.00	56
Any education	0.37*	0.37*	0.37*	120
<b>Caste</b>				
SC and ST®	1.00	1.00	1.00	100
General and OBC	2.96**	2.73**	2.76**	76
<b>Type of family</b>				
Nuclear®	1.00	1.00	1.00	72
Non-nuclear	0.91	0.82	0.80	104
<b>Number of living children</b>				
No or one child®	1.00	1.00	1.00	81
Two or more children	0.92	0.96	0.94	95
<b>Exposure of women to mass media</b>				
Low exposure®	1.00	1.00	1.00	50
High to medium exposure	2.31	2.29	2.37	126
<b>Standard of living</b>				
Low SLI®	1.00	1.00	1.00	61
High to medium SLI	2.29	2.24	2.22	115
<b>Distance to nearest health facility</b>				
More than 5 km®	1.00	1.00	1.00	43
Within 5 km	2.22*	2.22*	2.18*	133
<b>Had discussion about need for ANC</b>				
No®	1.00	1.00	1.00	17
Yes	0.84	0.82	0.80	159
<b>Women’s autonomy</b>				
Low autonomy®	1.00	1.00	1.00	103
High to moderate autonomy	0.38**	0.41**	0.44*	73
<b>Decision-making power</b>				
Low DMP®	--	1.00	1.00	104
High to moderate DMP	--	0.69*	0.67	72
<b>Gender attitude of women</b>				
Low equitable attitude®	--	--	1.00	37
High to moderate equitable attitude	--	--	1.19	139

Note: ® Reference category; Level of significance: \* p≤0.100; \*\* p≤0.050; \*\*\* p≤0.001

Logistic regression results for women’s treatment seeking behaviour of health problems faced during pregnancy in the three models show that women aged 20-24 years are less likely to seek treatment for their antenatal problems compared with women of 15-19 years. Similarly, women’s education did not seem to be influencing their treatment-seeking behaviour for their health problems during pregnancy. However, the regression models show that women belonging to general and other backward classes were 2.7 to 3 times (Model-1 OR 3.0, Model-2 OR 2.7, Model-3 OR 2.8) significantly better in seeking

treatment compared with the SC and ST women. Though women having high to medium exposure to mass media as well as standard of living were almost 2.3 times more likely to seek treatment for their pregnancy related health problems compared with their counter groups, their association is not significant. All the regression models highlight that women staying within five kms distance from a health facility were 2.2 times more likely to seek treatment for their health problems during pregnancy compared with those who are staying more than five kms. It was also found that women having low autonomy were significantly high in seeking treatment for their health problems compared with women of high or moderate autonomy. This could be due to a substantial proportion of low autonomous women facing any pregnancy-related complications. Almost similar results were found for women with low decision-making power, where a majority of them had problems during their last pregnancy and better in seeking treatment for their problems compared with women of high to moderate decision-making power. Though women having high to moderate equitable gender attitude were slightly better in seeking treatment compared with women of low equitable attitude, it is not significant.

### 5.3. Knowledge and practice about delivery care

Under delivery care, this chapter explains about the awareness and practice of young women about the place of delivery, care taken during delivery, health problems experienced and treatment-seeking behaviour. Subsequent analysis was carried out to see the association between the place of delivery and socio-demographic characteristics of respondents.

**Table 5.3.1: Awareness and utilization of place of delivery**

Place of delivery	Aware of ideal place of delivery	Number of women	Place of delivery of last child	Number of women*
Home	2.8	9	26.5	80
Government hospital	91.6	297	69.5	210
Private hospital/clinic	5.6	18	4.0	12
<b>Total</b>	<b>100.0</b>	<b>324</b>	<b>100.0</b>	<b>302</b>

Note: \* Excludes women who had abortion.

Respondents were asked their opinion regarding the place of delivery and actual place of delivery for their last child. A majority of young women (97 per cent) said that a woman should deliver in a government or private health facility. Yet, 27 per cent women did not deliver their last baby in a health facility, but at home. Qualitative findings show that

though women get information from different sources regarding delivering the baby in a health facility, they don't go there because of poor services.

A woman in an FGD said,

*“ASHA and anganwadi didi tell us to go to Government hospital for delivery. We also know this from TV. We will get some money if we deliver there”.*

Another woman said,

*“In the Government hospital ANM and aya (support staff for delivery) don't behave properly, and often they ask for money during delivery. In our village there are many home deliveries taking place and the children are healthy and many of them are going to school now”.*

**Table 5.3.2: Awareness and practice of birth preparedness**

<b>Essential arrangements for birth</b>	<b>Aware of essential arrangement for birth</b>	<b>Number of women</b>	<b>Made essential arrangement for birth</b>	<b>Number of women*</b>
Clean place for delivery	29.3	95	36.3	29
Clean hands (soap to wash hands) for conducting delivery	46.9	152	60.0	48
New blade to cut cord	49.4	160	90.0	72
New thread to tie cord	31.5	102	55.0	44
Clean cloth to wipe and wrap baby	76.9	249	82.5	66
Use of disposable delivery kit	2.5	8	0.0	0
Trained birth attendant	22.5	73	23.8	19
Identified vehicle to go to institution in case of emergency	0.6	2	0.0	0
<b>Total (N)</b>	--	<b>324</b>	--	<b>80</b>

Note: Total percentage exceeds hundred due to multiple responses.

\* Includes women who had home delivery.

Out of 324 women, 80 women delivered at home. They were asked about the arrangements made to protect the health of mother and baby. It was found that 90 per cent women arranged a new blade to cut the umbilical cord, and 83 per cent arranged clean cloth to wipe and wrap the baby. Only 55 per cent women arranged new thread to tie the umbilical cord (which is critical to prevent the baby from cord infection). Astonishingly, not a single woman responded that she had identified a vehicle to go to an institution in case of emergency. Awareness about most of the essential birth arrangements were not satisfactory except arranging clean cloth to wipe and wrap baby (which accounted for 77 per cent of 324 young women).

**Table 5.3.3: Opinion and practice of institutional delivery by socio-demographic characteristics**

Socio-demographic characteristics	Aware of need for institutional delivery	Number of women	Delivered last baby in an institution	Number of women*
<b>Education level of women</b>				
No education	94.7	114	62.5	104
Class 1-5	100.0	58	94.7	57
Class 6-8	96.0	75	64.4	73
Class 9 and above	100.0	77	82.4	68
<b>Educational level of husband</b>				
No education	98.6	70	60.3	68
Class 1-5	91.7	36	84.8	33
Class 6-8	93.2	73	67.2	64
Class 9 and above	100.0	145	80.3	137
<b>Age of women</b>				
15-19 years	100.0	96	84.1	88
20-24 years	96.1	228	69.2	214
<b>Caste</b>				
General	100.0	46	95.1	41
SC	95.3	127	64.2	120
ST	94.1	51	54.2	48
OBC	100.0	100	86.0	93
<b>Duration of marital life</b>				
0-1 year	100.0	80	79.2	77
2-4 years	97.5	121	80.6	108
5 years and above	95.1	123	63.2	117
<b>Number of living children</b>				
No child or 1 child	100.0	157	80.7	140
2 children	94.9	118	71.7	113
3 or more children	93.9	49	57.1	49
<b>Ever experienced infant mortality</b>				
Yes	100.0	61	73.8	61
No	96.6	263	73.4	241
<b>Had discussion about place of delivery*</b>				
Yes	97.8	268	75.0	268
No	91.2	34	61.8	34
<b>Women's autonomy</b>				
High autonomy	100.0	34	61.8	34
Moderate autonomy	96.0	75	80.9	68
Low autonomy	97.2	215	73.0	200
<b>Gender attitude of women</b>				
High equitable attitude	100.0	53	83.0	47
Moderate equitable attitude	97.3	223	71.6	208
Low equitable attitude	93.8	48	72.3	47
<b>Exposure to mass media</b>				
High exposure	100.0	40	83.3	36
Medium exposure	98.5	202	78.4	190
Low exposure	92.7	82	56.6	76
<b>Standard of living</b>				
High standard of living	100.0	27	100.0	22
Medium standard of living	100.0	196	74.3	191
Low standard of living	91.1	101	65.2	89
<b>Total</b>	<b>97.2</b>	<b>324</b>	<b>73.5</b>	<b>302</b>

Note:\* Excludes women who had abortion.

