

**HEALTH SEEKING BEHAVIOUR AMONG WOMEN
WITH REFERENCE TO REPRODUCTIVE AND CHILD
HEALTH IN PUNJAB**

Thesis Submitted for the Award of the Degree of
DOCTOR OF PHILOSOPHY

**In
Sociology**

**By
SHARANDIP KAUR**

Registration Number: 11720096

**Supervised By
Dr. Jaspal Kaur (28308)
(Assistant Professor)**



LOVELY PROFESSIONAL UNIVERSITY, PUNJAB

2025

DECLARATION

I, hereby declared that the presented work in the thesis entitled “Health Seeking Behaviour Among Women With Reference To Reproductive and Child Health In Punjab ” in fulfilment of degree of **Doctor of Philosophy (Ph.D.)** is outcome of research work carried out by me under the supervision of Dr. Jaspal Kaur, working as Assistant Professor, in the School of Liberal and Creative Arts (Social Sciences and Languages) of Lovely Professional University, Punjab (India). In keeping with general practice of reporting scientific observations, due acknowledgements have been made whenever work described here has been based on findings of other investigator. This work has not been submitted in part or full to any other University or Institute for the award of any degree.

(Signature of Scholar)

Name of the scholar: Sharandip Kaur

Registration No.:11720096

Department/school: Sociology/ School of Liberal and Creative Arts

(Social Sciences and Languages)

Lovely Professional University, Phagwara, Punjab (India)

CERTIFICATE

This is to certify that the work reported in the Ph.D. thesis entitled “Health Seeking Behaviour Among Women With Reference To Reproductive and Child Health In Punjab ” submitted in fulfillment of the requirement for the award of degree of **Doctor of Philosophy (Ph.D.)** in the Sociology / School of Liberal and Creative Arts (Social Sciences and Languages) is a research work carried out by Sharandip Kaur, 11720096, is bonafide record of his/her original work carried out under my supervision and that no part of thesis has been submitted for any other degree, diploma or equivalent course.

(Signature of Supervisor)

Name of supervisor: Dr. Jaspal Kaur

Designation: Assistant Professor

UID - 28308

Department/school: Sociology/ School of Liberal and Creative Arts

(Social Sciences and Languages)

Lovely Professional University, Phagwara, Punjab (India)

ACKNOWLEDGMENT

I am filled with gratitude as I reflect on the completion of my PhD thesis in Medical Sociology. This academic journey has been a profound and transformative experience, and I owe my heartfelt thanks to several individuals who have supported and guided me along the way.

First and foremost, I extend my deepest gratitude to Baba Murad Shah Ji and Sai Laddi Shah Ji for their spiritual blessings and encouragement. Your words of positivity have been a source of strength for me, and I am truly grateful for your presence in my life.

To my loving parents, Mother Kulwinder Kaur and Father Jaswant Singh, I offer my profound gratitude. Your endless love, support, and sacrifices have been the foundation of my success. I am forever indebted to you for believing in me and instilling in me the values of perseverance and dedication.

I am immensely thankful to my academic supervisor, Dr. Jaspal Kaur, for her exceptional guidance, insights, and mentorship throughout the research process. Your expertise and encouragement have been instrumental in shaping this thesis, and I am grateful for the knowledge and skills I have gained under your supervision.

I would also like to acknowledge the contributions of my former supervisors, Dr. Durga Rao Pedada and Dr. Debahuti Panigrahi. Your support and guidance during the initial stages of my research laid a strong foundation for this thesis. I am grateful for the valuable feedback, encouragement, and academic rigor you instilled in me.

Lastly, I extend my gratitude to the universe, for the serendipitous moments, the challenges that have shaped me, and the abundance of blessings that have guided me through this journey. I am humbled by the support and kindness I have received, and I am excited to share this thesis with the world, knowing that it is a product of collective effort, learning, and growth.

Thank you, from the bottom of my heart, for being a part of this remarkable chapter in my life.

With sincere appreciation and warm regards,

Sharandip Kaur

ABSTRACT

Women's Health Seeking Behaviour (HSB) significantly impacts healthcare systems worldwide, particularly concerning reproductive and child health. Maternal health care service utilization plays a crucial role in reducing maternal morbidity and mortality. This study examines the health-seeking behaviour of reproductive-age women in rural areas of Jalandhar and Kapurthala districts, Punjab, India and explores women's HSB related to reproductive health such as antenatal, intranatal, and postnatal care, child wellbeing, contraceptive methods, and awareness of reproductive system infections and diseases. Punjab, a region known for its rich cultural heritage and diverse population, faces significant challenges in ensuring adequate healthcare services for women, especially concerning reproductive and child health. The societal norms and traditional practices prevalent in Punjab influence women's health-seeking behaviour, often leading to delays in seeking appropriate healthcare services. Understanding these cultural dynamics is crucial in designing effective interventions to improve women's health outcomes. Accessibility to healthcare facilities is a crucial determinant of women's health-seeking behaviour. In rural Punjab, inadequate healthcare infrastructure poses challenges for women in accessing vital maternal and child healthcare. Long distances to health care centres, limited transportation, and a lack of skilled professionals often prevent timely medical intervention. This study will assess the effect of healthcare accessibility on women's health-seeking actions and propose solutions to enhance access to medical care. The quality of healthcare services provided in Punjab significantly influences women's decisions to seek reproductive and child health services. Issues such as long waiting times, inadequate facilities, lack of privacy, and poor communication between healthcare providers and patients impact women's satisfaction with healthcare services. By examining the quality of healthcare services from the perspective of women, this research aims to identify areas for improvement and enhance the overall healthcare experience for women in Punjab. The study employs a descriptive research design, using interview schedules. Data collected from 160 reproductive women . Random sampling enhances external validity. Women with higher education and economic stability exhibit better awareness and utilization of antenatal care. However, even among less educated women, economic well-being significantly influences proper care-seeking behaviour.

Despite proximity to health centers, women underutilize government services. In conclusion, this thesis will contribute to the existing literature on health-seeking behaviour among women with reference to reproductive and child health in Punjab. Policymakers should empower Anganwadi Workers (AWWs) to advocate for women's health.

CONTENTS		
1	CHAPTER-I INTRODUCTION	1-39
1.1	Health and Its Significance	4
1.2	Health indicators	6
1.3	Health Seeking Behaviour	8
1.4	Reproductive and Child Health	10
1.5	Importance of Health Seeking Behaviour in Reproductive and Child Health	28
1.6	Advancing Women's and Child Health Status: Government Initiatives in India	29
1.7	Significance of the Study	35
1.8	Objectives	36
1.9	Research Questions	36
1.10	Limitations of the Study	36
1.11	Key Terms	37
1.12	Thesis Outline	37
	Summary	39
2	CHAPTER –II THEORETICAL FRAMEWORK AND REVIEW OF LITERATURE	40-70
2.1	Theoretical Framework	40
2.1.1	Theory of Care Seeking Behaviour	40
2.1.2	Foucault Theory	41
2.1.3	Maternal Attainment Theory	43
2.1.4	Bonding and Attachment Theory	44
2.1.5	Theory of Planned Behaviour	44
2.2	Literature Review	43
	Summary	70
3	CHAPTER-III RESEARCH METHODOLOGY	71-86

3.1	Study Area	72
3.2	Research Design	79
3.3	Sampling Method and Sampling Size	79
3.4	Data Analysis Process	81
	Summary	86
4	CHAPTER-IV DATA ANALYSIS AND INTERPRETATION	87-177
	Summary	178
5	Chapter – V SUMMARY AND CONCLUSION	179-189
5.1	Conclusion	180
5.2	Recommendations	187
	REFERENCES	191-204
	LIST OF APPENDICES	205-215

LIST OF TABLES

Table no.		Page no.
01	Maternal Mortality rate in India and other major states 2018-20	15
02	Distribution of Maternal/Non-Maternal Deaths According to Age Group in India	16
03	Child Mortality Rate In India	20
3.1	Sample Size and Sampling Details	81
4.1	Distribution of Respondents as per Age Group	87
4.2	Distribution of Respondents according to Religion	89
4.3	Distribution of Respondents according to their Caste	90
4.4	Distribution of Respondents by Education Level	91
4.5	Distribution of Education level among Respondent's Husbands	92
4.6	Distribution of Respondents by Occupation	94
4.7	Distribution of Husband's Occupation among Respondent	95
4.8	Distribution of Respondents according to Income	97
4.9	Distribution of Family Types among Respondents	98
4.10	Distribution of Respondents based on Housing Conditions	99
4.11	Distribution of Respondents by Age At Menarche	102
4.12	Distribution of Respondents based on their Age at Marriage	103
4.13	Distribution of Respondents based on their Number of Children	105
4.14	Distribution of Respondents by Menstrual Complications	106
4.15	Distribution of Respondents by Perineal Problem	108
4.16	Distribution of Respondents by General Medical Illness	109
4.17	Distribution of Respondents by Treatment Preference	110
4.18	Distribution of Respondents based on their Child Bearing Age	112
4.19	Distribution of Respondents based on their Abortion History	113
4.20	Distribution of Respondents according to Miscarriage Status	114
4.21	Distribution of Respondents based on their Antenatal Care	115
4.22	Distribution of Respondents based on their Follow-Up Health Checkups During Pregnancy	119

4.23	Distribution of Respondents based on Health Worker Visits	122
4.24	Distribution of Respondents based on Problems related to Pregnancy	125
4.25	Distribution of Respondents based on Delivery Care	128
4.26	Distribution of Respondents based on the Baby Born Status	132
4.27	Present Antenatal Care Profile	136
4.28	Distribution of Respondents based on Postnatal Care	138
4.29	Distribution of Respondents based on Breast Feeding Practices	143
4.30	Distribution of Respondent's Knowledge regarding Supplementary Food	146
4.31	Distribution of Respondents by Child Care Practices	149
4.32	Distribution of Child Illness History among Respondents	153
4.33	Distribution of Respondents based on their knowledge for Ideal Age Gap between Children	156
4.34	Distribution of Respondent's Awareness Regarding Contraceptive Methods	158
4.35	Awareness of Contraceptive Methods among Respondents in Tashpur Village	162
4.36	Awareness of Contraceptives Methods among Respondents in Hussainpur Village	163
4.37	Awareness of Contraceptives among respondents in Nawapind Khalewal Village	164
4.38	Awareness of Contraceptives among respondents in Dalla Village	165
4.39	Use of Contraceptives by Respondents	167
4.40	Use of Contraception by Respondent's Husband	168
4.41	Exploring Contraceptive Source Preferences among Respondents	170
4.42	Awareness of Reproductive Tract Infections/Sexually Transmitted Diseases among Respondents	171
4.43	Awareness of HIV/AIDS among Respondents	173

LIST OF FIGURES

FIGURES		
Figure no.		Page no.
01	Maternal Mortality rate in India	14
02	Causes of child mortality	20
03	Poshan Abhiyaan Target, 2022	35
3.1	District map of Punjab state	73
3.2	Map of Kapurthala	75
3.3	Map of Jalandhar	76
3.4	Representation of multistage sampling	80
3.5	Data Analysis Process	84
4.1	Distribution of Respondents as per Age Group	88
4.2	Distribution of Respondents according to Religion	89
4.3	Distribution of Respondents according to their Caste	90
4.4	Distribution of Respondents by Education Level	92
4.5	Distribution of Education level among Respondent's Husbands	93
4.6	Distribution of Respondents by Occupation	94
4.7	Distribution of Husband's Occupation among Respondent	96
4.8	Distribution of Respondents according to Income	97
4.9	Distribution of Family Types among Respondents	98
4.10	Distribution of Respondents based on Housing Conditions	100
4.11	Distribution of Respondents by Age At Menarche	103
4.12	Distribution of Respondents based on their Age at Marriage	104
4.13	Distribution of Respondents based on their Number of Children	105
4.14	Distribution of Respondents by Menstrual Complications	107
4.15	Distribution of Respondents by Perineal Problem	108
4.16	Distribution of Respondents by General Medical Illness	110
4.17	Distribution of Respondents by Treatment Preference	111
4.18	Distribution of Respondents based on their Child Bearing Age	112
4.19	Distribution of Respondents based on their Abortion History	113

4.20	Distribution of Respondents according to Miscarriage Status	115
4.21	Distribution of Respondents based on their Antenatal Care	116
4.22	Distribution of Respondents based on their Follow-Up Health Checkups During Pregnancy	120
4.23	Distribution of Respondents based on Health Worker Visits	122
4.24	Distribution of Respondents based on Problems related to Pregnancy	126
4.25	Distribution of Respondents based on Delivery Care	130
4.26	Distribution of Respondents based on the Baby Born Status	134
4.27	Present Antenatal Care Profile	---
4.28	Distribution of Respondents based on Postnatal Care	140
4.29	Distribution of Respondents based on Breast Feeding Practices	144
4.30	Distribution of Respondent's Knowledge regarding Supplementary Food	147
4.31	Distribution of Respondents by Child Care Practices	150
4.32	Distribution of Child Illness History among Respondents	154
4.33	Distribution of Respondents based on their knowledge for Ideal Age Gap between Children	157
4.34	Distribution of Respondent's Awareness Regarding Contraceptive Methods	159
4.35	Awareness of Contraceptive Methods among Respondents in Tashpur Village	162
4.36	Awareness of Contraceptives Methods among Respondents in Hussainpur Village	163
4.37	Awareness of Contraceptives among respondents in Nawapind Khalewal Village	164
4.38	Awareness of Contraceptives among respondents in Dalla Village	165
4.39	Use of Contraceptives by Respondents	167
4.40	Use of Contraception by Respondent's Husband	169
4.41	Exploring Contraceptive Source Preferences among	170

	Respondents	
4.42	Awareness of Reproductive Tract Infections/Sexually Transmitted Diseases among Respondents	172
4.43	Awareness of HIV/AIDS among Respondents	17

LIST OF CONFERENCES AND PUBLICATIONS

Sr no.	Title of paper	Name of journal / conference	Published date	Issn no/ vol no, issue no	Indexing in Scopus/ Web of Science/UGC-CARE list
1.	Effectiveness Of A Structured Teaching Programme On Breast Self Examination Knowledge Among Adolescent Girls In Rural School: A Study In Jalandhar, Punjab	Educational Administration: Theory and Practice	2024 May	2148-2403 30 & 4	Scopus
2.	Handicraft and Economic Development : A Case Study Of Border Areas Of Jammu and Kashmir	Madhya Pradesh Journal of Social Sciences	01-06-2024	0973-855X 29 & 6	UGC- CARE-I
3.	Knowledge, Attitude and Practice on Menstrual Hygiene among Adolescent Girls in Kapurthala District Of Punjab	International Journal Of Education and Social Science Research Review	Nov- Dec- 2003	2448-6557 10 & 6	Referred Journal

4.	Hand Hygiene Knowledge among men and women in 15-23 years in Slum area , Lohian Khas, Jalandhar	Presented in Conference on Sociological Understanding of Technological Advancement In Knowledge Society	2024	-----	-----
5.	Utilization of Janani Suraksha Yojna by eligible Pregnant Women in rural area , Kapurthala	International Conference on Equality, Diversity and Inclusivity: Issues and Concerns	2022		
6.	COVID-19 Pandemic and Pregnancy	Presented in Conference on Recent Innovations in Sciences, Humanities and Arts	2021	-----	-----
7.	Impact of climate change with reference to reproductive women and children	Presented in Conference on Environment, Social and Religious Consequences on Human Evolution	2021	-----	-----

LIST OF WEBINARS

Sr no.	Title of Webinars/ Seminars	Name of Organizer	Year
1.	Indian Diversity, Pluralism and Constitutional Nationalism	Raffles University, Neemrana	2021
2.	Society, Crime and Corrections	Raffles University, Neemrana	2021
3.	Stop violence against women (National)	Delhi State Legal Services Authority	6-09-2020
4.	Gender Equity Matters in theTime Of Pandemic Crisis : An Overview (National)	Mehr Chand Mahajan DAV College for Women	04-09-2020

CHAPTER 1

INTRODUCTION

Women's Health Seeking Behaviour (WHSB) especially in terms of reproductive and child health is vital aspect of healthcare systems around the world. "Health seeking behaviour (HSB) refers to those activities undertaken by individuals in response to symptom experience" (Tones, 2004, pp. 829-832). The process of seeking healthcare is influenced by individual and household behaviour, community norms, expectations, and the characteristics and behaviour of healthcare providers (Ihaji, Gerald, & Ogwuche, 2014). Exploring women's HSB is important in determining health status and mortality rates, as well as useful in planning and providing need-based healthcare services to the target population. It is one of the key indicator that shows a woman's health status. The WHO acknowledges that women's health is a key determinant of social and global development. It is addressed in various government programmes and policies such as the National Population Policy, Sustainable Development Goals, and Reproductive and Child Health Programme (Sunder, 2011, p. 67). Woman's health directly influence the health of her family. Approach to quality health care, encompassing reproductive and child health, is essential for the well-being of women and their children. In the context of India, despite the constitution providing equal rights for women and men, patriarchal practices persist, and shaping women's lives through deeply rooted traditions. Women are often taught that they are inferior and passive to men, and sons are well-regarded. This structure of society can impact women's health-seeking behaviour and overall health outcomes. The right to health is a fundamental human right for women. Human rights encompasses various fundamental rights, such as the right to life, access to health services, privacy, education, freedom from torture, and protection from discrimination. Women's reproductive health is interconnected with these multiple human rights (United Nations, n.d.). By emphasizing equality and access, in article 12 of "Convention on Elimination of all forms of Discrimination against Women" (1979), States commit to "All appropriate measures to eliminate discrimination against women in the healthcare field to ensure equality, granting both

gender have equal access to health care services, including those related to family planning” (World Medical Association, 2024).

In general, women are generally more vulnerable to health issues in their reproductive years, especially in childbearing period. However, many women die during childbirth in many countries around the world, especially in developing countries. The health and nutritional status of women, their education and economic status play a vital role in determining not only their own health but also the health status of their children. It is also influenced by factors like age at marriage, fertility behaviour, antenatal care, natal care, postnatal care and medical attention at the moment of delivery. In many countries, women neglect their health needs for household tasks and depends on domestic remedies and informal service providers for treatment. Maternal health problems directly affect their children’s health and health serves as a barrier to a nation’s social and economic growth. The significance of Reproductive and Child Health (RCH) in social and economic development can be seen from the inclusion of maternal and child mortality on the list of Millennium Development Goals (MDGs) in 2000, which are universally accepted as the benchmark for developmental initiatives undertaken by governments, donors and non-governmental organizations (Barbhuiya, 2014). Therefore, reducing maternal mortality has been priority for public health programmes worldwide. The goal was to achieve universal reproductive health access by 2015 in order to reduce maternal and child mortality rate. Maternal deaths has been decreased significantly – from 523,000 in 1990 to 289,000 in 2013 – but the rate of reduction is less than half that of the MDG target of a three-quarters reduction in mortality ratio over the 1990-2015 periods and there has been considerable progress in reducing mortality among children under 5. In 2013, the mortality rate of children under 5 was 6.3 million as compared to 12.7 million in 1990. Despite these improvements, the world is projected to fall well short of the MDGs of two-thirds of 1990 mortality levels by 2015 (MDGs, 2018). In 2015, Sustainable Development Goals (SDGs) replaced the MDGS. The SDGs aim to achieve peace and prosperity for all people by 2030, recognizing the connection of different areas of development. They emphasize the importance of balancing in social, economic, and environmental sustainability. SDG 3 seeks to "Ensure healthy lives and promote well-being for all at all ages"(United Nations, n.d.). SDGs 3.1 and 3.2 aims

to decrease the maternal and infant mortality rate (up to 1 year) worldwide and eliminate the preventable deaths of children under 5 years old by 2030. The SDGs take a broader approach, recognizing the interconnection of health with other areas such as poverty, education, and gender equality. This holistic approach may be helpful in achieving your goals, as it addresses the underlying social determinants of health

Cultural norms, socio-economic factors, and a lack of knowledge about available services are significant obstacles to health care access for women. In rural settings, there might be stigma associated with seeking medical care at hospitals or clinics. Women may fear judgment or negative perceptions from their community if they visit healthcare facilities. Some cultural norms favour home remedies or traditional healers over formal medical institutions. Women may depend on local healers or spiritual practitioners for health issues. In rural Punjab, women's HSB is heavily influenced by patriarchal beliefs and gender roles. Women's autonomy in healthcare decisions is often restricted in the patriarchal society, which restricts women's access to timely medical (Yadav et al., 2022). Furthermore, geographical and infrastructure constraints mean that healthcare facilities are limited and often located far from the villages (Mahajan & Kaur, 2021). HSB is also influenced by economic factors. The costs of healthcare, including transportation and daily wages, discourage women from seeking care (Mushtaq et al., 2020) and further aggravated by the financial constraints faced by many households in rural Punjab, where immediate economic needs take preference over healthcare (Singh, 2010). Social stigma and community pressure can also discourage women from seeking healthcare services in rural Punjab. Fear of social segregation and the weight of traditional expectations, often prevent women from seeking care, leading to delayed care and poor health outcomes for both mothers and children (Anwar, 2021). In addition, the healthcare system in rural Punjab is not without problems. Public health institutions are often understaffed, which results in a low level of trust among community members. As a result, people prefer private healthcare services, despite the fact that they are more expensive. The recent NFHS-5 survey in rural Punjab has highlighted the challenges faced by women when it comes to health-related issues. Pregnant and non-pregnant women were suffering from anaemia in 54.4% and 58.6% respectively in rural areas,

only a small percentage of women in the area are received adequate care during their pregnancies (58.4%) and only 54.8% had completed 100 days of iron folic acid course, which is essential for reducing the rate of maternal and child mortality (NFHS-5, 2019-21).

Understanding HSB is essential for effective interventions to improve Maternal and Child health outcomes in many countries, including India. India has made considerable progress in enhancing maternal and child health over the past few years, with the NHM (National Health Mission) aimed at providing affordable and accessible healthcare services, but challenges remain, particularly in remote areas with limited healthcare access. In the context of Punjab, a predominantly agrarian state in India, rural women face numerous challenges and barriers when accessing healthcare services related to RCH. Understanding the dynamics of HSB among this demographic group is essential for developing effective interventions and policies catering to their needs. To address this issue, several initiatives have been taken to encourage rural women to seek health care. These initiatives include raising awareness, improving health care infrastructure, and tackling socio-cultural and economical barriers that prevent women from accessing timely and appropriate health services.

1.1 HEALTH AND ITS SIGNIFICANCE

Health is a common scenario in all communities around the world. Every community has different perceptions of the term “Health” around the world. A new philosophy of health states that health is a fundamental human right, a central concept, and a worldwide social goal. The right to health has historically been one of the most commonly pro-claimed rights in the constitutions of many countries worldwide. Strengthening health care is an important part of health services. “Primary health care is essential health care made universally accessible to individuals and acceptable to them, through their full participation and at a cost that the community and country can afford”, The Alma-Ata declaration at the 31st World Health Assembly in 1978 approved this definition for health maintenance. In the words of Berthet (General Secretary of the International Union for Health Education, Paris), “We should no longer define health only in terms of sickness, but rather in relation to the holistic development of every individual’s personality” (Konwar, 2001).

A wide range of personal, societal, and cultural perspectives can be applied to the concept of health. There is no doubt it is a physical and mental state, but it is also a fundamental and societal state. Health is basically shaped by an individual's perceptions and social influences on their health. Cox et al. (1987) talked about "what health is" and suggest that it is basically people's perception of their own health and how they influence their own health. As a result, people's perceptions of their own health, particularly reproductive health, have had a significant impact on their decision making process when it comes to seeking medical care. Therefore, many studies have been conducted on health-seeking behaviour, which explains the wider relationship between the population behaviour and the health care system. Many studies on HSB reveal that the utilization of health services is not adequately used. Therefore, it is necessary to understand the behaviour of an individual to improve their health behaviour and practices, especially in reproductive and child health (Elizabeth & Khan, 2015).

Good health is the fundamental right of an individual. Optimum level of internal and external growth of the body cannot achieve without maintaining health. It is essential to enable the individuals to live a productive and quality life. Moreover, health is not personal responsibility but also a national and global priority, recognized as a key goal by international health organizations (Swarankar, 2009).

"Health is state of complete physical, mental, social well being and not merely an absence of disease or infirmity" (WHO, 1948).

In the past few years, there has been increasing attention on women's health in India, especially following important events such as the "International conferences on population and development (ICDP) in September, 1994 (Cairo, Egypt)" and "The fourth world conference on women held in Beijing in September 1995". The women's health, empowerment, and reproductive rights were received considerable attention during both of these conferences.

Despite all the talk about health, it's still not a priority. At the individual level, it cannot be said that health occupies an important place; it usually subject to other needs defined as more important, e.g., wealth, knowledge, power, prestige, safety and security. People often fail to appreciate the importance of their health until they lose it. At the international level, health was "forgotten" when the convention pertaining to

the League of Nations was formulated following the First World War. World health was finally brought in, at the last moment. Health was again “forgotten” when the charter of the United Nations was composed post after World War II. The subject of health had to be introduced at the United Nations conference at San Francisco in 1945 (Evans, K. 1967).

Sustainable Development Goal (SDG) 3, Good health and well-being; emphasizes the importance of health. SDG 3 aims to enhance the living standards of individuals of all ages around the world. The goals are to reduce the global rate of maternal mortality to below 70 per 1,00,000 live births by 2030, eliminate preventable deaths among newborn, infants and children under the age of 5, reduce neonatal mortality rates to at least 12 per 1000 live births, reduce under the age of five mortality levels to at least 25 per 1000 live births, and ensure universal health coverage for all people without financial hardship (United Nations, 2015).

Health significantly impacts overall well-being and quality of life of women and children. For women, good health is important throughout their life. During pregnancy, maternal health directly affects fetal health. Ensuring a healthy environment in the uterus is essential for foetus growth. Good nutrition, prenatal care, and emotional support can have a positive impact on mother and newborn. Postpartum health is also important, as it builds up the mother's capability to offer care to her newborn. Child health is essential for their growth and development in terms of physical and mental ability. Adequate nutrition, immunization, and access to health services during infancy and childhood are essential. Early detection of health problems allows early intervention to prevent long-term problems. Children's health directly impacts on cognitive development, physical ability and emotional strength. Women and children's health is not just about survival, it's about investing in a healthier and more prosperous future for our families and communities and overall development.

1.2 HEALTH INDICATORS

These are variables that are used to measure the changes in health status and to provide factual information about the performance of health services. They can be used operationally to check progress towards achieving objectives and targets. These can also be referred to as variables. For example, a health index can be prepared based

on health indicators. These should be reliable, valid, relevant, feasible and specific in nature.

1.2.1 Objectives of health indicators are:

1. To identify community health standards.
2. To compare health standards across countries.
3. To evaluate the need for health services.
4. To evaluate health activities, programmes and goals of health services.

1.2.2 Types of Health Indicators

The concept of health encompasses many aspects. Therefore, to find Health, various health indicators are needed. The main health indicators include mortality indicators, disease indicators, disability indicators, healthcare delivery indicators and health policy indicators.

A. Mortality Indicators: These indicators include:-

a. Infant Mortality Rate (IMR)

This express the ratio of infant deaths registered in a particular year to the total number of live births registered in the same year, expressed as a rate per 1000 live birth.

It can be calculated by -

Number of deaths of infants in a year/number of total live births in the same year
 $\times 1000$

b. Neonatal Mortality rate (NMR)

It expresses number of neonates deaths (less than 28 days) in a specific year per 1000 live birth in that year. It is measured by:

Number of deaths of children less than 28 days of age in a year /total live births in same year $\times 1000$

c. Maternal Mortality Rate (MMR)

According to WHO maternal mortality rate expresses “the death of woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of pregnancy complications that arise from or worse by pregnancy and its care, but not from accidental or incidental causes”. It is calculated by:

Total number of women deaths due to pregnancy, child birth or puerperial complications (42 days after delivery) during the given year /total no of live births in the same area and year $\times 1,00,000$

B. Morbidity Indicators.

These indicators show the health condition of population but it cannot express the under demonstrative and hidden disease present in the community. Morbidity in a community is assessed on the basis of following: Rate at which disease occurs, rate of notifying the disease, outdoor patient attendance rate, admission, discharge and readmission rate, occupancy rate in the hospital and the rate of absence from the school.

1.3 HEALTH SEEKING BEHAVIOUR

Health is a fundamental need for both individuals and society. It significantly impacts various aspects of human life, including physical and mental health, and overall quality of life, gives social implications. Health affects our interactions with others, our ability to work, and our participation in society. For instance, a healthy workforce contributes to economic productivity and social stability. Improving the health standard of an individual is a challenging situation for medical practitioners as well as social workers. Many factors such as gender, age, type of disease, availability to services, and perceived the quality of the services all influence the health care behaviour.

Health seeking behaviour defined as “any action or inaction undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy” (Olenza, 2004).

HSB also referred as sick-term behaviour or illness behaviour. HSB is a wide concept of health care behaviour, which encloses the activities for health promotion, to prevent illness, as well as deal with the deterioration of health (Mackian , 2003). Practicing healthy behaviour is related with preserving a sound state of the body and mind. It has been found that utilization of health services are liked with social, geographical, economic and cultural factors (Moyer, 2003). People's health-related behaviour is linked to cultural aspects that have an effect on their health. For example-socioeconomic status, cultural beliefs, access to health services or health facilities having significant relation in maintaining health seeking behaviour or health

care decision among population. Inappropriate health seeking behaviour results into health illness, morbidity, mortality and poor health statistics. The pursuit of better health can be compared to a decision-making process that is carried out by both the individual and the community. It is influenced by a number of elements including the behaviour of the individual, their knowledge, their awareness of the disease condition, and their access to health resources. When it comes to patterns of health seeking behaviour, particularly in rural areas, diverse populations have embedded cultural practices that differ from one another. Their behaviour can be directly attributed to their social standing, biological factors, previous experiences with health institutions and services, the impact of the community, and the availability of health care services or providers.

1.3.1 Factors affecting health seeking behaviour

Health-seeking behaviour are the actions that people take to maintain or improve their health, or to seek healthcare when they feel a need for it. This behaviour can vary from person to person, culture to culture, and even from society to society.

Here are some common factors that influence health behaviour, supported by the literature.

1. Socioeconomic factors: Socioeconomic status plays an important role in health behaviour. People with higher incomes and higher levels of education are more likely to receive timely and appropriate health care. On the other hand, people with lower socio-economic status face barriers such as financial constraints and limited access to health services, which can result in delayed or inadequate care. (Adler et al., 2016; Berkman et al., 2014)

2. Cultural and social factors: Cultural beliefs, norms, and social support systems have a strong influence on health-seeking behaviour. Cultural beliefs about health, the causes of disease, and desirable treatments influence individuals' decisions to seek medical care. Social networks and support from family, friends, and community members can positively influence health-seeking behaviour by facilitating and supporting access to health services. The stigma associated with reproductive health concerns often causes women to delay seeking medical assistance until their symptoms become severe. This 'culture of silence' highlights societal taboos linked to discussing reproductive matters. (Andersen et al., 2014, Kishore et al., 2013)

3. Perceived illness awareness: An individual's perception of his or her health status and the severity of symptoms influence the behaviour. Interpretations of symptoms, beliefs about the need for medical care, and perceptions of disease risk can motivate the people for seeking immediate medical attention. (Andersen et al., 2014; Janz and Becker, 1984)

4. Availability of health services: Availability, affordability, and physical access to health services. Easy to use has a significant impact on health behaviour. Barriers such as long distance to health care facilities, lack of transportation, and high costs can prevent people from receiving health care. On the other hand, the availability of convenient and affordable health care services increases the likelihood of prompt medical care. (Penchansky and Thomas, 1981; Andersen et al., 2014)

5. Knowledge and health literacy: Knowledge about diseases, symptoms, and available health services plays an important role in health-seeking behaviour. People with high health literacy are better able to recognize symptoms, understand the importance of seeking medical care, and use the health care system more effectively. Lower levels of education are linked to a reduced likelihood of pursuing medical care. (Nutbeam, 2000; Berkman et al., 2014)

6. Trust and Confidence in Healthcare Providers: Trust and confidence in healthcare providers significantly influence health-seeking behaviour. Positive experiences, effective communication, and respectful treatment by healthcare professionals enhance trust and encourage individuals to seek care when needed. Negative experiences or a lack of trust can prevent individuals from seeking healthcare services. (Hall et al., 2002; Mainous et al., 2004)

It is important to understand that these factors are interrelated and interact in intricate ways. Additionally, individual preferences, past experiences, and personal beliefs also contribute to health-seeking behaviour.

1.4 REPRODUCTIVE AND CHILD HEALTH

Since last four decades, family planning and mother and child welfare services are being provided in our country. As a result, there was a sharp decline in mortality rate but reduction in birth rate is very little. Along with it there is no desired improvement in the health level of our country. The following reasons are responsible -

- Limited expansion of services

- Poor quality of services
- Emphasis on target achievement in family planning services
- Emphasis on tubectomy of women

An action plan was prepared to overcome these shortcomings and to strengthen the child safety and safe motherhood programme, which was started in 1985. In this plan, special emphasis was given to the improvement in quality and expansion of services; change in the methodology of achieving targets of family planning and participation of the community. The Integrated Child Health Programme (ICDP) recommended a great change in the methods of implementing family planning programmes. It also included conducting programmes on reproductive and child health (RCH). Reproductive health is generally defined as complete physical, mental and social well-being and not merely an absence of disease or infirmity. It deals with the reproductive system and functions at all stages of life. The International Conference on Population and Development (ICDP) states that “reproductive health implies that people are able to have a satisfying and safe sex and that they have the capability to reproduce and freedom to decide if, when and how often to do”. Implicit in this last condition are rights of women and men to be informed and accessible to safe, affordable, effective and acceptable methods of family planning as their choice, as well as other methods of their choice for regulation of fertility which are not illegal. The right to proper health care services that allows women to experience pregnancy and childbirth safely and give couples the best opportunity to have a healthy child. Additionally, it covers sexual health, which goes beyond counselling and care for sexually transmitted illnesses and focuses on improving one's quality of life and interpersonal relationships.

Reproductive health plays an important role in general health and is central part of human development. It reflects health during childhood and is essential during adolescence and adulthood, setting the attitude for health after the reproductive years for women and men alike, and influences the health of future generations. The health of a newborn is largely determined by the health and nutrition of the mother and her access to care. Reproductive health is a universal issue, but it is especially important for women during the reproductive years of life. However, Men have specific roles and responsibilities in regards to women's reproductive health due to their decision-

making power in matters of reproductive health. Individual needs vary at every stage of life, and failing to address reproductive health issues at any stage of life sets the stage for future health and development issues. Reproductive health is necessary for social, economic, and human development. Having the best possible health is not only an essential human right for everyone, but it is also a requirement. Human energy is essential for human development, and they cannot be produced by sick and tired people. A healthy and active individual can contribute for economic and social development. (DLHS-3)

Inadequate diet, infectious diseases, early marriage, physical abuse, unwanted pregnancy, and unprotected sex are often associated with poor reproductive health. The Cairo Conference's key accomplishment was to position individuals at the core of development initiatives, making them active participants in their reproductive health and lives, rather than passive recipients of external interventions. These interventions aim to enhance reproductive health and rights, rather than focusing on population policies or fertility control. This involves empowering women and young people (including providing access to education), incorporating women and children in the planning and execution of programs and services, engaging the poor, migratory, and excluded population, and assuming more responsibility for men's reproductive health (United Nation Population Fund, 2014).

Programmes that address various aspects of reproductive health are present almost everywhere. However, they have often been executed in isolation, without connections to all objectives of the programme. There is still lacking of holistic approach. For example, family planning programmes have predominantly been influenced by demographic necessities, with minimal emphasis on associated health issues such as maternal health or sexually transmitted diseases (STDs) and strategies for their prevention and management. Evaluation reveals that priority given on quantity over quality - the count of contraceptive acceptors rather than build their capacity to make informed reproductive health decisions. Generally, these programmes have been exclusively women-centred, but slight attention paid to the socio-cultural and personal realities of women's reproductive lives and their capacity to make reproductive decisions. Services have primarily rendered to married individuals, with youth being the exception. Services have rarely been designed to

address men's reproductive health concerns, even though men have their own reproductive health concerns, particularly those related to STDs. Moreover, men's involvement in reproductive health matters is important, as they play a significant role in family planning, family size, and accessing health services.

The needs and concern of reproductive health, as well as the policies and programmes to address them, differ from one country to another. On a global scale, the epidemiological evidence suggest that interventions in reproductive health are more likely to focus on family planning, prevention and management of STDs and prevention of Maternal and infant mortality and morbidity, as well as reproductive tract infections, gender based violence, infertility and malnutrition, reproductive tract cancers, and other related issues.

All reproductive health strategies must first and foremost focus on the well-being of individuals and their families. When implementing reproductive health strategies, it is the considerable service should be accessible with high-quality care to all, while respecting the individual. Special emphasis should be placed on meeting the needs of adolescents in reproductive health.

1.4.1 Components of Reproductive Health

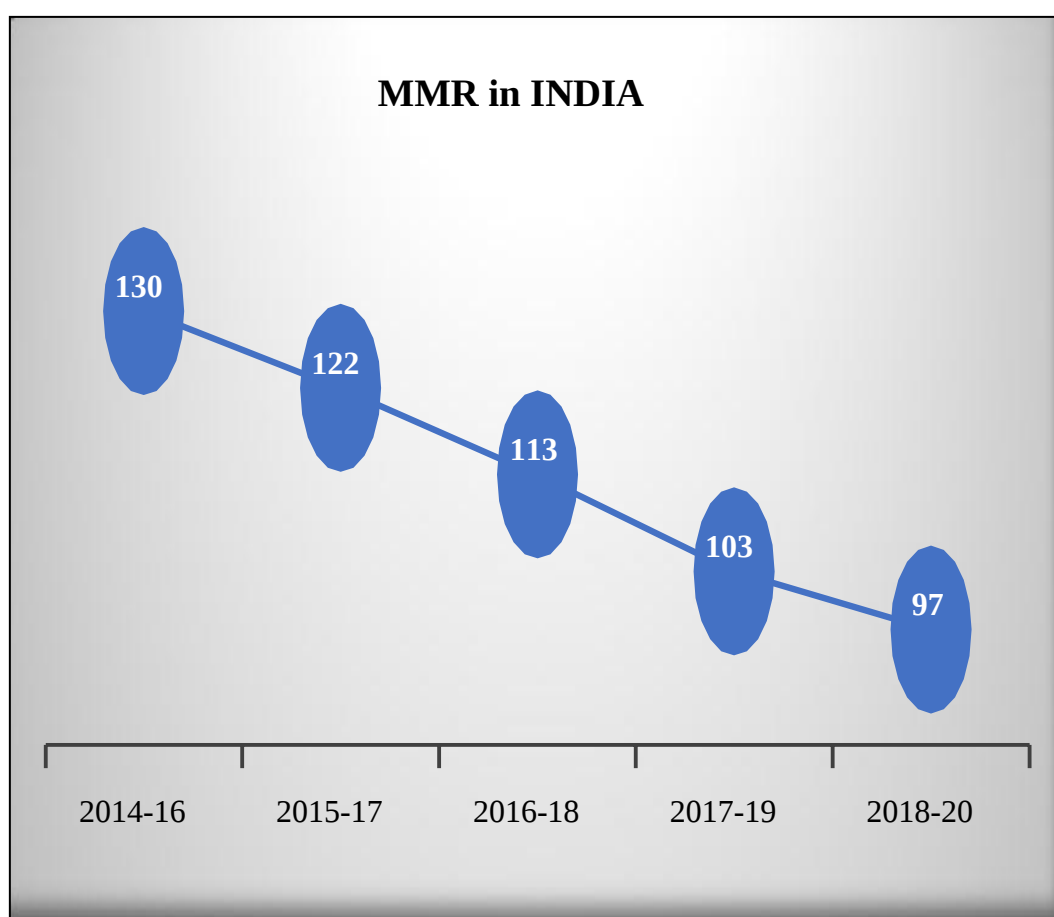
The Reproductive and Child Health Programme (RCH), initiated by the Government of Health on 15th October 1997, is a comprehensive effort to address maternal and child health. The main components of RCH include antenatal and postnatal care for mother, child care, family planning, and prevention of reproductive tract infections and sexually transmitted diseases.

1. Maternal Health

Maternal health is essential for the mother and child wellbeing. It has a direct impact on pregnancy and childbirth outcomes, including survival and health of mother and newborn. Globally, in 2020, nearly 800 women died each day due to preventable causes associated with pregnancy and childbirth (WHO, 2021). In India it is 97 in 2019-20 (fig.1) which is improved by previous years, reported by per Sample Registration System. Direct causes of maternal deaths include excessive blood loss, infections, hypertension, unsafe abortion and obstructed labour, postpartum haemorrhage and indirect causes include anemia, malaria and heart disease. The high incidence of maternal deaths in

some regions is a reflection of inequalities in access to high-quality health services.

Figure: 1 Maternal Mortality rate in India



Source - Special Bulletin Maternal Mortality, Office of the Register General, India, November 2022

Table No- 01- Maternal Mortality rate in India and other major states 2018-20

India&MajorStates	Maternal Mortality Ratio	Maternal Mortality Rate	Lifetime risk
INDIA	97	6.0	0.21%
Assam	195	12.1	0.42%
Bihar	118	11.2	0.39%
Jharkhand	56	4.2	0.15%
MadhyaPradesh	173	15.3	0.53%
Chhattisgarh	137	9.9	0.35%
Odisha	119	7.3	0.25%
Rajasthan	113	9.6	0.33%
Uttarakhand	103	6.3	0.22%
AndhraPradesh	45	2.4	0.08%
Telangana	43	2.3	0.08%
Karnataka	69	3.5	0.12%
Kerala	19	0.9	0.03%
TamilNadu	54	2.7	0.09%
Gujarat	57	3.9	0.14%
Haryana	110	8.0	0.28%
Maharashtra	33	1.8	0.06%
Punjab	105	5.4	0.19%
WestBengal	103	5.0	0.18%
Otherstates	77	3.9	0.14%

Source- Special Bulletin Maternal Mortality, Office of the Register General, India, November 2022

Table No-02

Distribution of Maternal/Non-Maternal Deaths According to Age Group in India

AgeGroup	Maternal deaths	Non-maternal Deaths
	Proportion	Proportion
15-19	6.0%	9.0%
20-24	32.0%	11.0%
25-29	30.0%	12.0%
30-34	20.0%	13.0%
35-39	8.0%	14.0%
40-44	3.0%	18.0%
45-49	2.0%	22.0%
15-49	100%	100%

Source- Special Bulletin Maternal Mortality, Office of the Register General, India, November 2022

In order to get a full picture of women's reproductive health, there is need to understand the issues they face during their reproductive age. Maternal care is the most important factor to maintain reproductive health, and to understand health behaviour regarding reproductive health. Components of reproductive health have a strong connection to health seeking behaviour, which determine an individual's reproductive health. Therefore, reproductive behaviour needs to be studied. Ensuring prevention of maternal deaths is a top global priority. Maternal health services play an important role in preventing and managing complications leading to maternal mortality and disease. Services are:

a. Antenatal Care (ANC)

It refers to well-planned care includes medical care, continuous risk assessment, nutritional guidance and psychosocial care ideally started before conception and continued through the first few months of pregnancy and beyond. Early and consistent prenatal care increases chance of healthy newborn and good maternal health. Risk detection and assessment are part of a well-planned program. Scheduling obstetric visits is adapted to each woman's individual needs. Women who have had adverse pregnancy outcomes or vaginal bleeding before should seek care as soon as possible. Women who are conceived through infertility treatment or are carrying multiple babies should be checked as early as possible. An uncomplicated pregnant woman should be seen every week for the initial 28 weeks of pregnancy. After that, she should have check up every 2 weeks up to 36 weeks and weekly after that. Women obstetrical complications may need more frequent monitoring (ACOG, 2017, p. 149). ANC model recommends there should be at least eight contacts: one in first trimester, two in the second trimester, and five in the third trimester (WHO, 2016).

b. Intranatal care

It is also called intrapartum care which covers the care of mother during delivery process. Approximately 140 million births occur annually worldwide; with the majority of women giving birth do not have any risk factors for them or their unborn child at the start of or during labour but sudden complications can significantly raise the risk of morbidity. Almost 70% of all maternal deaths causes are haemorrhage, infection, unsafe abortion, and hypertension during pregnancy, and obstructed labour (Ayenew, 2021). The new Global Strategy for Women and Children, and Adolescents Health and Sustainable Development Goal 3 (2016–2030) goal is to “Ensure healthy lives and promote well-being for all at all ages” and their focus is to reduce the chances of complications by providing quality of care in appropriate infrastructure (WHO, 2018).

c. Postnatal care (PNC)

The postnatal care also known as the postpartum care which extends up to 6 weeks (42 days) after the child birth. During this time, mother and newborns require comprehensive care to promote health, prevent complications, and to ensure a smooth change to motherhood and infancy. In this period, within the first 24 hours after child birth, mothers should receive essential care which includes monitoring the vital signs, uterine tone, and amount of bleeding. Newborns, within the first hour after birth, should receive neonatal care. Monitor newborn's respiration rate, heart rate, temperature is essential as well as cleanliness and dryness, skin-to-skin contact with mother , and early initiation of breastfeeding. Newborn should be under observation first 48 hours of birth for jaundice, and any other signs of illness. Breastfeeding is an important part of postnatal care. Mothers should be encouraged to breastfeed for the first 6 months. Educate her on proper handling of newborn, positioning, and how to overcome breastfeeding challenges. Educate the mothers and families about warning signs of infection and complications in both mothers and newborn is essential. Watch the mother for complications such as postpartum hemorrhage (PPH), pre-eclampsia and hypertensive a disorder is vital part of assessment. Approximately 70,000 maternal deaths worldwide are caused by PPH each year (WHO, 2022). Preeclampsia and related hypertensive pregnancy conditions affect the lives of almost 76,000 mothers annually around the world (Preeclampsia Foundation 2013).

Early postnatal care is essential to avoid these complications, promotion in of health and well being of both mother and newborn. Subsequent postnatal visits should be done with 7 days of frequency up to 6 weeks after birth. (WHO,2013).

2. Child Health

Childhood is a crucial phase of life in which physical and mental growth occurs. Early childhood influenced by maternal care, environmental factors. Child growth follows the various stages of development during different phases of their early years. Understanding health-related issues during these stages is vital. Children are more vulnerable to infections and diseases in earlier years of

life. Infancy (up to 1 year) is most caring period. This stage encompasses the first year of life, characterized by rapid physical growth, sensory development, and attachment to caregivers. Remarkable progress has been made in child survival rate over the past three decades. Globally in 2022, there is considerable improvement 1 in 11 children died before the age reaching to 5 as compared to 1 in 27 in 1990. Despite this progress, improving child survival remains an urgent concern. The neonatal period is the first 28 days of life .in this period neonates are at the greatest risk of death in their first month, with an average global death rate of 17 per 1000 live births in 2022, 53 per cent decrease from 1990's 37 per 1000 live births. Globally, in 2022, there were 2.3 million neonatal died in the first month, it is about 6,300 per day. A total of 4.9 million children died under the age of five died in 2022. This would equate to 13,400 deaths per day for children under the age of five. Infectious disorders such as malaria, pneumonia, and diarrhoea continue to be the top cause of mortality for children under five worldwide, along with premature delivery and complications associated to childbirth (UNICEF, 2024)

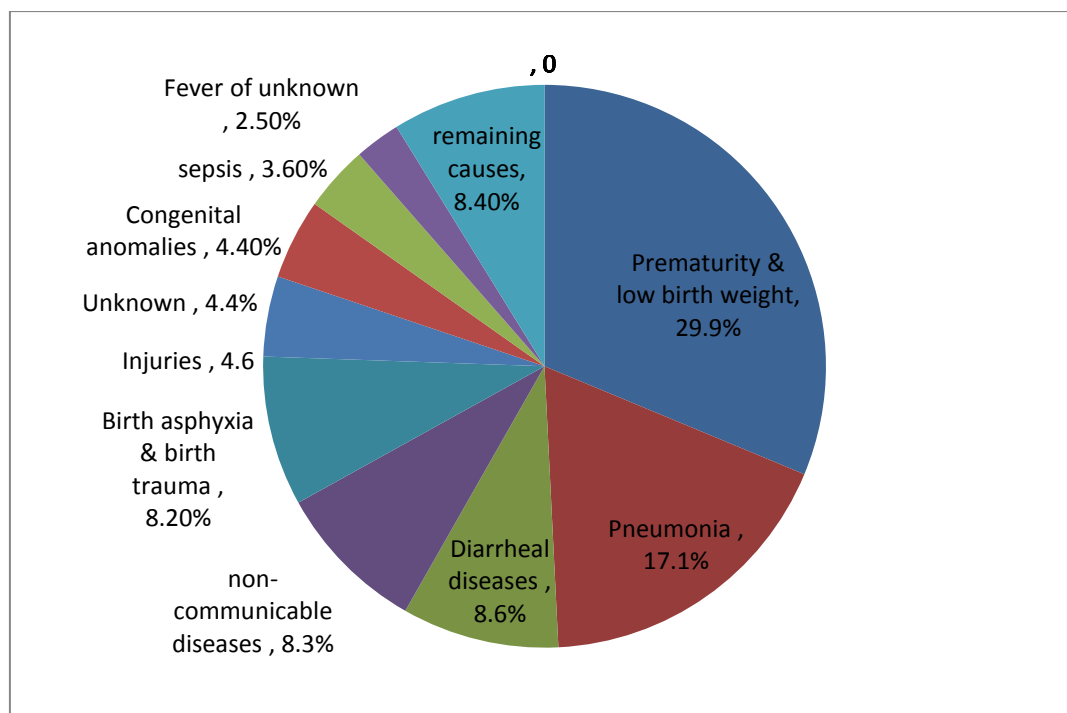
India faces continuously challenges in the area of child survival and health. Every year, over 26 million infants are born and died 20 and 28 in neonatal and infancy period respectively. India's under-five mortality rate, according to the most recent data, is 32 per 1,000 live births. This amounts to an approximate 9.6 lakh deaths of children under five per year. More than any other nation, India has the highest health burden on infants and young children (Press Information Bureau, 2022).

Table No – 3
Child Mortality Rate In India

INDICATORS	SRS 2014	SRS 2019	SRS 2020
Crude Birth Rate (CBR)	21.0	19.7	19.5
Total Fertility Rate	2.3	2.1	2.0
Early Neonatal Mortality Rate (ENMR) – 0- 7 days	20.0	16.0	15.0
Neonatal Mortality Rate (NMR)	26.0	22.0	20.0
Infant Mortality Rate (IMR)	39.0	30.0	28.0
Under 5 Mortality Rate (U5MR)	45.0	35.0	32.0

Source – Sample Registration System (SRS) Statistical Report, 22 September 2023

The two conditions which represent the most risks to a child's survival are underweight and malnutrition. Factors contributing to malnutrition among infants include low adoption of exclusive breastfeeding due to cultural inhibitions, lack of awareness about nutritional needs, unequal distribution of available food, and improper and poor food habits. Unemployment, inadequate health care services, lack of clean water and poor hygiene, indirect causes of malnutrition among babies.



Data source- National Health Mission, 2017

Figure 2 : Causes of child mortality

Child health is an important part of health care system that cannot be ignored. India's National Population Policy (2017) emphasizes to lower IMR and reduce risks to mother and child life as much as possible.

The National Health Mission (NHM) integrates interventions that enhance child survival and addresses the factors that contribute to infant and under five mortality. It is now widely accepted that child survival can't be addressed on its own, as it is closely linked to mother's health and her health status during an adolescent period. Therefore the Continuum of Care, which focuses on care during life's critical stages in order to enhance child survival, is followed in the national programme. Another dimension of the approach is to provide critical services at home through community outreach and health care facilities, such as primary, first referral units and tertiary health care centers (THCs). The newborn and child health have now become the two pillars of the reproductive, maternal, newborn and child and adolescent health strategy (RMNCH + A) 2013 (National Health Mission, n.d.).

3. Family planning

The importance of family planning plays an important role in the reproductive health with the focus on eligible couples and women. Better family planning and contraception can help to prevent unwanted pregnancies and helps in space births, as well as protect against sexually transmitted diseases (STDs). Furthermore, it can help to reduce the number of maternal and infant deaths and morbidity. It is estimated that 214 million women from developing countries want to avoid pregnancy, but they are not utilizing current contraception methods (WHO, 2018). In 2021, globally out of the 1.9 billion women between 15-49 of age, 1.1 billion expressed a need for family planning. Among these, 874 million are utilizing modern methods of contraception, while 164 million still have an unmet need for these services and in 2022 contraceptive prevalence was estimated to be 65%, and the prevalence of modern methods among married women was 58.7% (WHO, 2023). The global review of the SDG target (3.7.1) "Proportion of Women of Reproductive Age (15-49) who satisfy their need for family planning with modern methods" works as a foundation for SDG aim (3.7) is to "Ensure Universal Access to Sexual and Reproductive Health-Care Services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes, by 2030" (United Nations, n.d.). The SDG indicator is helpful in measure overall levels of family planning coverage. Having access and using an effective method of preventing pregnancy helps women and men to use their right to freely and decide how many children they will have.

4. Prevention and management of Reproductive Tract Infections (RTIs) and Sexually Transmitted Infections (STIs)

These pose significant health challenges for both men and women worldwide. While men can also experience RTIs the consequences are more severe for women. These infections are critical, are closely linked to HIV/AIDS. While precise data on STI prevalence in India are lacking, estimates suggest that 40% of women have RTI/ STI at any given time. However, only 1% affected individuals complete full treatment for both partners. More than 1 million

people acquired STIs every day globally(WHO,2023).In 2020, there were an estimated 374 million new infections with one of the following curable STIs:

- Chlamydia: Chlamydia is bacterial infection. It affects both men and women, but women are at higher risk for complications. Regular screening is essential.
- Gonorrhea: Gonorrhea is caused by the bacterium *Neisseria Gonorrhoeae*. It can lead to serious health problems if left untreated.
- Syphilis: Syphilis is caused by the bacteria *Treponema Pallidum*. It has several stages and can affect various organs of the body
- Human Papilloma virus (HPV): HPV is a viral infection associated with genital warts and an increased risk of cervical cancer. Over 311 000 cases of cervical cancer are directly related to human papilloma virus (HPV) infection each year (WHO, 2023).
- Herpes Simplex Virus (HSV): HSV causes oral and genital herpes. Antiviral medications can manage symptoms.
- Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS): HIV/AIDS remains a significant global health concern.

Ministry of Health and family Welfare continuously efforts for the prevention and management of RTIs and STIs. Safe Sex Practices with the use of condoms during sexual activity reduces the risk of STD transmission. Regular screening helps in detect infections in its early stage. Pap smear test should be regular (yearly) and HPV vaccination protect against the virus to reduce the risk of cervical cancer.

1.4.2 Factors affecting Reproductive Health

Reproductive health is influenced by a wide range of factors including social, economic, educational, employment, living conditions, relations with spouse, traditional practices and legal structures. The attainment of reproductive health cannot be achieved only through the intervention of the health sector. However, most reproductive health issues cannot be effectively treated without health services, medical expertise and skills. Women's status in society and the way they are treated are important factors in maintaining their reproductive health. Having access to education for girls and women has a significant impact on their status and the power

they have over their lives and health and fertility. Women's empowerment is an essential element of health.

There are several factors that influence reproductive health:

I. Status of women

Maternal mortality and morbidity are two of the most important indicators of a woman's status in society. Women's reproductive health is directly related to their education and knowledge, understanding, and action on family planning. Educating the women is the most effective way to improve their status. They should be exposed to information about family planning, contraception, and the benefits of having a small family through the media, such as television, posters, and news articles. Exposure to these media is the most important factor that can have an indirect impact on fertility.

II. Psychological stress

High levels of stress can disrupt hormonal balance and affect reproductive functions. Managing stress through relaxation techniques, exercise, and counseling is important.

III. Nutrition

Nutrition has a direct impact on health. The term "nutrient" is used to refer to specific nutrients like proteins, vitamins, and minerals. Folic acid and vitamin B12 are essential for cell division in body. Lacking of folic acid leads to anaemia and fetal abnormalities, similarly vitamin B12 lacking affect on fertility. The availability of these nutrients to both the child and mother during pregnancy is essential and breastfeeding is an important nutritional need of the child for his growth and development (Sethi, 2012). Balanced diet is essential for growing well and enjoying good health.

IV. Environment exposure

Exposure to pollutants, harmful chemicals or radiation in the environment can impact reproductive health. Reducing exposure to toxins is necessary for maintaining reproductive well-being.

V. Substance abuse

Alcohol, tobacco, and recreational drugs like marijuana, cocaine, heroin can negatively affect fertility and reproductive organs. Avoiding substance abuse is

essential for maintaining reproductive health for both women and men (Sharma et al, 2013).

VI. Age at marriage

Early marriage age also affects the reproductive health. Adolescent fertility is a major problem, with an estimated 21 million teenage girls in developing regions becoming pregnant every year, and 12 million of them giving birth. The AFR (Adolescent Fertility Rate) is calculated as the number of babies born per 1,000 teen girls from 15-19 years of age. High AFR can lead to high overall fertility rate. Adolescent pregnancies are often caused by a lack of options in marriage and contraception. These pregnancies put young women at risk, with a higher chance of death than a woman who waits until she is in her 20 years of age to become pregnant (WHO, 2024). Sexually transmitted diseases (STDs) are a major health issue, affecting millions of young people worldwide. Many rural women think that STDs are caused by inappropriate diet and promiscuous behaviour, but the real cause of STDs is the result of unprotected intercourse and sexual abuse. They don't even know the difference between HIV and AIDS.

VII. Low use of contraceptives

Lack of knowledge and misconceptions about family planning methods can prevent women from using modern methods. Some have even expressed their fear of the potential side effects, such as physical weakness, dizziness, pain. Many users have reported side effects of contraceptives, which gives trouble to the health of the mother. Therefore, the widespread use of spacing methods is essential for the maintaining maternal health and prevention of HIV/AIDS and STDs

VIII. Maternal care

Maternal mortality is much higher in developing countries than developed ones. Pregnancy is a critical and unique time in a woman's life cycle. Many women in India die from pregnancy-related complications and during childbirth. The six main causes of maternal mortality in developing countries are anaemia, haemorrhage, eclampsia, obstructed labour, infection, and abortion. All of these causes can be prevented. The primary goal of maternal health is to provide all the necessary facilities during the pregnancy and delivery period to ensure a safe delivery and a healthy and normal baby. Maternal care is made up of antenatal Care, natal Care, and post-natal Care.

Antenatal Care is the care given to the woman during her pregnancy. The purpose of this care is to support, protect the mother's health. Natal care refers to care during delivery to prevent any complication. Post-natal Care is the care provided to the mother and newborn.

IX. Unsafe Abortion

An unsafe medical practice leads to major infections. Safe abortion is the most significant aspects of reproductive health. Legal measures, such as the MTP Act passed by India in 1971, aim to reduce the risk of maternal mortality caused by illegal abortion.

1.4.3 Reproductive health problems: its impact on women

Women are disproportionately affected by reproductive health issues, including pregnancy and childbirth complications, unsafe abortion, contraceptive use, and reproductive tract infections. Women of reproductive age lose their healthy years because of reproductive health issues, such as fertility problems, maternal mortality, and STDs. This burden is not due to biological factors, but rather due to their social, economic, and political disadvantages. Additionally, young people of both genders are disproportionately affected, as they lack access to information and services.

1.4.4 Reproductive System Disorders in Women

Reproductive system disorder is a term used to describe all diseases that affect the reproductive organs of human beings. These diseases can be inherited or acquired, and can include abnormal functioning of glands related to sex hormones, infections, and other diseases that come from unknown causes. Women with reproductive system diseases should be treated as soon as possible, as the risk of transmission to healthy people is high, especially if the disease is sexually transmitted.

I. Amenorrhea

Amenorrhea is a condition in which a woman does not menstruate. There are two types of amenorrhea: primary amenorrhea, which is an abnormal delay in the start of the menstrual cycle, and secondary amenorrhoea, which is an abrupt cessation of the menstrual cycle after many years of regular menstruation. Women who have not reached perimenopause may develop secondary amenorrhea.

II. Oligomenorrhea

Oligomenorrhea is a condition in which there is a gap between two menstrual cycles. In normal menstrual cycles, a woman will menstruate for 3 to 4 days. In this condition, a woman will only menstruate for 4 to 9 menstrual cycles in a year. It can be caused by a lack of estrogen and can lead to infertility.

III. Polycystic ovarian syndrome (PCOS)

PCOS is the common hormonal disorder in females of reproductive age. It is characterized by irregular menses, hyperandrogenism, and polycystic ovaries (Rasquin et al., 2022)

IV. Cervical erosion

Cervical erosion refers to the formation of ulcers in the area around the opening of the cervix. These ulcers appear as bright red or pink spots. At the beginning of the disease, the body sheds patches of mucus.

V. Cervicitis

Cervicitis is a condition caused by inflammation of the lining of the uterus. The lining of the uterus contains many glands that keep the vagina lubricated. These glands also create a conducive environment that allows bacteria and other microbes to grow. As a result, vaginal infections can spread to the lining of your uterus, resulting in the development of cervical cancer.

VI. Infertility

Infertility is defined as not being able to conceive after one year of unprotected sexual intercourse. It is a serious reproductive health issue. It can be either primary or secondary, Poor nutrition and repeated abortion which may result into infertility. Furthermore, the cost of treatment for infertility is higher, and it takes a long time to heal.

VII. Puerperal fever

It is also called Child bed fever. It is most commonly experienced within 10 days after the birth or miscarriage of the baby. The placenta that is separated from the baby is very susceptible to infection and laceration. This illness is marked by very high fever and must be reported to the doctor (Sira, 2011).

1.5. IMPORTANCE OF HEALTH SEEKING BEHAVIOUR IN REPRODUCTIVE AND CHILD HEALTH

The health of women is closely linked to their status in society. To improve women's health in developing countries, there is a demand for health services associated with health seeking behaviour must be increased and encouraged. In addition to physical access to understand the main determinants of women's health seeking behaviour in context of reproductive and child health care. It helps in promoting positive health outcomes, especially in developing countries where access to healthcare services can be challenging. HSB refers to the actions individuals take to seek out healthcare services in response to symptoms or preventive needs. Timely Interventions and Care play an important role in maintaining overall health. When individuals actively seek care, they are more likely to receive timely interventions. Promotion and maintenance of maternal and child health gained through the components of antenatal care and postnatal care. Antenatal care (ANC) is the systematic examination of the women in pregnancy. The supervision and examination should be on regular bases and according to the need of the women (Dutta , 2018). It is provided by health care personnel to the pregnant women to ensure the health of mother and her baby during pregnancy. The principle of ANC is to reduce the risk of mortality and morbidity and detect the complications and provide education on preventive care, immunization, diet in pregnancy and prepare the mother for child birth. Early care-seeking is vital for reducing maternal and infant mortality rates. High quality prenatal health care is the core of a safe pregnancy and encompasses following main components: risk assessment, treatment of medical conditions (or risk reduction), monitored for growth and development of foetus and health education such as antenatal exercise, diet, and general health .Counsellors are provided on the various stages of pregnancy, Pregnant women who do not receive prenatal care are three times more likely to give birth to a low birth weight baby (weighing less than 2,500 grams) and four times more likely to newborn die in infancy period than women who receive adequate care (James et al, 2005, Pp-183- 84).). Postpartum care is equally important to monitor maternal recovery and to address any complications. The postnatal care is the systematic examination and supervision of the mother and advice for the care of newborn. Access to family planning services also empowers individuals to make informed

decisions about their reproductive health. Family planning advice and methods allows space pregnancies appropriately and improve maternal health by avoiding frequent pregnancies. Sexual and reproductive health is particularly important for women in rural areas; their susceptibility is more to pregnancy and childbirth related deaths and disability, unsafe abortion, and HIV/AIDS, as well as reproductive infections and cancers. In addition personal and institutional barriers hinder rural women from their fundamental sexual and reproductive rights, which includes the right to control over their reproductive health decisions, marriage, contraception, ,and abortion(solo 1987).In conclusion, the importance of HSB among women with reference to reproductive and child health is undeniable. It not only ensures the well-being of the mother and child but also contributes to the overall health of the community. Therefore, it is imperative to promote and facilitate health-seeking behaviour, especially in the context of reproductive and child health.

1.6 ADVANCING WOMEN'S AND CHILD HEALTH STATUS: GOVERNMENT INITIATIVES IN INDIA

The Government of India is concerned with the pitiable conditions of sufferings of women as a marginalized category in the Indian society. So, it is taking up plans and programs not only to end the misery of the women but also to uplift her status and empower her.

1.6.1. National Health Policy (NHP),2017

The policy aims to shape health systems in India across various dimensions. It focuses on investments in health, healthcare service organization, disease prevention, and health promotion. The primary goal is to achieve the highest possible level of health and well-being for all age groups. This involves a preventive and promotive healthcare approach, ensuring universal access to quality healthcare without causing financial hardship. While maternal and child mortality rates have declined but target is not acheived, non-communicable diseases and infectious diseases pose new challenges. The policy adapts to these changing health priorities. The policy addresses the growing incidence of catastrophic healthcare costs, which contribute significantly to poverty. It aligns with global strategic directions, emphasizing improved access,

enhanced quality, and cost reduction in healthcare delivery. In summary, its goal is to create a healthier nation by ensuring universal access to quality healthcare without causing financial hardship, while adapting to changing health priorities and economic growth. NHP sets ambitious targets for improving health outcomes by 2025. These are :

- The policy aims to elevate life expectancy at birth from the current 67.5 years to 70 years. Achieving this will require comprehensive health interventions, disease prevention, and better healthcare access.
- Ensures antenatal care coverage above 90%, early detection of risks, safe pregnancies, and healthy outcomes for both mothers and babies
- The goal is to reduce under-five mortality to 23 deaths per 1,000 live births. This involves strengthening neonatal care, nutrition programs, and disease management.
- The target is even more specific: lowering neonatal mortality to 16 deaths per 1,000 live births. Early detection, skilled birth attendance, and postnatal care play vital roles.
- The policy emphasizes achieving a “single-digit” stillbirth rate. This necessitates improved antenatal care, monitoring, and timely interventions.
- Enhance utilization of public health facilities by 50% compared to current levels. Strengthening infrastructure, staffing, and community awareness will be pivotal (National Health Policy, 2017).

1.6.2. National Quality Assurance Standards (NQAS)

These standards were launched in 2013, in India play a vital role in improving the quality of care provided in public healthcare facilities and are designed to ensure safe, effective, and patient-centered care. These standards allow healthcare providers to assess their own quality against predefined benchmarks. By meeting these standards, facilities (Hospitals/Institutions) can seek certification (National Health Systems Resource Centre, 2021).

1.6.3. Rashtriya Kishor Swasthya Karyakram (RKSK)

This is an initiative implemented by the Ministry of Health and Family Welfare, Government of India, since 2014. The program aims to reach out to 253 million

adolescents, including male and female, rural and urban, unmarried and married, and in-school and out-of-school adolescents. RKSK focuses on the holistic development of adolescents by addressing various aspects of their health and well-being.

1.6.4. Menstrual Hygiene Scheme (MHS) was launched by the Ministry of Health and Family Welfare (MoH&FW) to promote menstrual hygiene among adolescent girls aged 10-19 years in rural areas. The scheme has two main objectives: (a) To increase awareness about menstrual hygiene among adolescent girls. (b) To enhance access to high-quality sanitary napkins for rural adolescent girls. Aganwadi worker plays a role in distribution of sanitary pads and awareness regarding menstrual hygiene.

1.6.5. Maternal, Neonatal and Child Health Programmes

1.6.5. (a). Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA)

This initiative launched by the Government of India in 2016 focuses on providing quality antenatal care to pregnant women across the country with the primary goal to provide high-quality antenatal care services to every pregnant woman. On the 9th day of every month, pregnant women can access antenatal care services provided by specialists and medical officers at Primary Health Centers (PHCs), Community Health Centers (CHCs), and District Hospitals (DHs). This additional care complements the routine ANC services available at health facilities. If the 9th day of the month falls on a Sunday or a holiday, the services should be provided on the next working day. Health workers identify and reaching out to pregnant women who are not registered for ANC (left out or missed ANC), addressing registered pregnant women who did not avail ANC services (dropout) and ensuring high-risk pregnant women receive necessary care. During the campaign, trained service providers and ASHAs emphasize completing scheduled ANC visits and essential investigations. These services aim to ensure the well-being of both the pregnant woman and her unborn child. Promoting maternal health is essential for reducing maternal mortality, improving birth outcomes, and enhancing overall family well-being. By providing specialized care on a fixed day each month, the PMSMA contributes significantly to achieving these goals (Ministry of Health and family Welfare, 2023).

1.6.5. (b). Janani Shishu Suraksha Karyakarm (JSSK)

The program was implemented in the state since October 2011, to encourage pregnant women to deliver in public health facilities and encourages them to stay for 48 hours after delivery. It provides free medical treatment to mother and infant, meals during hospital stay.

1.6.5.(c). Janani Suraksha Yojana (JSY): The scheme has been operational since 2005-06 and is implemented in all government hospitals across the country, including Jammu and Kashmir. JSY encourages institutional deliveries to reduce maternal, infant, and neonatal mortality rates. It specifically targets needy and economically disadvantaged pregnant women in both rural and urban areas. After delivery but before discharge (within 7 days), eligible mothers receive financial incentives. In cases of referrals, payment is made within 15 days. All payments are facilitated through Direct Benefit Transfer (DBT). Rural and Urban beneficiaries get 1400 and 1000 respectively. ASHAs (Accredited Social Health Activists) play a vital role in facilitating antenatal checkups and accompanying mothers to health institutions for delivery.

1.6.5.(d). LaQshya programme

Labour Room Quality Improvement Initiative is launched by the Ministry of Health and Family Welfare in India. Its primary objectives are to enhance the quality of care during labor and the immediate post-partum period in Labour Rooms and Maternity Operation Theatres (OT) to reduce maternal and newborn morbidity and mortality.

1.6.5.(e). Rashtriya Bal SwasthyaKaryakaram (RBSK) is an initiative by the MoH&FW under the National Health Mission(NHM). Its goal is to screen children aged 0 to 18 years for defects, deficiencies, developmental delays, and disabilities. Children diagnosed with these conditions receive free treatment, including surgical interventions and follow-up care at tertiary-level health institutions. The program aims to enhance the overall quality of life for children, reduce child mortality and morbidity, and alleviate financial burden for low-income families. Under this initiative, mobile health teams comprising doctors and paramedical staff conduct screenings at the block level. They screen all children aged 6 weeks to 5 years enrolled in Anganwadi Centres at least twice a year. Additionally, they screen all children aged 6 to 18 years attending government and government schools. Newborns

are screened for birth defects in health facilities by service providers, and during home visits by Accredited Social Health Activists (ASHAs) within the first 6 weeks of life.

1.6.5.(f). Universal Immunisation Programme (UIP) The Universal Immunization Programme (UIP) launched in India, is one of the largest immunization programs globally. Annually, it aims to vaccinate 2.6 crore newborns and 3 crore pregnant mothers. More than 90 lakh immunization sessions are conducted each year, supported by nearly 27,000 cold chain points across the country. Under UIP, the Indian government provides vaccination to prevent diseases including Diphtheria, Pertussis, Tetanus, Polio, Measles, severe Childhood T.B (Tuberculosis), Hepatitis B, and meningitis & pneumonia caused by Haemophilus influenza type B. In addition to the other vaccinations it also provides vaccines against Rubella, Rotavirus Diarrhea (in specific states), and Japanese Encephalitis (in districts where it is endemic). These efforts contribute to maintain public health and preventing the spread of preventable diseases.

1.6.5.(g). Navjaat Shishu Suraksha Karyakram (NSSK), launched by the Government of India in 2009, aims to provide comprehensive newborn care services nationwide. NSSK offers free services such as hypothermia prevention, infection control, early breastfeeding initiation, and basic newborn resuscitation. Over time, the program has evolved to enhance training methods and clinical skills for health workers and doctors involved in delivery and newborn care.

1.6.6. National Nutritional Policy

It was adopted in India, 1993 with a aim to eradicate malnutrition across the country. This policy takes a multi-sectoral approach, utilizing both direct short-term interventions and long-term strategies. It focuses on vulnerable groups, especially women and children, who are disproportionately affected by under nutrition. By addressing malnutrition, the policy aims to improve overall health, productivity, and well-being.

1.6.7. Mothers' Absolute Affection (MAA) Programme

This program is a nationwide initiative by Central Government of India. Its primary focus is to promote optimal Infant and Young Child Feeding (IYCF) practices. Encouraging mothers to initiate breastfeeding within one hour of childbirth. This

practice can prevent up to 20% of newborn deaths. Promoting exclusive breastfeeding for the first six months, infants who are exclusively breastfed during this period are 11 times less likely to die from diarrhea and 15 times less likely to die from pneumonia. After six months, adequate complementary feeding is emphasized. The program encourages mothers to continue breastfeeding for at least two years and beyond. Breastfeeding provides essential nutrients and supports child health and maternal well-being.

1.6.8. National Iron Plus Initiative (2013)

This has focuses on tackling Iron Deficiency Anaemia (**IDA**) at different life stages. It specifically targets adolescents and non-pregnant or non-lactating women in the reproductive age group. The program includes providing Iron Folic Acid (IFA) supplements to improve iron levels, distributing deworming medication every two years to lower iron and blood loss from intestinal worm infections such as hookworm, and encouraging the consumption of iron-rich foods and good hygiene. To achieve this, the initiative involves three primary ministries: Health and Family Welfare, Women and Child Development, and Education, with Health and Family Welfare taking the lead.

1.6.9. The Poshan Abhiyaan Programme

It works under the National Nutrition Strategy of National Institute of Transforming India Aayog, which is set on realizing "Kuposhan Mukat Bharat," or a nation free from malnutrition by 2022. The Poshan Abhiyaan is dedicated to check the India's most undernourished areas by enhancing the availability of essential Anganwadi services and boosting the provision of Anganwadi nutritional services. Anamia Mukat Abhiyan comes under Poshan Abhiyaan and targets are given in figure 4.

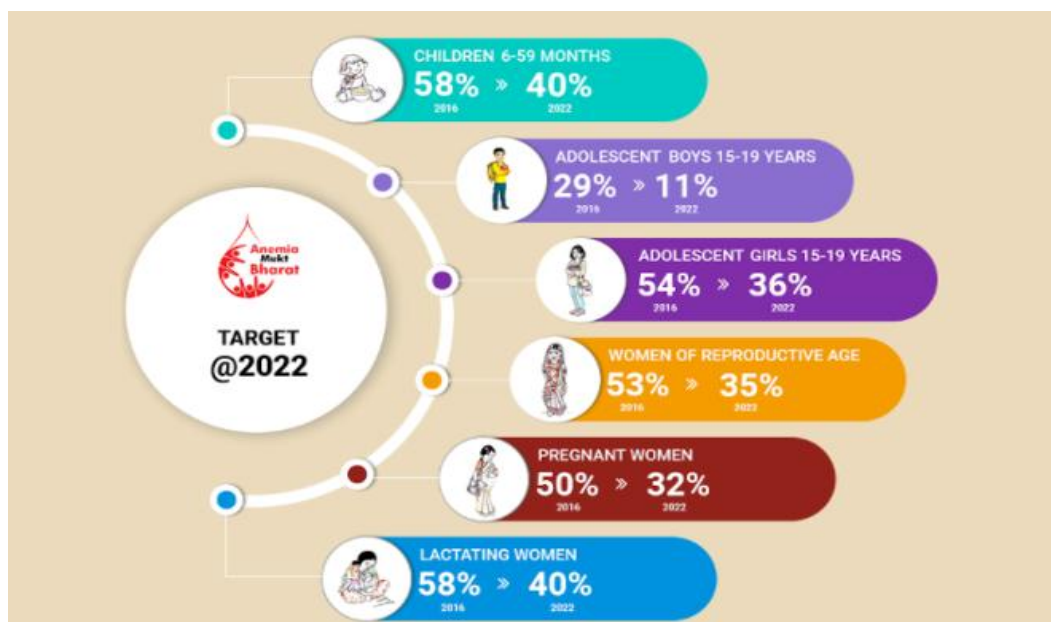


Figure 3 - Poshan Abhiyan Target, 2022

Source – Poshan Abhiyan, Govt. of India, 2022

1.6.10. National Population Policy (NPP)

It addresses the issues and challenges related to family planning, that plays an important role in the reproductive health with the focus on eligible couples and women.

1.7. SIGNIFICANCE OF THE STUDY

Women are the backbone of the family. Their quality of life is influenced by the home environment. According to Constitution, women have equal rights as men. However the outlook and attitude of the society is not better. In the fact of population, women constitute half of the population. But the health of women is hardly recognized. As a result there are large numbers of women still lacking maternal and reproductive care in their 15-49 years of age and morbidity pattern is high (Gill, 2015). Most of the rural women are the victims of ignorance, poor health and illiteracy and caught between social, cultural and religious boundaries. There is need to remove all barriers and create awareness (Muela, 2003)

Health seeking behaviour is a very important factor in maintaining the health of community. Health is affected by social, environmental, political and economic factors. Women bear the greatest burden associated with reproduction. They are

having risk of ailments and complications from their pregnancy to childbirth. Reproductive health is a very important part of women's health which should be started as earlier. NFHS-5 reports show there so many lacking in Punjab regarding reproductive and child health. . Specifically, in the districts of Kapurthala and Jalandhar, the consumption of iron and folic acid among women is low at 57.9% and 53.9% respectively. Furthermore, the percentage of women who received full antenatal check-ups is only 51.4% in Kapurthala and 72.8% in Jalandhar (NFHS-5, 2019-21). These figures give emphasis to the urgent need for improvements in women's health in these regions.

1.8. RESEARCH GAP

There were so many studies conducted on the health seeking behaviour about reproductive health in married women as well as on adolescent girls in other states of aIndia (Kaur et al., 2018 ; Chaudhary et al., 2017). Still, full coverage of reproductive and child health determinants was lacking, and no study was conducted on reproductive and child health with all characteristics in Punjab. The present study intended on the Health seeking behaviour among women regarding Reproductive and Child Health including all aspects of reproductive health which are menarche age, marriage age, menstrual hygiene, antenatal and postnatal care, use of contraceptive methods and family planning as well as child care.

1.9. OBJECTIVES

The objectives of the present study are :

- To study the demographic profile of women.
- To understand the health care practices of women with reference to reproductive health.
- To assess the knowledge of women about child care.
- To analyse the health seeking behaviour among women.

1.10. RESEARCH QUESTIONS

The research questions are:

1. What are the demographics indicators?
2. What type of health practices used by the rural women?

3. How many women are aware from the standardized health practices for their and child health?
4. How women access healthcare services and care during reproductive age?

1.11 LIMITATIONS OF THE STUDY

1. The present study limited to Kapurthala and Jalandhar districts.
2. Women involved who are married and at least one child.
3. The study limited to 10% sample of 15-49 years of reproductive women from four village of Kapurthala and Jalandhar districts respectively.

1.12. KEY TERMS

1.12.1. Health

“Health is state of complete physical, mental and social well being and not merely an absence of disease or infirmity” (WHO, 1948).