As most of the women (97 per cent) reported that a woman should deliver her baby in a health facility, no significant difference by their socio-demographic characteristics was observed. However, it is important to see the difference between their opinion and actual practice of institutional delivery. Results showed that about 74 per cent women reported delivering their last baby in a health facility and a little variation was found in selected socio-demographic characteristics of women. Education does not seem to be influencing much on institutional delivery as women with lower education also delivered their last baby in an institution. It was found that 84 per cent of women in the age group 15-19 years delivered their last baby in an institution, while this was 69 per cent for the women in the age of 20-24 years. Though nearly 95 per cent of SC and ST women were aware that women should deliver the baby in a health facility, only 64 per cent of SC and 54 per cent of ST women delivered their last baby in a health facility. It is gratifying that 95 per cent of the general caste women and 86 per cent of other backward class women delivered their last baby in a health facility. Women having no or less children have a positive association with institutional delivery. It was found that all the women with no or one child were aware and 81 per cent of them delivered their last baby in an institution, whereas 57 per cent of women who had three or more children delivered their last baby in an institution. Seventy-five per cent women who had a discussion with health service providers or any household member regarding place of delivery, delivered their last baby in an institution, while this was 62 per cent for those who did not have any discussion. Exposure to mass media was found to have a positive impact on institutional delivery. All the women who had high exposure to mass media said that they should delivery baby in an institution. This was 98 and 92 per cent for women who had moderate and low exposure to mass media respectively. Similarly, 83 per cent women who were highly exposed to media delivered their last baby in a health facility, whereas this was lower for women who had medium (78 per cent) and low (57 per cent) exposure to mass media. As expected, women having high and medium standards of living were more prone to institutional delivery. Though all the women in this category were aware that delivery should take place in a health facility, all the women having a high standard of living, 74 per cent of them having medium standard of living and 65 per cent of them having low standard of living delivered their last baby in a health facility.



**Table 5.3.4: Logistic regression results for institutional delivery of the last pregnancy**

Independent or predictor variables	Odds of institutional delivery of last pregnancy			N (302)
	Model-1	Model-2	Model-3	
<b>Age of women</b>				
15-19 years®	1.00	1.00	1.00	88
20-24 years	0.45**	0.71	0.59	214
<b>Education level of women</b>				
No education®	1.00	1.00	1.00	104
Any education	1.48*	1.46*	1.57*	198
<b>Caste</b>				
SC and ST®	1.00	1.00	1.00	168
General and OBC	4.71***	4.06***	4.26***	134
<b>Type of family</b>				
Nuclear®	1.00	1.00	1.00	105
Non-nuclear	0.60	0.42**	0.33**	197
<b>Number of living children</b>				
No or one child®	1.00	1.00	1.00	140
Two or more children	0.74	0.87	0.90	162
<b>Exposure of women to mass media</b>				
Low exposure®	1.00	1.00	1.00	76
High to medium exposure	2.23**	2.07*	2.74**	226
<b>Standard of living</b>				
Low SLI®	1.00	1.00	1.00	89
High to medium SLI	0.59	0.51*	0.41**	213
<b>Distance to nearest health facility</b>				
More than 5km®	1.00	1.00	1.00	77
Within 5km	0.70	0.78	0.62	225
<b>Had discussion about place of delivery</b>				
No®	1.00	1.00	1.00	34
Yes	1.95*	1.64*	1.62*	268
<b>Women's autonomy</b>				
Low autonomy®	1.00	1.00	1.00	200
High to moderate autonomy	1.29	1.66	2.76**	102
<b>Decision-making power</b>				
Low DMP®	--	1.00	1.00	175
High to moderate DMP	--	0.27***	0.22***	127
<b>Gender attitude of women</b>				
Low equitable attitude®	--	--	1.00	47
High to moderate equitable attitude	--	--	4.24**	255

Note: ® Reference category; Level of significance: \* p≤0.100; \*\* p≤0.050; \*\*\* p≤0.001.

Logistic regression analysis for institutional delivery highlights that compared with the younger women (15-19 years), older women (20-24 years) were less likely to deliver their baby in an institution. However, this did not show a significant relation in all the three models. The likelihood of women delivering their last baby in a health facility was 1.5 to 1.6 times more (Model-1 and 2 OR 1.5, Model-3 OR 1.6) for women with any level of education compared with those who did not study at all. The regression models highlighted that there was a significant association between caste and institution delivery. Women in the general and other backward classes were 4.1 to 4.7 times (Model-1 OR 4.7, Model-2

OR 4.1, Model-3 OR 4.3) more likely to delivery their last child in a health facility compared with women of SC and ST. Similarly, compared with women who had low mass media exposure, women having high to moderate mass media exposure were more than twice prone to institutional delivery. Women who had discussion about the place of delivery with the health service provider or any household member were 1.6 to 2 times (Model-1 OR 2.0, Model-2 and 3 OR 1.6) more likely to deliver their last child in a health facility. After controlling all the socio-demographic variables, decision-making power and gender attitude variables, it was found that women with high to moderate autonomy were 2.8 times significantly high in delivering the last child in an institution compared with women of low autonomy. Likewise, women having high to moderate equitable gender attitude were 4.2 times high in institutional delivery compared with their counter group.

**Table 5.3.5: Awareness and practice of basic delivery care (birth preparedness)**

<b>Birth preparedness</b>	<b>Percentage</b>	<b>Number of women</b>
Have all basic knowledge about the precautions to be taken during delivery (N=324)	0.6	2
Arranged all basic things for delivery (N=80)*	0.0	0

Note: Basic delivery care includes clean place, soap, new blade, new thread, clean cloth, TBA and vehicle for emergency.  
\* Includes women who had home delivery.

Preparedness for delivery or birth planning is an important aspect to protect health of mother and baby as well as to save life. This is essential for those who don't want to go to a health facility for delivery and also for others because delivery can happen any time before reaching the facility. Thus, the basic needs have to be thought of and arranged by pregnant women to prevent infection of mother and child. They include a clean place for delivery, soap to wash hands before conducting delivery, new blade to cut umbilical cord, new thread to tie umbilical cord, clean cloth to dry and wrap baby, identification of a trained birth attendant to conduct delivery and finally identification a vehicle to go to a health facility in case of emergency. Data shows that out of 324 young married women, only two had knowledge about these basic requirements for delivery and none arranged it.

**Table 5.3.6: Awareness of health problems faced during delivery**

<b>Type of problem</b>	<b>Percentage</b>	<b>Number of women (N=283)</b>
Premature labour	0.7	2
Obstructed labour	71.4	202
Prolonged labour	13.1	37
Convulsions	1.8	5
Excessive bleeding	43.8	124
Breech presentation	3.9	11
Aware of health problem (N=324)	87.3	283

Data revealed that more than 87 per cent young married women were aware of some or other health problem a woman can suffer during delivery and of those the most common problem highlighted by young women included obstructed labour (71 per cent) and excessive bleeding (44 per cent). Similarly, women were asked about their experience of different health problems during pregnancy.

**Table 5.3.7: Experience of health problems during delivery**

<b>Type of problem</b>	<b>Percentage</b>	<b>Number of women (N=113)</b>
Premature labour	1.8	2
Obstructed labour	39.8	45
Prolonged labour	14.2	16
Convulsions	0.0	0
Excessive bleeding	36.3	41
Breech presentation	7.1	8
Experienced any health problem (N=302)	37.4	113

It is found that 37 per cent women experienced some problem during delivery and a majority of them had problems like obstructed labour and excessive bleeding. Data revealed that about 79 per cent of women who had any problem sought treatment. Those who did not seek treatment mostly delivered their last baby at home.

**Table 5.3.8: Experienced health problems during home delivery and treatment seeking behaviour**

<b>Health problems and treatment</b>	<b>Percentage</b>	<b>Number of women</b>
Experienced problems (N=80)	17.5	14
Sought treatment (N=14)	21.4	3

There were 80 women who delivered their last baby at home and of them 14 women experienced a health problem while only three sought treatment.

#### **5.4. Knowledge and practice about postnatal care**

Periodic postnatal check-up up to six weeks after delivery is essential to ensure well being of both mother and new born. The reproductive health standards are that the first postnatal check-up should be done within 24 hours of r delivery by a medical health professional. In the present study, women who delivered at home and a health facility were covered to understand the opinion of young women regarding postnatal check-up as well as the status of post-natal check-up after the last delivery.

**Table 5.4.1: Awareness and acceptance of first post-natal check-up among women delivered at home and health facility**

Indicators	Among all women*		Among women delivered at home		Among women delivered in a health facility	
	%	N	%	N	%	N
<b>Aware of first post-natal check-up</b>						
Within one day of delivery	80.2	260	61.2	49	87.4	194
After one day of delivery	2.2	7	7.5	6	0.5	1
Thought not necessary	3.7	12	3.8	3	4.1	9
Did not know	13.9	45	27.5	22	8.1	18
<b>Received first post-natal check-up</b>						
Within one day of delivery	68.2	221	12.5	10	91.4	203
After one day of delivery	3.1	10	8.8	7	0.0	0
Did not go for check-up	28.7	93	78.8	63	8.6	19
<b>Total</b>	<b>100.0</b>	<b>324</b>	<b>100.0</b>	<b>80</b>	<b>100.0</b>	<b>222</b>

Note: \* Includes women who had abortion.

Results depicted that among all the young women, more than 80 per cent were aware that post-natal check-up should be done within one day (24 hours) of delivery and about 14 per cent didn't know when to do it. A similar analysis for women by their place of delivery showed that 61 per cent women who delivered at home and 87 per cent women who delivered in a health facility were aware that the first post-natal check-up should be done within one day of delivery. On the contrary, 28 per cent of home delivered women and 8 per cent of institutional delivered women did not know when the first post-natal check-up should be done. Of those who delivered at home, about 79 per cent did not do any postnatal check-up, whereas among those who delivered at an institution, more than 90 per cent received first postnatal check-up within one day of delivery. This is because women who delivered in a health facility had to stay there for 48 hours and by default they were visited by doctors and ANMs, whereas this did not happen in the case of home deliveries.

According to our findings though women have to stay in the health facility at least for 48 hours after delivery, often they come home after one day in case of normal deliveries. One of the women having a baby of 4 months said,

*“I delivered my baby in the evening, the nurse didi asked me to stay for two days in the hospital after delivery, but I didn't like to stay there, I came the next day morning”.*

**Table 5.4.2: Awareness of health problems faced after delivery**

<b>Awareness of post-delivery problems</b>	<b>Percentage</b>	<b>Number of women (N=268)</b>
High fever	20.9	56
Lower abdominal pain	56.7	152
Foul smelling vaginal discharge	4.1	11
Excessive bleeding	60.1	161
Severe headache	14.9	40
Weakness / dizziness	42.2	113
Breast engorgement	3.4	9
Aware of any health problem (N=324)	82.7	268

Women were asked whether they knew about different health problems a woman can experience after delivery and it was found that about 83 per cent were aware of it. The subsequent probing depicted that 60 per cent knew about excessive bleeding, 57 per cent about lower abdominal pain, 42 per cent about weakness, 21 per cent about high fever, 15 per cent about severe headache, and 4 per cent about breast engorgement and foul smelling discharge. Surprisingly, not a single woman was aware of all of them.

**Table 5.4.3: Experience of health problems after delivery**

<b>Post-delivery problems</b>	<b>Percentage</b>	<b>Number of women (N=126)</b>
High fever	27.8	35
Lower abdominal pain	42.9	54
Foul smelling vaginal discharge	2.4	3
Excessive bleeding	45.2	57
Severe headache	12.7	16
Weakness /dizziness	34.1	43
Breast engorgement	0.0	0
Experienced any health problem (N=302)	41.7	126

Our findings revealed that 42 per cent young women suffered from some problem after delivery and most of them (45 per cent) complained about excessive bleeding, followed by lower abdominal pain (43 per cent), weakness (34 per cent), high fever (28 per cent) and severe headache (13 per cent). Not a single women complained of breast engorgement. Subsequent analysis showed that among the women who suffered from some post-natal health complications, only 66 per cent sought treatment. Remaining women did not seek treatment mostly due to negligence and high treatment cost.

**Table 5.4.4: Awareness and treatment seeking behaviour of health problems faced during post-natal period by socio-demographic characteristics**

Socio-demographic characteristics	Awareness of problems during post-natal period	Number of women	Sought treatment of problems	Number of women
<b>Educational level of women</b>				
No education	81.6	114	56.6	53
Class 1-5	86.2	58	76.9	13
Class 6-8	84.0	75	66.7	30
Class 9 and above	80.5	77	76.7	30
<b>Educational level of husband</b>				
No education	74.3	70	63.3	30
Class 1-5	94.4	36	83.3	18
Class 6-8	87.7	73	50.0	32
Class 9 and above	81.4	145	71.7	46
<b>Age of women</b>				
15-19 years	77.1	96	87.1	31
20-24 years	85.1	228	58.9	95
<b>Caste</b>				
General	80.4	46	87.5	18
SC	81.1	127	50.0	52
ST	82.4	51	69.0	29
OBC	86.0	100	81.1	27
<b>Duration of marital life</b>				
0-1 year	82.5	80	62.1	29
2-4 years	81.0	121	78.0	41
5 years and above	84.6	123	58.9	56
<b>Number of living children</b>				
No child or 1 child	80.9	157	75.0	56
2 children	84.7	118	67.9	56
3 or more children	83.7	49	21.4	14
<b>Ever experienced infant mortality</b>				
Yes	85.2	61	74.1	27
No	82.1	263	63.6	99
<b>Had discussion about need for PNC</b>				
Yes	75.8	91	72.7	22
No	85.4	233	64.4	104
<b>Women autonomy</b>				
High autonomy	91.2	34	50.0	20
Moderate autonomy	94.7	75	80.9	47
Low autonomy	77.2	215	59.3	59
<b>Gender attitude of women</b>				
High equitable attitude	64.2	53	80.0	15
Moderate equitable attitude	83.4	223	60.3	73
Low equitable attitude	100.0	48	71.1	38
<b>Exposure to mass media</b>				
High exposure	65.0	40	76.9	13
Medium exposure	85.1	202	80.9	68
Low exposure	85.4	82	40.0	45
<b>Standard of living</b>				
High standard of living	88.9	27	100.0	12
Medium standard of living	79.6	196	76.7	60
Low standard of living	87.1	101	46.3	54
<b>Total</b>	<b>82.7</b>	<b>324</b>	<b>65.9</b>	<b>126</b>