1.12.2. Health Seeking Behaviour

“Health-seeking behaviour represents the range of activities that individuals undertake to promote or restore health, including health promotion/protective activities, self-management of health problems, use of informal resources such as the family network, and use of formal professional resources” (Weinert, 1994).

1.12.3. Reproductive Health

“A state of complete physical, mental and social well-being and not merely an absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and they have the capability to reproduce and the freedom to decide if, when and how often to do so” (United Nations Population Fund, 1994).

1.12.4. Maternal Health

“Maternal health refers to the health of women during pregnancy, childbirth and the postnatal period” (WHO, n.d.).

1.12.5. Child Health

“Child health is a state of physical, mental, intellectual, social and emotional well-being and not merely the absence of disease or infirmity. Healthy children live in families, environments, and communities that provide them with the opportunity to reach their fullest developmental potential” (First Things First, 2007).

1.13. THESIS OUTLINE-

Chapter1

Introduction- This chapter covers the background of the Study, Health and Its Significance, Health Indicators, Health-Seeking Behaviour –Definition of health-seeking behaviour, Overview of Reproductive and Child Health. Reproductive Health includes maternal health, family planning, and antenatal and postnatal care. Child Health covers such as immunization, nutrition, and child development, understanding the relevance of health-seeking behaviour to reproductive and child health, health programmes for maternal and child health and Key Terms.

Chapter 2

This chapter covers the theoretical framework and literature review and summarizes existing research on health-seeking behaviour among women

Chapter 3

This chapter provides Area description, research design, sampling procedure, data collection.

Chapter 4

Data analysis and findings presents the results of analysis, focusing on health-seeking behaviour patterns among women and interpret the findings, discussion and implications.

Chapter 5

This chapter includes summary and conclusion of the study.

SUMMARY

A significant portion of women in rural areas face barriers in accessing healthcare, with nearly half requiring permission from family members to seek medical care. Additionally, only one-third of women promptly seek medical attention upon experiencing symptoms, and many turn to unqualified practitioners and home remedies as their first line of consultation. The healthcare-seeking behaviour of rural women is heavily influenced by low socioeconomic and geographical factors (far away from hospital), with considerations such as consultation fees and location often taking precedence over the qualifications and quality of healthcare professionals. Ignorance, social stigma, communication barriers, and limited access to healthcare further contribute to inappropriate healthcare-seeking behaviour among rural women. It is crucial to adopt an integrated and structural approach to raise awareness about common health issues and improve health seeking behaviour among women.

CHAPTER II

THEORETICAL PERSPECTIVE

AND

REVIEW OF LITERATURE

The study of health-seeking behaviour among women, especially in relation to reproductive and child health necessitates a thorough comprehension of the theoretical frameworks and critical review of existing literature. The aim of this chapter is to examine the multi-faceted nature of women's health-seeking behaviour, which are influenced by a complex combination of social, cultural, economic, and ecological elements. The theoretical perspective provides a framework through which to understand and analyze the complexity of these behaviours. At the same time, the literature review will provide a broad overview of the current state of research in this area, highlighting the progress made and the shortcomings that persist. This combination of theory and literature will not only help to review women's actions in health-seeking but also provide the way for subsequent empirical investigation.

2.1. THEORETICAL PERSPECTIVE

2.1.1. Theory of Care Seeking Behaviour

This theory was developed by Diane Lauver in 1992, after reviewing the health belief model and theory of reasoned action. This theory proposes the health-seeking behaviour, emphasizing psychosocial variables and supporting conditions. This theory aligns with health-seeking practices among women in the context of reproductive and child health.

(a). Affect and Emotions: Lauver's theory acknowledges that emotions play a vital role in care-seeking behaviour. Fear of serious diagnoses or discomfort can drive women to seek medical attention during pregnancy, childbirth, and postpartum.

(b). Expectations and Value: Beliefs about the likelihood of specific outcomes influence care-seeking decisions. When women perceive positive outcomes (such as healthy pregnancies and safe deliveries), they are more likely to seek care.

(c). Utility: The utility term represents the overall value of care-seeking. It combines expectations and value ratings related to desired outcomes. For women, this utility encompasses maternal and child health benefits.

(d). Social Norms: Other people's ideas about seeking care are helpful in shaping behaviour. Community norms influence whether women seek antenatal, delivery, and postnatal care.

(e).Personal Norms: It refer to an individual's beliefs about what is right or wrong (morally correct), and these beliefs guide their behaviour in seeking care. Women take into account both societal expectations and their own personal values when deciding to seek care.

(f).Habits: Past experiences influence behaviour. Women's habitual responses to symptoms whether seeking immediate medical attention or delaying care, impact maternal and child health outcomes.

(g).Clinical and Demographic Variables: While these factors don't directly affect behaviour, they indirectly influence theoretical variables. Education, birth order, and knowledge about pregnancy complications interact with psychosocial factors.

To summarize, recognizing and overcoming psychosocial obstacles can lead to better health-seeking actions in women, which can positively impact reproductive and child health results.

2.1.2 Foucault Theory

This theory discovered by Michel Foucault, a French philosopher (1926-1984). His theoretical concepts examines how power, discourse, and knowledge shape women's health-seeking behaviour in Punjab. By exploring frameworks such as biopower, governmentality, and disciplinary surveillance, the research uncovers how reproductive norms are both externally enforced and internally accepted. These tools illuminate how maternal health choices are influenced not just by personal agency but by broader social structures and institutional practices. The key concepts are :

(a). Discourses

Foucault emphasized that discourses shape how we think, act, and speak about health, bodies, and norms. The discourse of the "ideal mother" emphasizes institutional childbirth, vaccination, and exclusive breastfeeding .Women's self-perception as mothers and caretakers is influenced by these health discourses, especially when delivered through mass media, ASHA workers, and frontline health personnel.

(b). Power/Knowledge

Foucault's theory asserts that knowledge and power are co-produced. Government campaigns like Janani Suraksha Yojana act as sources of knowledge that direct women toward certain behaviour.

(c). Sovereign Power and Disciplinary Power

There is difference between sovereign power (top-down, visible control) and disciplinary power (subtle, internalized regulation).

- Sovereign power is reflected in direct state interventions: health incentives for hospital deliveries, penalties for not completing immunization schedules, mandatory registration of births.
- Disciplinary power operates more tactfully. Health workers making home visits monitor women's compliance. Posters, village health days, and group meetings act as tools of normalization, making certain behaviours feel obligatory.

(d). The Panopticon/ surveillance

It is related to a system of surveillance where individuals regulate themselves because they feel constantly observed . In rural Punjab the presence of ASHAs and anganwadi workers creates a network of "health investigators". Women are aware that their attendance at clinics or participation in campaigns is noticed and sometimes reported. It is self-monitoring, where women make health choices based on how they will be judged—by the system or community.

(e). Governmentality and Biopower

It means how state government deal with population to improve their health behaviour. The government promotes maternal and child health not to protect individuals, but to ensure a productive, healthy population through awareness programmes. The government advocates for the health of mothers and children not merely to safeguard individuals, but to cultivate a productive and healthy population through awareness initiatives.

Biopower embodies this capacity to govern life itself—such as childbirth, spacing, and feeding habits—via policies and programs. Power flows through connections, institutions, societal norms, and knowledge frameworks, significantly influencing women's reproductive decisions. Women's reproductive decisions are framed as matters of "good citizenship," aligning personal health with national progress.

This theory demonstrates that health-seeking behaviours are not purely individual acts but social products. Power flows through connections, institutions, societal norms, and knowledge frameworks, significantly influencing women's reproductive decisions.

2.1.3. Maternal Attainment theory

This theory was developed by Mercer Began born in 1929. This theory helps to provide proper health care to mothers to develop good maternal identity. Maternal Roles Attainment Theory offers a framework for supporting socially health seeking behaviour among mothers, including pregnant, postpartum, adoptive, and foster mothers. The concept of maternal role attainment was defined as “a developmentally, interactive, adaptive, and committed multi-dimensional process based on the discovery of pregnancy, characteristics of the mother, receiving social support, which leads to maternal identity, formation of maternal skills, resiliency, development of newborn, improvement of mother-newborn interactions and increased well-being of the mother”(Began, n.d).

The theory emphasizes the need for mothers to develop a strong sense of motherhood and guides interventions that support this development. Individuals in various caregiver (Nurse, Anganwadi worker, ASHA) roles can help mothers to develop a sense of motherhood by providing information, resources and emotional support throughout pregnancy and postpartum care. This can include connecting them to support networks, giving them access to educational resources, or providing counselling sessions that focus on their individual needs and issues and help them navigate their care giving roles, build strong relationships, and feel more connected to their children.

It has four phases.

Anticipatory phase: - This phase gives social and psychological adaption to the maternal role.

Formal phase: - It is associated of maternal role at child birth.

Informal phase: - It is related to when the mother develop her own methods of nursing or mothering the child, that is not learned from society.

Personal phase:-this is called joy or happiness phase, in which mother develop confidence, joy, happiness.

In summary, Mercer's Maternal Role Attainment Theory highlights the importance of nurturing maternal identity and facilitating positive mother-child relationships. By understanding the phases and offering specific assistance, healthcare providers can enable mothers in their journey to effective motherhood.

2.1.4. Bonding and Attachment theory

It was originally developed by John Bowlby (1907-1990). It proposes the affectional tie between the mother and infant that ensure infant will be cared for during their years of dependency. Attachment theory emphasizes the primary caregiver's role in creating a sense of safety and security for babies and encourage skin to skin contact and early breast-feeding, which promote bonding and promote maternal health.

In summary, attachment theory highlights the role of primary caregivers in providing a sense of security for infants. By understanding the mechanism of attachment, healthcare professionals can support the women to follow the best possible care for reproductive and child health.

2.1.5. Theory of Planned Behaviour

The theory was elaborated by Icek Ajzek. The theory of planned behaviour is psychological theory that links beliefs to the behaviour. According to the theory of planned behaviour, an individual's intention to engage in a certain behaviour facilitates the practice of the behaviour. Individuals are much more likely to intend to have healthy behaviour (use of health facility for childbirth) if they have positive attitudes about the behaviour, believe that perceived subjective norms (social pressure) are favorable towards those behaviour and believe they are able to perform those behaviour correctly.

2.2. LITERATURE REVIEW

A review of literature is a collection of papers written by previous scientists and published as books, articles in journals. Every scientific investigation begins with a review of literature. In fact, a review of literature is an important part of research. It helps to create ideas, develop important questions and is considered to be an essential part of research design.

This section binds the review of literature related to health seeking behaviour in women for their reproductive health as well as child health.

2.2.1. Health seeking behaviour among women

Kang et al., (2022) highlights the health seeking behaviour and improvement of maternal health. The success of maternal health outcomes depends on women's health literacy. A cross-sectional study conducted on the 100 rural women who were pregnant or had had a live birth within the last six months were selected from five villages in Patiala district, Punjab to exploring the areas in which women look for information can help us understand their health information needs better. Most of the women were between 26–30 years of age and reported that they were dependent on their husbands and family members to choose sources of health information during pregnancy. Women said that doctors, nurses and the Internet were valuable sources of health information, but they also mentioned long lines and inconvenient service hours when going for an antenatal check-up in health settings. These findings highlight the need to strengthen and improve existing services for availability of education and communication resources, as well as maternal services within the public health sector. Yadav et al., (2022) reviewed a large body of research on health-seeking behaviour and healthcare utilization among rural people in North India. The study, which was conducted in the 28 villages of Gorakhpur District. The study found that a large proportion of the population relied on private healthcare services, as public health facilities were not used by the majority of the population. The majority of people (63%) preferred private healthcare services over public health facilities (37%). The preference for private services was due to the perceived quality of treatment, as well as the closeness of private facilities.

Ibarra Nava et al., (2020) conducted cross-sectional study to understand the reasons why young married women in India desire to delay their first childbirth. The sample was limited to married women between the ages of 15-24 who were never pregnant and pregnant and who have planned pregnancy. The results showed that 21.49 % of never pregnant yet, married women ages 15-24 had a preferred waiting time of 2 or more than 2 years for their first birth. The factors that significantly influenced the preferred waiting time were - good economic status, higher education, marriage after 18, and education level of the husband. The study concluded that partner behaviour influenced young women's childbearing intentions after marriage and suggested that delaying their first birth could improve women's educational and economic prospects,

health, and well-planned children. The study stressed the importance of supporting and respecting women's right to choose who and when to get married, and to have children.

Reddy et al., (2020) investigated the health seeking behaviour of rural women in Telangana. A cross-sectional study was conducted. Data collected from representative sample of rural women using questionnaires and interviews. The study focused on various aspects health seeking behaviour, including factor influencing the decision making, sources of health information, utilisation of health services and barriers to health care. This study highlights geographical location, education, partner's support health awareness and community influence all play a role in shaping the health care seeking behaviour of rural woman. There is need to strengthen the services in adequate and accessible form.

Gopalakrishnan et al., (2019) observed the health behaviour among antenatal and postnatal mothers in a rural region of Tamil Nadu. The results showed that only 21% participants have sufficient knowledge about the risk signs of pregnancy. 62.3% of the participants preferred primary health centres for delivery, and 87.3% had adequate prenatal care, also showed that iron and folic acid consumption were associated with health-seeking behaviour. The findings suggest that health education should be provided to all pregnant and expectant mothers to ensure they are aware of the risks of pregnancy and the importance of proper prenatal care. This would help to reduce the overall maternal mortality and morbidity.

Gwande et al., (2018) conducted the community based study on reproductive tract infection and HSB in the rural area of Mumbai. The aim of this study to investigate the prevalence of reproductive tract infections in relation to demographic variables. 265 women were collected through PHC (Primary health centre) register. The results show that the prevalence of RTI was 143 (53.96), the most common symptom found was the vaginal discharge 59 (22.26) and among them only 13.74% women visited medical practitioner for treatment.

Sharma et al., (2018) conducted community-based cross-sectional study aimed to assess the prevalence of RTI symptoms and treatment-seeking behaviour among married women of reproductive age. Reproductive tract infections (RTIs) make a significant public health challenge, particularly in developing countries like India. The

associated stigma often deters women from seeking healthcare. 276 women interviewed, approximately one-third (35.5%) of women reported symptoms suggestive of RTIs. The most common symptoms were foul-smelling vaginal discharge (69.4%) and lower abdominal pain unrelated to menstruation (52.0%). Only 57.1% of those with RTI symptoms sought treatment. This study highlights the importance of addressing RTIs and promoting awareness among women to improve their health-seeking behaviour.

Shrestha et al., (2017) carried out a descriptive study to assess the HSB in Bhimtar, Nepal by involving 147 women who were randomly selected from a purposive sample. The majority of the women (80.9%) reported having gynecological issues. The most common issue was low back pain with 43.75% of women reporting it. Other issues included lower abdominal pain with 35.2%, dysmenorrhoea with 27.3%, and menstrual irregularities with 27.3%. The majority of women (51%) said modern medical facilities are not available in their area. The main obstacles are accessing health services, lack of female physicians and distance to the nearest healthcare center with 37.5%. The conclusion of the study was that a large number of women prefer traditional practices because of the distance from healthcare centers and lack of doctors in the area.

Agrwal et al., (2014) explored the safe sex practices, and treatment-seeking behaviour of married women. A cross-sectional study involving 440 participants was conducted at the RTI Clinic of Medical College, Gwalior. Findings revealed that out of 440 patients diagnosed with RTIs, 312 (71%) had some knowledge of reproductive tract infections. The most common symptom reported was vaginal discharge, experienced by 305 (69%) of the women. Barriers to seeking treatment included embarrassment and perceiving symptoms as minor issues not warranting medical attention. Only 67 (22%) women reported consistent condom use by their partners during intercourse. Prevalence of symptoms was higher in the age group 25-35 years compared to both older (>35 years) and younger (15-25 years) age groups. Housewives, those with lower educational status, and lower socioeconomic classes were greater than working women, highly educated women, and those from higher social classes. In conclusion, although married women demonstrated a high level of knowledge regarding RTIs and

STIs, their attitudes toward safer sex and treatment-seeking behaviour did not consistently

Nandwani et al., (2013) conducted a study to observe HSB and level of satisfaction of Reproductive and Child Health services among working and non-working women. Results show that working women have good health behaviour as compared to non working women. Non-working 52% and 42% were delivered at private hospital and government hospital respectively but working women delivered at private hospital.

Ranjan and Sayeed (2013) investigated the awareness of reproductive and sexual health among young individuals. Their research focused on a demographic of married adolescents aged between 15 and 19 years. The study revealed that 15% of the women surveyed reported symptoms indicative of reproductive tract infections, including lower abdominal pain, low backache, dyspareunia, genital irritation and infection, and vaginal discharge. Furthermore, the study identified a correlation between attitudes towards medical care and socio-demographic characteristics, highlights a significant lack of understanding regarding treatment-seeking behaviour.

Mani et al., (2013) examines health care behaviour among married women reporting reproductive tract infections in rural Tamil Nadu. The objective is to explore the association between socio-demographic variables and health-seeking behaviour. The study design was descriptive, focusing on women aged 18-45 years in Kancheepuram district. A simple random sample of 520 participants was included. Findings revealed that 33.3% of women experienced reproductive tract infection symptoms in the past 12 months, but only 51.45% sought healthcare. The review emphasizes the need for widespread awareness about reproductive tract infections and effective management strategies.

Bajaj et al., (2017) conducted an exploratory study on the knowledge of reproductive and child health among primi gravida mothers , covered the 100 mothers attending antenatal check-ups at a civil hospital in Moga, Punjab. The results indicated that 44.1% of mothers had an average knowledge, 37% had below average knowledge, and 19.6% had good knowledge regarding reproductive and child health.

Chaudhry et al., (2017) states the importance of reproductive behaviour of the woman during the earlier years of their married life should be adequate because in this time period women are vulnerable to reproductive illness.

Paul et al., (2017) investigated the health-seeking behaviour among married women in rural areas to understanding the factors influencing treatment-seeking decisions is essential for improving health outcomes. This study employed a simple convenient sampling method, selecting 270 married women as study participants. The main aim is to assess whether women sought treatment for their perceived health issues. Among the all participants, 72.6% reported seeking treatment for their health concerns, 44.4% preferred private health facilities over public ones and 48% of women who did not seek treatment for their symptoms because it does not hinder their daily activities. It highlights the need for targeted interventions to improve health-seeking behaviour among rural married women. By promoting awareness and ensuring accessible healthcare services, overall well-being in women can be achieved.

Ade et al., (2014) Studied the health seeking behaviour among Muslim women (18-45) related to their reproductive health. Women health is the nation's health. Data was collected from 82 women by unstructured interview method. Results show that 57 women were suffering from reproductive tract infections and the expected cause found that they were married at the age of 12-15 years, total no. of births 3-4, not using birth spacing methods, birth interval is 1 year. There is need to emphasize on education regarding accurate age of marriage, family planning, reproductive tract infection treatment.

Karlsen et al., (2011) finds the association between maternal education status and mortality among women who give birth in health care facilities. It also looks at the relationship between maternal age and marital status, parity and institutional capacity, and state level investment in health care. The cross-sectional data (WHO) collected from 287,035 women who gave birth in 373 healthcare facilities in 24 countries from 2004-2005 (Africa and Latin America) to 2007-2008 (Asia and Latin America). The results reveals the association between indicators measured at individual, institutional, and country levels and the incidence of maternal mortality during the "intrapartum" period (from admission to discharge from the hospital where the women delivered the baby) and found that women with no education were 2.7 times more likely to have a higher risk of maternal deaths than those with between 1 and 6 years of education. But women with over 12 years of education were also more likely to have higher rates of maternal mortality.

Sharma and Parthy (2004) talks about reproductive health services Punjab. The study was conducted in two district- Roopnagar and Patiala. Primary data was collected from the 1000 households (each district 500). Finding reveals that maternal mortality is not stabilized, still challenging situation. There is need to strengthen the reproductive health service in Punjab.

Anderson (1973) focused on the different social dimensions that have a direct relation to utilization of health care services. The five different dimensions: the socio-cultural, socio-psychological, socio-demographic, organizational and social systems. These approaches provide important points in utilization behaviour. It's important to understand these dimensions are interconnected and can collectively influence an individual's behaviour regarding health care utilization.

2.2.2. Age at Menarche

Canelon and Boland (2020) provides systematic literature review explored factors influencing the timing of menarche. It considered environmental, physiological, sociological, disease-related, and genetic contributions to variations in menarche age. The study aimed to understand both the causes and consequences of abnormal menarche timing. This reveals multiple factors are associated with early menarche.

Tarannum et al.(2018) conducted a descriptive study on the menarche age among adolescent girls (422), Aligarh. The aim was to determine the age of menarche and its association with socio-demographic variables. Results found that majority of them (69.9%) had attained menarche between the ages of 12-14 years. Mothers were the main sources of information.

Pathak and Tripathi (2016) studied the most important health issue that is secular trends in menarche age, India. They examined that the secular trends, regional disparity and the association of anthropometric and socioeconomic factors with menarche age in married women (15-49years) in India. Results found that the mean menarche age in Indian women was 13.76 years in 2005 and according to heterogeneity disparity it was 15 years in Himachal Pradesh in 1955-1965 and in Assam it was 12.2 years during 1985-87.

2.2.3. Menstrual Hygiene Practices

Kaur et al., (2018) studied menstrual hygienic practices and waste management among girls and women of developing countries. They observed girls and women still

facing cultural, religious and social restrictions especially in rural areas. Girls and women having very low knowledge related to reproductive health. The study found that a lack of knowledge related to reproductive health makes difficult experience during menstruation.

Pandey and Shukla (2018) observed the menstrual hygiene practices among married women aged 15-49 attending the outpatient department at CIMS, Bilaspur. Women's knowledge and perceptions of menstrual hygiene has been assessed through questionnaire. The study highlighted that a significant age group of the participants (36%) was between 20-30 years. The findings indicated that more than half of the women (50.8%) were using cloth during menstruation, with 45.5% reusing the same washed clothes each month. The study concluded that these unhygienic practices were predominantly due to low literacy level among the women.

Yadav et al., (2018) conducted study on menstrual hygiene management among the adolescent girls. The study, which involved 276 students, used a self-structured questionnaire to collect data. The results revealed that 67.4% of the participants had fair knowledge, 26.4% had good knowledge, and only 40% were practicing good hygiene.

Ramachandra et al., (2015) suggested that the lack of knowledge regarding menstrual hygiene and reproductive health leads to the more reproductive health problems. The study aimed to assess the knowledge and attitude, hygienic practices during menstruation. Results found that 34% girls aware of menstruation before menarche, 69% girls were using sanitary pads and 6% were using old clothes.

2.2.4. Age at marriage

In India, the practice of child marriage was initially prohibited by the Child Marriage Restraint Act of 1929, which stated that marriage of girls under 14 and boys under 18 was not allowed. This act was amended in 1978 to raise the minimum age to 18 for females and 21 for males. The Prohibition of Child Marriage Act, 2006 replaced the 1929 Act, maintaining the same minimum age limits. The Prohibition of Child Marriage (Amendment) Bill, 2021 aims to raise the minimum marriage age for females to 21. The bill was forwarded to the Standing Committee on Education, Women, Children, Youth, and Sports on December 21, 2021. In June 2020, the federal government established a committee (Chairperson: Ms. Jaya Jaitly) to investigate the

link between the age at which women get married and have children with: (a) the health, medical conditions, and nutritional status of both the mother and foetus during pregnancy, childbirth, and after, (b) important indicators like Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR), Total Fertility Rate (TFR), Sex Ratio at Birth (SRB), Child Sex Ratio (CSR), and (iii) any other pertinent issues related to health and nutrition in this area. The committee was also tasked with proposing strategies to encourage more women to pursue higher education. As per reports from the media, the committee's findings were released in December 2020, during which it recommended raising the marriage age for women to 21. However, the committee's report has not been made public (PRS Legislative Research, 2021).

Ministry of Women and Child Development, India (2021) presents a report according to the National Family Health Survey 2019-21 (NFHS-5), it was found that 23.0% of women of 20 to 24 age were married before turning 18. This percentage has shown a significant decline over the years, dropping from 47.0 % in NFHS-3 (2005-06) to 27.0% in NFHS-4 (2015-16).

United Nations International Children Emergency Fund (UNICEF, 2018) stated that marriage before the age of 18 is a fundamental violation of human rights. Globally it is observed that 1 in 6 adolescent girls are married between the ages 15 to 19. In the central Africa it has high proportion (27%) followed by southern Africa and Eastern (20%) and North Africa and Middle East (13%).

Chaudhry et al. (2017) conducted a study in the rural community, it covered the 15 villages (Ludhiana district). 195 newly married women are selected for this study for a period of one year and follow them monthly till the first conceiving. Most of them 56.4% belongs to 22-24 years of age group and 31.3% are belongs to 25 years and above. It finds those mean age at marriage is 22 years and conceived during the first year of the marriage.

Marphatia et al. (2017) gave views on the women's marriage age and observed that adverse health of mothers closely related to early marriage. Women marriage age plays a very vital role in their health. Data collected from the India, Nepal and Pakistan in which marriage age is almost same that is minimum 18 years. Early age of marriage is proportionally related to maternal child mortality and morbidity.

State of the World's Children 2007, states "Child marriage leads to premature pregnancy and motherhood. Girls under 15 face a fivefold higher risk of maternal mortality during pregnancy and childbirth compared to women in their twenties"(Child Marriage India, 2019).

Allendorf (2010) investigates women in Madhya Pradesh, India, who have better family relationships are more likely to receive good maternal care, using data from the Women's Reproductive Histories Survey. Women in nuclear families who have stronger marriage bond, are more possibilities to receive adequate prenatal care and give birth in a medical institution and who belongs to joint families are more likely to use prenatal care, if they get along better with their in-laws. The finding covers that some, but not all, of the relationship quality effect on maternal health care. In Western contexts, marital quality is a well-established predictor of health; but, in non-Western contexts, the significance of relationship quality to health is mainly restricted to addressing domestic violence.

Indian Institute for population sciences (IIPS), Mumbai (October,2000) shows that babies who have a high risk of dying under the 1 year of age are divided into two categories: those who had born to young age mothers and those born to women past their prime childbearing years. Many adolescent (13 to 19) women in the poor countries are not physically mature, which increases their high risk of suffering from gynaecological and obstetrics problems. For example- anaemia and malnourishment in women during pregnancy lead to obstructed labour and low birth weight baby. In addition, adolescent pregnant individuals are less likely to receive antenatal care compared to adult women. For married women aged 20 to 49, the average age of first pregnancy is 19.6 years.

2.2.5. Antenatal Care

Quincer et al., (2024) suggests that immunization is the strategy to protect mothers and infants from unfavourable health outcomes or infectious diseases during prenatal period.

Islam and Sathi (2022) investigated the factors influencing the utilization of antenatal care (ANC) services among pregnant women in 29 developing countries. The objective was to align with the Sustainable Development Goals (SDGs) and decrease

maternal mortality rates by 2030. Strengthen maternal education and media access in rural areas to enhance ANC services.

Abu-Raya et al., (2020) recommend immunization during pregnancy. The goal of this approach is to prevent severe infectious diseases, morbidity and mortality among pregnant women and infants. Currently, immunization in pregnancy is incomplete to tetanus vaccines, inactivated influenza vaccines and pertussis. New vaccines have been developed especially for pregnant women (Respiratory Syncytial virus vaccines and group B streptococcus vaccines) and there is need to support vaccinated during pregnancy period. However, there are still significant gap in knowledge and future studies need to address these gaps in order to ensure optimal protection for both mother and foetus.

Mutowo and Yazbek (2021) Studied on “Barrier to utilization of antenatal care services in a rural Zimbabwe”. The study found that the primary barriers are lack of resources at health centers, lack of knowledge among mothers, lack of partner support and involvement in traditional protective practices, and fear of HIV testing. A multifactorial approach can help improve the utilization of antenatal care services.

Ali et al.(2021) writes on “factors affecting the utilization of antenatal care among pregnant women: A literature review”. Antenatal care is important component for the safe Pregnancy and healthy baby. ANC services are important determinant of maternal care, are the good strategies to improve mother and unborn child health. WHO has recommended at least eight visits for safe pregnancy and child birth. Demographic and social cultural factors influencing the use of maternal health services i.e. age, number of children, residence education, occupation, cost are significantly associated with antenatal care. The findings of this review can be used to plan and implement the strategy for the effective use of antenatal care.

Kumar et.al (2019) study on “utilization, equity and determinants of full antenatal care in India; Analysis from National Health Survey4”observed that women did not utilize ANC services in adequate form. Further it has been analyzed that only 21% pregnant woman used full ANC services. Half of the Indian women utilized minimum ANC services. Low utilization of ANC services are associated with their residence, low education, lack of spouse support, low income sources, social economic status,

cultural factors. There is need to strengthen the services like maternal health programme and reproductive and child health programme.

Awasthi et al. (2018) conducted study on utilization of ANC in Dalit community in Gorkha, Nepal. They found that antenatal care is the main component of maternal health. The main aim of the study is to find out the average of utilization of maternal health care services in terms of antenatal care. The information was collected from mothers by interview method and the result revealed that 70% had received TT injections during their last pregnancy and 76% attended ante partum visit having their last pregnancy. Even though there are good sources rendering by the government but lacking of awareness is the main component.

Islam and Masud (2018) conducted a study on “determinants of frequency and contents of antenatal care visit: assessing the extent of compliance with the WHO recommendations”. Data collected from the Bangladesh demographic and health services (BDHS) of married women between 15 to 49 years of age group. Results show that only 6% women receive 8 or more than eight antenatal care visit and 22.1% of the mothers received full ANC services and 21% of the woman never utilized antenatal care services. There is a greatest association between frequency of antenatal visit and utilization of antenatal care services. Social economic status, education, planned pregnancies, exposure to media; good health services in local area are associated with more antenatal visits. They concluded that low level of coverage of antenatal care services observed in Bangladesh. There should be proper strategies for the utilization of antenatal care services.

Kaur et al. (2018) in their study “Knowledge and Practices regarding ANC among the mothers of infants” mentioned that 830 women died every day in the world in 2015 due to pregnancy related complications either during pregnancy or Child birth. The study was conducted on women having a child less than one year. It was concluded that Health care workers have an important role in motivating the women and their family to utilize ANC services. But Health care providers need training about the available services. Besides women should be made aware that all these services are provided free of cost.

Sharma, Connor and Jolivet (2018) conducted a study on antenatal care. The key findings are in developed countries, ANC has emerged as a comprehensive service

delivery. It is associated with improved attendance, higher satisfaction, and better health outcomes for pregnant women and newborn. ANC services aim to promote the health of pregnant women and their unborn babies, ensuring a healthy mother and baby at the end of pregnancy. Good quality healthcare services should be available during the antenatal period to prevent the maternal and child mortality and morbidity rate.

Geta and Yallew (2017) Conducted study on early starting of antenatal care and factors associated to early ANC in Southern Ethiopia. Antenatal care is the essential health care given to pregnant mothers to protect from any complication. The aim of this study was to assess the determinants of early antenatal care. Study conducted on 608 mothers who had attended the Shebedino District health care centre. Out of them only 132 mothers attended the antenatal care centre on the recommended time. There is great need of creating awareness related to antenatal care among married women and antenatal mothers.

Sharma, Kumar and Devgan S (2017) conducted a “study to assess the utilization of antenatal care services and factor affecting it in the slum area Amritsar”. 1600 houses were selected randomly in which 659 married woman of 15 to 49 year age group who having at least one child. Total 659 interviews were conducted by using predesigned Performa. Results found that 58.4% of respondents at least one antenatal visit. 57.1% consumed less than 100 iron folic acid tablets. 65.6% were fully immunized with the tetanus toxoid injection. Lack of knowledge is the most given reason that is 31% by respondent for not utilize the antenatal care services. There is the greatest need of awareness and intensive efforts for the effective use of antenatal care services.

Sharma and Sharma (2017) suggest that reproductive health is an important ingredient of Women's Health. They conducted study in rural area of Ludhiana Punjab. 120 women of 15 to 45 years of age group were selected randomly. The interview was conducted in Punjabi and Hindi language. Results found that 76.6% had taken iron and folic acid, 23.33% had not used the iron folic acid supplements. 90% respondents immunized with complete tetanus toxoid injection and 10% are not immunized. There is greatest need of awareness regarding utilization of reproductive services.

Narayana, Siddalingappa and Mishra (2016) conducted the study on the “Assessment of utilization of antenatal care services by mothers attending immunization sessions at

a primary health centre in Mysore district, Karnatka, India”. Health status of the community depends on the health of women. Good care during pregnancy assures an uneventful birth. The study was conducted on the 200 mothers and the data was collected by questionnaire method. The result was found that 93% women were utilizing antenatal care services and revealed that there is greater need of awareness and utilization of services.

WHO (2016) recommended that pregnant women must attend their first ANC visit in the first trimester, followed by two visits in second trimester and five visits in the third trimester.

Ateeq and Rusaiees (2015) highlight the importance of the health education during antenatal period. The main aim of this teaching during prenatal period is to provide guidance, assurance and to treat the minor problems during pregnancy period, and to emphasize on regular antenatal screening and organize the educational activities for client satisfaction.

Shora et al. (2015) conducted study on knowledge regarding ANC services, its use, and delivery practices in rural area. Antenatal care is the important care to reduce the mortality rate among mothers and infant. The cross sectional study was conducted in Krishna Nagar village, Jammu. The data was collected by interview method. The results found that 89.9% had register for antenatal care, out of which 64.5% and 9.9% had registered in the 2nd and 1st trimester respectively and revealed that 79.2 % deliveries were institutional.

Jones and Heath (2014) examine the delicate interaction between immune suppression during pregnancy and infancy. The increased susceptibility to infections can lead to serious health problem. Infants are at the highest risk of infectious diseases, with incidence rates reaching 100/100,000 in the population. In order to protect infants until their immune system mature enough to respond effectively to vaccines, maternal vaccination is a strategic intervention that increases maternal antibodies specific to pathogens.

Agus and Horiuchi (2012) explored the factors affecting the utilization of ANC services in the rural west of Sumatra (Indonesia).A total number of 145 married women of 15 to 49 years of age group were collected. The result found that 77.9% woman really received antenatal care services more than four times and 22.1 received

less than four times. In summary, this study highlights the importance of addressing cultural beliefs, family encouragement, and parity to improve antenatal care. There is greatest need to create awareness among women to improve their perception for their health as well as the utilization of health services.

Onasoga et al. (2012) conducted study on the “Factor influencing utilization of antenatal care services among pregnant women in life Central Lga, Osun State Nigeria”. The aim of study is to review and understand the knowledge of women regarding antenatal care. They suggested that antenatal care is the important key for reducing maternal and neonatal mortality and morbidity. Data was collected from 102 pregnant women from life central Local Government. The results reveal that majority of respondents 48 first heard of ANC in the hospital. The majority of respondents (85%) demonstrated awareness of the services provided at antenatal clinics and recognized the significance of antenatal care. Additionally, the study revealed that factors influencing utilization included affordability of services, ANC scheduling, lack of awareness about available services, and spouse acceptance.

Ram and Singh (2005) exposed that receiving antenatal care significantly predicts safe deliveries. However, women often face barriers due to a ‘culture of silence,’ leading to delays in seeking timely healthcare. Additionally, limited mobility restricts their access to services beyond their usual activities.

Alam et al. (2004) investigated antenatal care utilization among urban slum women in Islamabad. A cross sectional study was conducted between October 2003 to April 2004. The sample included 200 married women aged 15 to 49 years. Results show that 151 women were aware of antenatal care during their last pregnancy about antenatal care and 37 women were showed ignorance of antenatal care and 9 reported that antenatal facilities were far away 3 women mentioned that they were not allowed by house members. In summary, this study highlights the importance of awareness, accessibility, and family support in promoting antenatal care utilization among women in urban slum areas.

UNICEF (July 2002) states that antenatal care is essential care for the pregnant woman and her unborn child. It is a part of preventive care. ANC services are provided by skilled health care workers to aware them about the warning signs of high- risk pregnancy, provide psychological support to the mothers, and encourage

them to attend at least 8 clinical health check-up for her pregnancy. Antenatal care services are provided free of cost with nutrient supplements like Iron and folic acid (IFA) and Tetanus Toxoid (TT).

Stevens and O' Connell (1992) Antenatal care is a strong variable associated with the healthy baby birth. Much number of barriers exists, however, in women seeking antenatal care. Most of times, women are feeling hesitate to take antenatal care because of the cost. It is observed that 25 % of women in childbearing age having no private or public health insurance.

2.2.6. Postnatal Care

Postnatal or Postpartum care refers to the care and support provided to mothers and new-born babies after birth. The postpartum period is critical for the health and wellbeing of both the mother and the baby. Effective postnatal care has the potential to significantly reduce maternal and perinatal mortality and morbidity. This review looks at the key components of postpartum care and the tools used to evaluate postpartum care quality.

Galle et al. (2023) conducted a scoping review to evaluate the quality and validity of PNC, in line with the 2022 PNC recommendations of the WHO. It followed the preferred reporting items for systematic reviews and meta-analyses extension for scoping reviews and included a search for five e-bibliographic databases, as well as grey literature, 62 studies were identified that provided measures in line with the WHO's PNC recommendations (Maternal Care, Neonatal Care, and Health System and Health Promotions interventions).The review also highlighted gaps in current PNC measures in relation to several recommendations, as well as limited measure validity.

Kashyup et al. (2022) emphasize onthe postnatal education, it should be included in the plan of care prior to discharge, including breastfeeding and educating family members on the newborn's care and the mother's care. The importance of postnatal education is to improve infant growth, reduce the mortality and morbidity rate in infant.

McCauley et al., (2022) identified 22 essential components of postnatal care and developed 14 signal functions using a narrative synthesis of literature published between 2000 and 2020. These functions are essential for effective interventions that

address the reasons for maternal and perinatal morbidity or mortality. The study highlights screening and management of infectious diseases, pre-eclampsia, maternal Anaemia, and mental Health as universal components. It also emphasizes the importance of promoting exclusive breastfeeding and modern methods of contraception.

Deniel and Gill (2021) conducted a descriptive study on postnatal care practices among mothers from different cultures in Ludhiana (Punjab). Quantitative approach and non experimental design was adopted for this study, 150 women from Bihar, Punjab, Rajasthan culture were selected. The results found 38.71% mothers belongs to 32 to 38 years of age group and 42% women having a primary education, 56.6% belong to nuclear family and 70.3% are non-vegetarian and having 1 to 2 children. Different cultures have a different attitude and behaviour towards postnatal care. Education is the most important factor noticed among them; who having a good education status tended to good practices for their health as well as postnatal care.

Mohammad et al. (2018) conducted study on determinants of PNC services utilization, Ethiopia. In postnatal period is the highest risk of death for mothers and newborns. Despite improvements in maternal care services coverage, utilization of postnatal care service in Ethiopia is still extremely low. A Community based survey was conducted from November 2016 to November 2017 in which 510 mothers were covered by interview. It revealed that the incidence of full postnatal care services utilization was found to be 28.4%. There is great need for emphasize the existing policies to raise the level of awareness among women regarding postnatal care.

Priyanka (2017) conducted study on the postnatal mothers in selected hospitals of Moga, Punjab. The objective of study is to find the relation between knowledge and practice regarding care newborn among postnatal mothers. 100 sample were collected by convenient sampling technique. Results found that 58.6% mothers have good knowledge, 42.4% having a unsatisfactory response and very low knowledge. There is need to create awareness among the postnatal mothers regarding new born care to reduce the neonatal mortality rate.

Purani charul et al. (2015) conducted a study on the knowledge, awareness, and practices of postnatal mothers. They administered a pre-structured at a tertiary care center. it was conducted within 1-5 days after stabilization in the postnatal period. The

findings revealed that mothers had good knowledge about breastfeeding practices (78%), thermal care (89%), and skin and eye care (72%). However, their knowledge was poor regarding the dangers of pre-lacteal feeding (45%), timing of the first bath after birth (60%), umbilical cord care (60%), and vaccination (36%).