Analysis of awareness and treatment seeking behaviour for post-natal health problems by different background characteristics showed that 85 per cent women in the older age group (20-24 years) and 77 per cent in the younger age group (15-19) were aware of the health problems a woman can suffer during post-natal period. Among the 15-19 years old women who suffered from any health problem, 87 per cent women sought treatment, while 59 per cent for women in 20-24 years did so. More than 80 per cent women belonging to different caste categories were aware of different post-natal health problems and sought treatment. However, seeking treatment for post-natal health problem is less among SC (50 per cent) and ST (69 per cent) women. Education of women, education of husbands and duration of marital life was not found to have positive influence on awareness and treatment seeking for post-natal health problems. Women with less number of living children were better in seeking treatment as 75 per cent of them with no or one child, 68 per cent with two children and 21 per cent with three or more children sought treatment for their health problems during the post-natal period. Similarly, 74 per cent women who had seen infant mortality sought treatment for their post-natal health problems which was lower by almost ten per cent points for those who not witnessed infant mortality. It was found that 85 per cent of women who did not have any discussion about the need for post-natal care with a health service provider or household member were still aware of post-natal care and this was low by about ten per cent points for the women who had such discussions. This could be because a larger proportion of studied women did not have discussion with any one regarding the need for post-natal care. On the other hand, about 73 per cent women who had discussed the need for post-natal care and 64 per cent of them who did not have any discussion sought treatment for their post-natal health complications. Women's autonomy, gender attitude and exposure to mass media did not seem influence much the awareness about post-natal care as well as treatment of post-natal problems. All the women having high standard of living, 77 per cent women having middle standard of living and 46 per cent women having low standard of living sought treatment for their post-natal health complication. Awareness related to this did not vary much with young women's standard of living.

When women were asked about their source of information for post-natal health problems, more than 80 per cent of them said that they received it from the health service providers like ANM, ASHA, anganwadi, etc. Mothers, mothers-in-law and TV programmes were other major source of information for them.

**Table 5.4.5: Logistic regression results for women’s treatment seeking behaviour of health problems faced during post-natal period**

Independent or predictor variables	Odds of seeking treatment for health problems during PNC period			N (126)
	Model-1	Model-2	Model-3	
<b>Age of women</b>				
15-19 years®	1.00	1.00	1.00	31
20-24 years	0.24**	0.45*	0.12**	95
<b>Educational level of women</b>				
No education®	1.00	1.00	1.00	53
Any education	0.52	0.46	0.40	73
<b>Caste</b>				
SC and ST®	1.00	1.00	1.00	81
General and OBC	3.27**	2.18*	4.14**	45
<b>Type of family</b>				
Nuclear®	1.00	1.00	1.00	60
Non-nuclear	1.45	1.29	1.38	66
<b>Number of living children</b>				
No or one child®	1.00	1.00	1.00	56
Two or more children	2.81	3.90**	8.17**	70
<b>Exposure of women to mass media</b>				
Low exposure®	1.00	1.00	1.00	45
High to medium exposure	7.16***	7.51**	2.58***	81
<b>Standard of living</b>				
Low SLI®	1.00	1.00	1.00	54
High to medium SLI	1.89	1.98	1.66	72
<b>Distance to nearest health facility</b>				
More than 5km®	1.00	1.00	1.00	36
Within 5km	0.20**	0.18**	0.51***	39
<b>Had discussion about need for PNC</b>				
No®	1.00	1.00	1.00	104
Yes	5.52**	4.28**	7.72**	22
<b>Women’s autonomy</b>				
Low autonomy®	1.00	1.00	1.00	59
High to moderate autonomy	2.33	2.32*	8.04**	67
<b>Decision-making power</b>				
Low DMP®	--	1.00	1.00	57
High to moderate DMP	--	0.26**	0.14**	69
<b>Gender attitude of women</b>				
Low equitable attitude®	--	--	1.00	38
High to moderate equitable attitude	--	--	3.79***	88

Note: ® Reference category; Level of significance: \* p≤0.100; \*\* p≤0.050; \*\*\* p≤0.001  
 Women who had still births were included in the analysis.

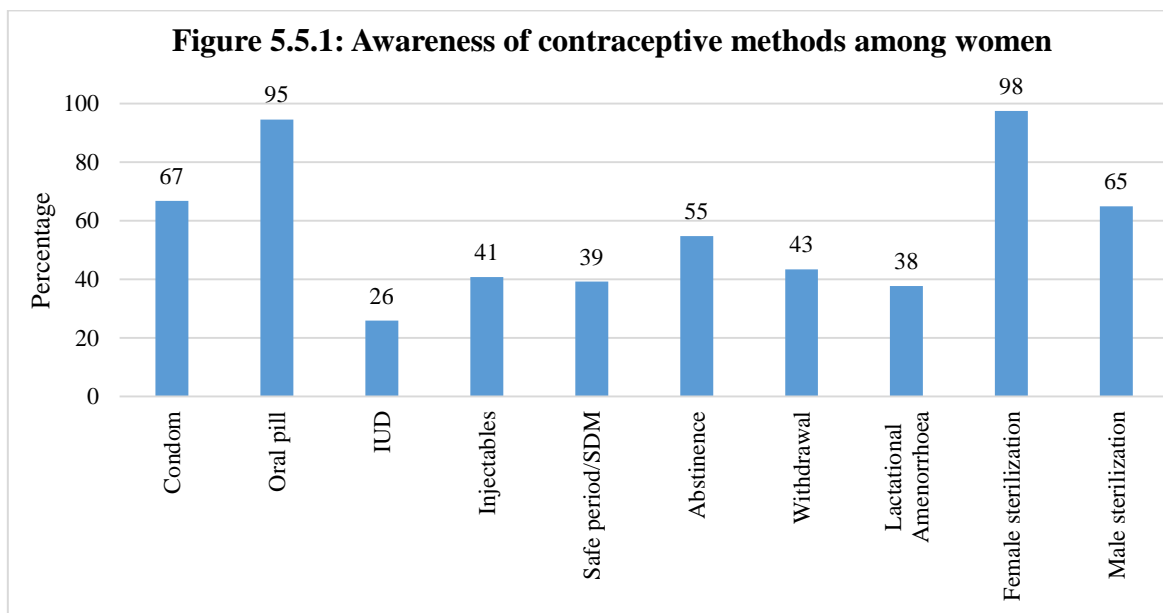
Different models of logistic regression results for women’s treatment seeking behaviour of health problems faced during post-natal period depicted that women of 15-19 years were more likely to seek treatment for their post-natal problems compared with women of 20-24 years. Women of general and other backward classes were up to four times (Model-1 OR 3.3, Model-2 OR 2.2, Model-3 OR 4.2) more likely to seek treatment for their post-natal health problems compared with SC-ST women. The likelihood of treatment seeking



behaviour for women who had two or more children, high to medium exposure to mass media, had discussion about the need for PNC and high to moderate autonomy was significantly more compared with their counter groups and also varied across the models. After controlling the socio- demographic variables, women’s autonomy, decision-making power and gender attitude, it was found that women with two or more children were 8.2 times, high to moderate autonomy were 8 times and those who had discussion about need for PNC were 7.7 times more likely to seek treatment for their post-natal health problems compared with their respective counter groups. Similarly, after excluding “gender attitude of women” from the full model, the odds of treatment seeking were found 7.5 times more for the women who had high to moderate exposure to mass media compared with those who had low exposure. The full model of the regression analysis depicted that women having high to moderate gender equitable attitude were almost 3.8 times more likely to seek treatment for their post-natal health problems compared with those of low equitable gender attitude.

### 5.5. Knowledge and practice about family planning

Family planning is an important component of reproductive health which has a direct impact on core demographic measures like fertility, infant mortality and maternal mortality. Thus, the use of modern family planning methods to delay pregnancy and sufficiently space between children becomes crucial to control fertility and reduce infant and maternal mortality. In the current study young married women were asked about their knowledge as well as use of family planning methods.



It was found that out of 324 women, 316 (98 per cent) were aware of a family planning method. They were also aware of at least one modern family planning method. However, most of the women were aware about female sterilization (98 per cent), followed by oral pill (95 per cent), condom (67 per cent) and male sterilization (65 per cent).

**Table 5.5.1: Current use of family planning methods**

Family planning method	Percentage	Number of women (N=324)
Any family planning method	63.9	207
Any modern family planning method <sup>1</sup>	28.4	92
Any modern spacing family planning method <sup>2</sup>	9.6	31
Any limiting family planning method <sup>3</sup>	18.8	61
Any traditional family planning method <sup>4</sup>	35.5	115

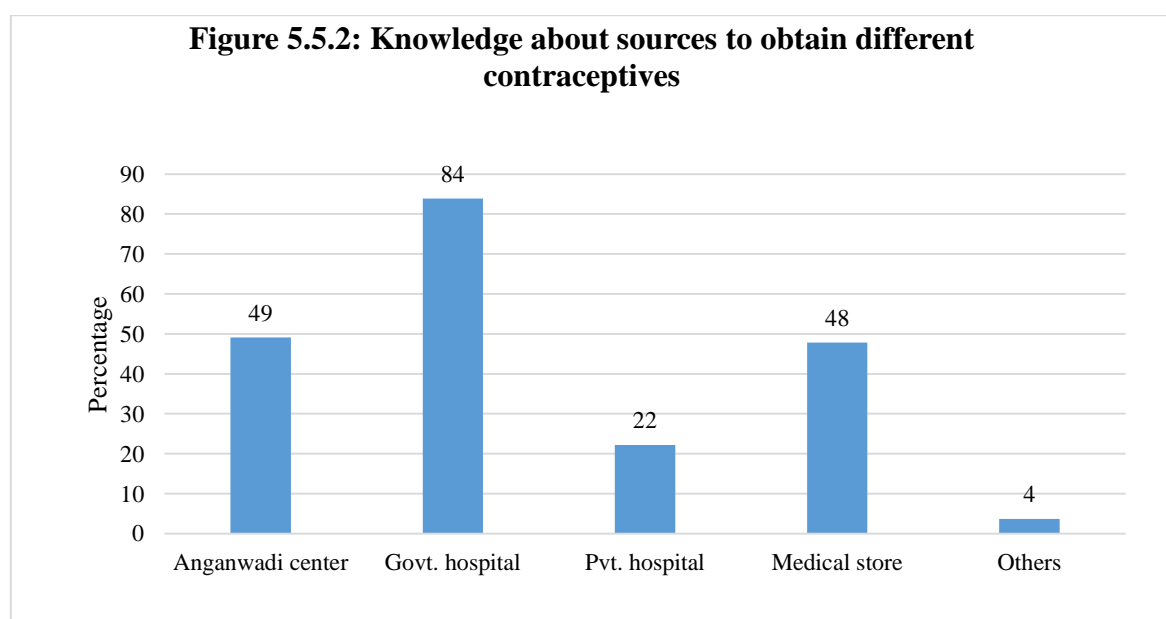
Note: <sup>1</sup>Includes condom, oral pill, IUD, norplant, injectables, female and male sterilization.

<sup>2</sup>Includes condom, oral pill, IUD, norplant and injectables.

<sup>3</sup>Includes female and male sterilization.

<sup>4</sup>Includes safe period/SDM, abstinence, withdrawal, and lactational amenorrhoea

Subsequent analysis of use of family planning method revealed that 64 per cent of young women used a family planning method, whereas only 28 per cent used a modern method. This clearly proves a considerably high proportion (36 per cent) of traditional method users in the studied population. Among the 92 modern method users, 31 women used modern spacing method and 61 women used a limiting family planning method, which accounted for 10 per cent and 19 per cent respectively. Women reported different sources to obtain contraceptives of their choices.



\* Others include ASHA, husband and local general stores.

Nearly 84 per cent young women knew that modern contraceptives could be obtained from government hospitals. Similarly, of all the women, 49 per cent mentioned anganwadi centre, 48 per cent medical store and 22 per cent private hospital as a source for getting contraceptives. Often women considered anganwadi centre and medical store as places to obtain condoms and oral pills. This was evident from focus group discussion with women.

During FGD one woman said during it,

*“ASHA and anganwadi didi keep Nirodh and give us when necessary. Sometimes my husband brings them from medical stores”.*

As mentioned earlier, the level of awareness regarding modern contraceptives is very high among women, thus very negligible differences by socio-demographic characteristics were found. High level of contraceptive awareness could be because of the Government's door step service provision of condom and oral contraceptive pills, wherein front line health workers like ANM, ASHA and anganwadi worker provide the products as well as information about it. However modern contraceptive use was still very low (28 per cent) and there were variations by socio-demographic characteristics of women. Thirty per cent of women in the age group of 20-24 years used a modern family planning method, which was 24 per cent for the 15-19 year old women. Similarly, 37 per cent of women who completed more than five years of marital life and 45 per cent of women who had more than three children used a modern contraceptive method. The same was found in about 11 per cent and 15 per cent respectively for the women who were in the first year of marital life and had no or one child. Contraceptive use increased with an increase in marital duration (31 per cent use for 2-4 years and 37 per cent for 5 years and above of marital duration) and number of children (39 per cent for two children and 45 per cent for three or more children). Despite a high level of contraceptive awareness, only half of the young women who never had a discussion with husband about the number and timing of having children were aware of any modern contraceptive and no such woman used a modern method. Experience of infant mortality, autonomy and gender attitude of women did not have much influence on contraceptive use.

**Table 5.5.2: Awareness and use of modern family planning method by socio-demographic characteristics**

<b>Socio-demographic characteristics</b>	<b>Awareness of a modern family planning method</b>	<b>Currently using a modern family planning method</b>	<b>Number of women</b>
<b>Education level of women</b>			
No education	93.9	31.6	114
Class 1-5	100.0	29.3	58
Class 6-8	98.7	25.3	75
Class 9 and above	100.0	26.0	77
<b>Educational level of husband</b>			
No education	91.4	24.3	70
Class 1-5	100.0	16.7	36
Class 6-8	98.6	35.6	73
Class 9 and above	99.3	29.7	145
<b>Age of women</b>			
15-19 years	100.0	24.0	96
20-24 years	96.5	30.3	228
<b>Caste</b>			
General	100.0	10.9	46
SC	97.6	33.1	127
ST	96.1	33.3	51
OBC	97.0	28.0	100
<b>Duration of marital life</b>			
0-1 year	96.2	11.2	80
2-4 years	100.0	30.6	121
5 years and above	95.9	37.4	123
<b>Number of living children</b>			
No child or 1 child	98.1	15.3	157
2 children	99.2	39.0	118
3 or more children	91.8	44.9	49
<b>Ever experienced infant mortality</b>			
Yes	100.0	26.2	61
No	97.0	28.9	263
<b>Inter-spousal communication about number and timing of having children</b>			
Yes	100.0	29.9	308
No	50.0	0.0	16
<b>Women's autonomy</b>			
High autonomy	94.1	14.7	34
Moderate autonomy	96.0	29.3	75
Low autonomy	98.6	30.2	215
<b>Gender attitude of women</b>			
High equitable attitude	98.1	22.6	53
Moderate equitable attitude	99.1	31.8	223
Low equitable attitude	89.6	18.8	48
<b>Exposure to mass media</b>			
High exposure	97.5	32.5	40
Medium exposure	96.5	30.7	202
Low exposure	100.0	20.7	82
<b>Standard of living</b>			
High standard of living	100.0	14.8	27
Medium standard of living	98.0	33.7	196
Low standard of living	96.0	21.8	101
<b>Total</b>	<b>97.5</b>	<b>28.4</b>	<b>324</b>