WHO (2015) new guidelines recommend that postnatal care should be started as early as possible for the mother and baby within 24 hours. Early discharge should be avoided, at least 24 hour observation and examination of mother and baby is necessary and at least 4 checkups should be conducted in first 6 weeks of postnatal period.

Uzma Sayed et al.(2006) evaluated essential immediate and early care of new born and postnatal mothers interventions in rural areas of Bangladesh. The 3325 mothers were taken as sample. Results found that there was major lacking of postnatal care i.e 27.3% newborn check-up, 38.6% breastfeed within half hour. This concise review highlights the need for improved postnatal care practices and underscores the role of community health workers in achieving positive outcomes for maternal and newborn health.

2.2.7. Child Care

WHO (July 2022) states that immunization is the most important public health intervention. Immunization coverage has been successful over the last decade. WHO reported that in 2021 the 81% of the worldwide infants received diphtheria, tetanus and pertussis (DPT) vaccine to protect against infectious diseases that can cause illness and disability or be fatal. And 25 million children over the age of 1 year have not received vaccines since 2009 all over the world.

Melako, Geremew and Birhanu (2017) assessed coverage of the child immunization in Southwest Ethiopia. Immunization is the very cost effective public health service that prevents from the six killer diseases and help in reduction of child morbidity and mortality. Study involved the 322 mothers. Results found that only 42.2% were completely immunized, 49.4% and 8.4% are partially and not immunized respectively.

Rajeev and Radhamani (2016) conducted study on immunization status of anganwadi children in rural area of north Kerala, India. The data was collected from the Anganwadi workers of the 2-5 years of children. Results found that 94% children were

fully immunized and revealed the factors: education of parents, religion are the causative factors of non-immunized children.

Ahmed Sanaa (2013) conducted a study on mothers awareness and knowledge of under five years children regarding immunization in Minia city Egypt. The study aimed to identify factors associated with incomplete immunization. The 97 mothers were part of this study. Results show that 46.4% mothers were aware of vaccination importance and 50% illiterate didn't give vaccination to their children at a time.

Nlanjana et.al. (2013) studied the factors influencing health seeking behaviour of mothers for their children in rural community, Darjeeling district. The study was based on community and used the simple random technique. Questionnaires were distributed to 256 mothers to collect the data. Results show that the literacy level, family structure, socio economic status, mass media exposure and gender difference among children were the factors associated with health seeking behaviour of the mothers.

2.2.8. Breastfeeding Practices

McGuigan and Larkin (2024) highlights the benefits of laid-back breastfeeding (LBBF) position, which has been shown to significantly reduce breast problems and facilitate better latching. The study, conducted via a cross-sectional descriptive survey, reveals that while 81.4% of midwives and student midwives are aware of LBBF, only 6.8% frequently use it, and over a third have never used this position with mothers. Barriers to its use include lack of education, confidence, time, and experience, as well as culture, a tendency to use more familiar positions, and concerns about mothers' anatomy and unfamiliarity with LBBF. It concludes that specific education related to using LBBF in practice is required to overcome these barriers, and recommend this method as a first choice, potentially leading to more successful breastfeeding establishment and maintenance.

UNICEF and WHO (2023) highlights the importance of breastfeeding during World Breastfeeding Week. It emphasizes the importance of enhancing breastfeeding support in all sectors to sustain and increase breastfeeding rates globally. Over the past decade, the frequency of exclusive breastfeeding worldwide has increased significantly by 10% points to 48%. Countries as diverse as Côte d'Ivoire, the Philippines, Vietnam, and Somalia have achieved significant levels of breastfeeding

rates, which show that progress is possible when breastfeeding is protected, promoted, and supported. On the other hand, women and families face barriers (lack of knowledge) to achieve their breastfeeding objectives. This should be addressed in order to reach the global aim of 70 % by 2030.

Perez-Escamilla et al. (2023) explored the interaction between mother and infant attributes at the individual level and breastfeeding factors at other levels. Their findings suggest that implementing multilevel and multicomponent interventions across various socio-ecological settings can lead to rapid improvements in breastfeeding practices at a population level.

Beggs et al. (2021) studied comprehensive reviews to explore women's perceptions and experiences of breastfeeding. The results revealed that many mothers underestimate the challenges associated with breastfeeding and struggle to adapt. Furthermore, lack of support from partner, social network, and healthcare professionals significantly influences women's decision to breastfeed. It is important to address these challenges and provide assistance to mothers in order to advance the rate of breastfeeding.

Krol and Grossmann (2018) present a comprehensive review of the psychological impacts of breastfeeding on both children and mothers. It highlights that breastfeeding not only offers nutritional and health benefits but also significantly influences infant's brain development, cognitive, and socio-emotional development. For mothers, breastfeeding is also beneficial for their mood, reducing stress level, and physiological function of the body. The review underscores the multifunctional role of breastfeeding in psychological functioning, discussing potential mechanisms.

Smith et al. (2017) investigated the correlation between early initiation of breastfeeding and neonatal deaths. Compared the infants who started breastfeeding within 1 hour of birth, and who started breastfeeding between 2 and 23 hours after birth had a 33% higher risk of neonatal mortality.

Chandhiok et al. (2015) analyzed the national family health survey -3 and studied the effects of the breast feeding on the child survival rate along with different factors: demographic, socioeconomic, and health services. They observed that there is less risk (97%) of infant death who were breastfeed. The Conclusion is that promotion of breastfeeding is essential to reduce the infant and child death rate.

Kaur (2015) conducted an exploratory study to check the knowledge of mothers who have five-year-old children in Punjab. The findings revealed that 12% of mothers have good knowledge, 40% have average knowledge, and 48% have below average knowledge regarding immunization. Knowledge is significantly related to age, education, occupation, income, religion, caste, number of children, and source of information. This study concludes that levels of knowledge vary with demographic variables.

Mohan Lal (2015) suggests breast milk is a nutritional element for the growth and development of child. The cross-sectional study was conducted in the rural area of Punjab. Three sub-centers were selected randomly, and 286 mothers of children ages 12–24 months were taken for the interview schedule. The study reveals that 9.8% of mothers started breastfeeding within an hour of the birth of the child, and 20.9% and 64.4% started breastfeeding within 24 hours and after 48 hours, respectively. The majority of rural mothers practiced giving breastfeed to their children.

Dieterich et al., (2013) emphasizes "Breastfeeding saves lives" and "Breasts are best!" are slogans known by doctors and women. In the United States, breastfeeding a newborn is now considered "normal" and 75% of women do so. Globally Breastfeeding also reduces maternal disease burden. It also looks at the latest evidence on the effects of breastfeeding on the health of both the baby and the mother. The findings of this review support current national and international breastfeeding recommendations.

Andre et al. (2008) suggests vaccination is a very important aspect of child health and for the reduction of infectious diseases (six killer diseases) and talks about the eradication, elimination, and control of morbidity, mortality, and complications.

2.2.9. Family planning and use of contraceptives

Sharma and Kumar (2022) investigated the connection between women's education and contraceptive utilization. They discovered that only 34% of women with a high level of autonomy actively use contraceptives. Social and cultural factors, along with educational limitations, serve as barriers to contraceptive adoption. To address this, health workers play a significant role in motivating couples to embrace contraceptive methods.

The population research centre (2020-21) sheds light on the rate of hysterectomy has been noted higher in Malwa region Ludhiana and Patiala and in Doaba region Nawanshahr, Jalandhar and hoshiarpur and in Maja region- Amritsar. Nawanshahr having a high rate of hysterectomy that is 9.37%. The hysterectomy findings indicate that it is linked to the age and fertility of the woman, not associated with the standard of living and cost. The rate of hysterectomy is higher among the general category 3% than BC 2.5% and SC 2.3% communities.

Kaur et al. (2019) conducted a study on the knowledge and use of contraceptive devices in reproductive age group in Amritsar district of Punjab. This study lights on the National Family Health Programme 1952 with the aim of, “reducing the birth rate to the extent necessary to stabilize the population at a level consistent with requirement of national economy”. She observed that overall use of contraception has been increased but not rise. The sample size was 200, the respondents were married couple female 15 to 45 year age group who have shown their interest in this study. 95% of women are belong to 15 to 35 year age group. Among of them 81% woman aware about the family planning and 64% women were aware the use of contraception. In the 64% of population woman 86.6% aware of oral pills, 97.6% women were aware about the condoms, 15.8% women aware of copper T. 44% were aware of tubectomy and 9% woman were aware of vasectomy. And 57% women knew that from where they can get the contraceptives. There is need to motivate couples by the doctors and health workers to promote the use of contraceptives.

Beson, Appiah and Afari Adomah (2018) investigated the utilization of modern contraceptives by women in reproductive age in Ghana, Africa. They conducted a cross-sectional survey with 217 randomly selected women. Despite high levels of knowledge and awareness (98%) about modern contraception, only 21% of participants were actually using modern contraceptives. Factors such as marital status, partner consent and support, and religious beliefs significantly influence the use. The study underscores the importance of focused family planning interventions to enhance contraceptive adoption.

Hossain et al. (2014) suggested that awareness and knowledge of sexually transmitted diseases is important for women and there is need to improve education strategies regarding sexually transmitted diseases especially in rural areas.

Thappa and Sourmya (2007) observed the current status of the sexually transmitted infection in India. Sexually transmitted infections are the more active infections than the other infections. Author had reviewed the previous research on sexually transmitted infections epidemiology in India and found that the pattern of epidemiology is changing. Human papiloma virus and Herpes genitals are increases. There is a need to improve facilities at the peripheral centres.

Angelillo et al. (1999) viewed on Mothers and vaccinations: knowledge, attitudes, and behaviour. They focused on mothers should have accurate knowledge regarding immunization of their child.

Fathalla (1993) focused on the women's health and contraception. Contraception has a complex relation with sexually transmitted diseases. The use of contraceptive has a huge influence on women's health. Contraception is important for public health especially women. Contraception saves the women and protect from unwanted pregnancy. The family planning is like a movement by women for women.

2.2.10. Awareness regarding HIV/AIDS and Sexually Transmitted Diseases (STDs)

Seifu et al. (2024) assessed comprehensive knowledge about HIV/AIDS among reproductive age women in Liberia. The prevalence was 33.5%. Factors positively associated with knowledge included women's age, education, and proximity to health facilities. However, community poverty level negatively impacted knowledge. Finding reveals that low prevalence highlights the need for targeted awareness programs to improve women's understanding of HIV/AIDS

Bhattacharyya et al. (2023) found only 24.8% of women aged 15–49 with awareness of HIV had comprehensive knowledge in India. Education level significantly influenced knowledge. Secondary and higher education levels were associated with better understanding of HIV/AIDS. There should be strengthening educational initiatives can enhance HIV/AIDS awareness among Indian women.

Malik et al., (2023) investigated secondary data from India's NFHS-5 (2019–2021) and NFHS-4 (2015–2016) to find the variables associated with a lack of knowledge and a negative attitude towards people living with HIV, a logistic regression analysis was used. The NFHS-5 sample comprised 202052 individuals, while the NFHS-4 sample had 225876 participants. In NFHS-5, 26.54% of participants stated they had a

positive attitude, and 25.80% said they were fully aware of HIV; these figures show a little decrease from 26.38% and 28.67%, respectively, in NFHS-4. Reading newspapers and watching television, and having a higher school education were all associated with significantly higher chances of know everything.

Hasan et al. (2022) explored the HIV/AIDS knowledge level and socio-demographic factors that affect HIV/AIDS knowledge amongst married women in Bangladesh by using three waves of the MICS (Multiple Indicator Cluster Survey): 33843, 20727, and 29724 respondents from 2006, 2012, and 2019. A score was prepared based on their interrogation. In this study, the respondents with the highest education level had a 4.03 times higher chance of obtaining a 'High Score' in 2019, which was 5.30 times higher than the respondents with the lowest education level. In addition, respondents from urban areas had a 1.13 times higher chance of achieving 'HIV/AIDS' in 2019, which was 1.14 times higher than that of respondents from rural areas. This study also found that respondent age, division, and mass media access, as well as wealth status, had a significant impact on HIV/AIDS knowledge in Bangladesh. Although a large proportion of women had sufficient knowledge about HIV/AIDS, it is still necessary to protect against these diseases.

Haque et al., (2018) identify the factors that influence HIV awareness among married women in Bangladesh by using the latest data from the BDHS-2014. Out of the total of 12,593 respondents who heard about HIV/AIDS, around 2,300 were successfully interviewed on 11 basic questions. The survey found that 62% of respondents had sufficient knowledge. Education status, social media, and living area and working status had a significant impact on awareness. The higher the respondent's education level, the more aware they were compared to those with no education. While the majority of women had sufficient knowledge of HIV/AIDS, educational programmes related to it should be included in the course to create a uniform level of knowledge across the nation.

Singh et al., (2015) conducted cross-sectional study on 400 married women who were taking treatment from the tertiary health care center. Findings shows that rural women's awareness of STI/RTI is substantially correlated with their level of education. The majority of them are wives of truck drivers and migrant labourers, who are primarily impacted by HIV infection and STIs. Rural women need education

in order to become competent to understand the sexual and reproductive health, as they have been proven to be more susceptible to STIs and RTIs in general. A female counsellor is required to address the issue of STIs and RTIs among women and provide information on appropriate treatment in a timely manner. The majority of women are reluctant to discuss their issues and symptoms, particularly related to sex. Promotion of condoms is also discussed as the greatest way to lessen the effects of STIs and RTIs. this study emphasize on implementation of programmes, it would be beneficial for STI/RTI awareness campaigns in rural areas.

Bhasin et al., (2020) analyzed data from the NFHS, a cross-sectional household survey conducted between 2015 and 2016. The survey covered 699,686 women aged 15 to 49, of which 91,818 ever sexually active. They answered to questions related to symptoms of reproductive tract infections. The researchers estimated the prevalence of reported symptoms and treatment-seeking patterns, described regional variation, and identified factors associated with women's treatment-seeking behaviour, only 39% of women who reported symptoms of RTIs required any advice or treatment. Women's testimony for treatment-seeking in India has not changed significantly since the last national survey conducted a decade earlier. It is varied widely across India, ranging from 64% in Punjab to 8% in Nagaland, with no clear regional pattern. 17% of symptomatic women utilised services in the public sector, while 22% in the private sector, with wide variation by state. Treatment was associated with age, higher education, sound economic status, and recent employment. Women aged 25–35 had higher odds of seeking treatment, along with those with more than eight years of schooling and from rich background. Despite policy efforts, women's utilization of services for RTIs remains a challenge in most areas of India. The findings put emphasis on the need to deal with barriers to seeking care and progress the measurement of gynaecological ailments in national survey.

Chirwa (2011) provides insight into married couples' knowledge of and behaviour regarding HIV prevention in a few communities in Malawi, Southeast Africa. Semi-structured interviews with 60 couples were conducted. The majority of couples (67%) had only completed elementary school, but they were aware of HIV prevention strategies and had discussed it with each other as a couple. These conversations were started by husbands and wives. Few couples (6) expressed doubts about their partners'

ability to remain faithful, while the majority of couples (54) confirmed mutual trust between spouses. 25 couples had evidence of marital infidelity, frequently involve husbands. Only five couples had undergone HIV testing. It's noted that none of the couples supported condom use as a means of HIV prevention with their spouses. Although Couples who have high level of awareness and acceptance of HIV preventive techniques, but incompatibility with socio-cultural norms resulted in low adoption rates. In order to promote HIV prevention techniques in rural communities, the study suggests focusing intervention efforts on couples.

Sogarwal & Bachani (2009) looks at the relative importance of the level of awareness of STDs, HIV/AIDS, and condom use in India in relation to socio-economic variables. Data collected from National Family Health Survey (NFHS) 2005-06 was used to conduct the study. The study included a total of 124,385 married women aged 15-49 from 29 major states in India. Logistic regression was used to understand the importance of the HIV awareness on the condom use. The analysis showed that the awareness among women about STDs excluding HIV was only 3.2 % and only 4.8 % of the women reported using a condom. 42-50 % of the married women from 4 major states in India (Rajasthan, Jharkhand, Chhattisgarh, and Uttar Pradesh) were not aware of any STDs or HIV/AIDS. The study found that socio-economic characteristics like residence, education and socio economic status had a significant impact on the level of HIV knowledge and condom use, especially among poor, rural, uneducated women. The study highlighted the importance of integrated prevention programmes that focus on the use of condoms for HIV prevention and STDs prevention.

Sambamoorthi et al., (2004) compared the antenatal care with knowledge of HIV a prevention methods and finds a strong correlation. However, there is an extreme lack of awareness and knowledge about HIV prevention among married women. Therefore, outreach and intervention efforts should focus on raising comprehensive knowledge about HIV prevention, particularly through broadcast media.

SUMMARY

In conclusion, the review of literature on health-seeking behaviour among women with reference to reproductive and child health underscores the key role of awareness in shaping women's healthcare decisions. The findings from the studies reviewed highlight the significance of women's knowledge, perceptions, and understanding of reproductive and child health issues in influencing their health-seeking behaviour. The level of education has a profound effect on women's health outcomes. Women who have limited or no formal education often exhibit lower health literacy. In rural Punjab, numerous women lack awareness regarding their health rights and the healthcare services that are available to them. Stigma, especially surrounding reproductive health services, can discourage many women from seeking necessary care. Unmarried and younger women may face increased scrutiny, which further obstructs their ability to obtain suitable healthcare services. Traditional gender roles limit women's independence in making health-related decisions. This gap in knowledge can lead to delays in primary care or professional treatment. An increased awareness of the importance of maternal and child health services, preventive care, and early intervention appears to be a key driving force behind women's engagement with healthcare systems.

CHAPTER III

RESEARCH METHODOLOGY

In the world of academia, the term "methodology" encompasses several meanings. In its most specific sense, it refers to the examination of methods and procedures within a particular research endeavor, as well as a general type of research activity. However, it is often used incorrectly as a more impressive-sounding synonym for "method." In the realm of philosophy of science, "methodology" takes on a broader meaning, encompassing not only the methods of research, but also the concepts and analytical structure of an academic discipline. When used in this way, the term encompasses more complex issues such as the assumptions about the nature of reality (ontology), the nature of obtainable knowledge (epistemology), the process of reasoning used to obtain knowledge, and the tools and techniques employed in data collection and analysis.

In the evolution of social sciences, there has been significant contemplation on the nature of their disciplines as a science and the approach they can or cannot take to achieve the ideal of science in their pursuit of knowledge. This ongoing contemplation and strategic planning in social sciences is discussed under the heading of 'research methodology.' Reflecting the "growing-pains of an immature discipline," sociology, more than other social sciences, has been particularly focused on research methodology. Sociologists have, as the French mathematician and philosopher Jules Henri Poincare (1854–1912) once stated, remained "hierophants of methodology" (Merton 1968, p-141).

This section focuses on the methods of the study. It includes research design, study area, study population, data collection method, sample size, sample and sampling technique, and research tools. This study observes the health-seeking behaviour among women with concerning reproductive and child health in the Jalandhar and Kapurthala districts of Punjab. This study adopts a descriptive research design, which aims to describe and analyze existing phenomena without manipulating variables, thereby providing a comprehensive overview of a specific population or situation. Qualitative and quantitative approach has been used. The study utilizes a multistage sampling technique. This approach involves progressively reducing the

population into smaller, more controllable groups at various stages. In this case, the study begins with the selection of districts, followed by blocks within those districts, then villages within the blocks, and finally, a sample of eligible women within those villages. To ensure the validity and reliability of the results, the study employed a simple random sampling method within a multistage framework. This method involves selecting subjects in such a way that every individual in the population has an equal chance of being selected. This random method helps to minimize biases and allows the findings to be more representative of the entire population.

3.1.STUDY AREA

Punjab, located in the northwest part of India, is a prosperous state. It is named after the combination of the words "Punj" (five) and "Aab" (water). The five rivers of the state are the "Sutlej", "Beas", "Ravi", "Chenab", and "Jhelum". Only the Sutlej River flows in the present-day state of Punjab. The remaining two rivers are part of Pakistan. The state is divided into the three regions of Majha, Doaba, and Malwa, Punjab. Agriculture is the primary economic activity in the state, and it accounts for almost two-thirds of the country's food grains and one-third of milk production. The state has achieved significant economic progress since independence in 1947, and the people of the state have been very supportive for the Green Revolution, a major agricultural initiative. Despite having a small population, the Punjabis make up one of India's most prosperous races. Punjab has a population of 2,7,43,338 as per the 2011 Census of India. The population of Punjab has increased by 13.89% from 2001 to 2011. Punjab has the highest per capita income in the country. It has the best infrastructure in the country, including roads, rail, air, and river transport connections. It has the lowest poverty rate. According to the Indian Government's statistical data, Punjab has the best state performance.

(a). Geographical area

The state covers an area of 50,362 square kilometers (19,445 square miles). The cultivation area is fully irrigated. The state has an average elevation of 300 meters above the sea level, with the southwest reaching about 180 meters above sea level and the northeastern border exceeding 500 meters above sea level.

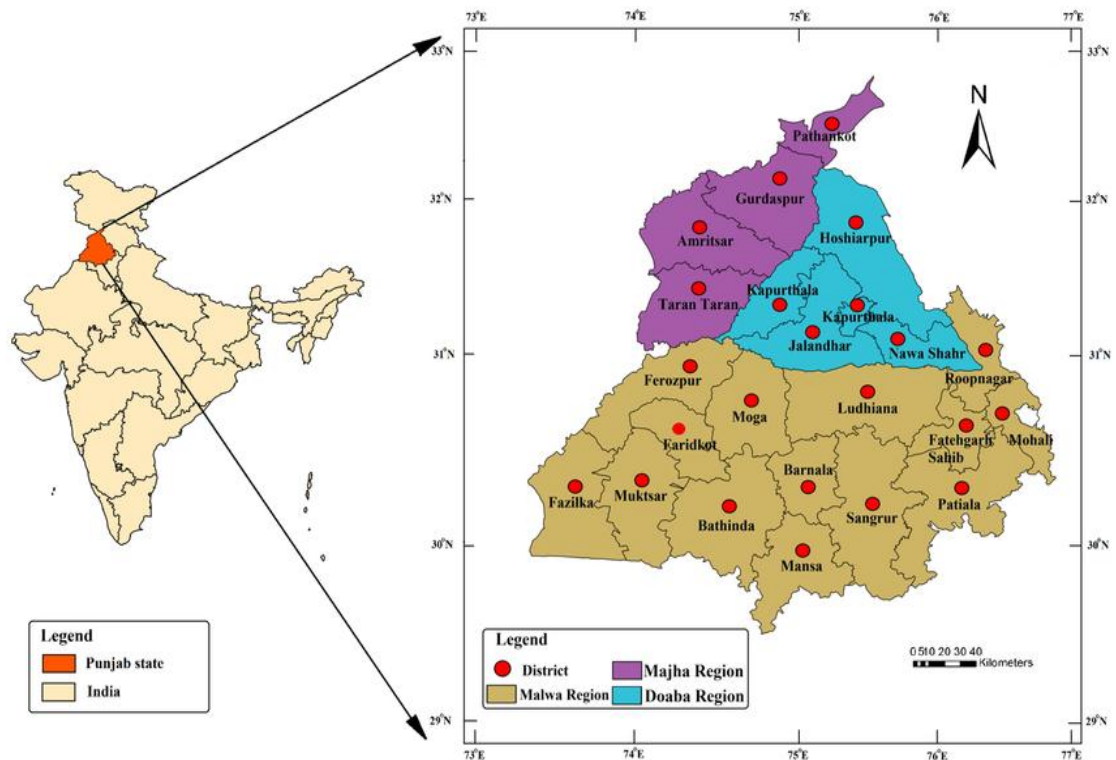


Figure 3.1: District map of Punjab state

Source: https://www.researchgate.net/figure/District-map-of-Punjab-state-India_fig1_371132815

(b). Location

Punjab is located at a latitude of 29.30° north by a longitude of 32.32° north and a latitude of 73.55° east by a longitude of 76.50° east. Punjab borders Pakistan on the west, Jammu and Kashmir on the north, Himachal Pradesh on the northeast, and Haryana and Rajasthan on the south.

(c) Climate

Punjab has a unique climate, with three distinct seasons: summer, monsoon, and winter. Each season is distinct and can be enjoyed in its own way. The monsoon season lasts from early July to the end of September, while the winter season begins in October and lasts until the end of March, making it the best time to visit the state. The area around the foothills of the Himalayas receives heavy rainfall, while the region far away from the hills experiences sparse rainfall and high temperatures. The summer months run from mid-April to the end of June, and the winter season is from December to March.

(d) Culture

The culture of Punjab is one of the oldest and richest in the world. The Punjabis celebrate many religious and seasonal festivals. These include Dussehra, Diwali, Baisakhi, and many others. There are also many anniversary celebrations in honour of the 10 religious leaders of the Sikhism and various saints. Dance is a common part of these festivals. The most popular dances in Punjab are bhangra, jhumar, and sammi. Giddha is also a typical Punjabi tradition. It is a humorous song and dance performed by women in Punjab. In addition to the traditional music, there are also semi-classical forms of Mughal music such as khyal dance, thumri, ghazal, qawwali, and other vocal performance genres (Culture – Government of Punjab, India, n.d.).

(e) Language

The state's official language is Punjabi (Gurmukhi), which is the 10th most spoken language worldwide and the 4th most spoken in Asia. The state's language of origin is the Punjabi language, which is one of the only living languages of Indo-European origin that is fully tonal.

Other languages spoken in the state are Hindi, English and Urdu, which is the most popular language in the state (Know Punjab – Government of Punjab, India, n.d.).

3.1.1 Kapurthala and Jalandhar

A. Kapurthala

As per to historical records, Kapurthala is thought to have been established in the early 11th century under the rule of Mahmud Ghaznavi. The town's name, Kapurthala, is said to have come from Rana Kapoor, who is believed to be its founder. Consequently, the town was named Kapurthala in his honor. The Kapurthala State came into existence in 1772. It is well known that Sardar Jassa Singh Ahluwalia served as accountable for the consolidation and strengthening of Kapurthala (History of Kapurthala, n.d.). The district headquarter is Kapurthala, and the distance from it to Jalandhar is 23 km.

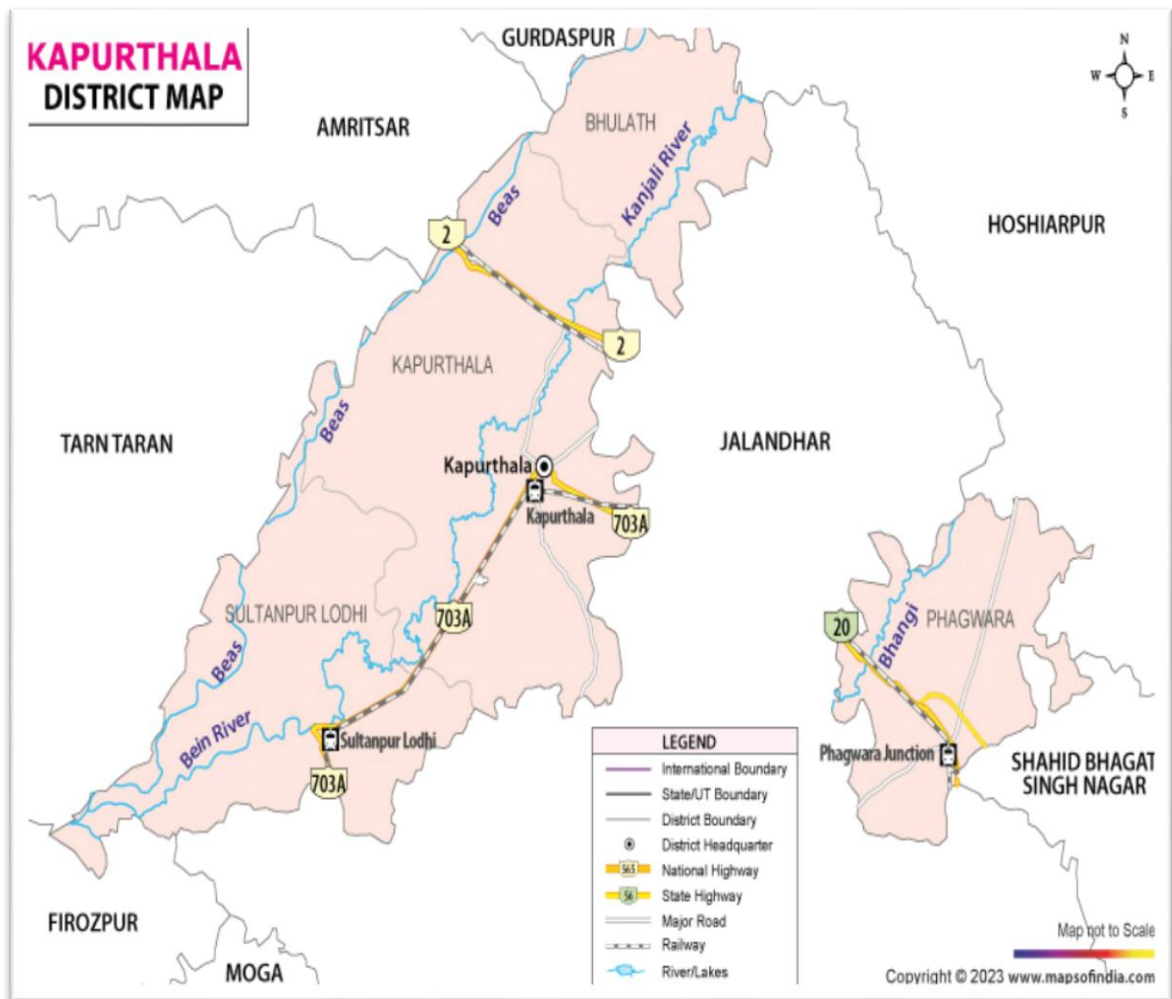


Figure 3.2- Map of Kapurthala

Source -Google Maps: map of Kapurthala, Punjab, India (n.d.)

B. Jalandhar

Jalandhar is a municipal area located in the Punjab state of India. It has a significant population, securing the third place in terms of population among cities in the state and standing as the largest urban area in the Doaba area. It ranks 208th among the total of 640 districts in India. The city might be named after Jalandhara. According to historical records, it was established by Devasya Verma as per the Vedas. Other theories suggest that it was the capital of the Lava kingdom, the son of Rama, or that its name comes from the local term Jalandhar, meaning the region between the wateri.e. rivers Satluj and Beas. The entire Punjab region, including the current Jalandhar District, was once a part of the Indus Valley Civilization. The cities

of Harappa and Mohenjo-daro are among the well-documented sites of the Indus Valley Civilization. During the Vedic era, Jalandhar was referred to as Prasthala and served as the capital of the Trigarta Kingdom (History of Jalandhar, n.d.). Muslims in Jalandhar were the majority before the partition of India. According to the census of 1941, Muslims accounted for 45.2% of the total population of the city, while Hindus and Sikhs accounted for 27.6% and 26.5% respectively. Within 10 years, from the census of 1941 to the 1951 census, the Muslim population of Jalandhar decreased from 45.2% to 0.2% percent.

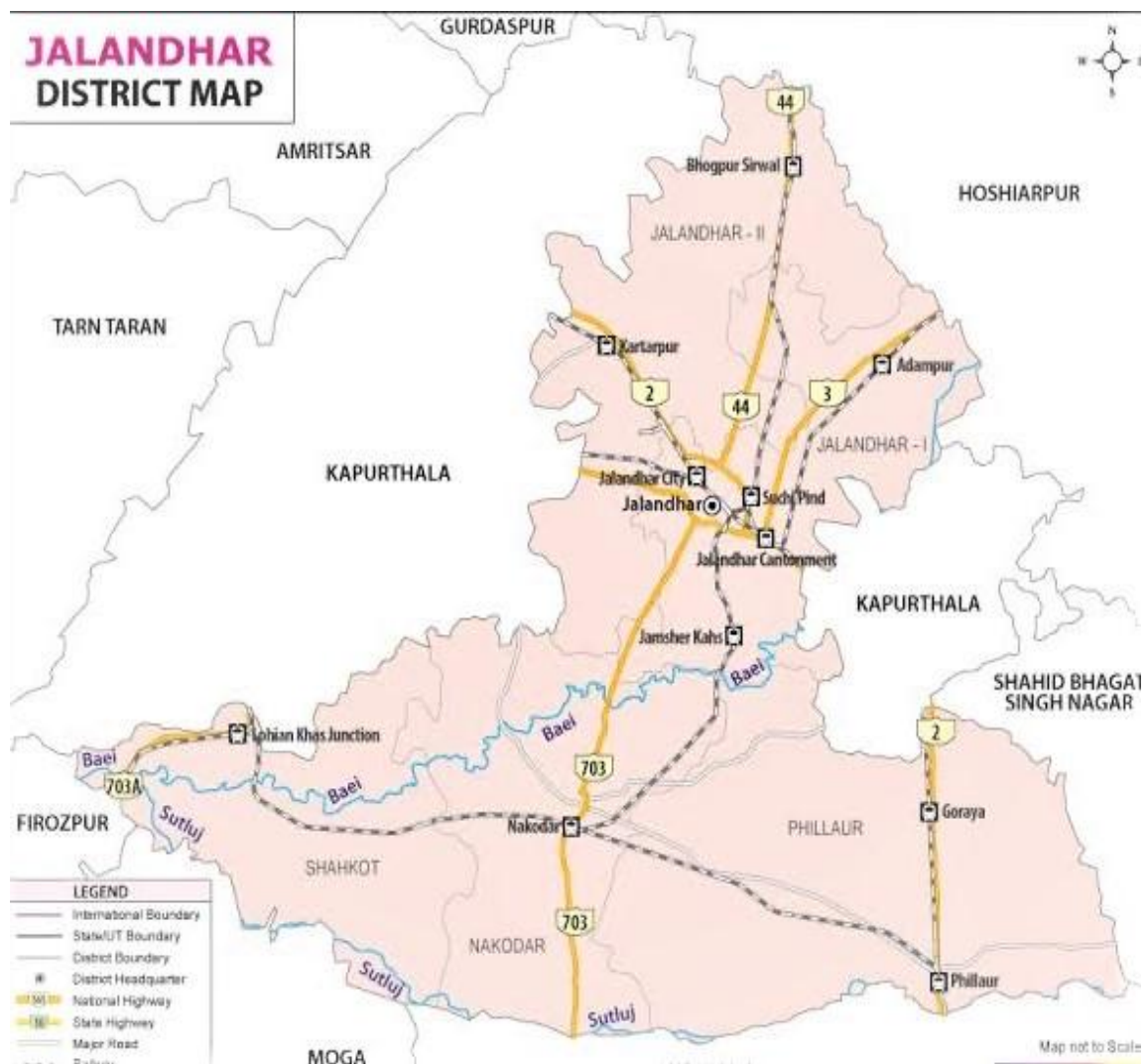


Figure 3.3: Map of Jalandhar District

Source : Google Maps: map of Jalandhar city centre (n.d.)

Kapurthala and Jalandhar

Geography:

Kapurthala is also a prominent district of Punjab, but it is one of the smallest district in terms of area and population. It covers the 1633 kilometer geographical area. It is divided into two parts: the main part, Kapurthala - Sultanpur Lodhi, and the rest part is Phagwara (Kapurthala Web Portal, n.d.).

Jalandhar is one of the largest and most densely populated district in Punjab State. It is part of the prosperous Doaba region and is located in the centre of the state. The district covers 5.3% of the total geographical area of the state.

Location

Kapurthala is located between the latitude and longitude of 31°22' N and 75°22' E. It is bordered on the north by the Beas River, on the east by Jalandhar, and on the west by the River Sutlej. It is separated from Gurdaspur district to the north, Amritsar district to the west, and Firozpur district to the south. The eastern point of the district is Hoshiarpur, while the western end is Phagwara.

Jalandhar lies on a level plain approximately 20 miles (32 km) east of the Beas River. It is situated between 71°31' east latitude and 30°33' north longitude. It is a market for agricultural products and is located 350 km from Delhi on the Delhi-Mohali Highway. It is bordered on the east by the Ludhiana district, on the west by Kapurthala, on the north by Hoshiarpur, and on the south by Ferozepur. It is connected by road and rail.

Climate

Kapurthala and Jalandhar are located in the central plain region of Punjab, Both cities share the same climatic conditions as they are both located in the agro-climate zone. The climate of both districts is humid subtropical monsoon, summers (April to June) are long and hot, and winters (November to February) are cool. The average annual rainfall in Jalandhar is 600 mm, while the Kapurthala record is 894 mm. The difference in the amount of rainfall may affect the agricultural patterns as well as the water resource management of the city. Despite the differences in the climate of the two cities, both of them benefit from the climate as it is conducive to agriculture and trade, which play an important role in the economy of the city (Climate-Data.org, n.d.).

Topography and Land

The topography in both districts is characterized by a typical alluvial plain, which is shaped by the rivers that flow through them. The landscape in Kapurthala is part of the “bist-doab” plain, and is shaped by the Beas and Satluj rivers, similar to the topography of Jalandhar. The alluvial deposits in Jalandhar are sculpted by the Sutlej River, and the industrious efforts of the local farmers have flattened these dunes into arable land. The soil in these districts is fertile and rich in nutrients, making it ideal for farming.

Vegetation:

The fertile plains around Jalandhar support a variety of vegetation. The region is known for its agricultural productivity and abundant greenery. The soil in the area supports a wide range of crops and vegetation. Kapurthala is home to palm trees, mango trees in the bordering area of Hoshiarpur, and shrubs such as Kikar, Shiamsam, Poplars, and Eucalyptuses. The area around Kapurthala i.e. ‘Bet’ is also home to shrubs such as leh, jhau, plichhi, and bla. Alluvial soil in both areas helps in the growth of crops like paddy, wheat, corn, potatoes, and sugarcane. Both districts play an important role in the agricultural economy in Punjab.

People and Population

Kapurthala district has a population of 8,15,168 according to the 2011 census, which has increased by 8.04% in the last 10 years. The population density is 499 per square kilometer, and the sex ratio of adults is 912 females per 1000 males. The ratio of children is 871 girls per 1000 boys, and overall the literacy rate is 79.07%. Male literacy is 83.15%, and female literacy is 74.63%.

Jalandhar city has population is estimated to be around 862,886 people. The total population of the district is around 21, 93,590 people. It is important to note that 52.93% of the population of the district lives in the urban area, while 47.07% lives in the rural area. In the urban region, the total population is 1,161,171 with 6,16,421 males and 5,44,750 females. The sex ratio in the urban area is 884, and the child sex ratio is 865. The number of children aged 0-6 years in the urban area is 1, 21,106, with 64,927 males and 56,179 females. This number of children in the district accounts for 10.53% of the total urban population in the district. The average literacy

rate was noted to be 85.99% in 2011, with males and females being 88.80% and 82.83% respectively.

The total population residing in rural areas was 1,032,419 with 5, 28,790 males and 5,03,629 females. The sex ratio in the rural areas of the district was 952 males per 1000 females. The child sex ratio was 885 to 1000, and the number of children aged 0-6 was 1, 05,196, with 55,813 males and 49,383 females. The child population accounted for 10.55% of the total rural population in the district. The average literacy was 78.53%, with males and females being 83.06% and 73.81%, respectively (Census 2011, n.d.).

Health Care System

The Jalandhar Municipal Corporation, the city has more than 800 hospitals. This makes it the city with the highest number of hospitals in Asia (The Tribune India, n.d.). On September 9 2020, Jalandhar witnessed the setting up of Three Health Centres.

3.2 RESEARCH DESIGN

A descriptive research design was adopted for this study. The researcher designed a less structured questionsto conduct an interview schedule to gather data. Both primary and secondary data sources were also used for data collection in the present research.