Women with low equitable gender attitude were slightly less aware as well as less user of modern contraceptives as compared with those of moderate and highly equitable attitude. Though most of the young women in different standards of living were aware of modern contraceptive methods, about 34 per cent women of the medium standard of living reported using a modern method, which was 15 per cent for women of high standard of living and 22 per cent for women of low standard of living.

**Table 5.5.3: Logistic regression results for use of modern family planning method**

Independent or predictor variables	Odds of using modern family planning method			N (324)
	Model-1	Model-2	Model-3	
<b>Age of women</b>				
15-19 years®	1.00	1.00	1.00	96
20-24 years	0.64	0.61	0.56	228
<b>Education level of women</b>				
No education®	1.00	1.00	1.00	114
Any education	0.56**	0.55*	0.59	210
<b>Caste</b>				
SC and ST®	1.00	1.00	1.00	178
General and OBC	0.52**	0.52**	0.51**	146
<b>Type of family</b>				
Nuclear®	1.00	1.00	1.00	113
Non-nuclear	0.61*	0.63	0.59*	211
<b>Number of living children</b>				
No or one child®	1.00	1.00	1.00	157
Two or more children	5.33***	5.19***	5.40***	167
<b>Exposure of women to mass media</b>				
Low exposure®	1.00	1.00	1.00	82
High to medium exposure	3.07**	3.15**	3.34**	242
<b>Standard of living</b>				
Low SLI®	1.00	1.00	1.00	101
High to medium SLI	2.04*	2.07*	2.02*	223
<b>Distance to nearest health facility</b>				
More than 5km®	1.00	1.00	1.00	80
Within 5km	0.78	0.77	0.70	244
<b>Inter-spousal communication about number and time of having children</b>				
No®	1.00	1.00	1.00	16
Yes	5.41*	5.58*	4.64**	308
<b>Women's autonomy</b>				
Low autonomy®	1.00	1.00	1.00	215
High to moderate autonomy	0.89	0.86	1.04*	109
<b>Decision-making power</b>				
Low DMP®	--	1.00	1.00	196
High to moderate DMP	--	1.18*	1.16**	128
<b>Gender attitude of women</b>				
Low equitable attitude®	--	--	1.00	48
High to moderate equitable attitude	--	--	2.06*	276

Note: ®Reference category; Level of significance: \*  $p \leq 0.100$ ; \*\*  $p \leq 0.050$ ; \*\*\*  $p \leq 0.001$ .

Three different logistic regression models were tested to understand the factors influencing modern contraceptive use. Analysis showed that age, higher education and type of family did not have any significant influence on the use of modern family planning methods. However, SC and ST women were found more likely to use a modern method compared with general and other backward class women. The likelihood of modern contraceptive use is significantly high among women who have two or more children (Model-1 OR 5.3, Model-2 OR 5.2, Model-3 OR 5.4). Women who have high to medium exposure to mass media were almost thrice more likely to use a modern family planning method, compared with those who had low exposure. Similarly, women of high to medium standard of living were twice more likely to use a modern method compared with women of low standard of living. Results from three logistic regression models illustrated that the odds of modern contraceptive use were 4.6 to 5.6 times higher for women who had discussion with their husbands regarding number and timing of having children. After controlling all the socio-demographic variables including women's autonomy and decision-making power, it was found that women having high to moderate equitable gender attitude were almost twice more likely to use a modern contraception compared with women having low equitable attitude.

### 5.6. Knowledge about RTI/STI and treatment seeking behaviour

Reproductive tract and sexually transmitted infections (RTI/STI) are important public health problems in India. They are common among women who do not maintain reproductive hygiene and have unhealthy sexual practices. Unless RTI/STI is treated in time, it may lead to major reproductive health complications. The prerequisite for treatment depends on a woman's understanding about the symptoms and seriousness of RTI/STI. The current research has tried to explore the awareness level of young women about different symptoms of RTI/STI, their experience and treatment seeking for such problems.

**Table 5.6.1: Awareness of RTI/STI problems faced by women**

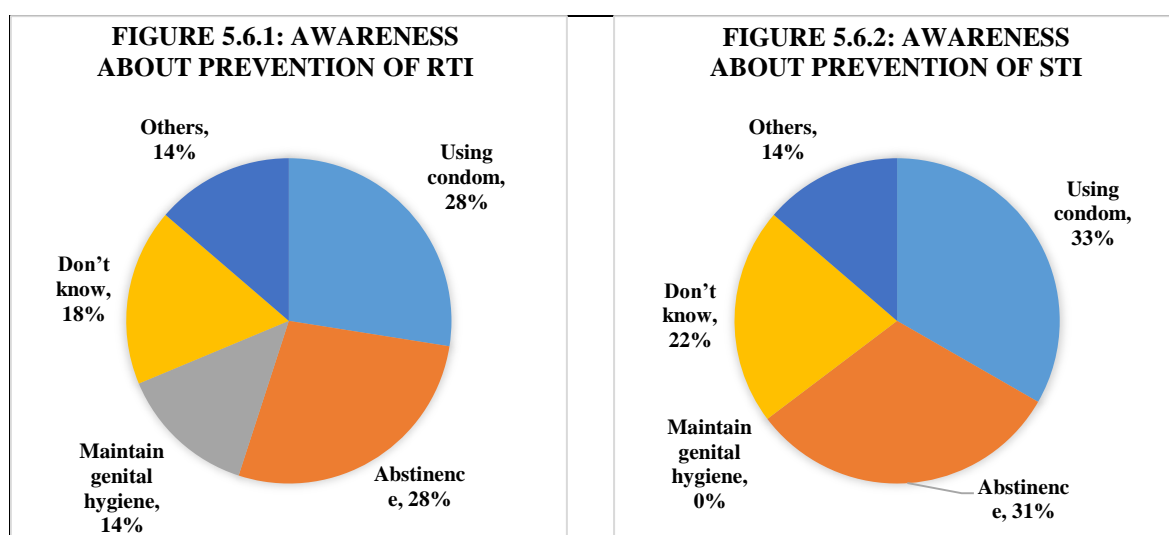
Type of problem	Percentage	Number of women (N=51)
Excessive vaginal discharge	19.6	10
Foul smelling discharge	25.5	13
Ulcers/sores in genital area	35.3	18
Swelling on groin area	11.8	6
Pain during intercourse	3.9	2
Itching in genital area	58.8	30
Pain in lower abdomen	37.3	19
Painful urination	19.6	10
Awareness of RTI/STI (N=324)	15.7	51

It was found that 16 per cent of 324 women were aware of RTI/STI that they can suffer from. Among them, 59 per cent women knew itching in genital area as a symptom of RTI/STI, followed by pain in the lower abdomen (37 per cent), ulcers/sores in genital area (35 per cent), foul smelling discharge (26 per cent), and excessive vaginal discharge and painful urination (20 per cent). Further, young women are asked about their experience of RTI/STI in the past six months.

**Table 5.6.2: RTI/STI problems faced by women**

Type of problem	Percentage	Number of women (N=44)
Excessive vaginal discharge	2.8	9
Foul smelling discharge	1.5	5
Ulcers/sores in genital area	1.9	6
Swelling on groin area	0.9	3
Pain during intercourse	1.5	5
Itching in genital area	6.8	22
Pain in lower abdomen	6.2	20
Painful urination	1.9	6
Experience of any RTI/STI (N=324)	13.6	44

Nearly 14 per cent (44 out of 324) women reported experience of a symptom. Among them, 22 reported itching in genital area and 20 pain in lower abdomen. Those who suffered from any of the RTI/STI symptoms, only 46 per cent women sought treatment. The remaining women did not seek treatment mostly due to negligence, high treatment cost and ignorance of the place of treatment.



Women were asked about the prevention mechanism for RTIs and STIs separately. It was found that about 28 per cent women knew the use of condom and that abstaining from the husband can prevent RTIs. The most critical thing is that nearly 18 per cent young women did not know how it could be prevented. Similarly, 33 and 31 per cent women said that STI could be prevented by using condom and 31 per cent women said that by abstaining from husband. About 22 per cent women did not know how to prevent STI.

**Table 5.6.3: Awareness and treatment seeking behaviour for RTI/STI problems by socio-demographic characteristics**

<b>Socio-demographic characteristics</b>	<b>Aware of any RTI/STI problem</b>	<b>Number of women</b>	<b>Sought treatment of RTI/STI problems</b>	<b>Number of women</b>
<b>Education level of women</b>				
No education	12.3	114	16.7	12
Class 1-5	17.2	58	66.7	6
Class 6-8	8.0	75	20.0	10
Class 9 and above	27.3	77	75.0	16
<b>Educational level of husband</b>				
No education	12.9	70	45.5	11
Class 1-5	16.7	36	33.3	6
Class 6-8	11.0	73	36.4	11
Class 9 and above	19.3	145	56.2	16
<b>Age of women</b>				
15-19 years	10.4	96	0.0	5
20-24 years	18.0	228	51.3	39
<b>Caste</b>				
General	15.2	46	100.0	7
SC	14.2	127	30.0	20
ST	5.9	51	0.0	3
OBC	23.0	100	50.0	14
<b>Duration of marital life</b>				
0-1 year	23.8	80	52.9	17
2-4 years	14.0	121	61.5	13
5 years and above	12.2	123	21.4	14
<b>Number of living children</b>				
No child or 1 child	16.6	157	57.7	26
2 children	18.6	118	41.7	12
3 or more children	6.1	49	0.0	6
<b>Ever experienced infant mortality</b>				
Yes	11.5	61	0.0	3
No	16.7	263	48.8	41
<b>Had discussion about need for RTI/STI treatment</b>				
Yes	85.3	34	66.7	9
No	7.6	290	40.0	35
<b>Women's autonomy</b>				
High autonomy	29.4	34	60.0	5
Moderate autonomy	29.3	75	26.7	15
Low autonomy	8.8	215	54.2	24
<b>Gender attitude of women</b>				
High equitable attitude	13.2	53	100.0	2
Moderate equitable attitude	14.3	223	46.2	26
Low equitable attitude	25.0	48	37.5	16
<b>Exposure to mass media</b>				
High exposure	22.5	40	77.8	9
Medium exposure	15.8	202	40.7	27
Low exposure	12.2	82	25.0	8
<b>Standard of living</b>				
High standard of living	55.6	27	87.5	8
Medium standard of living	12.2	196	42.3	26
Low standard of living	11.9	101	20.0	10
<b>Total</b>	<b>15.7</b>	<b>324</b>	<b>45.5</b>	<b>44</b>



Subsequent analysis on awareness and treatment seeking behaviour of RTI/STI by different socio-demographic characteristics revealed that women who completed higher studies were better aware of RTI/STI and also sought treatment for the problems compared with women with no education. More specifically, 27 per cent of the women who completed more than Class IX were aware of RTI/STI problems and 75 per cent of the same category women sought treatment for them. A similarly pattern is observed for women whose husbands completed Class IX and above. More than half of them in the age group of 20-24 years who experienced an RTI/STI symptom have sought treatment, while only 18 per cent of such women were aware about RTI/STI problems. It was good to see that all the women in the general caste category and half of the other backward class sought treatment for their RTI/STI problems. Duration of marital life, number of living children, experience of infant mortality and women's autonomy did not seem to have substantial influence on awareness and treatment seeking of RTI/STI. However, women who had discussion about the need for RTI/STI treatment with a health service provider or household member were much better aware (85 per cent) as well as sought treatment (67 per cent) for their RTI/STI problems. Exposure of women to mass media appears to have a positive association with RTI/STI awareness and treatment, whereas 23 per cent of women with high exposure, 16 per cent with medium exposure and 12 per cent with low exposure were aware of RTI/STI problems. Likewise, 78 per cent of women with high exposure, 41 per cent with medium exposure and 25 per cent with low exposure sought treatment for their RTI/STI problems. Almost a similar trend was found for standard of living, where 56 per cent women having a high standard of living were aware of RTI/STI, while the corresponding figure was about 12 per cent for women having medium and low standard of living. Eighty-seven per cent women having a high standard of living sought treatment for their health problems, and this was 42 per cent and 20 per cent for women in medium and low standard of living respectively. In this bi-variate analysis, some of the results related to RTI/STI treatment may not be attributable due to low cell count.

**Table 5.6.4: Place of treatment for the health problems faced during different reproductive stages of women**

Nature of problems	% treated in Govt. facility	% treated in pvt. facility	% treated in other places*	% not treated	Total
Problems faced during last pregnancy (N=176)	48.9	28.4	2.8	19.9	100.0
Problems faced during delivery (N=113)	77.0	1.8	0.0	21.2	100.0
Problems faced during post-natal period (N=126)	54.8	7.9	3.2	34.1	100.0
RTI-STI problems faced in last six months (N=44)	29.5	15.9	0.0	54.6	100.0

Note: \*Other places include home remedy, quacks, ASHA and anganwadi workers.

Treatment seeking behaviour of young women for their problems faced during pregnancy, delivery, post-natal period and RTI/STI problems are further analysed by the place of treatment. Government health facilities (SC/PHC/CHC) were the most preferred place of treatment for health problems, followed by private health facility. However, a significant proportion of young women did not seek treatment for their health problems. More specifically, 49 per cent women who had any health problem during pregnancy sought treatment in a government facility, while 20 per cent never sought treatment. Of the women who faced any problem during delivery, 77 per cent sought treatment in a government facility, while 21 per cent did not seek treatment. Similarly, 55 per cent women who experienced any problem during post-natal period sought treatment in a government facility, while 34 per cent women did not seek treatment. More than half of the women (55 per cent) who experienced any RTI/STI symptom in the past six months did not seek treatment. Only about 30 per cent women sought treatment in a government facility and 16 per cent of them in a private health facility.

### 5.7. Summary

Most of the young women (93 per cent) were aware that a woman should receive at least three ANC's during her pregnancy. But only 77 per cent women had received 3 ANC's during pregnancy. Further, when they were asked about the timing of ANC, more than 95 per cent women said that, a woman should receive her first ANC during initial three months of pregnancy, but actually 71 per cent of woman received the first ANC in the first trimester. While it is essential to get the first ANC during first trimester, still 24 per cent of the women received first it in the second trimester and 6 per cent in the third trimester of pregnancy. They received ANC services mostly at government hospital and anganwadi

centre. Provision of ANC services by ANM in every village in every month seems to be a major contributor for receiving such services in a non-medico platform like anganwadi centre.