3.3. SAMPLING METHOD AND SAMPLE SIZE

It was not feasible to conduct relevant research on the whole population of the study, and the study demands the selection of a representative sample. In this research study on reproductive and child health among women in Punjab, the multistage sampling methodology is used to get a comprehensive understanding of health-seeking behaviour. Two districts were randomly selected from the Punjab region, two blocks were selected randomly from each district, two villages were selected randomly from each block, and women aged from 15 to 49 years were selected under this study. ASHA workers are included in the study to collect the total number of eligible couples, 10% quota of reproductive women i.e 160were selected randomly by lottery method to collect data. Random sampling also allows for a diverse group of participants to be included in the study, which improves the external validity of the results. The selection of rural women for the study from the villages of Jalandhar and

Kapurthala districts, which ensures a representative sample of the wider population of rural Punjab.

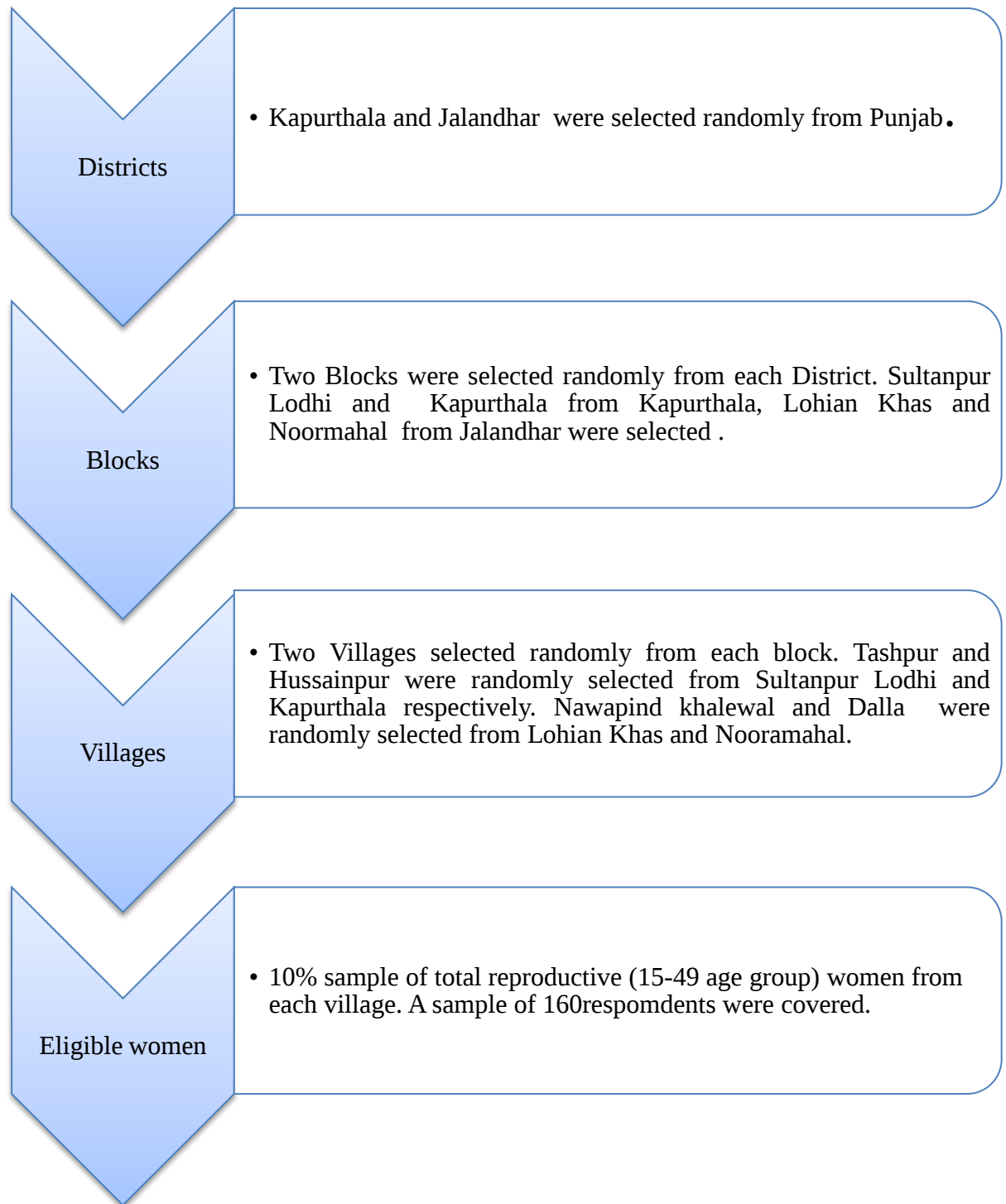


Figure 3.4- Representation of multistage sampling.

Table3.1: Sample Size and Sampling Details

Districts	Blocks	Villages name	Total number of households	Total women(15-49 years)	Sample women 10% of total reproductive women
Kapurthala	Sultanpur Lodhi	Tashpur	300	447	45
	Kapurthala	Hussainpur	435	648	65
Jalandhar	Lohiankhas	NawaPind Khalewal	161	196	20
	Noor Mehal	Dalla	220	302	30
Total					160

A sample of 160 women who were in the reproductive age group were covered from Kapurthala and Jalandhar districts of Punjab in this study.

3.4 Ethical Considerations

Ethical integrity was maintained throughout the research process. The study adhered to general ethical guidelines laid out by university letter of recommendation. Prior permissions were taken from local authorities Panchayat and Aganwadias well as ASHA functionaries. All respondents were informed about the purpose, scope, and nature of the study. Consent was obtained before participation. Collected data was stored securely and used strictly for academic purpose only.

3.5. DATA COLLECTION TOOLS

A semi-structured interview schedule was employed for collection of data from theselected women. This interview schedule was finalized based on content validity and face validity.

3.6. DATA ANALYSIS PROCESS

This study followed the mixed-methods approach both qualitative and quantitative data. It follows the data analysis and interpretation methodology. At this point, thematic analysis was applied to analyze and interpret qualitative data as clearly explained by Braun and Clark (2006). This involves bit by bit data collection and analysis. The purpose of this is to learn how to use the data collected during the research process to generate specific results in a scientific and organized way. The data analyzed in this module relates to the data collected only in quantitative studies. In a quantitative study, the numerical data collected by the researcher is presented along with the quantities and variables collected using tools like structured questionnaires, observations.

Descriptive analysis involves studying the distribution of a single variable, which helps to create profiles of companies, work groups, individuals, and other subjects based on various characteristics like size, composition, efficiency, and preferences. It's a statistical method that simplifies the data for easy presentation (C Emory). It is a statistical method that summarizes the data to provide a simple presentation.

Meaning of Data Analysis

It is a critical step in any research project, requiring expertise to manage the data collected in the predetermined research design.

Wilkinson and Bhandarkar, "Data analysis involves a series of interconnected processes aimed at summarizing the collected data and structuring it in a way that provides answers to research questions or suggests hypothesis and questions if none were initially considered for the study".

Goode, Barr and Scales, "Analysis is a process which enters into research in one form or another from the very beginning. It may be fair to say that research consists in general of two larger steps –the gathering of data, but no amount of analysis can validly extract from the data factors which are not present".

C.R. Kothari states that the concept of analysis “involves the calculation of certain measures and the search for patterns of relationship between data-groups.” Kothari cites G.B. Giles as saying that “as part of the analysis process, relationships or differences that support or conflict with the original or new hypothesis should be subject to statistical tests of significance to determine with which data points can be said to support any conclusions.” Therefore, whether it’s qualitative or quantitative research, even if the information is sufficient and valid, it won’t be useful unless it’s thoroughly analyzed and interpreted scientifically.

Once the data has been collected, the following steps are used to break down the data into more computable and summarize:

A. Editing

At the editing stage, all raw data collected is cross-checked for errors. In some cases, omissions are also checked for readability and consistency. This ensures that the data collected meets basic standards and allows for further processing.

B. Coding

Coding is the process of assigning numbers or other symbols to answers so that they can be grouped into a small number of categories or classes. These classes should be relevant to the research problem being considered. The classes must also be complete (i.e. there should be a class for every data item) and mutual exclusively. This means that a particular answer can only be placed in one cell of a given category set.

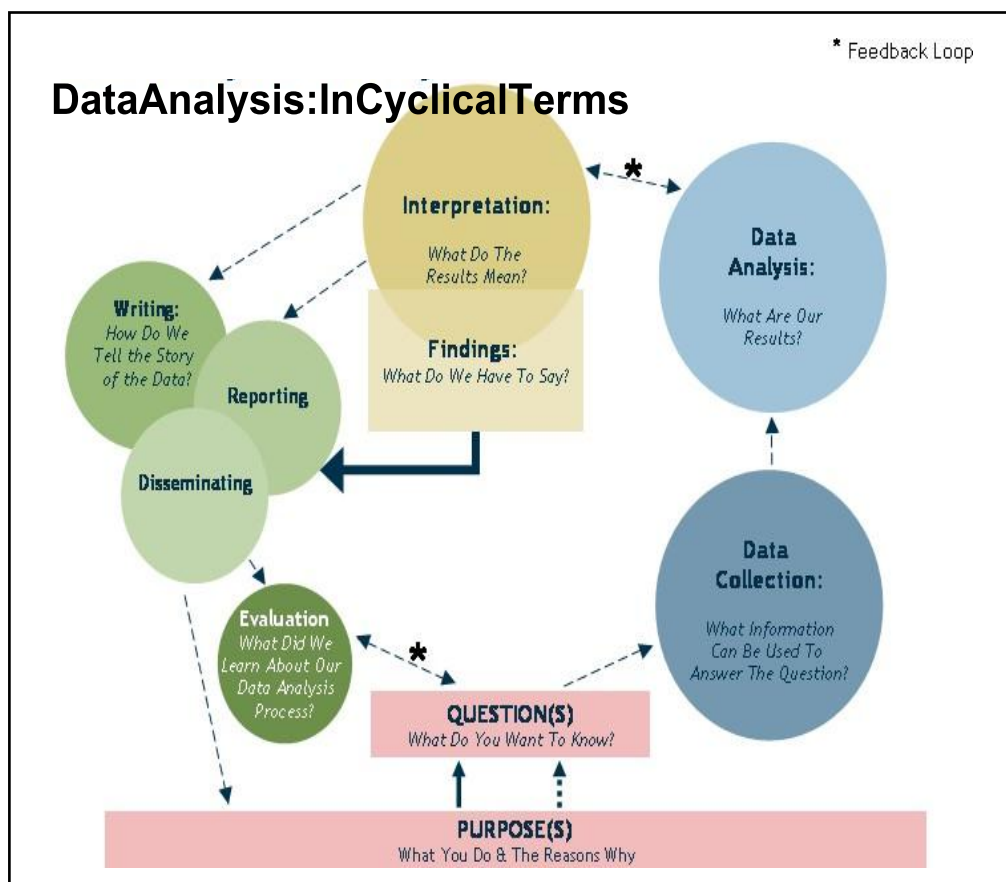


Figure3.5: Data Analysis Process

Pre coding is when codes are assigned to answers while they are being collected. Post coding is when answers are assigned to answers after they are collected. Closed-ended questions are easy to code for: there are relatively few categories, and you just need to allocate a different code for each category. On the other hand, open-ended questions can have hundreds of unique responses. Coding for open-ended questions is very similar to coding in content analysis. The researcher aims to create a coding structure that does not require a unique code for each respondent or case, but that accurately reflects the full range of answers. In this study menarche age, marriage age, maternal age, number of children, antenatal checkup, postnatal checkup, vaccination of children and health behaviour are involved.

The goal is to present the data in a way that is easy to understand and retain as much information as possible.

C. Classification

Once the data collection is complete, the data divided into different categories (Antenatal care, postnatal care, child care and family planning) for further analysis based on characteristics.

D. Tabulation

Tabulation is the act of aggregating raw data and displaying it in a compact form (statistical tables) for analysis. More generally, tabulation is the order of the data in columns and rows. Tabulation is important because:

1. It conserves space, reduces the number of explanations and descriptive statements, and simplify the comparison process.
2. It helps to summarize items.
3. It Identifies errors and emissions.
4. It provides the foundation for various statistical calculations.

Tabulation can be performed manually or by using a mechanical or electronic device. The choice is based on the size and nature of the study, cost implications, time constraints and availability of tabulating equipment or computers. For relatively large questions, we may choose to use mechanical or electronic tabulation if other factors are favorable and the necessary equipment is available.

A simple table/frequency distribution table has been used in this study, in which the different attributes are written in the left-hand column, and the frequency or range of occurrence of each attribute is written in the right-hand column.

E. Data Interpretation

After processing and analysis, the last step in the research process is to interpret the data. There is a fine line between analyzing the data and interpreting it. By interpreting, you understand what the research findings really mean and what the underlying generalization is that is reflected in the data collected. You can interpret the data as descriptive, analytical or theoretical. You interpret the data from the point of view of the research questions. While interpreting, generalizations are made. Interpretation consists of the conclusion that the researcher has arrived at after processing and analyzing the data.

SUMMARY

The study discusses research methodology and methods. It emphasizes clearly defining the research purpose using common concepts. The chapter covers data justified by the research and limited to an adequate basis. The introduction outlines the research design, population, sample size, and data collection instrument. The chosen qualitative method involves field interviews, observation and case studies.

CHAPTER IV

RESULTS AND DISCUSSIONS

The health of women, particularly in relation to reproductive and child health, is an important aspect of society's well-being. This study, explored the health-seeking behaviour among rural women 15-49 years of age group in Kaputhala and Jalandhar districts, with a specific focus on reproductive and child health. The data was collected from 160 households by interview schedule with less structured questions (mixed open and close) is used to provide a comprehensive understanding of the prevailing health practices and challenges. The following sections present a detailed analysis of the collected data, interpretation. The frequency and percentage distribution of respondents as per selected demographic variables and health practices for their reproductive and child health care.

The findings of this study are expected to contribute significantly to improve the health behaviour among women and health care system.

SECTION: I

DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

Table 4.1

Distribution of Respondents according to Age Group

Village	Tashpur		Hussainpur		Nawapind Khalewal		Dalla		Total	
Age	No.	%	No.	%	No.	%	No.	%	No.	%
15-19	0	0	0	0	0	0	0	0	0	0
20-24	2	4.4	5	7.7	1	5	2	6.7	10	6.3
25-29	9	20.0	12	18.5	4	20	7	23.3	32	20
30-34	8	17.8	16	24.6	3	15	5	16.7	32	20
35-39	12	26.7	15	23.1	4	20	10	33.3	41	25.6
40-44	8	17.8	14	21.5	5	25	5	16.7	32	20
45-49	6	13.3	3	4.6	3	15	1	3.3	13	8.1
Total	45	100	65	100	20	100	30	100	160	100

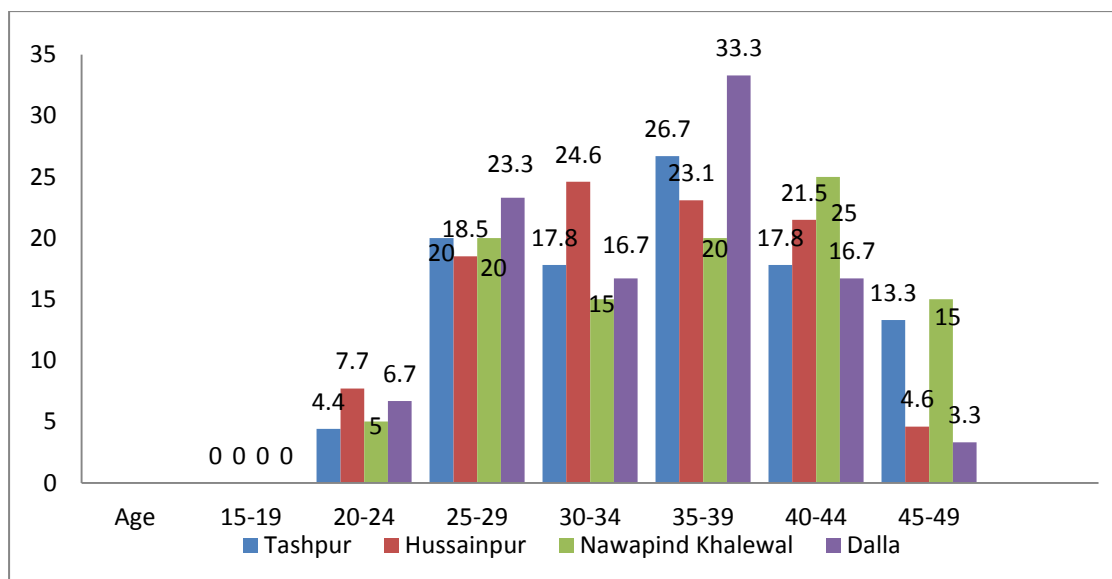


Figure 4.1: Distribution of Respondents according to Age Group

The Table 4.1 and Figure 4.1 exhibits the age distribution of respondents in four villages. In Tashpur village total of 45 women were interviewed. There are no women in the 15-19 age group, 20-24 made up of 4.4%, the largest group is the 25-29 years accounts 20%. Another large group, 30-34 years is 17.8%, and 35-39 age, constitutes another significant part 26.7%. The 40- 44 age group is the Smallest 13.3%, 45-49 year-olds smallest group, just 4.4%.

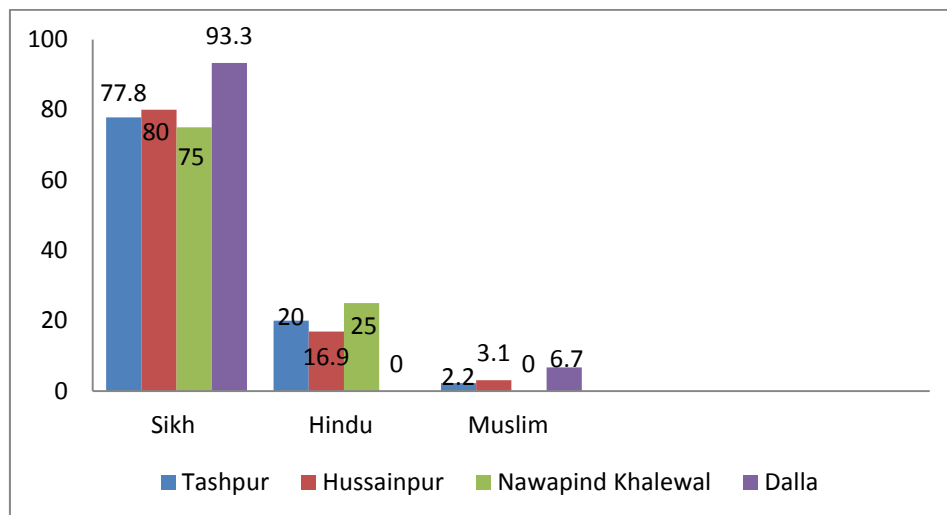
In Hussainpur village no women falls in age group 15-19 years, 7.7 % falls in age group of 20-24 years , 18.5 % women belongs to the age group 25-29 years, 24.6% belongs to 30-34 age group, 21.5% and 4.6 % belongs to 40-44, 45-49 years of age group respectively.

In Nawapind Khalewal , 25% respondents belongs to 40-44 age group. The 25-29 and 35-39 age groups all have an equal representation of 20%.and 30-34 and 45-49 have 15% representation for each age group. The 20-24 age group has the smallest percentage at 5%. No respondent belongs to 15-19 years of age group.

In Dallavillage, there are no women in the 15-19 age group. The 20-24 years category comprises 6.7%, while a significant portion falls within the 25-29 years range at 23.3%. The largest group is those aged between 35-39 years at 33.3%. The two smallest groups are those aged between 30-34 and 40-44 making up only a 16.7 % for each group and minor fraction 3.3% comes under 45-49 years if age group.

Table 4.2**Distribution of Respondents according to Religion**

Village	Tashpur (45)		Hussainpur (65)		Nawapind Khalewal (20)		Dalla (30)		Total (160)	
Religion	No	%	No.	%	No.	%	No.	%	No.	%
Sikh	35	77.8	52	80	15	75	28	93.3	130	81.3
Hindu	9	20	11	16.9	5	25	0	0	25	15.6
Muslim	1	2.2	2	3.1	0	0	2	6.7	5	3.1
Total	45	100	65	100	20	100	30	100	160	100

**Figure 4.2: Distribution of Respondents according to Religion**

The Table 4.2 and Figure 4.2 exhibits the distribution of respondents according to their religion across four villages. Tashpur has a significant Sikh population, with 77.8% adherents. This suggests that Sikhs form the majority religious group in Tashpur. Hindu constitutes 20%. A small minority of 2.2% are Muslims. Similar to Tashpur, Hussainpur also has a substantial Sikh population, accounting for 80%. Hindu make up 16.9% of the village, only 3.1% of the residents are Muslims. Nawapind Khalewal has a lower Sikh compared to the other two villages, with 75% adherents, there are no Hindu respondent in Dalla, Muslim constitutes 6.7% of the village. Dalla has a substantial Sikh population, with 93.3% following Sikhism. There are no Hindu reported in Dalla (0.0%), 6.7% belongs to Muslim.

Table 4.3**Distribution of Respondents according to their Caste**

Village	Tashpur (45)		Hussainpur (65)		Nawapind Khalewal (20)		Dalla (30)		Total (160)	
Caste	No	%	No.	%	No.	%	No.	%	No.	%
General	17	37.8	22	33.8	5	25	1	3.3	45	28.1
OBC	15	33.3	22	33.8	9	45	9	30	55	34.4
SC	13	28.9	21	32.3	6	30	20	66.7	60	37.5
Total	45	100	65	100	20	100	30	100	160	100

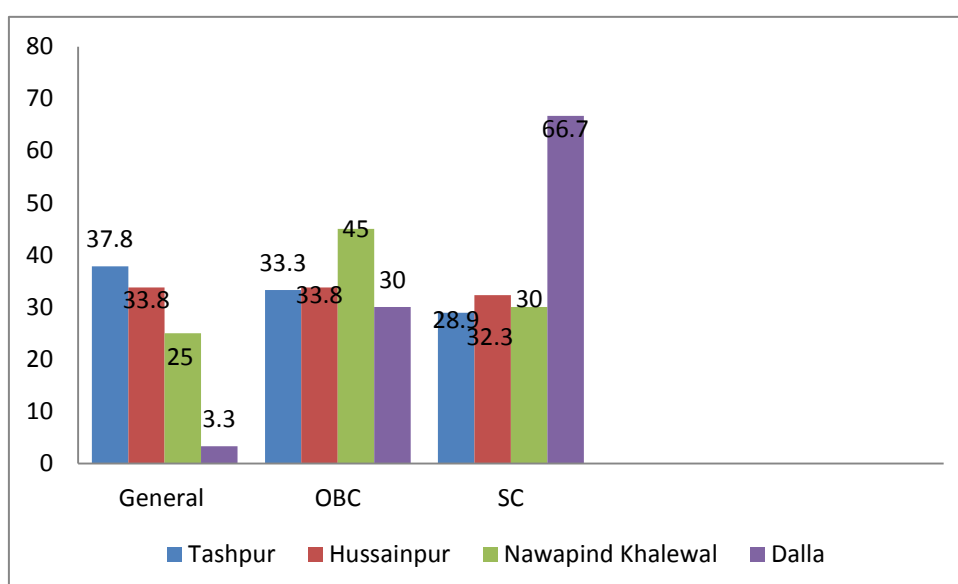
**Figure 4.3: Distribution of Respondents according to their Caste**

Table 4.3 and Figure 4.3 represents the general category constitutes 28.1% of the total population across all villages. Tashpur has the highest number of General category individuals 37.8 %, followed by Hussainpur 33.8% , Nawapind Khalewal 25 %, and Dalla 3.3%. The percentage distribution varies across villages, with Nawapind having the lowest representation 3.3%. OBC respondents make up 34.4% of the total. Among the villages, Tashpur and Hussainpur have the same number of OBC respondents 33.8 % while Nawapind Khalewal has the highest representation 45% and Dalla have 30 % OBC respondents. SC respondents account for 37.5% of the total sample . Dalla has the highest

number of SC individuals 66.7, followed by Hussainpur 32.3%, Nawapind Khalewal 30% and lowest in Tashpur 28.9%.

Table 4.4

Distribution of Respondents by Education Level

Respondent's Education	Tashpur (45)	%	Hussainpur (65)	%	Nawapind Khalewal (20)	%	Dalla (30)	%	Total (160)	%
Primary Education (upto 5 th)	1	2.2	2	3.1	2	10	3	10	8	5
Middle education (6 th -8 th)	4	8.9	2	3.1	1	5	2	6.7	9	5.6
High School education (10 th)	8	17.8	6	9.2	3	15	9	60	26	16.2
Higher Secondary Education (12 th)	19	42.2	25	38.4	8	40	9	60	61	38.1
Graduation	8	17.8	18	27.7	3	15	5	16.7	34	21.3
Post Graduation	2	4.4	5	7.7	1	5	1	3.3	9	5.6
Diploma	1	2.2	4	6.2	1	5	0	0	6	3.8
Illiterate	2	4.4	3	4.6	1	5	1	3.3	7	4.4
Total	45		65	100	20	100	30	100	160	100

Table 4.4 and Figure 4.4 represents the education level of respondents. In Tashpur village 2.2% of the respondents have completed only primary education, 8.9% have completed middle education, 17.2 completed high school, and 42.2% have completed their 12th-grade education. 17.8% have graduated. 4.4 % have completed post-graduation. 2.2% have a diploma. 4.4% are illiterate. Hussainpur represents the 3.1% has completed education up to 5th grade, 3.1% have completed middle education, 9.2% have high school education, 38.4 % have completed their secondary education, 27.7% have graduated, 7.7% have completed post-graduation, 6.2% have a diploma, and 4.6% are illiterate.

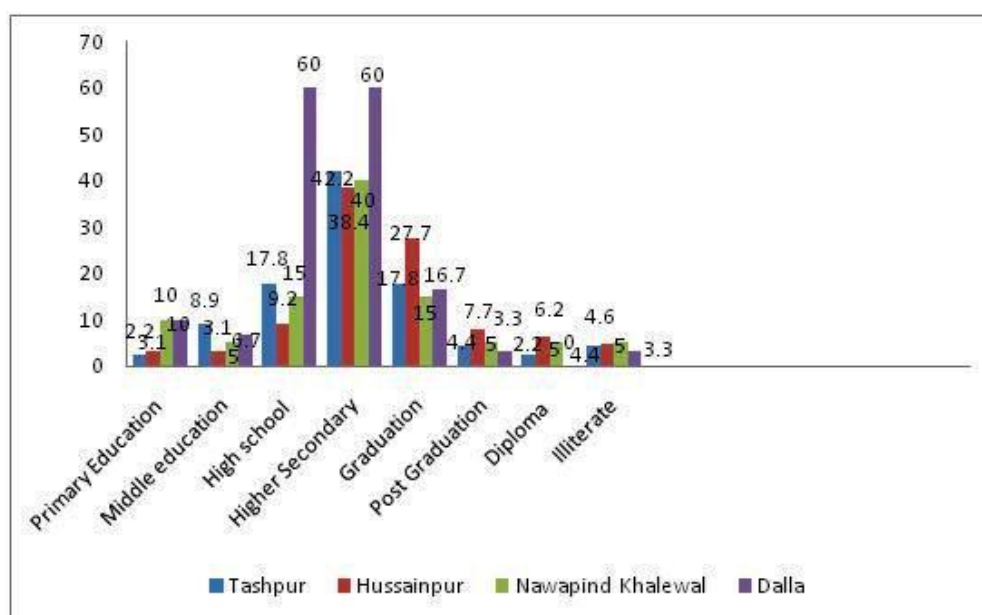


Figure 4.4: Distribution of Respondents by Education Level

In Nawapind Khalewal 10% respondents completed education up to 5th grade, 5% have completed middle education, 15% have high school education, 40% have completed their secondary education. 15% have graduated, 5% have completed post-graduation, 5% have a diploma, and 5% are illiterate. Dalla stands for the 10% who have completed education up to 5th grade, 6.7% have completed middle education, 60% have high school education, 60% have completed their secondary education, 16.7% have graduated, 3.3% have completed post-graduation, and 3.3% are illiterate.

Table 4.5

Distribution of Education level among Respondent's Husbands

Respondent's Husband Education	Tashpur (45)	%	Hussainpur (65)	%	Nawapind Khalewal (20)	%	Dalla (30)	%	Total (160)	%
Primary Education (upto 5 th)	1	2.2	2	3.3	0	0	1	3.3	4	2.5
Middle education (6 th -8 th)	3	6.7	3	4.6	2	10	4	13.4	12	7.5

High School education (10 th)	13	28.9	9	13.8	3	15	12	40	37	23.1
Higher Secondary Education (12th)	18	40	27	41.5	10	50	9	30	64	40
Graduation	5	11.1	14	21.5	1	5	2	6.7	22	13.8
Post Graduation	2	4.4	7	10.7	1	5	1	3.3	11	6.9
Diploma	0	0	3	4.6	0	0	1	3.3	4	2.5
Illiterate	3	6.7	0	0	3	15	0	0	6	3.7
Total	45	100	65	100	20	100	30	100	160	100

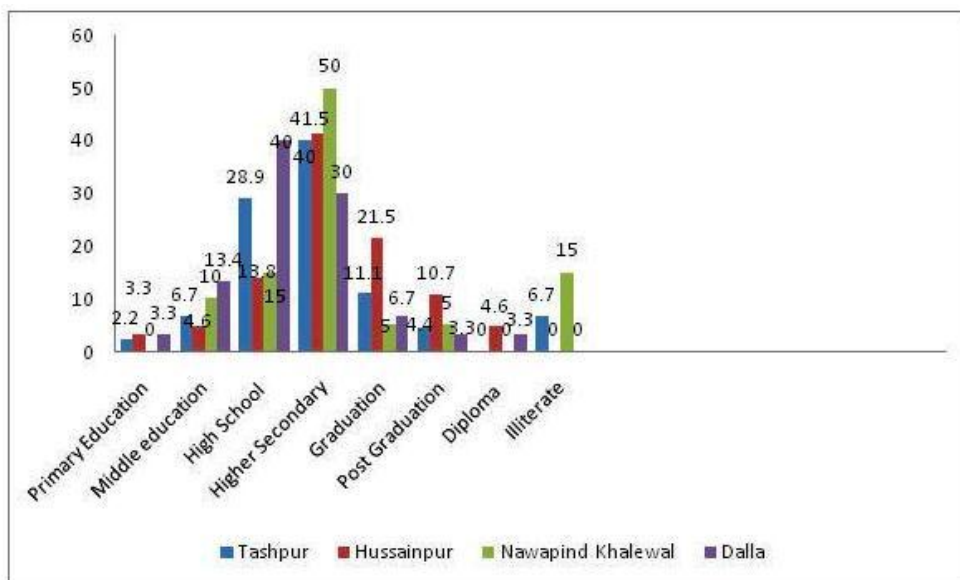


Figure 4.5: Distribution of Respondent's Husband Education Status

Table 4.5 and Figure 4.5 represents the education level of respondent's husband. In Tashpur village 2.2% of the respondents have completed only primary education, 6.7% have completed middle education, 28.9% completed high school, 40% have completed their 12th-grade education. 11.1% have graduated, 4.4% have completed post-graduation and 3% are illiterate. Hussainpur represents the 3.3% has completed education up to 5th grade, 4.6% have completed middle education, 13.8% have high school education, 41.5 % have completed their secondary education, 21.5% have graduated, 10.7% have completed post-graduation, 4.6% have a diploma, and no one is illiterate. In Nawapind Khalewal 10% respondents completed education up to 5th

grade,10% have completed middle education, 15% have high school education, 50% have completed their secondary education. 5% have graduated, 5% have completed post-graduation, no one is diploma holder and diploma, and 15% are illiterate. Dalla stands for the 3.3% who have completed education up to 5th grade,13.4% have completed middle education, 40% have high school education, 30% have completed their secondary education, 6.7% have graduated, 3.3% have completed post-graduation, 3.3% have diploma and no one is illiterate.

Table 4.6
Distribution of Respondents by Occupation

Respondent's occupation	Tashpur (45)	%	Hussainpur (65)	%	Nawapind Khalewal (20)	%	Dalla (30)	%	Total (160)	%
Service	7	15.6	19	29.2	4	20	6	20	36	22.5
Business	1	2.2	8	12.3	1	5	2	6.7	12	7.5
Labour	3	6.7	3	4.6	2	10	6	20	14	8.8
Housewife	34	75.5	35	53.9	13	65	16	53.3	98	61.2
Total	45	100	65	100	20	100	20	100	160	100

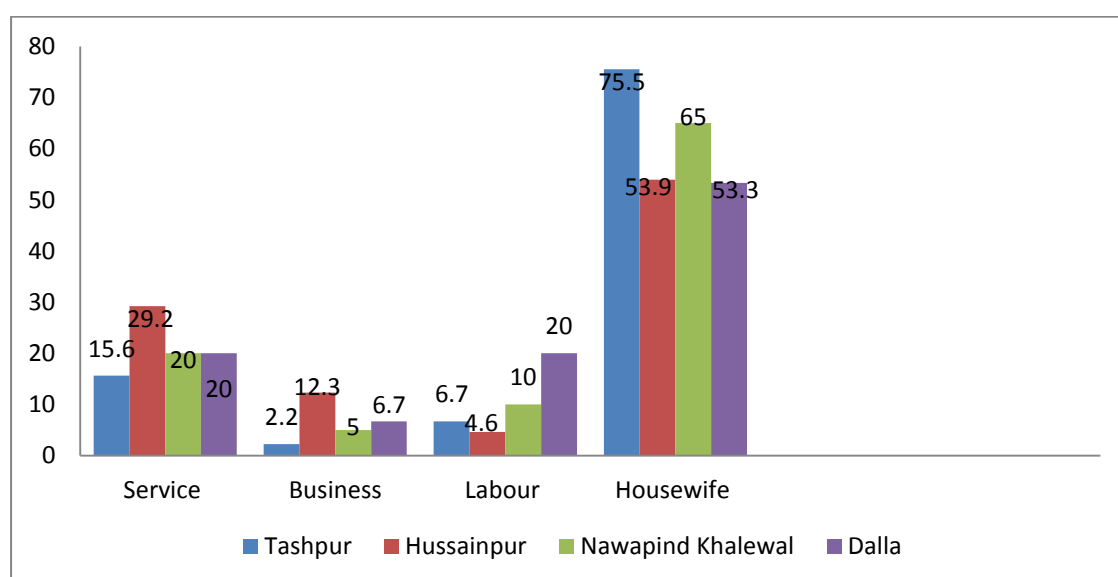


Figure 4.6: Distribution of Respondents by Occupation

The Table 4.6 and Figure 4.6 represents the distribution of occupation of respondents in four villages. The percentages indicate the proportion of individuals engaged in various types of work within each village. 15.6%, 29.2%, 20%, and 22.5% of the respondents are employed in service. Tashpur, Hussainpur, and Nawapind Khalewal, Dalla. Business activities are less prominent across all villages. 12.3%, 5%, and 6.7% participates in entrepreneur activities in the respective villages Hussainpur, Nawapind Khalewal, and Dalla. Only 2.2% of individuals are involved in business in Tashpur. 6.7%, 4.6%, 10%, and 8.8% of individuals work as labourers, and 75.5%, 53.9%, 65%, and 53.3% of women are house wives in their respective four villages.

Table 4.7

Distribution of Husband's Occupation among respondents

Respondent's Husband occupation	Tashpur (45)	%	Hussainpur (65)	%	Nawapind Khalewal (20)	%	Dalla (30)	%	Total (160)	%
Agriculture	2	4.4	4	6.2	2	10	1	3.3	9	5.6
Service	7	15.6	14	21.5	5	25	4	13.3	30	18.8
Business	9	20	12	18.5	5	25	5	16.7	31	19.4
Labour	27	60	35	53.8	8	40	20	66.7	90	56.2
Total	45	100	65	100	20	100	30	100	160	100

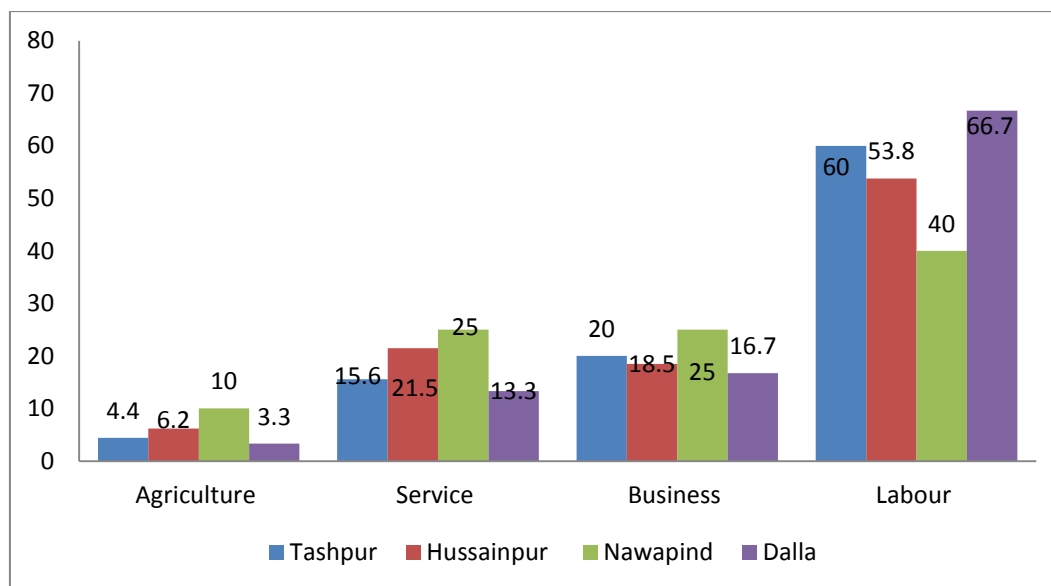


Figure 4.7: Distribution of Husband's Occupation among Respondent

Table 4.7 and Figure 4.7 represent the occupations of respondent's husband in four villages. The percentages indicate the proportion of individuals engaged in various types of work within each village. 4.4%, 6.2%, 10%, and 3.3% of the individuals involved in agriculture in their respective villages, i.e., Tashpur, Hussainpur, Nawapind Khalewal, and Dalla. Service and business activities are equally distributed across all villages. 15.6%, 21.5%, 25%, and 13.3% of individuals are involved in service in the respective villages. 20%, 18.5%, 25%, and 16.7% of individuals work as businessmen and 60%, 53.8%, 40%, and 66.7% are engaged in labour activities in their respective four villages - Tashpur, Hussainpur, Nawapind Khalewal, and Dalla.

Although these data tables primarily focus on the educational and occupational status of respondents and their spouses, these variables significantly influence the household decision-making dynamics. A significant proportion of women who have completed either secondary education or professional course and working in salaried roles or self-employed. This group has greater autonomy in health decisions. For example, during interviews women with secondary education and employment in teaching or nursing shared a noticeably higher sense of agency in matters related to child immunization and family planning. One respondent remarked, "My job gives me confidence. My husband respects my opinions more now—especially about our children's health." In contrast, respondents with minimal education and those engaged

in unpaid household labor often cited greater dependence on husbands for health-related decisions.

Table 4.8

Distribution of Respondents according to Income

Income	Tashpur (45)	%	Hussainpur (65)	%	Nawapind Khalewal (20)	%	Dalla (30)	%	Total (160)	%
≤ 1,00,000 annual	23	51.1	30	46.2	14	70	21	70	88	55
1,00,000- 3,00,000 annual	16	35.6	25	38.4	5	25	8	26.7	54	33.8
More than 3,00,000 annual	6	13.3	10	15.4	1	5	1	3.3	18	11.2
Total	45	100	65	100	20	100	30	100	160	100

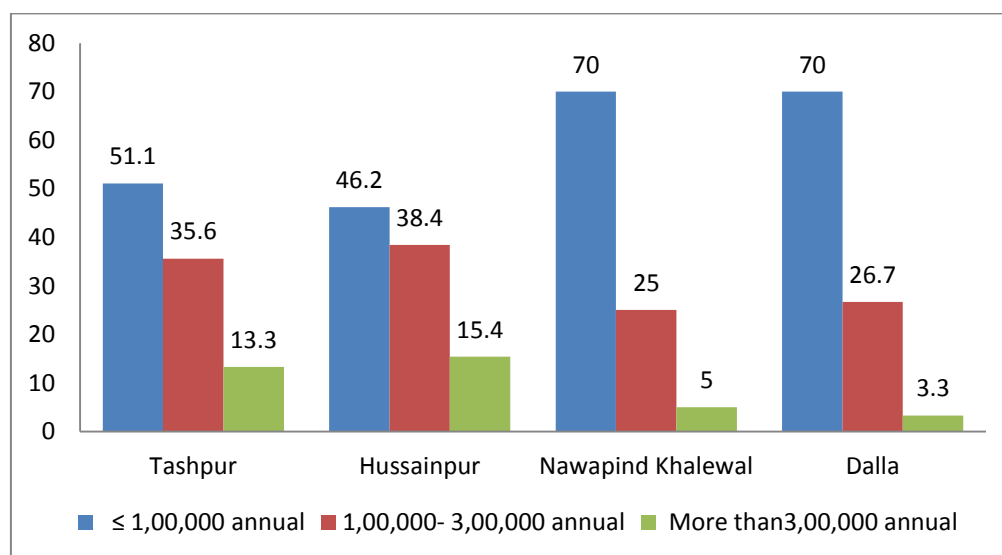


Figure 4.8: Distribution of Respondents according to Income

The Table 4.8 and Figure 4.8 exhibits the economic status in four villages. Tashpur has a significant proportion 51.1% of its subjects earning an income below or equal to

1,00,000 annually. This suggests that the majority of residents fall within the lower income bracket. Approximately 35.6% fall into 1,00,000-3,00,000 income. Only 13.3% subjects in Tashpur falls into this high-income (more than 3,00,000). Hussainpur constitutes 46.2% have low income, about 38.4% fall into moderate and only 15.4% belong to the high-income group. Nawapind Khalewal comprises 70% of subjects, who have lower income. Approximately 25% fall into moderate, only 5% belong to the high-income group. In Dalla village 70% have relatively low incomes, 26.7% fall into moderate income and 3.3% belong to the high-income group.

Table 4.9

Distribution of Family Types among Respondents

Family Type	Tashpur (45)	%	Hussainpur (65)	%	Nawapind Khalewal (20)	%	Dalla (30)	%	Total (160)	%
Joint family	20	44.4	36	55.4	9	45	20	66.7	85	53.1
Nuclear family	25	55.6	29	44.6	11	55	10	33.3	75	46.9

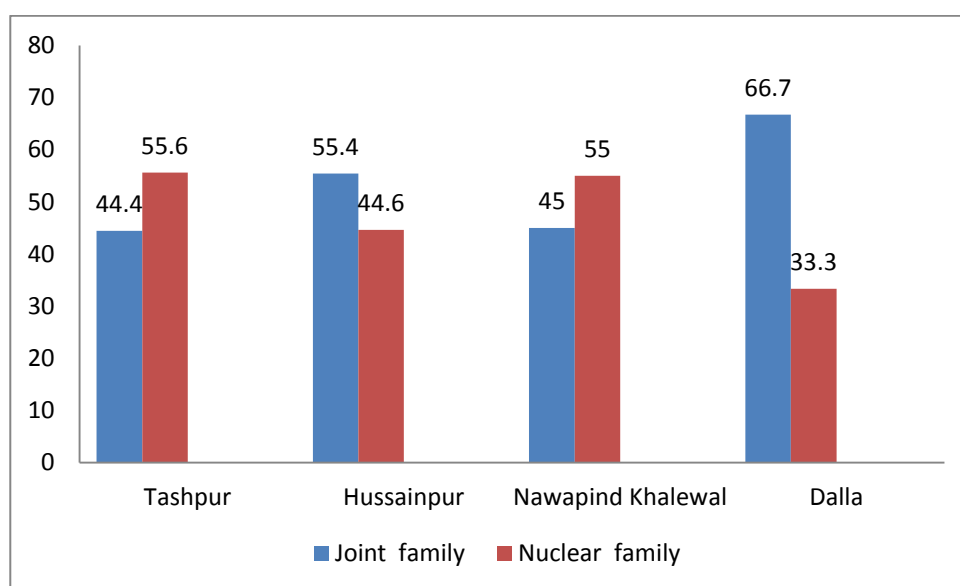


Figure 4.9: Distribution of Family Types among Respondents

These Table 4.9 and Figure 4.9 represent the distribution of family structure within each village. Some villages have a majority of joint family or nuclear family. In Tashpur the majority of families are nuclear, accounting for 55.6% of the total, while joint families make up the remaining 44.4%. In contrast, Hussainpur shows a higher prevalence of joint families, which constitute 55.4% of the total, with nuclear families making up 44.6%. Nawapind Khalewal presents a balanced picture, with nuclear and joint families 45% and 55% respectively. Dalla stands out with the highest percentage of joint families among the four villages, at 66.7%, compared to 33.3% for nuclear families.

Table 4.10 Distribution of Respondents based on Housing Conditions

Housing condition	Tashpur (45)	%	Hussainpur (65)	%	Nawapind Khalewal (20)	%	Dalla (30)	%	Total (160)	%
Type of house										
Kaccha	0	0	0	0	0	0	0	0	0	0
Semi pucca	0	0	1	1.54	0	0	0	0	1	0.64
Pucca	45	100	64	98.46	20	100	30	100	159	99.36
Toilet facility										
Yes	45	100	65	100	20	100	30	100	160	100
No	0	0	0	0	0	0	0	0	0	0
Avalibility of Electricity										
Yes	45	100	65	100	20	100	30	100	160	100
No	0	0	0	0	0	0	0	0	0	0
Source of water										
Tap water	13	28.9	23	35.4	3	15	7	23.3	33	20.6
Submersible	22	48.9	42	64.6	17	85	23	76.7	127	79.4
Cooking source										
Fire wood/ Chulla	0	0	0	0	0	0	0	0	0	0
LPG	45	100	65	100	20	100	30	100	160	100

Table 4.10 and Figure 4.10.1, 4.10.2, 4.10.3, 4.10.4 provide insights into the housing conditions across four villages: Tashpur, Hussainpur, Nawapind Khalewal, and Dalla. In terms of house type, all four villages predominantly consist of pucca houses, with

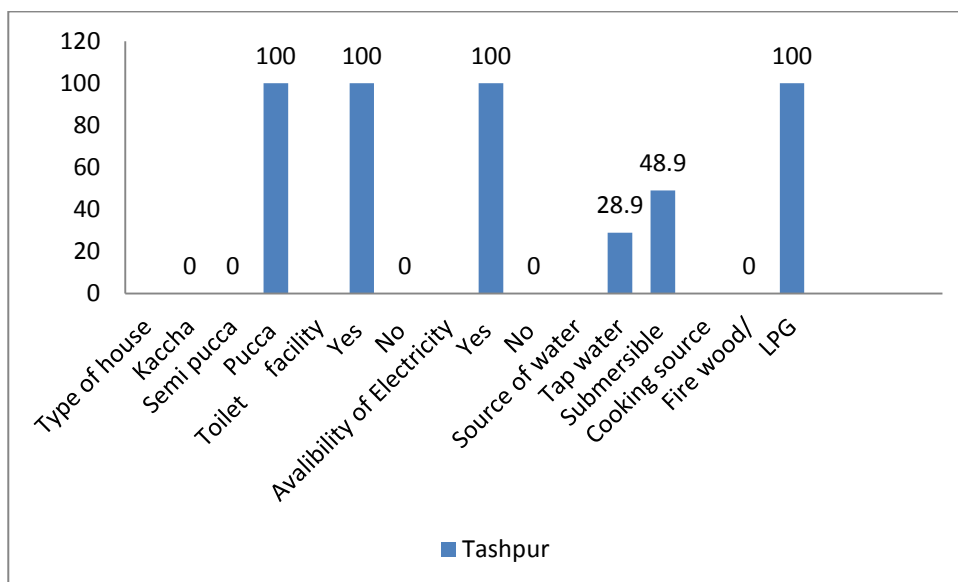


Figure 4.10.1: Distribution of Respondents based on Housing Conditions in Tashpur Village

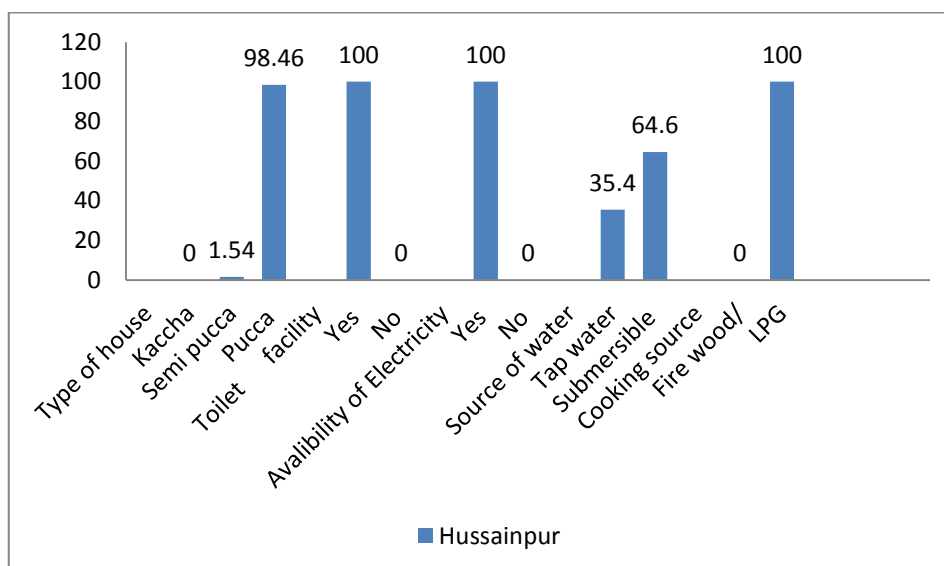


Figure 4.10.2: Distribution of Respondents based on Housing Conditions in Hussainpur Village

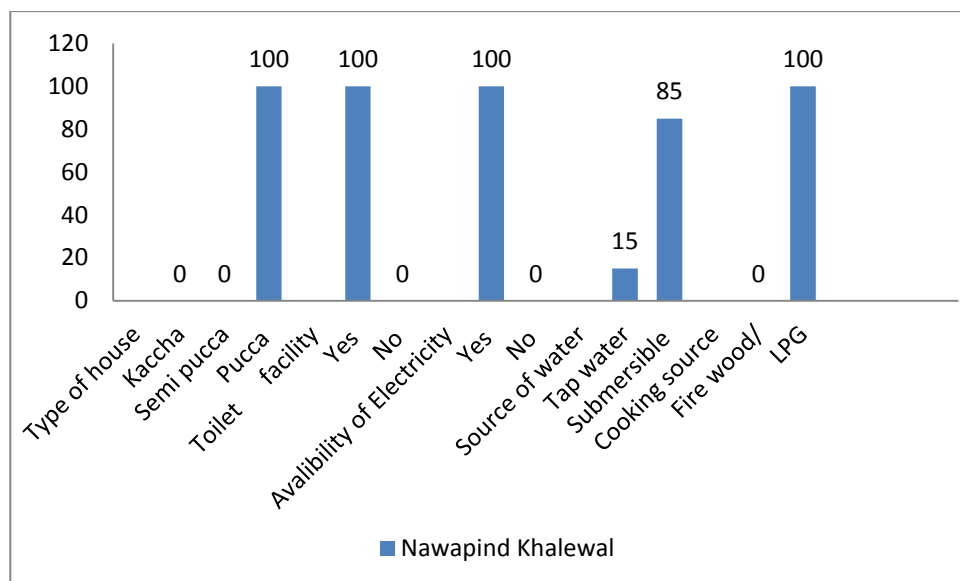


Figure 4.10.3: Distribution of Respondents based on Housing Conditions in NawapindKhalewal Village

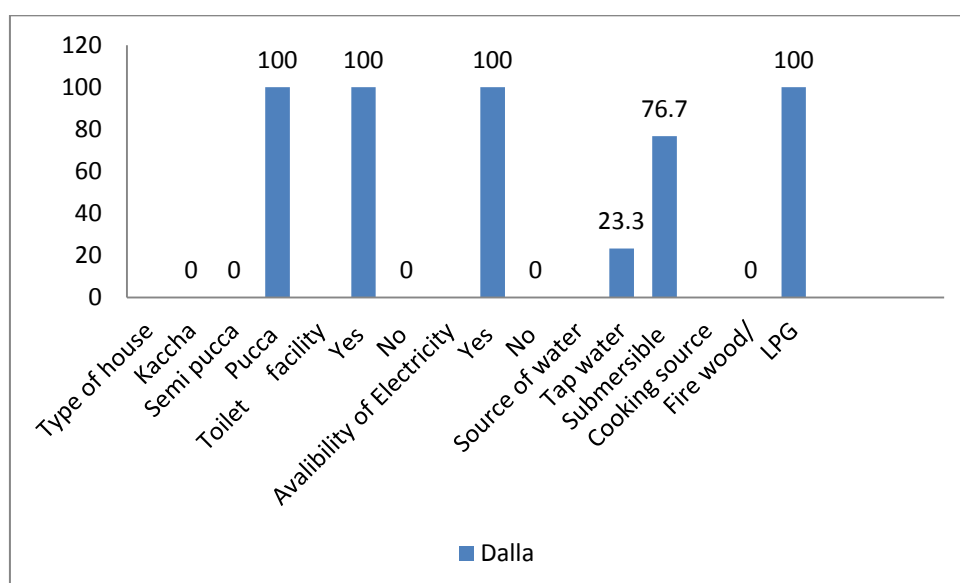


Figure 4.10.4: Distribution of Respondents based on Housing Conditions in Dalla Village

100% in Tashpur, Nawapind Khalewal, and Dalla, and 98.46% in Hussainpur. There is a negligible presence of semi-pucca houses, only in Hussainpur at 1.54%. No kaccha houses are reported in any of the villages. Regarding toilet facilities and

availability of electricity, all four villages show a 100% availability rate. This indicates that every household in these villages has access to these basic amenities. For the source of water, the majority of households in all four villages using submersible sources, with the highest usage in Nawapind Khalewal at 85%, followed by Dalla at 76.7%, Hussainpur at 64.6%, and Tashpur at 48.9%. Tap water is used less frequently, with the highest usage in Hussainpur at 35.4%, followed by Tashpur at 28.9%, Dalla at 23.3%, and Nawapind Khalewal at 15%. In terms of cooking source, all households in the four villages use LPG, indicating a 100% usage rate. No households reported using firewood or chulla for cooking.

AGE AT MENARCHE

Menarche refers to the onset of menstruation in females of reproductive age. It marks the beginning of the menstrual cycle. It is the periodic shedding of the uterine lining (Apter, & Vihko, 1983).

Table 4.11

Distribution of Respondents by Age at Menarche

Age at menarche	Tashpur (45)	%	Hussainpur (65)	%	Nawapind Khalewal (20)	%	Dalla (30)	%	Total (160)	%
12-13	9	20	9	13.9	1	5	1	3.3	20	12.5
13-14	19	42.2	29	44.6	6	30	5	16.7	58	36.2
14-15	12	26.7	21	32.3	10	50	13	43.3	56	35
15-16	5	11.1	6	9.2	3	15	11	36.7	26	16.3
Total	45	100	65	100	20	100	30	100	160	100

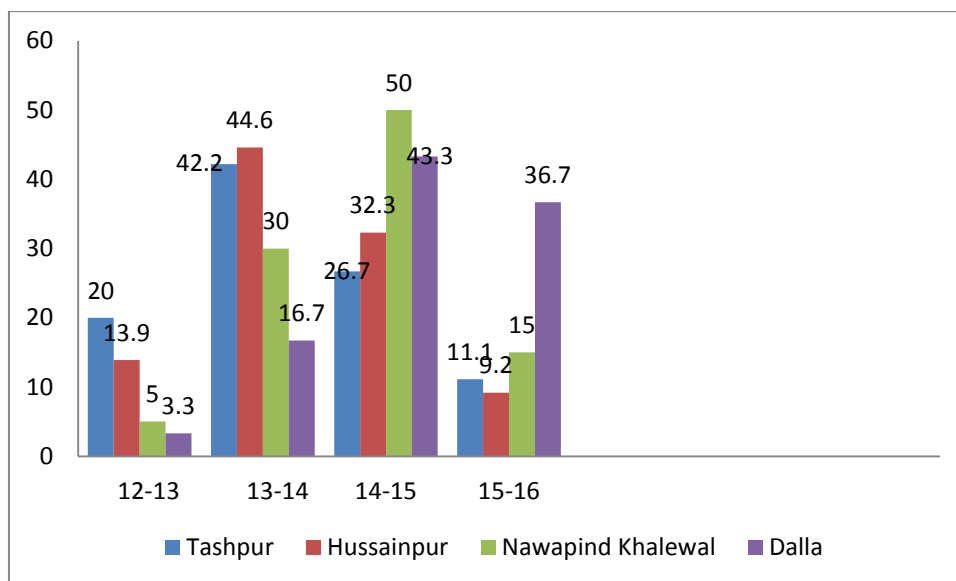


Figure 4.11: Distribution of age at menarche among respondents

Table 4.11 and figure 4.11 represent the distribution of age at menarche (the onset of menstruation) among women across four villages: Tashpur, Hussainpur, Nawapind Khalewal, and Dalla, have distinct patterns emerged. For the age group 12-13 years, Tashpur reported 20% while Hussainpur had a lower percentage of 13.9%. Nawapind Khalewal and Dalla reported 5% and 3.3% respectively. The 13-14 years category saw a higher incidence with Tashpur recording 42.2%, Hussainpur 44.6%, Nawapind Khalewal at 30%, and Dalla at 16.7%. A significant observation is made in the 14-15 years group, where Nawapind Khalewal reports the highest percentage of 50%, followed by Hussainpur with 32.3%, Tashpur at 26.7%, and Dalla at 43.3%. Overall, this age group constitutes 35% of the total. The 15-16 years category shows lower percentages across all villages with Tashpur at 11.1%, Hussainpur at 9.2%, Nawapind Khalewal at 15%, and Dalla having the highest in this group at 36.7%.

Table 4.12

Distribution of Respondents based on their Age at Marriage

Age at marriage	Tashpur (45)	%	Hussainpur (65)	%	Nawapind Khalewal (20)	%	Dalla (30)	%	Total (160)	%
Below 18	1	2.2	2	3.1	0	0	0	0	3	1.9
18- 21	21	46.7	16	24.6	11	55	16	53.4	64	40

22-25	17	37.8	29	44.6	7	35	10	33.3	63	39.3
26-29	4	8.9	16	24.6	2	10	3	10	25	15.7
30-33	2	4.4	2	3.1	0	0	1	3.3	5	3.1
Total	45	100	65	100	20	100	30	100	160	100

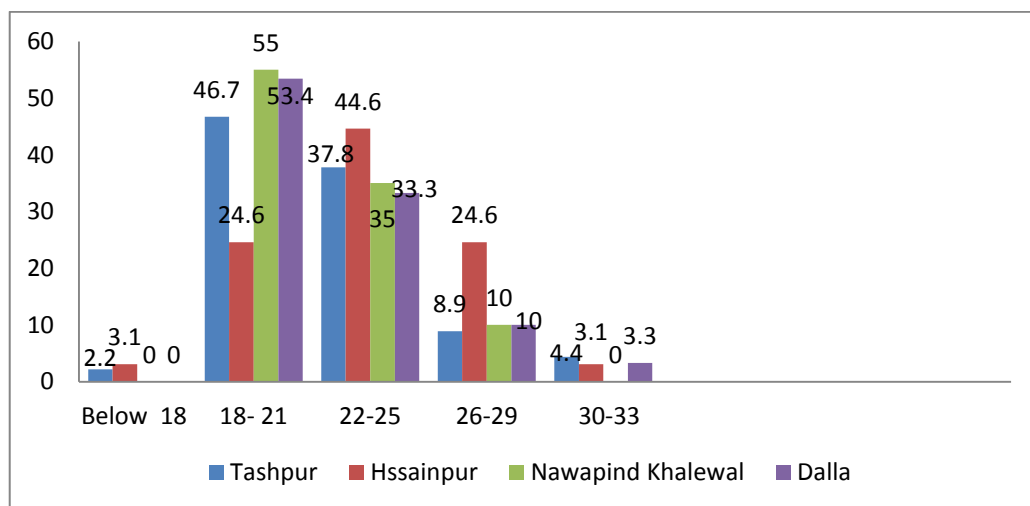
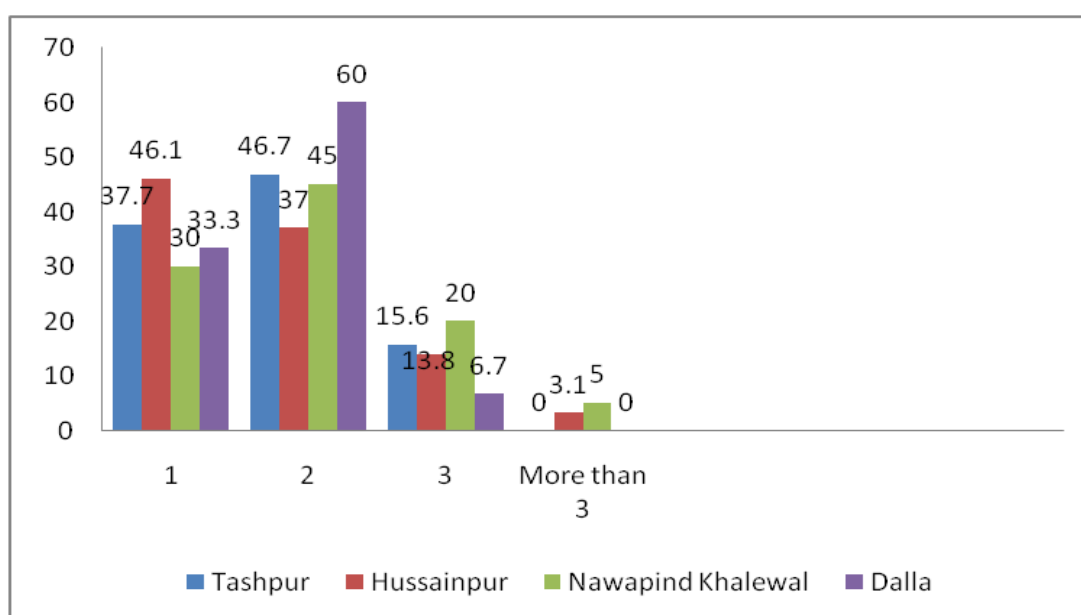


Figure 4.12: Distribution of Respondents based on their Age at Marriage

The Table 4.12 and Figure 4.12 represents age at marriage varied across the four villages. In Tashpur, the majority of marriages (46.7%) occurred between the ages of 18 and 21. A significant proportion (37.8%) took place between the ages of 22 and 25. Fewer marriages were recorded for the age groups 26-29 at (8.9%) and 30-33 (4.4%), and a small percentage (2.2%) were below the age of 18. In Hssainpur, the most common age at marriage was between 22 and 25 years (44.6%), followed by the age group 18-21 at 24.6%, and then 26-29 at 24.6%. The age groups below 18 and 30-33 both had the same percentage (3.1%). In Nawapind Khalewal, the majority of marriages (55%) took place between the ages of 18 and 21. This was followed by the age group 22-25 (35%), and then 26-29 (10%). There were no recorded marriages for the age groups below 18 and 30-33. In Dalla, the most common age at marriage was between 18 and 21 years (53.4%), followed by the age group 22-25 (33.3%), and then 26-29 (10%). Only a small percentage (3.3%) of marriages occurred in the age group 30-33, and there were no recorded marriages below the age of 18.

Table 4.13**Distribution of Respondents based on their Number of Children**

Number of children	Tashpur (45)	%	Hussainpur (65)	%	Nawapind Khalewal (20)	%	Dalla (30)	%	Total (160)	%
1	17	37.7	30	46.1	6	30	10	33.3	63	39.4
2	21	46.7	24	37	9	45	18	60	72	45
3	7	15.6	9	13.8	4	20	2	6.7	22	13.7
More than 3	0	0	2	3.1	1	5	0	0	3	1.9
Total	45	100	65	100	20	100	30	100	160	100

**Figure 4.13: Distribution of Respondents based on their Number of Children**

The table 4.13 and Figure 4.13 presents data on the number of children per household in four villages. In Tashpur the majority of households have two children (46.7%), followed by one child (37.7%) and fewer are with three children at 15.6%. There are no households with more than three children. Hussainpur is the most common for family size with one child (46.1%), followed closely by two children (37%) and three children (13.8%). A small percentage of households have more than three children (3.1%). Nawapind Khalewal's families with two children represent the largest group

(45%), with one child families making up 30%. A minority of households have three or more children : 20% and 5% respectively. While the Dalla has also the highest percentage of households have two children (60%), this is significantly higher than the other villages. One child families account for 33.3%, and a very small number have three children (6.7%).

SECTION II

REPRODUCTIVE AND CHILD HEALTH PROFILE

Ensuring the health and well-being of mothers, infants, and children is important as they are central to the socio-economic growth of our society. This profile aims to provide a comprehensive overview of the key indicators and statistics that reflect the status of reproductive and child health. The following tables present the data on various aspects such as maternal health, child health, and use of contraceptives and awareness regarding RTIs and STDs among women offering insights for informed healthcare decisions and policy-making.

PRESENT REPRODUCTIVE PROFILE

Table 4.14

Distribution of Respondents by Menstrual Complications

Health problem	Tashpur (45)	%	Hussainpur (65)	%	Nawapind Khalewal (20)	%	Dalla (30)	%	Total (160)	%
Menses abnormality										
No	43	95.6	54	83.1	13	65	16	53.3	126	78.8
Yes	2	4.4	11	16.9	7	35	14	46.7	34	21.2
If yes..Abdominal pain	2	100	11	100	7	100	12	85.7	32	94.1
Irregular menses	2	100	7	63.6	0	0	0	0	9	26.5
Over bleeding	0	0	4	36.4	0	0	1	7.1	5	14.7

Less bleeding	0	0	0	0	0	0	0	0	0	0
Failure to mensurate	0	0	0	0	0	0	0	0	0	0
Backache	2	100	2	18.2	7	100	9	64.3	20	58.8
Menopause	0	0	0	0	0	0	0	0	0	0

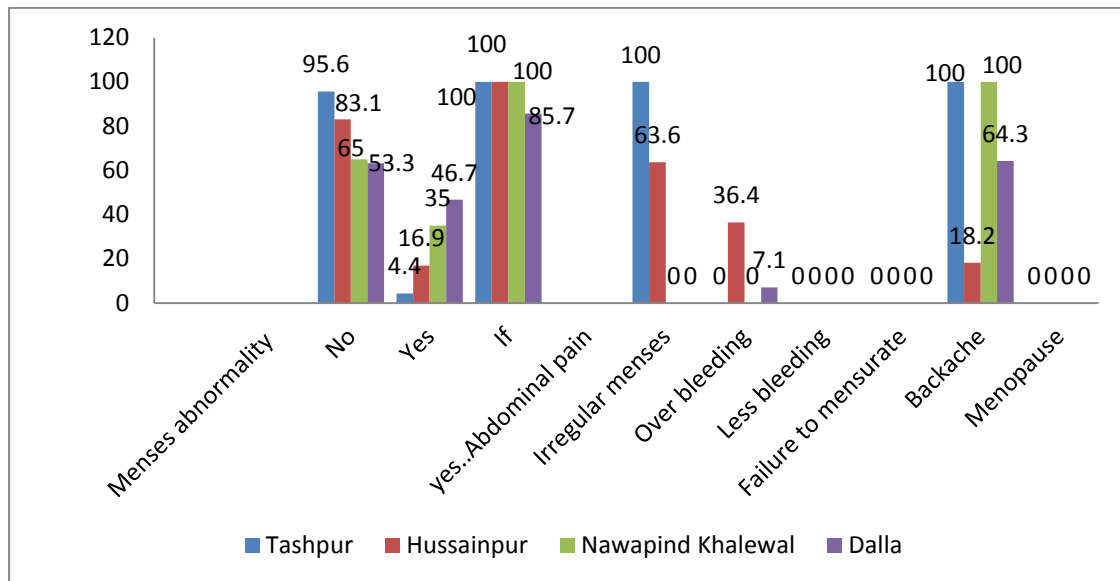


Figure 4.14: Distribution of Respondents by Menstrual Complications

The Table4.14 and Figure 4.14 present data for menstrual problems across four villages. The percentages reflect the proportion of women experiencing specific menstrual abnormalities. In Tashpur, a significant majority of women (95.6%) reported no menstrual abnormalities, among those who did report issues (4.4%), all experienced abdominal pain and irregular menses, but there were no cases of over bleeding, less bleeding, failure to menstruate, or menopause. Hussainpur had a lower percentage of women have no menstrual issues (83.1%) compared to Tashpur. Women with abnormalities (18.9%) , all reported abdominal pain, and a majority had irregular menses (63.6%) and over bleeding (36.4%). Backache was reported by 18.2% of the women. In Nawapind Khalewal, majority of women (65%) reported no menstrual problems and 35% reported the menstrual health issues, all experienced abdominal pain and backache, but none reported irregular menses or over bleeding. Dalla had the lowest percentage of women without menstrual issues

(53.3%). Of those with problems (46.7%), a significant number experienced abdominal pain (85.7%) and backache (64.3%), and a small percentage reported over bleeding (7.1%). There were no reports of irregular menses, less bleeding, failure to menstruate, or menopause.

Table 4.15

Distribution of Respondents by Perineal Problem

Perineal problem	Tashpur	%	Hussainpur	%	Nawapind khalewal	%	Dalla	%	Total	%
No	43	95.6	63	96.9	19	95	29	96.7	154	96.2
Yes	2	4.4	2	3.1	1	5	1	3.3	6	3.8
If yes..PCOD	1	50	1	50	0	0	0	0	2	33.3
Leucorrhoea	0	0	0	0	1	100	0	0	1	16.7
Fibroids	1	50	1	50	0	0	1	100	3	50

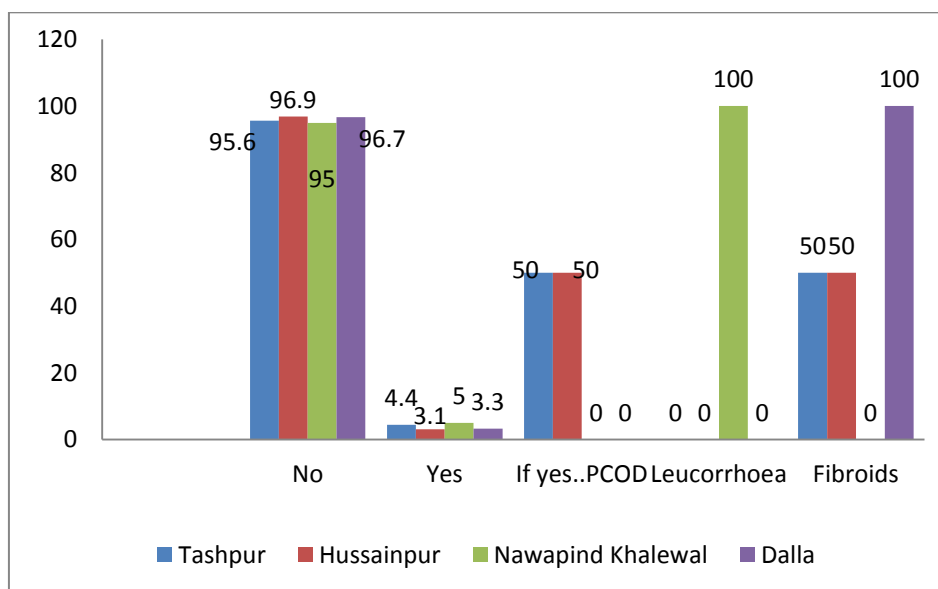


Figure 4.15: Distribution of Respondents by Perineal Problem

Table 4.15 and Figure 4.15 shows the data with perineal problems for the respective villages. In Tashpur the majority of residents (95.6%) reported no perineal problems. Only 4.4% of respondents in Tashpur experiencing perineal

problems. Among them 50% attributed to PCOD (Polycystic Ovary Syndrome). No cases of leucorrhoea were reported. One case of fibroids (50%) was identified. In Hussainpur most respondents (96.9%) did not report perineal problems. Only 3.1% having perineal issues. Among them 50% associated it with PCOD. No cases of leucorrhoea were documented. One case of fibroids (50%) was observed. In Nawapind Khalewal the majority (95%) of respondents did not experience any kind of perineal problem. Only 5% were reported perineal issues. No specific case such as PCOD or fibroid is identified. Only one case of leucorrhoea (100%) was recorded. A similar pattern seen in Dalla village, with 96.7% of respondents reporting no perineal problems. Only 3.3% experiencing perineal issues, in which one case of fibroids is reported.

Case Study 1: PCOD in a 26 Year-Old Female

She is a 30-year-old female, who has completed her education up to the 12th grade. She is married to a Registered Medical Practitioner (RMP). She is a mother of two children. She is of good socio-economic status.

Medical History - She has been diagnosed with Polycystic Ovary Disorder (PCOD), a hormonal disorder that affects the ovaries and can lead to irregular menstrual cycles. She has been experiencing weight gain and irregular menstruation, which are common symptoms of PCOS. She is taking allopathic treatment.

Table 4.16

Distribution of Respondents by General Medical Illness

General medical illness	Tashpur	%	Hussainpur	%	Nawapind khalewal	%	Dalla	%	Total	%
Breast cancer	0	0	0	0	0	0	0	0	0	0
Anaemia	3	6.7	10	15.4	0	0	2	6.7	15	9.4
Hypertension	4	8.9	4	6.2	1	5	0	0	9	5.6
Others	3	6.7	4	6.2	3	15	2	6.7	12	7.5
Hysterectomy	1	8.9	2	3.1	0	0	0	0	3	1.9

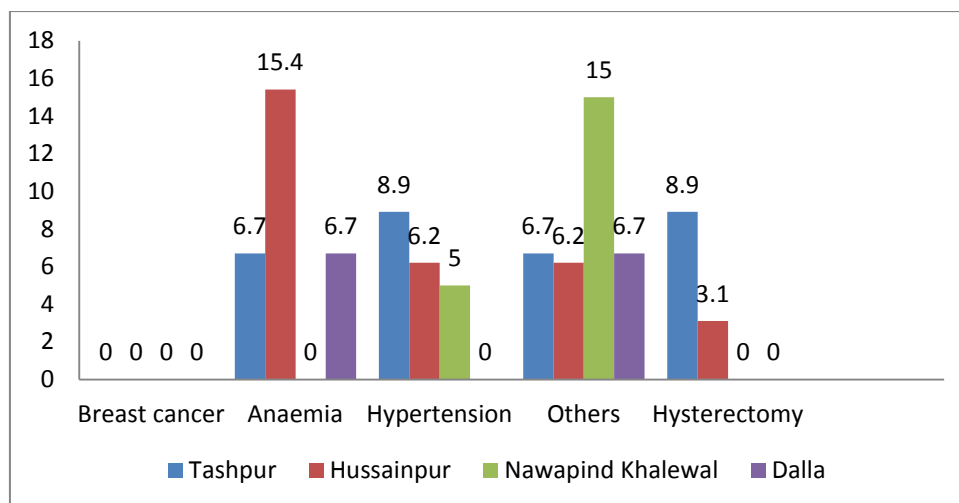


Figure 4.16: Distribution of Respondents as per General Medical Illness

Table 4.16 and Figure 4.16 present the data on general illness such as breast cancer, anaemia, hypertension and other problems in four villages. No case of breast cancer was found in four villages. Tashpur's respondents reported 6.7% of anaemia cases at present, 8.9% are suffering from hypertension, 6.7% of the population has other medical illnesses such as low B.P, headache and one respondent (8.9%) undergone a hysterectomy. In Hussainpur 15.4% are suffering from anaemia, 6.2% had reported hypertension, 6.2% has other medical illnesses and 3.1% of the population has undergone a hysterectomy. In Nawapind Khalewal no respondent is diagnosed with anaemia, 5% has hypertension and 15% of the population has other medical illnesses. In Dalla 6.7% women are suffering from has anaemia, 6.7% has other medical illnesses and no case is identified with hypertension and hysterectomy.

Table 4.17

Distribution of Respondents by Treatment Preference

Treatment preference	Tashpur	%	Hussainpur	%	Nawapind khalewal	%	Dalla	%	Total	%
Government hospital	4	26.7	9	27.3	3	25	13	68.4	29	36.7
Private hospital	8	53.3	14	42.4	2	16.7	3	15.8	27	34.2
RMP Doctor	3	20	10	30.3	7	58.3	3	15.8	23	29.1
Not consulted	0	0	0	0	0	0	0	0	0	0

Medicine preference										
Allopathy	45	100	61	93.8	19	95	29	96.7	154	96.2
Homeopathy	0	0	2	3.1	1	5	1	3.3	4	2.5
Ayurvedic	0	0	2	3.1	0	0	0	0	2	1.3
Others	0	0	0	0	0	0	0	0	0	0

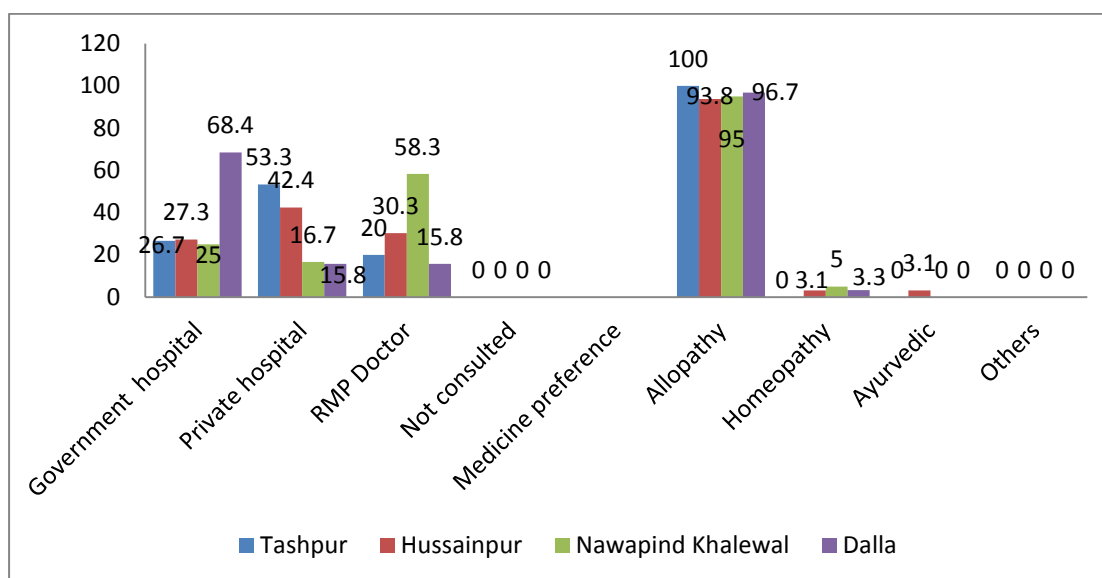


Figure 4.17: Distribution of Respondents by Treatment Preference

Table 4.17 and Figure 4.17 illustrate that, in terms of treatment preference, the majority of Tashpur (53.3%) and Hussainpur (42.4%) residents prefer private hospitals, while a significant proportion of Nawapind Khalewal (58.3%) prefers RMP doctors and Dalla (68.4%) respondents prefer government hospitals.