Awareness and receiving of three ANC services were found better with higher education of a woman and her husband. Data revealed that a majority of young women (90 per cent) with no education were aware that at least three ANC services are required. But only 61 per cent of similar women received three ANC services for their last pregnancy. More than 88 per cent women who studied higher than Class IX received at least three ANC services for their last pregnancy. Older young women had slightly better knowledge about ANC services. It was found that 78 per cent of the women with whom someone like front line health service providers or household members discussed about the need for ANC received three ANC services, whereas this was low (65 per cent) for women who did not have any discussion about the need for ANC. Women with high autonomy were better aware (97 per cent) as well as accepters (91 per cent) of three ANC services compared with women of moderate and low autonomy. Antenatal check-ups like BP, Hb, Protein urea and Abdomen examination are essential to identify high risk pregnancy. In the present study it was found that about 77 per cent of young women were aware of TT and IFA, and 89 per cent of them received them, although only about 7 per cent of them were aware and received the essential antenatal check-ups. Logistic regression results highlighted that the likelihood of receiving three ANC services was 2.5 times significantly high for women with any education and 2.3 times high for women belonged to general and other backward class compared with their respective other groups. Women who had higher standard of living, had discussion with a health service provider or family members about the need for ANC, and had high to moderate autonomy and decision-making power had significant impact on accepting three ANC services.

A majority of young women (97 per cent) said that a woman should deliver in a government or private health facility. But still 27 per cent women did not deliver their last baby in a health facility and delivered at home. Though most of the women think that a woman should deliver in a health facility, only a small number actually went there. This phenomena cuts across their socio-demographic characteristics. Education does not seem to much influence institutional delivery as women with lower education were aware and delivered their last baby in an institution. However, all the women in the younger age

group (15-19 years) were aware and 84 per cent of them delivered their last baby in an institution, while this was 69 per cent for women aged 20-24 years. Seventy-five per cent women who had a discussion with health service providers/household members regarding the place of delivery delivered their last baby in an institution, while this was 62 per cent for women who did not do so. Exposure to mass media had a positive impact on institutional delivery. Among the women who delivered at home, 90 per cent arranged a new blade to cut the umbilical cord, and 83 per cent arranged clean cloth to wipe and wrap the baby. Only 55 per cent women arranged new thread to tie the umbilical cord which is critical to prevent the baby from cord infection. Not even a single woman identified a vehicle to go an institution in emergency. The logistic regression models highlighted that there is a significant association between caste and institutional delivery, where women in the general and other backward class were 4.1 to 4.7 times more likely to delivery their last child compared with the SC and ST women. Likewise, women who had discussion about the place of delivery with the health service provider or household member were 1.6 to 2 times more likely to deliver their last child in a health facility. Women with high to moderate autonomy were 2.8 times significantly high in delivering the last child in an institution compared with women of low autonomy.

More than 87 per cent young married women were aware that a woman can suffer some health problem during delivery. Most of them were aware of obstructed labour (71 per cent) and excessive bleeding (44 per cent). Nearly 35 per cent women experienced a problem during delivery and of those about 79 per cent sought treatment. Those who had not sought treatment mostly delivered their last baby at home.

Nearly 80 per cent women were aware that post-natal check-up should be done within one day (24 hours) of delivery but about 14 per cent did not know when to do it. Among those women who delivered at home, about 79 per cent women had not done any postnatal check-up, whereas of those who delivered their last baby in an institution, more than 90 per cent received first postnatal check-up within one day of delivery. This is because women who delivered in a health facility had to stay there for 48 hours after delivery and by default they were visited by doctors and ANMs, whereas this does not happen in case of home deliveries. This was also evident from the qualitative findings. In the post-natal period about 83 per cent women were aware of some problem and nearly 42 per cent of them suffered from one or the other. Analysis of awareness and treatment seeking

behaviour for postnatal health problems by different background characteristics showed that 85 per cent women in the older age group (20-24 years) and 77 per cent women in the younger age group (15-19) were aware that a woman can suffer from them during post-natal period. Among the 15-19 years women who suffered from any health problem, 87 per cent sought treatment, while the corresponding figure was 59 per cent for women aged 20-24 years. All the women having a high standard of living, 77 per cent women of medium standard of living and 46 per cent women of low standard of living sought treatment for their post-natal health complications. Seventy-three per cent women who had discussion about the need for post-natal care and 64 per cent who did not have it sought treatment for their post-natal health complications. The logistic regression results also depicted that women of 15-19 years were more likely to seek treatment for their post-natal problems compared with women of 20-24 years. Women of general and other backward classes were up to four times more likely to seek treatment for their post-natal health problems compared with SC-ST women. Similarly, women having high to moderate gender equitable attitude were almost 3.8 times more likely to seek treatment for their post-natal health problems compared with those of low equitable gender attitude.

Most of the young women (98 per cent) were aware of a family planning method and about 64 per cent used one such method. Though awareness regarding a modern family planning method was the same, only 28 per cent women used a modern method. Further analysis illustrated that about 10 per cent women used a modern spacing method and 19 per cent a limiting method of family planning. Still, a significant proportion (36 per cent) of young women used traditional methods to prevent pregnancy. Nearly 84 per cent women knew that modern contraceptives are available in the government hospitals. Similarly, 48 to 49 per cent women said they are available in medical stores and anganwadi centres. Often women considered anganwadi centre and medical store as a place to obtain condom and oral pills. , which was evident from focus group discussions with women.

Awareness of family planning methods is high among women with all socio- demographic characteristics. However, there are variations in the use of contraceptives. by some socio-demographic characteristics of women. Thirty per cent women in the age group of 20-24 years used a modern family planning method. It was 24 per cent for women aged 15-19 years. Similarly, 37 per cent women who completed more than five years of marital life

and 45 per cent of women who had more than three children were found to be using a modern contraceptive method. The corresponding figures were about 11 per cent and 15 per cent for women in the initial one year of marital life and having no or one child respectively. Contraceptive use increased with longer marital duration and larger number of children. Despite a high level of contraceptive awareness, only half of the young women who never had a discussion with husbands about the number and timing of having children were aware of any modern contraceptive and none of such women also used a modern method. Regression analysis showed that SC and ST women were more likely to use a modern method compared with general and other backward class women. The likelihood of modern contraceptive use is significantly high among women who have two or more children. Similarly, women having high to moderate equitable gender attitude were almost twice more likely to use a modern contraception compared with women having low equitable attitude.

Nearly 16 per cent women reported that they were aware of one or the other symptom of RTI-STI. About 14 per cent women experienced at least one symptom in the past six months. About 28 per cent women knew the use of condom and that abstaining from husband could prevent RTIs. The most critical thing is that nearly 18 per cent young women did not know how to prevent it. Similarly, 33 per cent women said that STI could be prevented by using condom and 31 per cent women said by abstaining from husbands. There are about 22 per cent women who did not know how to prevent STI. However, of the 44 women who experienced at least one symptom of RTI/STI in the past six months, only 20 women (46 per cent) sought treatment either in a government or private hospital. Further analysis revealed that 27 per cent of the women who completed more than Class IX were aware of RTI/STI problems and 75 per cent of them sought treatment. A similar pattern is observed for women whose husbands completed Class IX and above. Women in the age group of 20-24 years who experienced any RTI/STI symptom sought treatment, while only 18 per cent of them were aware about RTI/STI problems.