Regarding medicine preference, Allopathy is the most preferred in all villages, with 100% preference in Tashpur, 93.8% in Hussainpur, 95% in Nawapind Khalewal, and 96.7% in Dalla. Homeopathy has a minimal presence, with 3.1% preference in Hussainpur, 5% in Nawapind Khalewal and 3.3% in Dalla. Ayurvedic medicine is only preferred in Hussainpur (3.1%).

IDEAL CHILD BEARING AGE

Table 4.18

Distribution of Respondents based on their Child Bearing Age

Child Bearing Age	Tashpur (45)	%	Hussainpur (65)	%	Nawapind Khalewal (20)	%	Dalla (30)	%	Total	%
Below 20	3	6.6	3	4.6	1	5	1	3.3	8	5
20-24	26	57.8	29	44.6	14	70	20	66.7	89	55.6
25-29	12	26.7	26	40	5	25	7	23.4	50	31.3
30-34	4	8.9	7	10.8	0	0	1	3.3	12	7.5
35 and above	0	0	0	0	0	0	1	3.3	1	0.6

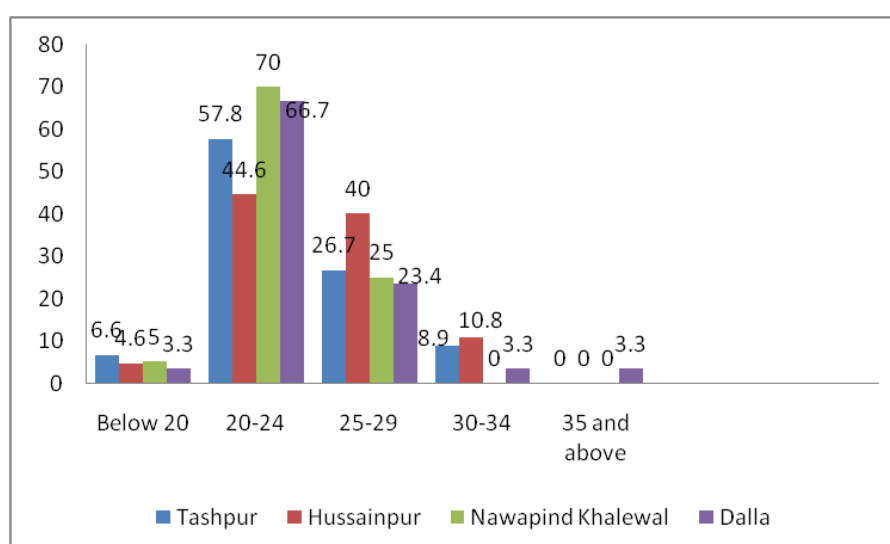


Figure 4.18: Distribution of Respondents based on their Child Bearing Age

Table 4.18 and Figure 4.18 represent the data for each village based on the percentage of childbearing age groups. In Tashpur, the majority of women fall in the 20-24 age group, accounting for 57.8%. It has a relatively young population of women who are likely to have children. Women aged 25-29 constitute 26.7%, followed by those aged 30-34 at 8.9%. The number of women below 20 years old is relatively low at 6.6%. There are no women aged 35 and above in the childbearing age group in Tashpur. In Hussainpur, the largest proportion of women falls within the 20-24 age group, making up 44.6% of the total childbearing population. The 25-29 age group

accounts for 40%, while the 30-34 age group represents 10.8%. There are also a few women below 20 years old (at 4.6%). Nawapind Khalewal has a similar distribution, with the highest percentage of women in the 20-24 age group (70%). The 25-29 age group constitutes 25%, a small percentage of women are below 20 years old (at 5%). Dalla has the highest percentage of women in the 20-24 age group, with only 66.7% falling into this category. The 25-29 age group accounts for 7%, a small number of women are below 20 years old and 35 and above (at 3.3% each).

ABORTION HISTORY

Abortion refers to the termination of pregnancy before the foetus is viable (capable of surviving outside the womb). It can be either spontaneous or induced (Moscrop, 2013).

Table 4.19

Distribution of Respondents based on their Abortion History

Village	Abortion History	%	No growth of foetus	%	Improper implantation	%
			Causes			
Tashpur	2	4.4	2	100	0	0
Hussainpur	1	1.5	0	0	1	100
Nawapind Khalewal	0	0	0	0	0	0
Dalla	0	0	0	0	0	0
Total	3	1.9	2	66.6	1	33.3

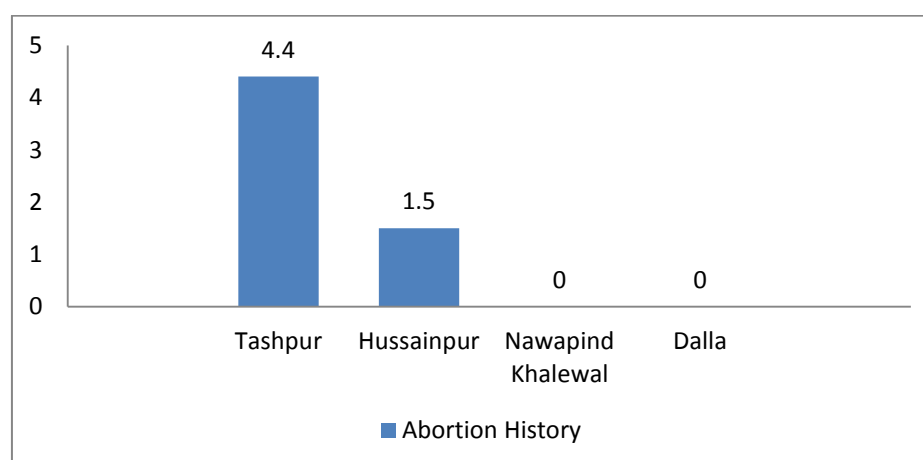


Figure 4.19: Distribution of Respondents based on their Abortion History

Table 4.19 and Figure 4.19 represents the abortion history of respondents in four villages: Tashpur, Hussainpur, Nawapind Khalewal, and Dalla. The causes are categorized into 'Abortion History', 'No growth of foetus', and 'Improper implantation'. The percentages indicate the proportion of each cause within each village.

In Tashpur, there were 2 cases of abortion accounting for 4.4% of the total cases. The cause was 'No growth of foetus' reported. In Hussainpur, there was 1 case of abortion due to improper implantation representing 1.5%. In Nawapind Khalewal and Dalla, there were no reported cases of abortion due to any of the listed causes.

MISCARRIAGE HISTORY

Miscarriage is a term used to describe the spontaneous loss of a pregnancy before the 20th week of gestation.

Table 4.20

Distribution of Respondents according to Miscarriage Status

Village	Miscarriage History	%	Habitual/hormonal imbalance	%	Weak uterus		Ovulation Disorder	%	infection	%
Causes										
Tashpur	3	6.6	1	33.3	0	0	0	0	2	66.7
Hussainpur	6	9.2	2	33.3	3	50	1	16.7	0	0
Nawapind Khalewal	1	5	1	100	0	0	0	0	0	0
Dalla	0	0	0	0	0	0	0	0	0	0
Total	10	6.3	4	40	3	30	1	10	2	20

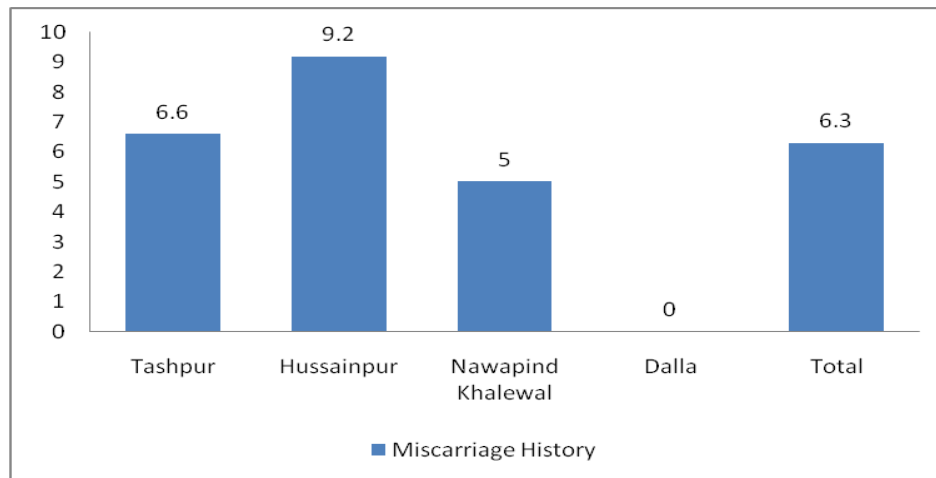


Figure 4.20: Distribution of Respondents according to Miscarriage History

The data provided in Table 4.20 and Figure 4.20 represents the history of miscarriages among respondents from four villages. In Tashpur, there were 3 cases of miscarriage accounting for 6.6% and 1 (33.3%) case is due to hormonal imbalance. However, 'Infection' was reported in 2 cases, accounting for 66.7%.

In Hussainpur, there were 6 respondents have miscarriage history, representing 9.2% of the total cases. Habitual/ hormonal imbalance cause was reported in 2 cases, making up 33.3%. Weak uterus was reported in 3 cases, accounting for 50%. Ovulation disorder was reported in 1 case, making up 16.7%.

In Nawapind Khalewal, there was 1 case of miscarriage due habitual/ hormonal imbalance to, representing 5%.

In Dalla, there were no reported cases of miscarriage.

PAST ANTENATAL PROFILE

Table 4.21

Distribution of Respondents based on their Antenatal Care

Antenatal Care	Tashpur (45)	%	Hussainpur (65)	%	Nawapind Khalewal (20)	%	Dalla (30)	%	Total	%
Pregnancy registered										
Yes	45	100	65	100	20	100	30	100	160	100
No	0	0	0	0	0	0	0	0	0	0

1st Antenatal Checkup										
1 st 3 month	44	97.8	63	96.9	20	100	30	100	157	98.1
4 th -6 th month	1	2.2	2	3.1	0	0	0	0	3	1.9
7 th -9 th month	0	0	0	0	0	0	0	0	0	0
At least one Antenatal Check-up										
Yes	45	100	65	100	20	100	30	100	160	100
No	0	0	0	0	0	0	0	0	0	0
Place of check-up										
Government Hospital	17	37.8	24	36.9	9	45.0	21	70.0	71	44.4
Private Hospital	28	62.2	41	63.1	11	55.0	9	30.0	89	55.6

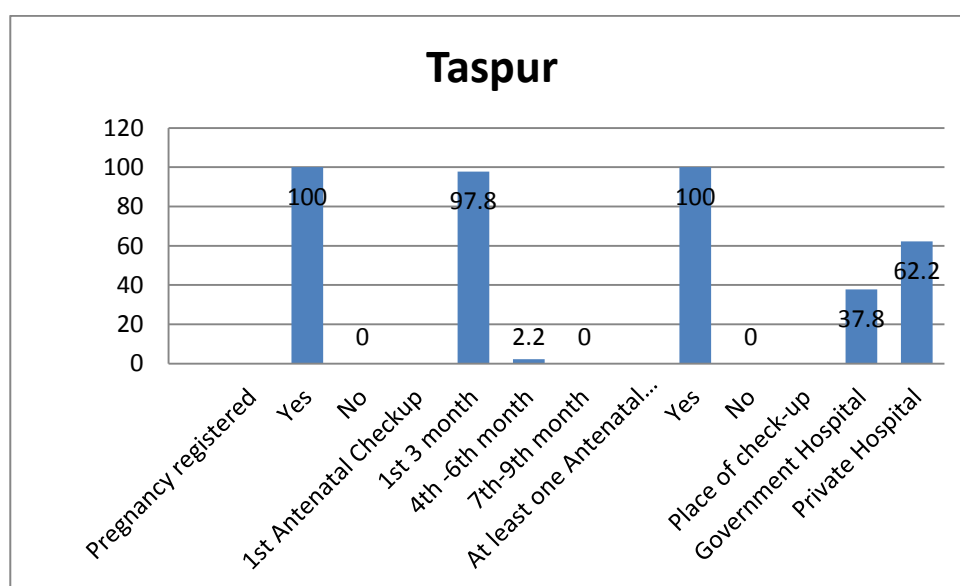


Figure 4.21.1: Distribution of Respondents based on their Antenatal Care in Village Tasapur

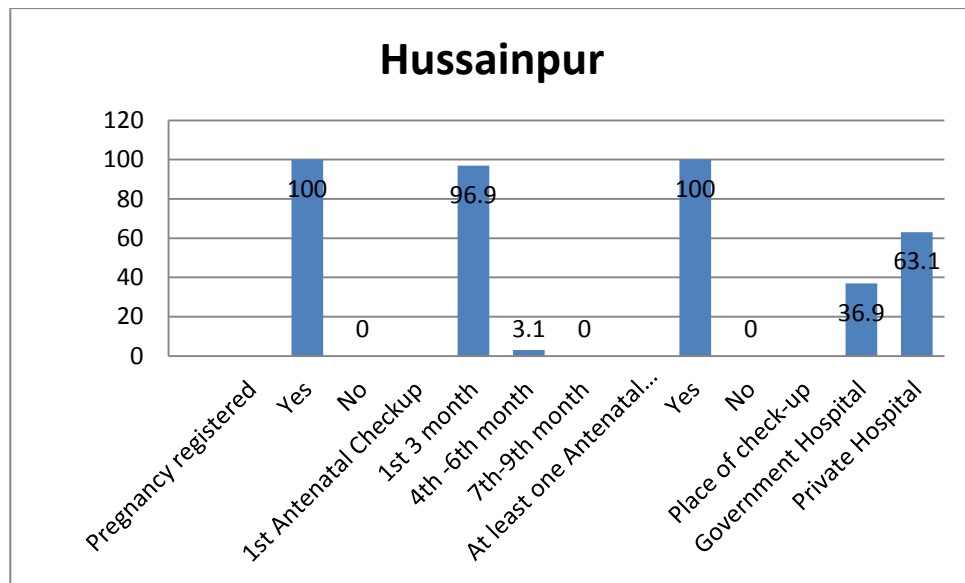


Figure 4.21.2: Distribution of Respondents based on their Antenatal Care in Village Hussainpur

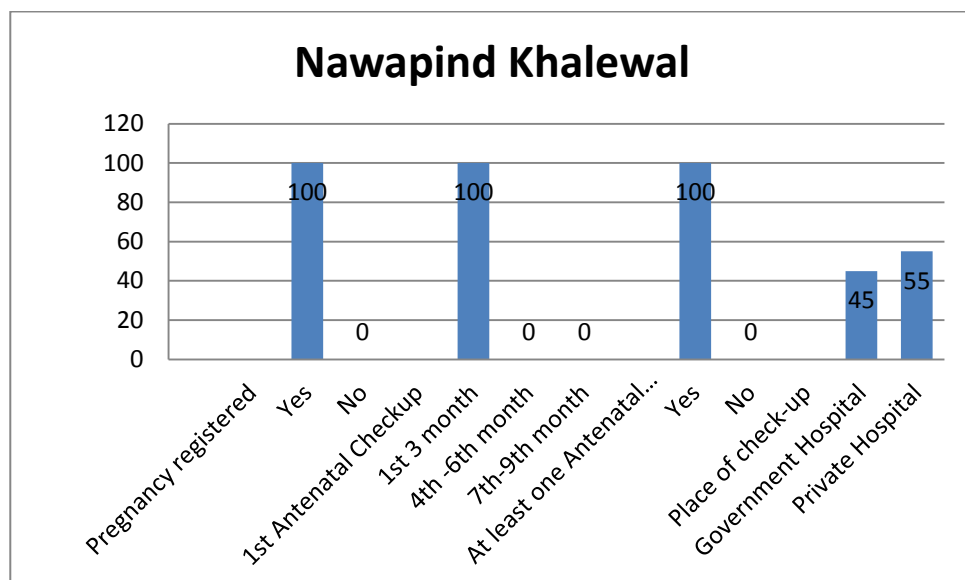


Figure 4.21.3: Distribution of Respondents based on their Antenatal Care in Village Nawapind Khalewal

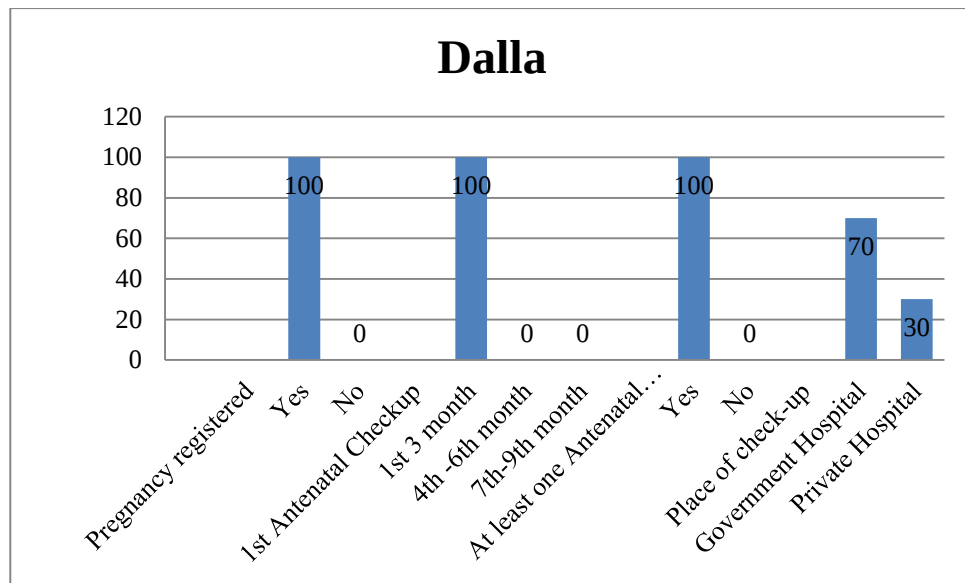


Figure 4.21.4: Distribution of Respondents based on their Antenatal Care in Village Dalla

The data provided in Table 4.21 and Figure 4.21.1 to 4.21.4 presents the antenatal care practices in four villages. In terms of pregnancy registration, all pregnancies were registered in all four villages, indicating a 100% registration rate across the board. Regarding the timing of the first antenatal checkup, the majority of pregnant women in all villages had their first checkup within the first three months of pregnancy. 97.8% in Tashpur, 96.9% in Hussainpur, and 100% in both villages Nawapind Khalewal and Dalla. A small percentage had their first checkup between the fourth to sixth months of pregnancy, specifically 2.2% in Tashpur and 3.1% in Hussainpur. No women had their first checkup in the 7-9 months of pregnancy in any of the villages. At least one check-up is completed by all respondents in antenatal period.

As for the place of check-up, private hospitals were the most preferred in Tashpur (62.2%), Hussainpur (63.1%), and Nawapind Khalewal (55.0%). In contrast, the majority of Dalla residents (70.0%) preferred government hospitals for their check-ups. Overall, private hospitals were slightly more preferred (55.6%) than government hospitals (44.4%).

Table 4.22**Distribution of Respondents based on their Follow-Up Health Checkups During Pregnancy**

Follow-Up	Tashpur (45)	%	Hussainpur (65)	%	Nawapind Khalewal (20)	%	Dalla (30)	%	Total	%
No of checkups										
At least 4 checkup	14	31.1	24	36.9	12	60.0	11	36.7	61	38.1
Less than 4 checkup	10	22.2	5	7.7	4	20.0	11	36.7	30	18.8
More than 4 checkup	21	46.7	36	55.4	4	20.0	8	26.6	69	43.1
Tetanus Toxoid immunization										
TT-I	45	100	65	100	20	100	30	100	160	100
TT-II	45	100	65	100	20	100	30	100	160	100
Folic Acid consumption										
Yes	41	91.1	58	89.2	18	90.0	28	93.3	145	90.7
No	4	8.9	7	10.8	2	10.0	2	6.7	15	3.3
If no..										
Not digested	3	75.0	7	100	2	100	1	50.0	13	86.7
Lack of knowledge	1	25.0	0	0	0	0	1	50.0	2	13.3

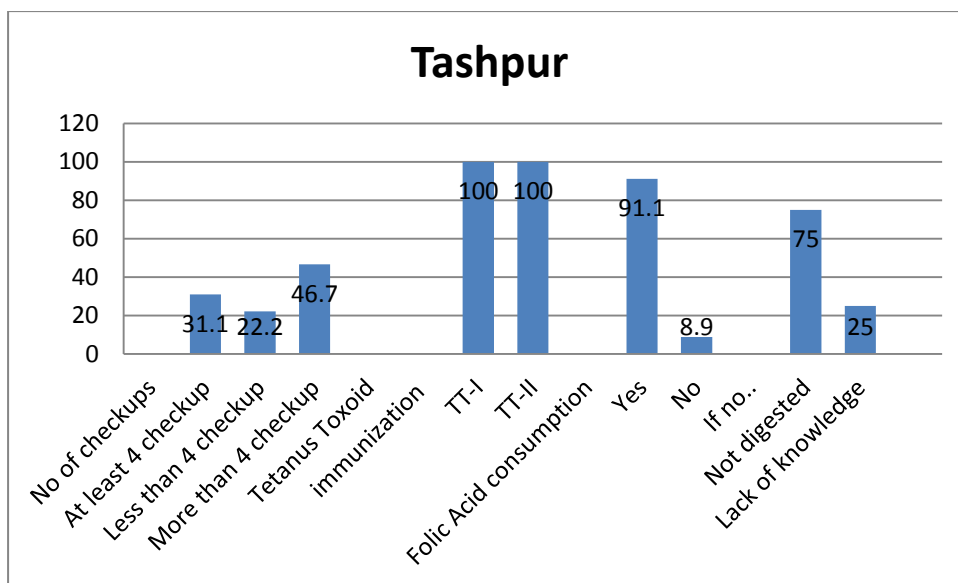


Figure 4.22.1 Distribution of Respondents based on their Follow-Up Health Checkups During Pregnancy in Tashpur Village

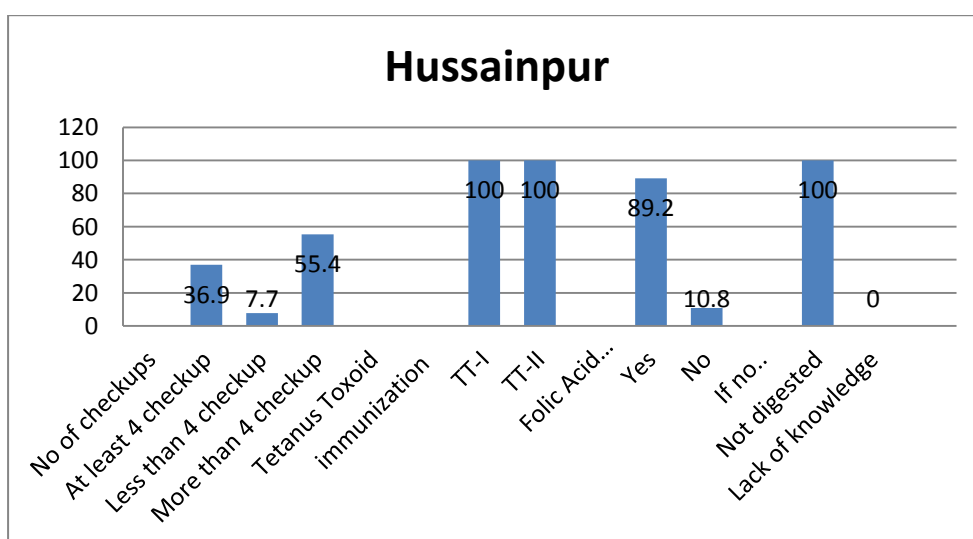


Figure 4.22.2 Distribution of Respondents based on their Follow-Up Health Checkups During Pregnancy in Hussainpur Village

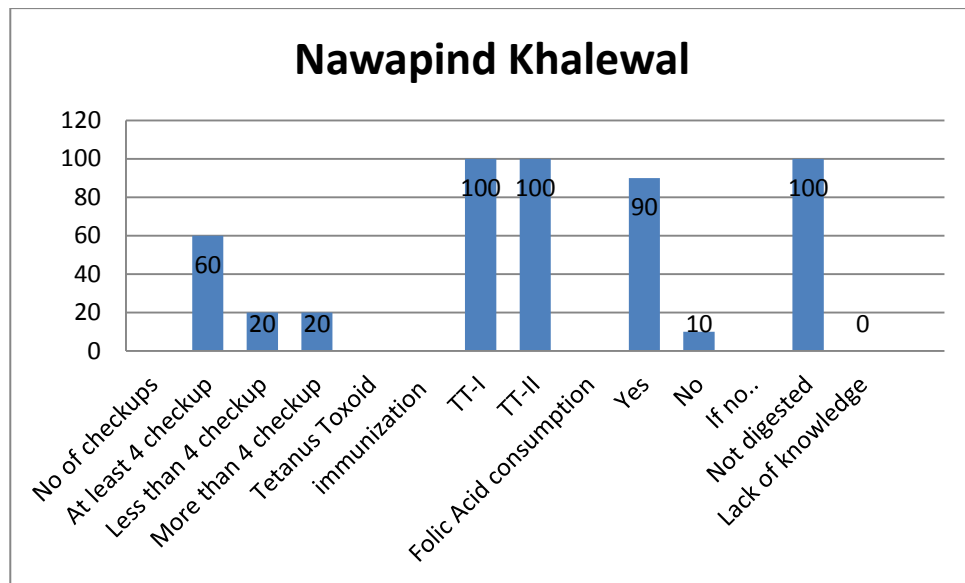


Figure 4.22.3 Distribution of Respondents based on their Follow-Up Health Checkups During Pregnancy in NawapindKhalewal Village

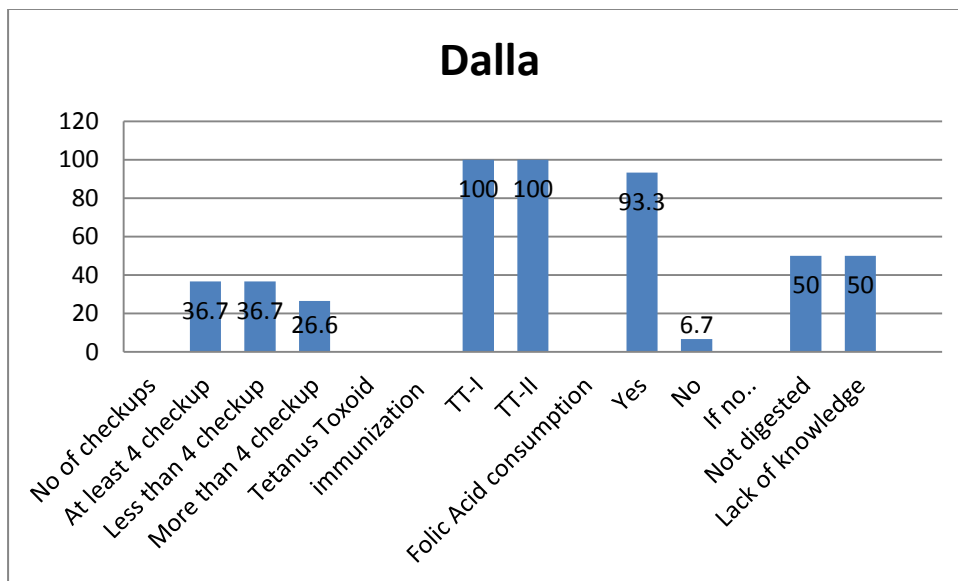
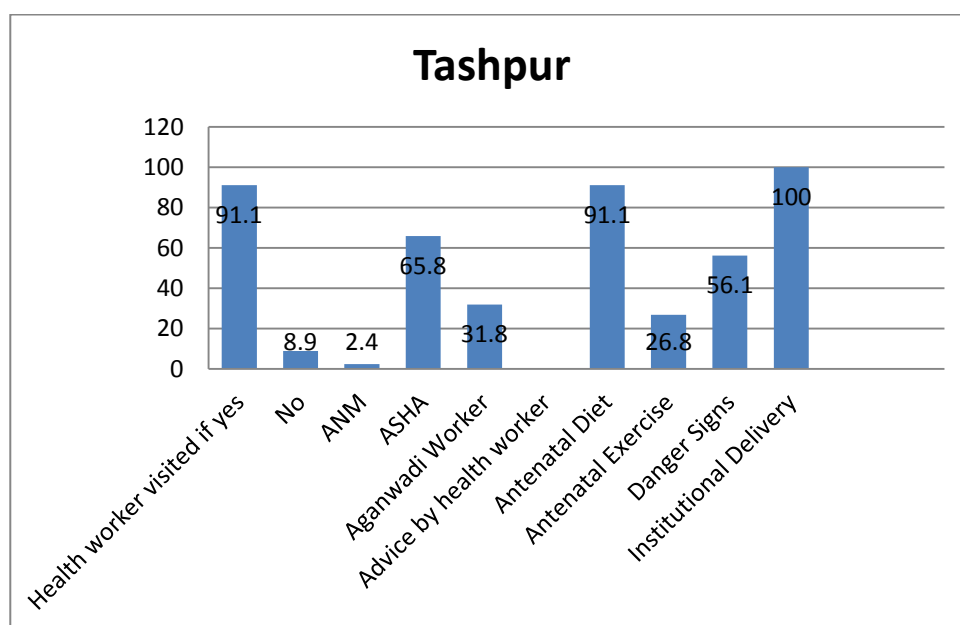


Figure 4.22.4 Distribution of Respondents based on their Follow-Up Health Checkups During Pregnancy in Dalla Village

Table 4.23**Distribution of Respondents based on Health Worker Visits**

Health worker visited	Tashpur	%	Hussainpur	%	Nawapind khalewal	%	Dalla	%	Total	%
Yes	41	91.1	58	89.2	20	100	30	100	149	93.1
No	4	8.9	7	10.8	0	0	0	0	11	6.9
If yes...										
ANM	1	2.4	1	1.7	0	0	0	0	2	1.3
ASHA	27	65.8	33	56.9	8	40.0	14	46.7	82	55.1
Aganwadi Worker	13	31.8	24	41.4	12	60.0	16	53.3	65	43.6
Advice by health worker										
Antenatal Diet	41	91.1	58	89.2	20	100	30	100	149	93.12
Antenatal Exercise	11	26.8	23	39.7	7	35.0	13	43.3	54	33.75
Danger Signs	23	56.1	27	46.6	13	65.0	17	56.7	80	50.0
Institutional Delivery	45	100	65	100	20	100	30	100	160	100

**Figure 4.23.1: Distribution of Respondents based on Health Worker Visits in Village Tashpur**

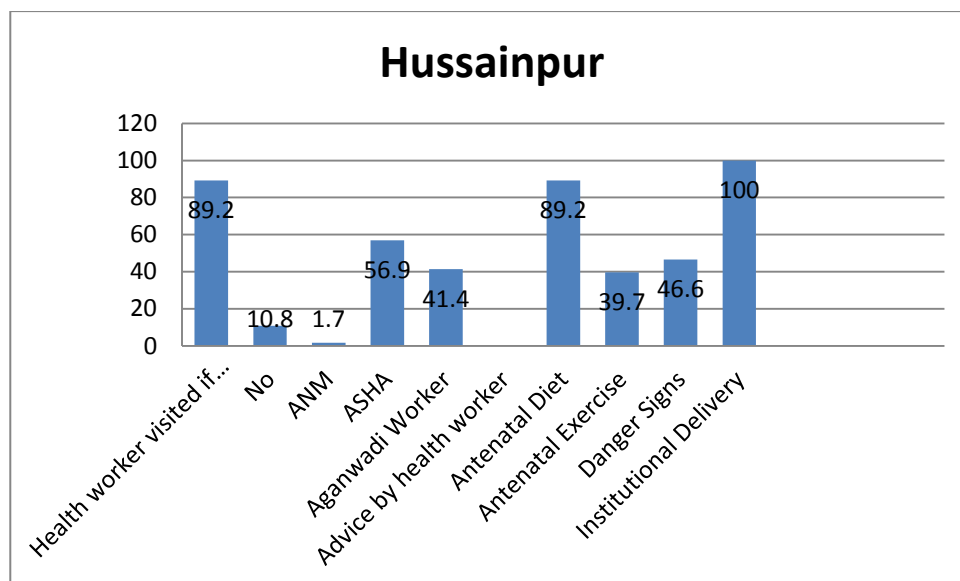


Figure 4.23.2: Distribution of Respondents based on Health Worker Visits in Village Hussainpur

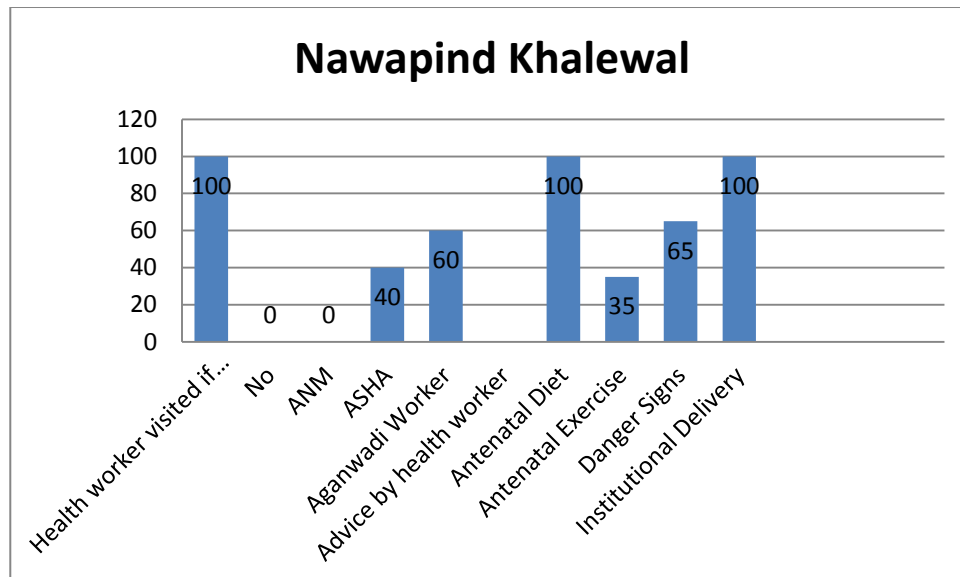


Figure 4.23.3: Distribution of Respondents based on Health Worker Visits in Village Nawapind Khalewal

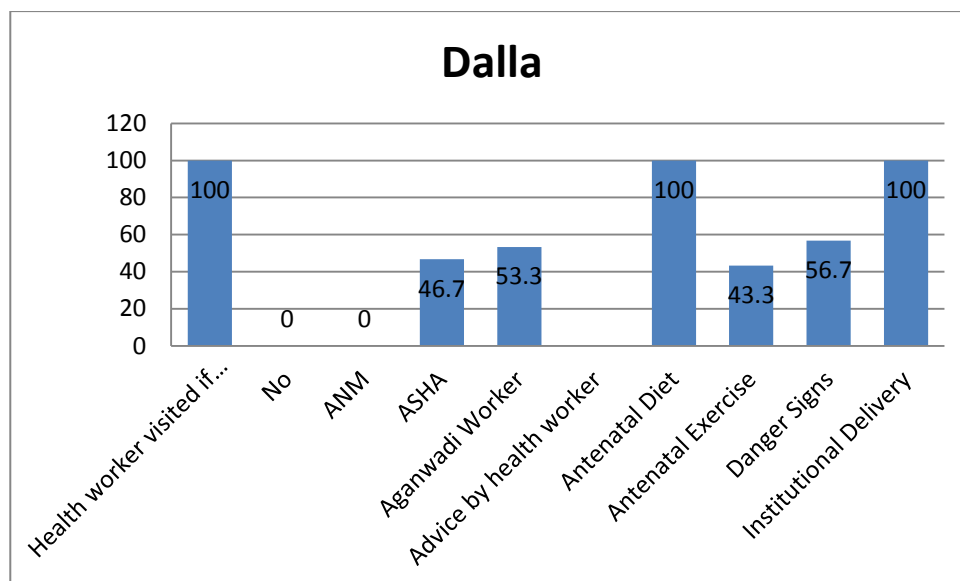


Figure 4.23.4: Distribution of Respondents based on Health Worker Visits in Village Dalla

The data in Table 4.23 and Figure 4.23.1 to 4.23.4 provides insights into the visits by health workers and the advice given during these visits in four villages. High percentage of visits were recorded in all villages, with Tashpur at 91.1%, Hussainpur at 89.2%, and both Nawapind Khalewal and Dalla at 100%. ASHA workers were the most common in Tashpur (65.8%) and Hussainpur (56.9%), while Aganwadi Workers were more common in Nawapind Khalewal (60.0%) and Dalla (53.3%). ANM workers had the least presence in all villages. Regarding the advice given by health workers, advice on antenatal diet was given in all visits across all villages, indicating a 91.1% and 89.2% in Tashpur and Hussainpur respectively, 100% in both in both villages – Nawapind Khalewal and Dalla. Advice on recognizing danger signs was given in 56.1% of visits in Tashpur, 46.6% in Hussainpur, 65.0% in Nawapind Khalewal, and 56.7% in Dalla. Antenatal exercise advice was less common, given in 26.8% of visits in Tashpur, 39.7% in Hussainpur, 35.0% in Nawapind Khalewal, and 43.3% in Dalla. All villages reported a 100% rate for advice on institutional delivery, indicating a strong emphasis on this aspect across all villages.

Table 4.24**Distribution of Respondents based on Problems related to Pregnancy**

Pregnancy Problems	Tashpur (45)	%	Hussainpur (65)	%	Nawapind Khalewal (20)	%	Dalla	%	Total	%
Swelling on hands and feets	1	2.2	12	18.5	1	5.0	0	0	14	8.8
Anaemia	2	4.4	12	18.5	2	10.0	2	6.7	18	11.2
Visual disturbance	0	0	8	12.3	4	20.0	5	16.7	17	10.6
Excessive bleeding	0	0	0	0	0	0	0	0	0	0
Hypertension	5	11.1	9	13.8	1	5.0	4	13.3	19	11.9
Convulsions	0	0	0	0	0	0	0	0	0	0
Weak movement of foetus	1	2.2	2	3.1	0	0	1	3.3	4	2.5
Others- vomiting/ dizziness/hypotension/backache	23	51.1	28	43.1	9	45.0	20	66.7	80	50.0
Place of check-up										
Government Hospital	9	20.0	10	15.4	2	10.0	7	23.3	28	29.5
Private Hospital	17	40.0	28	44.6	9	45.0	13	43.3	67	70.5

Table 4.24 and Figure 4.24.1 to 4.24.4 presents the various Problems in Pregnancy in four villages. Tashpur, exhibited varying health problems during past pregnancy. 2.2% reported swelling on their hands and feet, while 4.4% were affected by anaemia. No case of visual disturbance was reported. Hypertension affected 11.1% of the respondents, and 2.2% observed weak fetal movements. The most common symptoms included vomiting, dizziness, hypotension, and backache, reported by 51.1% of women. In terms of healthcare seeking behaviour, 20% visited government hospitals, while 40% preferred private hospitals.

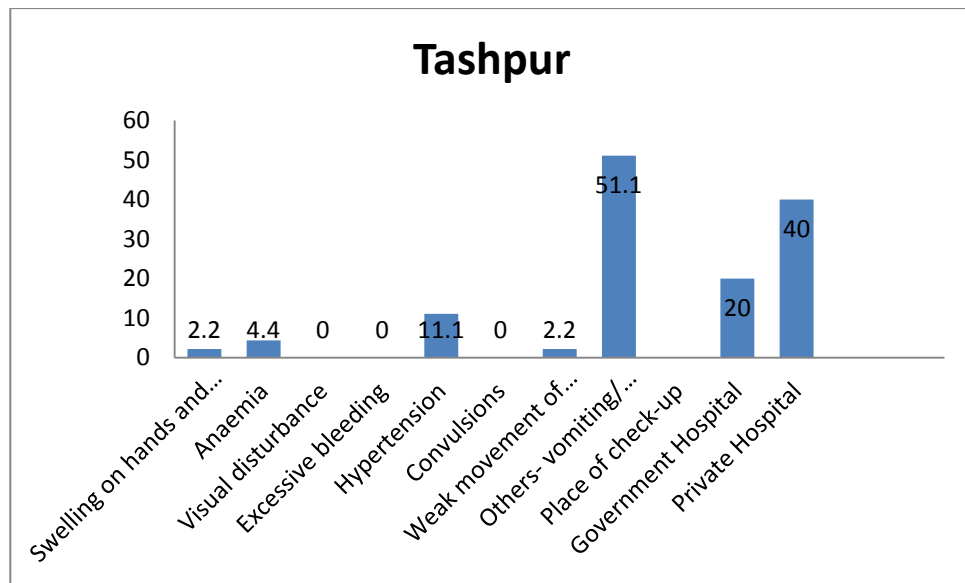


Figure 4.24.1: Distribution of Respondents based on Problems related to Pregnancy in Village Tashpur

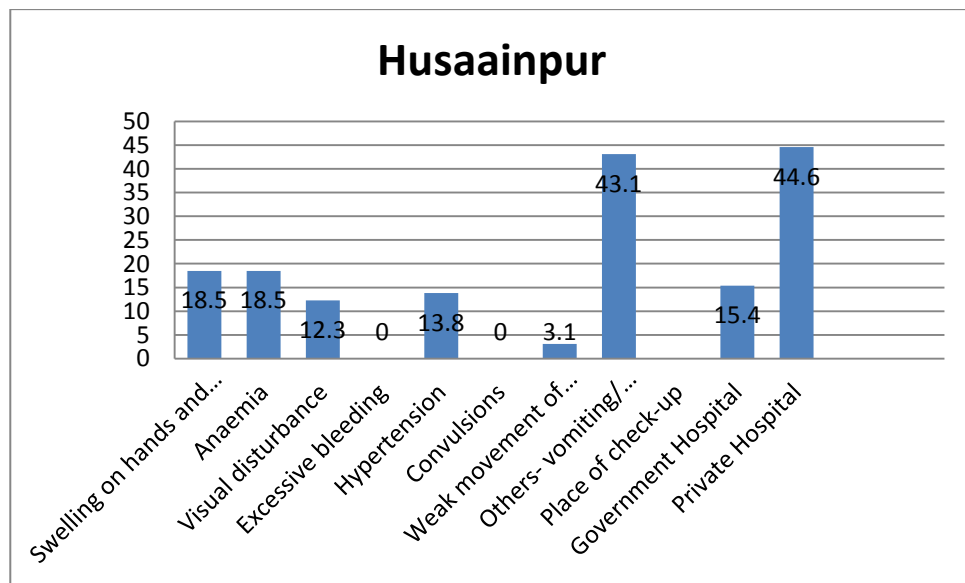


Figure 4.24.2: Distribution of Respondents based on Problems related to Pregnancy in Village Hussainpur

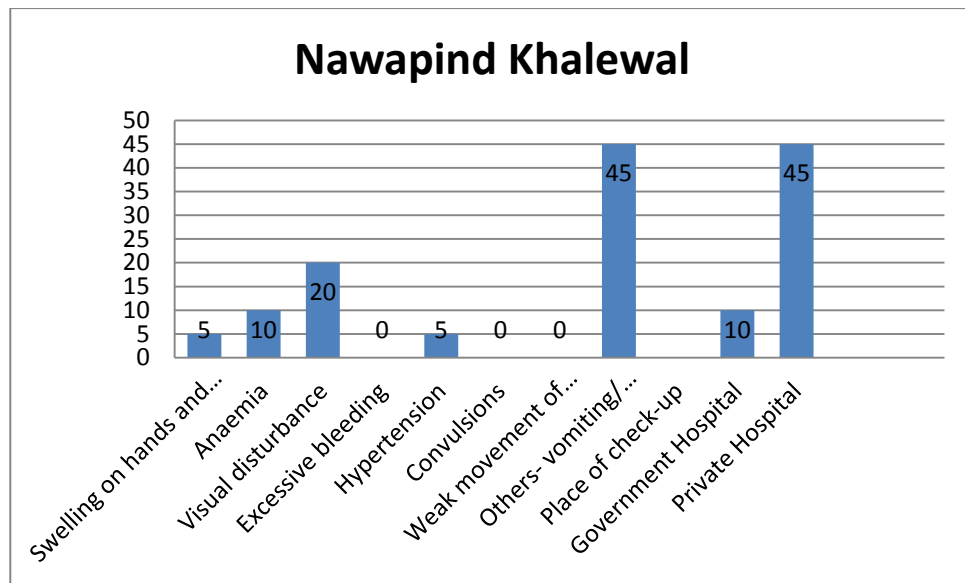


Figure 4.24.3: Distribution of Respondents based on Problems related to Pregnancy in Village Nawapind Khalewal

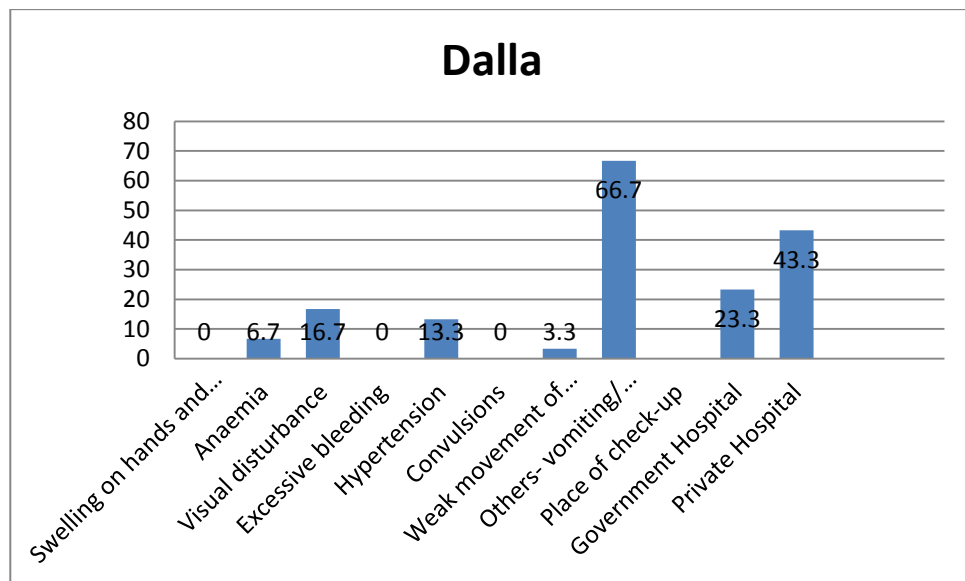


Figure 4.24.4: Distribution of Respondents based on Problems related to Pregnancy in Village Dalla

In Hussainpur, similar patterns emerged. 18.5% of pregnant individuals have a history of swelling on hands and feet and anaemia, while 12.3% experienced visual disturbances. Hypertension was observed in 13.8% of cases. Weak fetal movement was reported by 3.1% of individuals. The majority (43.1%) suffered from other

symptoms such as vomiting, dizziness, and backache. Notably, 44.6% and 15.4% of pregnant individuals in Hussainpur have chosen private and government hospitals for antenatal care.

Nawapind Khalewal displayed its unique health profile. 5% women have a history of swelling on hand and feet, anaemia affected 10% of pregnant individuals, while 20% reported visual disturbances. Hypertension was observed in 5% of cases. No cases of excessive bleeding or convulsions were reported. The most common symptoms were vomiting, dizziness, and hypotension (45%). Private hospitals were the preferred choice for 45% of pregnant individuals in this village.

Dalla, showed diverse health outcomes. 6.7% and 16.7%, 3.3% have a history of anaemia visual disturbance and weak movement of foetus respectively. Hypertension affected 13.3% of pregnant individuals. Other symptoms (vomiting, dizziness, hypotension, and backache) were reported by 66.7% of the respondents. Notably, no cases of excessive bleeding or convulsions were recorded. In terms of healthcare facilities, 43.3% chosen private hospitals and 23.3% preferred government hospitals.

Table 4.25

Distribution of Respondents based on Delivery Care

Delivery care	Tashpur (45)	%	Hussainpur (65)	%	Nawapind Khalewal (20)	%	Dalla (30)	%	Total (160)	%
Delivery conducted by										
Doctor	38	84.5	59	90.8	18	90.0	24	80.0	139	86.9
Nurse	5	11.1	3	4.6	2	10.0	4	13.3	14	8.7
Dai	2	4.4	3	4.6	0	0	2	6.7	7	4.4
Place Of Delivery										
Government Hospital	9	20	16	24.6	6	30.0	11	36.7	42	26.2
Private Hospital	30	66.7	45	69.2	13	65.0	15	50.0	103	64.4
Nursing Clinic	1	2.2	1	1.6	0	0	0	0	2	1.3
Home	5	11.1	3	4.6	1	5.0	4	13.3	13	8.1
Mode Of										

Delivery										
Normal	16	35.6	21	32.3	9	45.0	10	33.3	56	35.0
Episiotomy	11	24.4	13	20.0	3	15.0	9	30.0	36	22.5
Caesarean section	18	40.0	31	47.7	8	40.0	11	36.7	68	42.5

Case Study: 2

Sudden Cease of Labour Pain Leading to Emergency Cesarean Section

Mrs. XYZ, a 28-year-old arrived at the hospital on her expected date of delivery. She was well-educated, holding a graduate degree, and her husband worked as a mason, indicating a good socioeconomic status. The patient experienced the onset of labor pain one day before her expected delivery date, prompting her to seek medical assistance at the hospital. Upon arrival at the hospital, she started experiencing intense labor pains, indicating the progression towards a normal delivery. The healthcare team initially considered the possibility of a vaginal delivery. However, the situation took a sudden turn when the labor pain abruptly stopped, and lower fetal heart sounds were detected during monitoring. Doctor told there is the risk to the fetus, the medical team decided to perform an emergency cesarean section to ensure the safety of both the mother and the baby. The sudden cessation of labor pain and the deterioration in fetal heart sounds indicate to this immediate intervention to prevent any potential complications. The patient was taken to the operating room, where the cesarean section was performed successfully. Despite the unexpected turn of events, both mother and baby were delivered safely, and post-operative care was provided to ensure their well-being. The timely action taken by the healthcare team in response to the sudden change in the patient's condition highlights the importance of timely interventions in obstetric emergencies.

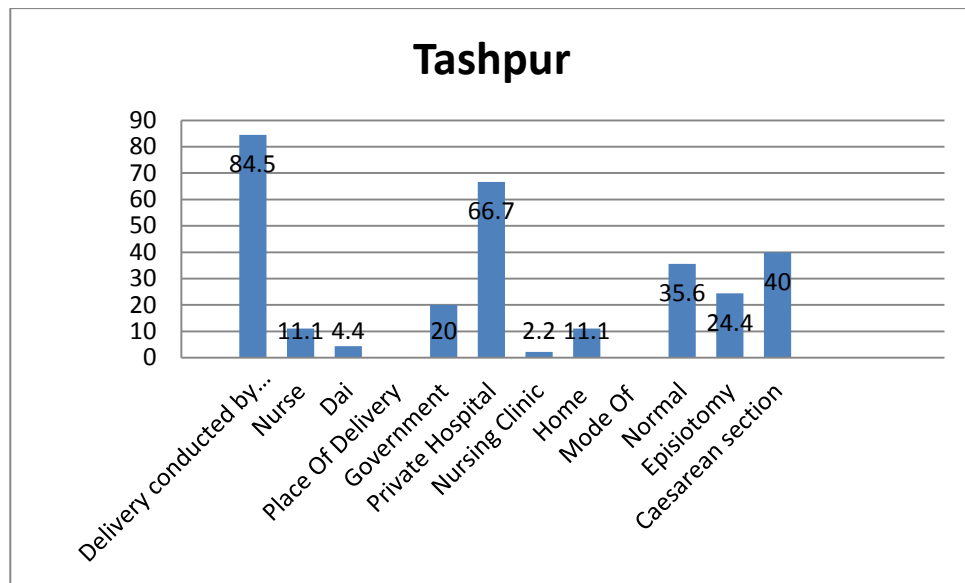


Figure 4.25.1: Distribution of Respondents based on Delivery Care in Tashpur Village

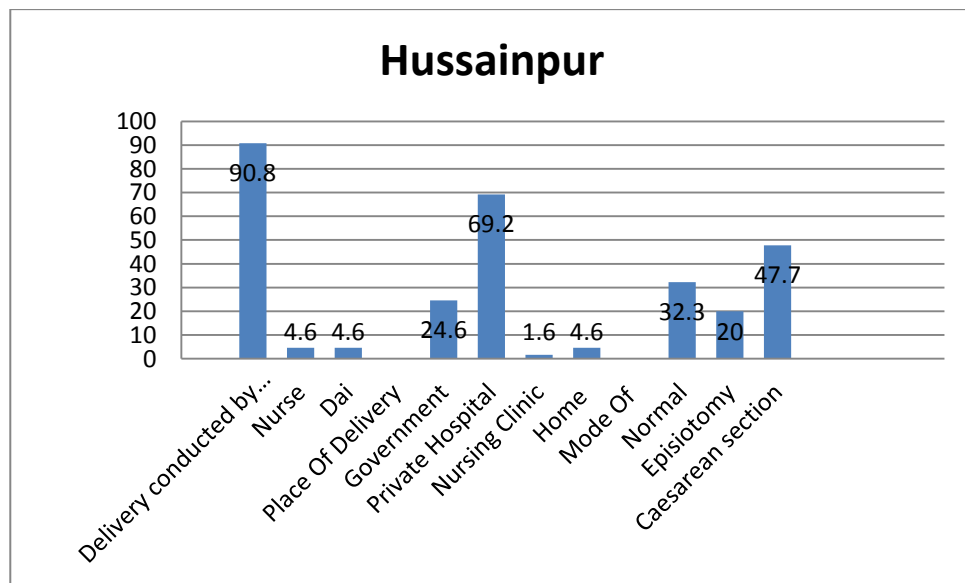


Figure 4.25.2: Distribution of Respondents based on Delivery Care in Hussainpur Village

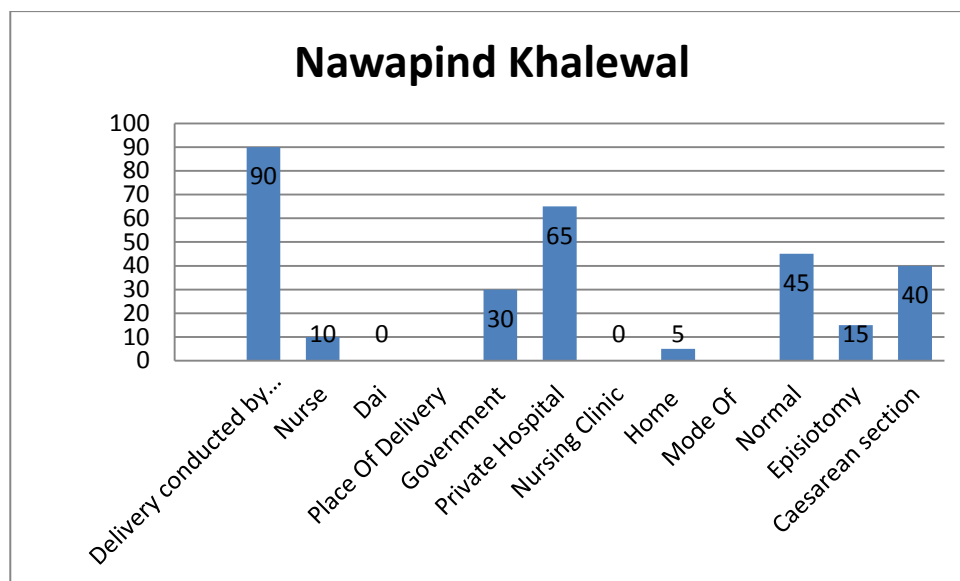


Figure 4.25.3: Distribution of Respondents based on Delivery Care in Nawapind Khalewal Village

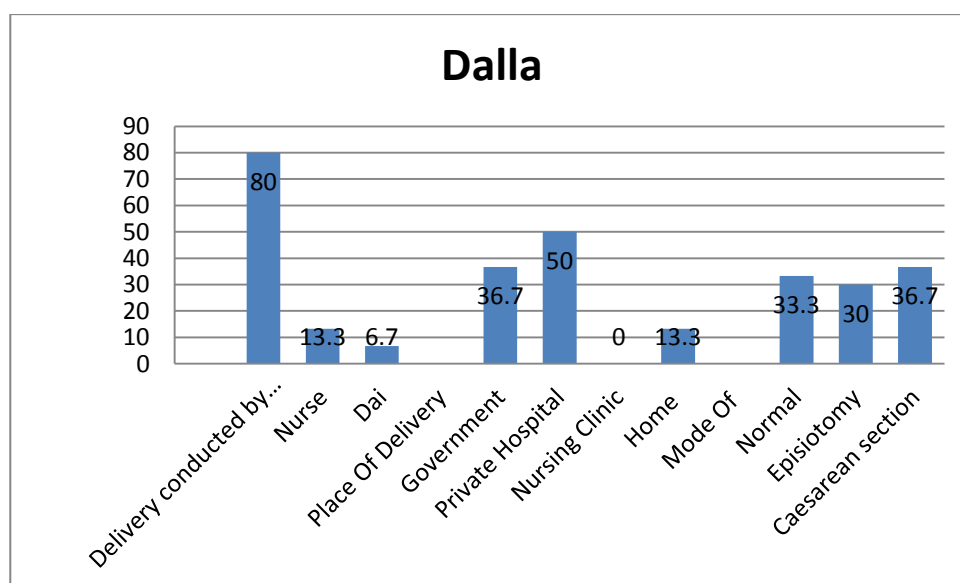


Figure 4.25.4: Distribution of Respondents based on Delivery Care in Dalla Village

InTable4.25 and Figure 4.25.1 to 4.25.4 represents the delivery care in all four villages. InTashpur, delivery care was mostly conducted by doctors, accounting for 84.5% of cases. Nurses assisted in 11.1% of deliveries, while traditional birth attendants (dais) were involved in 4.4% of cases. 20% of respondents delivered in

government hospitals, while a majority (66.7%) preferred private hospitals for their delivery. A small percentage (2.2%) utilized nursing clinics, and 11.1% preferred home deliveries. The mode of delivery varied. 35.6% were normal deliveries, 24.4% involved episiotomies, and 40% were caesarean sections.

In Hussainpur, 90.8% of deliveries were performed by doctors. Nurses played a minor role (4.6%), and dais were involved in 4.6% of cases. Private hospitals were the preferred choice (69.2%), while government hospitals accounted for 24.6%, 1.6 % for nursing clinics and 4.6% for home. Normal deliveries 32.3%, Episiotomies were performed in 20% of deliveries, and caesarean sections constituted 47.7%.

Nawapind Khalewal followed a similar pattern. Doctors managed 90% of deliveries, while nurses were involved in 10% of cases. Private hospitals remained popular (65%), and government hospitals accounted for 30% and 5% deliveries conducted at home . 45% deliveries conducted by normal labor procedure. Episiotomies were performed in 15% of cases, and caesarean sections were chosen by 40%.

Dalla exhibited comparable trends. Doctors conducted 80% of deliveries, nurses assisted in 13.3%, and dais were involved in 6.7% of cases. Private hospitals were the preferred choice for the delivery (50%), while government hospitals constituted 36.7% and home 13.3%. Normal deliveries comprised 33.3%, episiotomies 30%, and caesarean sections 36.7%.

Table 4.26

Distribution of Respondents based on the Baby Born Status

Baby Born status	Tashpur (45)	%	Hussainpur (65)	%	Nawapind Khalewal (20)	%	Dalla (30)	%	Total	%
Live	45	100	65	100	20	100	30	100	160	100
Dead History	0	0	1	1.5	2	10.0	1	3.3	4	2.5
Dead cause										
High fever	0	0	1	1.5	0	0	0	0	1	0.6
Lungs infection	0	0	0	0	1	5.0	0	0	1	0.6
Lungs dysfunction	0	0	0	0	1	5.0	0	0	1	0.6
Heart dysfunction	0	0	0	0	0	0	1	3.3	1	0.6

Still Birth	1	2.2	3	4.6	0	0	2	6.7	5	3.1
Causes of still birth										
Breathing problem	1	2.2	0	0	0	0	0	0	1	0.6
Late approach to hospital	0	0	1	1.5	0	0	0	0	1	0.6
Accidental injury to mother	0	0	1	1.5	0	0	0	0	1	0.6
Obstructed labour	0	0	1	1.5	0	0	0	0	1	0.6
Placental dysfunction	0	0	0	0	0	0	1	3.3	1	0.6
Prolonged labour	0	0	0	0	0	0	1	3.3	1	0.6

Case Study: 3

Overcoming Barriers (Ovulation Disorder) to Successful Pregnancy through In Vitro Fertilization (IVF)

XYZ, a 36-year-old respondent and her husband age is 38year and got married when she was 23 years old.

Medical History:

The patient has a history of an unspecified ovulation disorder, which has been a significant factor in her reproductive health. She experienced her first pregnancy at the age of 26, followed by two more pregnancies at the ages of 27 and 29, respectively. Unfortunately, all three pregnancies resulted in miscarriages, likely due to complications associated with the ovulation disorder.

Intervention :

After the recurrent pregnancy losses, the couple sought medical advice and go for In Vitro Fertilization (IVF) treatment. The IVF procedure was undertaken when the patient was 32 years old. The IVF treatment proved successful, and the patient was able to carry the pregnancy to term, overcoming the previous barriers to a successful pregnancy outcome.

This case highlights the complexities of reproductive health issues and the impact of medical interventions such as IVF in providing solutions for couples facing fertility

challenges.Despite the challenges faced by her health condition and the initial unsuccessful pregnancies, the patient's determination and the availability of advanced medical treatments like IVF have led to a positive outcome.

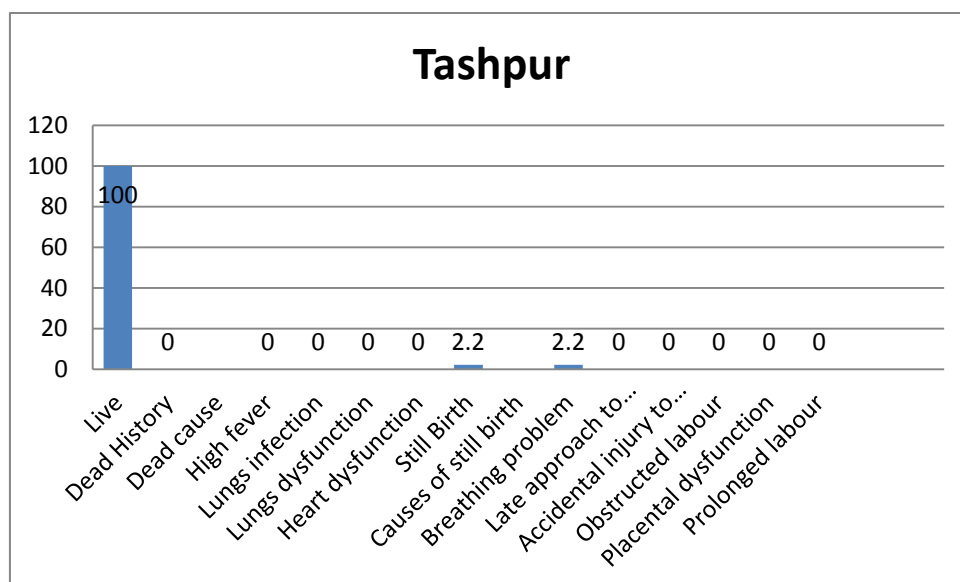


Figure 4.26.1: Distribution of Respondents based on the Baby Born Status in Village Tashpur

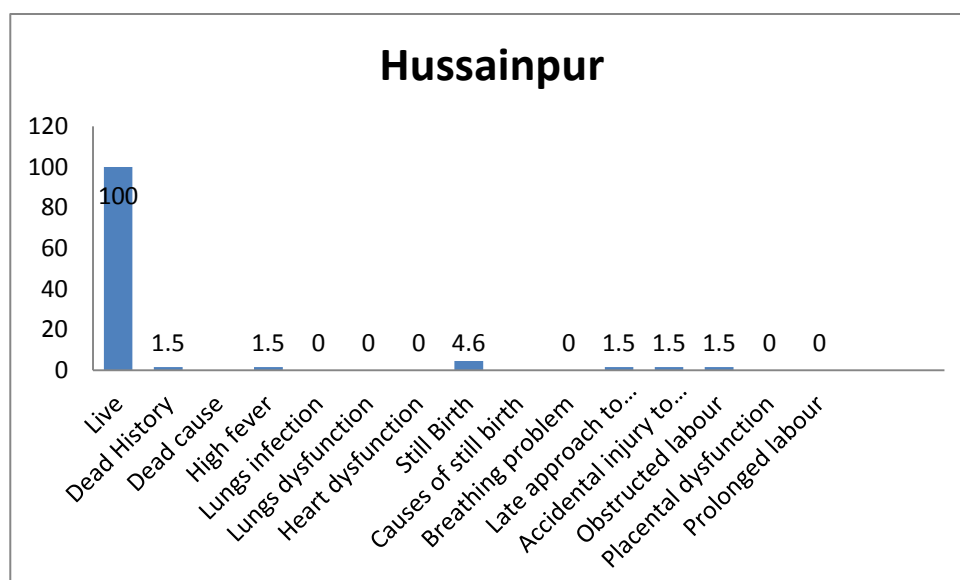


Figure 4.26.2: Distribution of Respondents based on Baby Born Status in Village Hussainpur

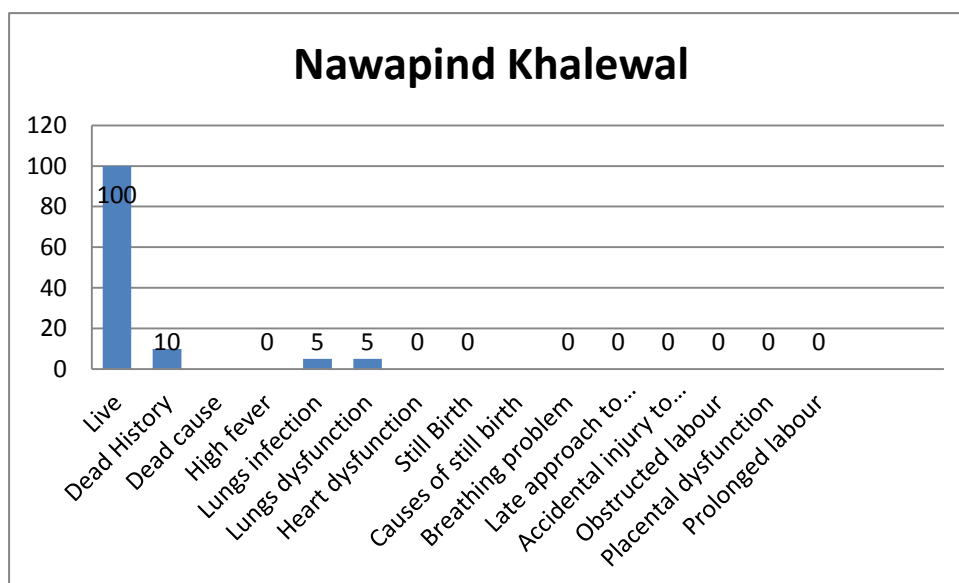


Figure 4.26.3: Distribution of Respondents based on Baby Born Status in Village Nawapind Khalewal

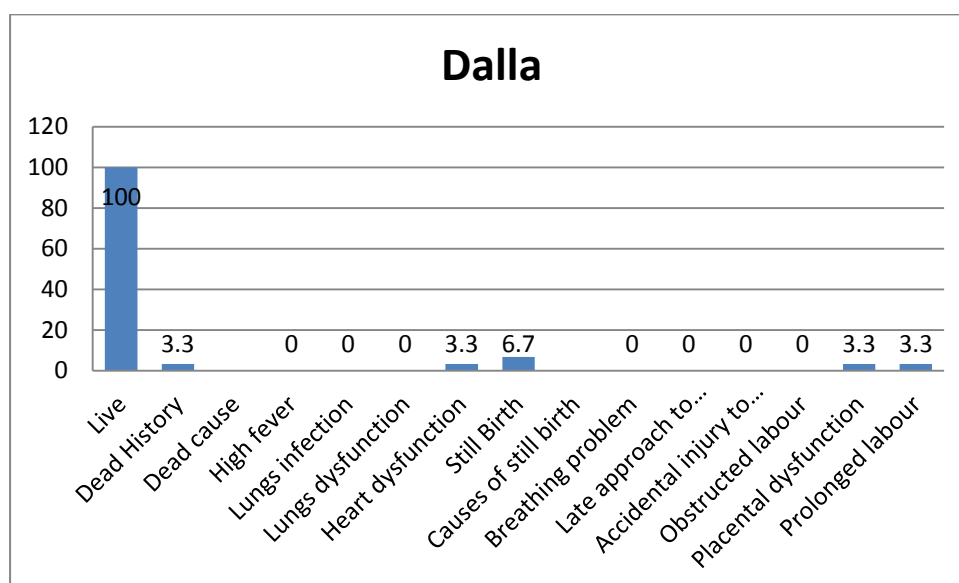


Figure 4.26.4: Distribution of Respondents based on Baby Born Status in Village Dalla

Table 4.26 and Figure 4.26.1 to 4.26.4 represents the baby born status in four villages. In Tashpur reported a total of 45 live births, constituting 100% of births in the village. There were no recorded deaths in Tashpur during the specified period.

In Hussainpur witnessed 65 live births, representing 100% of births in the village. Among the deceased, there was 1 case (1.5% of total births). The cause of death in this case was attributed to high fever.

In Nawapind Khalewal had 20 live births, accounting for 100% of births in the village. Two deaths (10.0% of total births) were reported. One death was due to lungs infection, and the other was attributed to lungs dysfunction.

Dalla recorded 30 live births, representing 100% of births in the village. One death (3.3% of total births) occurred, and it was associated with heart dysfunction.

PRESENT ANTENATAL PROFILE

Table 4.27

Present Antenatal Care Profile

Present Antenatal Care	Tashpur	%	Hussainpur	%	Total	%
Present pregnancy cases	1	2.2	1	1.5	2	1.25
Pregnancy registered						
Yes	1	100	1	100	2	100
No	0	0	0	0	0	0
At least one full body checkup	1	100	1	100	2	100
Regular checkup						
Yes	1	100	1	100	2	100
No	0	0	0	0	0	0
Place of checkup						
Government hospital	0	0	1	100	1	50
Private Hospital	1	100	0	0	1	50
Tetanus Toxoid immunization						
TT-I	0	0	1	100	1	50
TT-II	0	0	1	100	1	50

Iron folic acid consumption						
Yes	0	0	1	100	1	50
No	0	0	0	0	0	0
If no...						
Not started	1	100	0	0	1	50
Not digested	0	0	0	0	0	0
Lack of knowledge	0	0	0	0	0	0
Health worker visit						
Yes	1	100	1	100	2	100
No	0	0	0	0	0	0
If yes..						
ANM	0	0	0	0	0	0
ASHA	1	100	1	100	2	100
Aganwadi worker	0	0	0	0	0	0

Table 4.27 represents currently pregnant women in the two villages. In Tashpur, it is of 2.2% cases of pregnancy. It is registered and at least one full-body checkup 100% is done, indicating positive antenatal care. Regular checkups are being followed by expectant mother (100%) in private hospital. Tetanus Toxoid (TT) is not done because of earlier time period of pregnancy and Iron folic acid consumption is also not started. Health worker ASHA visits regularly.

In Hussainpur, 1.5% of pregnancy cases are currently ongoing, and this case of pregnancy (100%) is registered. At least one full-body checkup and regular checkups are being followed by expectant mother (100%) from Government hospital. TT-I is complete and iron supplements 100% is complete. ASHA visiting with a regular frequency.

POSTNATAL PROFILE

Table 4.28

Distribution of Respondents based on Postnatal Care

Postnatal care	Tashpur	%	Hussainpur (65)	%	Nawapind Khalewal (20)	%	Dalla (30)	%	Total (160)	%
Health problem in 6 Week										
Yes	1	2.2	5	7.7	1	5	2	6.7	6	3.8
No	0	0	0	0	0	0	0	0	0	0
If yes..										
High fever	0	0	0	0	0	0	0	0	0	0
Lower abdominal pain	1	2.2	0	0	0	0	0	0	1	0.6
Fowl smelling vaginal discharge	0	0	0	0	0	0	0	0	0	0
Convulsions	0	0	0	0	0	0	0	0	0	0
Headache	0	0	0	0	0	0	2	6.7	2	1.3
Infection	0	0	2	3.1	0	0	0	0	2	1.3
Post partum Heamorrhage	0	0	1	1.5	0		0	0	1	0.6
Others	0	0	2	3.1	1	5	0	0	3	1.9
Treatment by										
Doctor	1	2.2	5	7.7	1	5	2	6.7	9	5.6
Nurse	0	0	0	0	0	0	0	0	0	0
Place of treatment										
Government hospital	0	0	0	0	0	0	0	0	0	0
Private hospital	1	2.2	5	7.7	1	5	2	6.7	9	5.6
Postnatal checkups										
Yes	45	100	65	100	20	100	30	100	160	100
No	0	0	0	0	0	0	0	0	0	0

If yes..										
Once in a month	45	100	65	100	20	100	30	100	160	100
Once in 3 month	18	40	31	45.7	8	40	11	36.7	68	42.5
Once in 6 month	0	0	1	1.5	0	0	0	0	1	0.63
According to need	0	0	0	0	0	0	0	0	0	0
Health worker visited										
Yes	41	91.1	54	83.1	20	100	27	90	142	88.8
No	4	8.9	11	16.9	0	0	3	10	18	11.2
If yes...										
ANM	1	2.4	0	0	0	0	0	0	1	0.7
ASHA	26	63.4	28	51.9	7	35	16	59.3	77	54.2
Aganwadi worker	14	34.1	26	48.1	13	65	11	40.7	64	45.1
Advice by Health worker										
Physical health	23	56.1	30	55.6	7	35	17	62.9	77	54.2
Mood changes	0	0	0	0	0	0	0	0	0	0
Breastfeeding	41	100	47	87	14	70	23	85.2	125	88.1
The child's development and health	41	100	43	79.6	13	65	20	74.1	117	82.4
Immunization	41	100	47	87	16	80	23	85.2	127	89.4

The data in Table 4.28 and Figure 4.28.1 to 4.28.4 represents postnatal care across four villages: Tashpur, Hussainpur, Nawapind Khalewal, and Dalla. In terms of health problems within 6 weeks of the postnatal period, the overall percentage was low at 3.8%. The highest incidence was in Hussainpur at 7.7%, followed by Dalla at 6.7%, Tashpur at 2.2%, and Nawapind Khalewal at 5%. The most common health problems were lower abdominal pain (0.63%), headaches (1.3%), infections (1.3%), postpartum haemorrhage (0.6%) and other unspecified issues (1.9%).

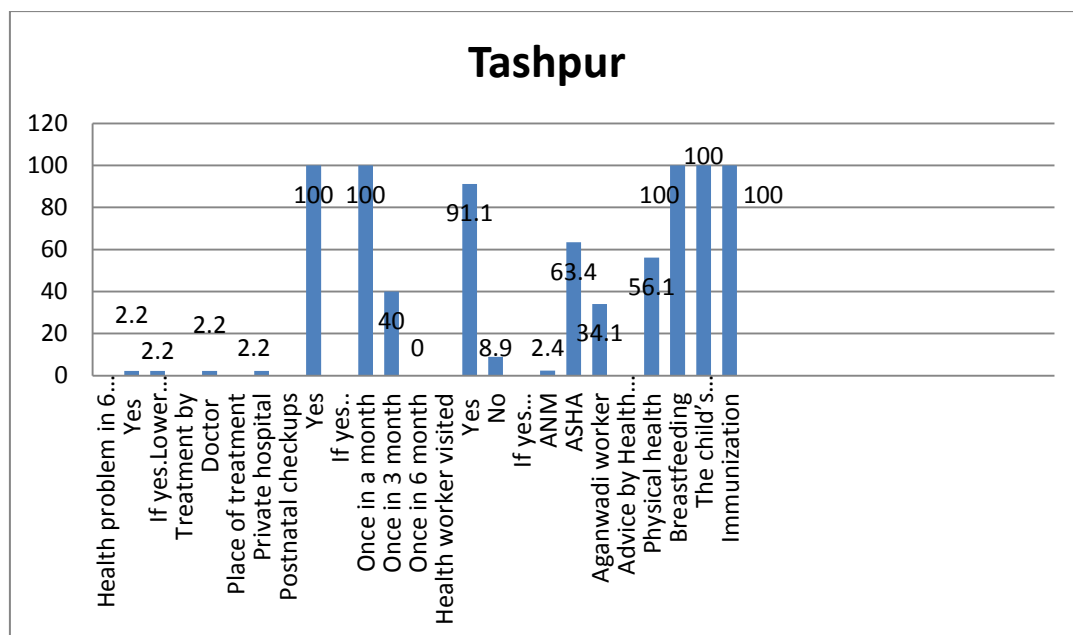


Figure 4.28.1 Distribution of Respondents by Postnatal Care in Tashpur Village

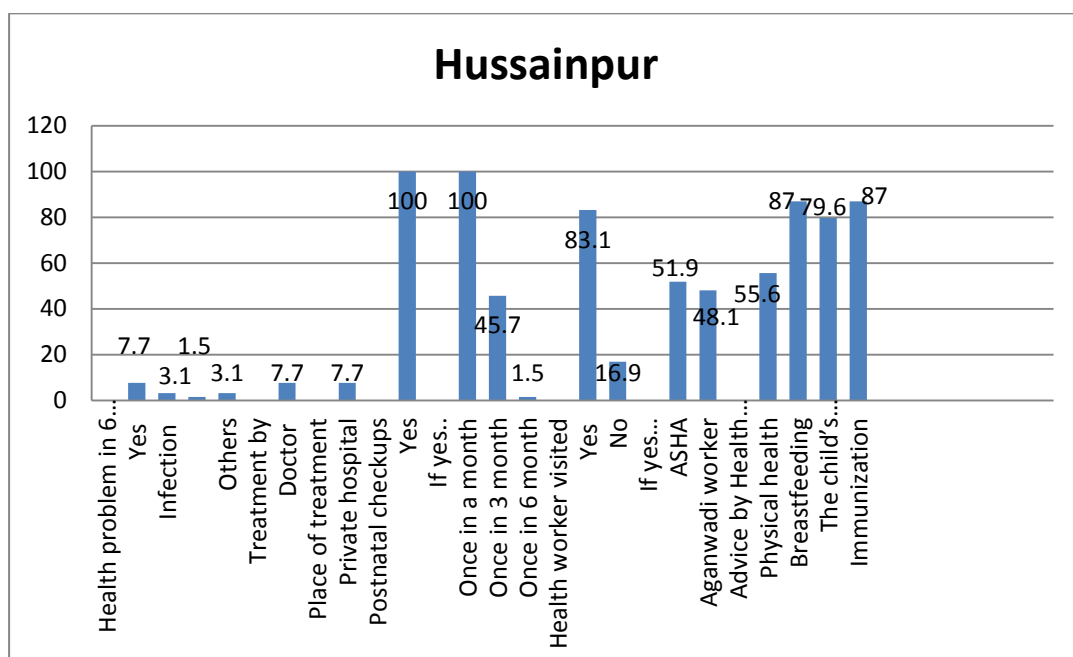


Figure 4.28.2 Distribution of Respondents by Postnatal Care in Hussainpur Village

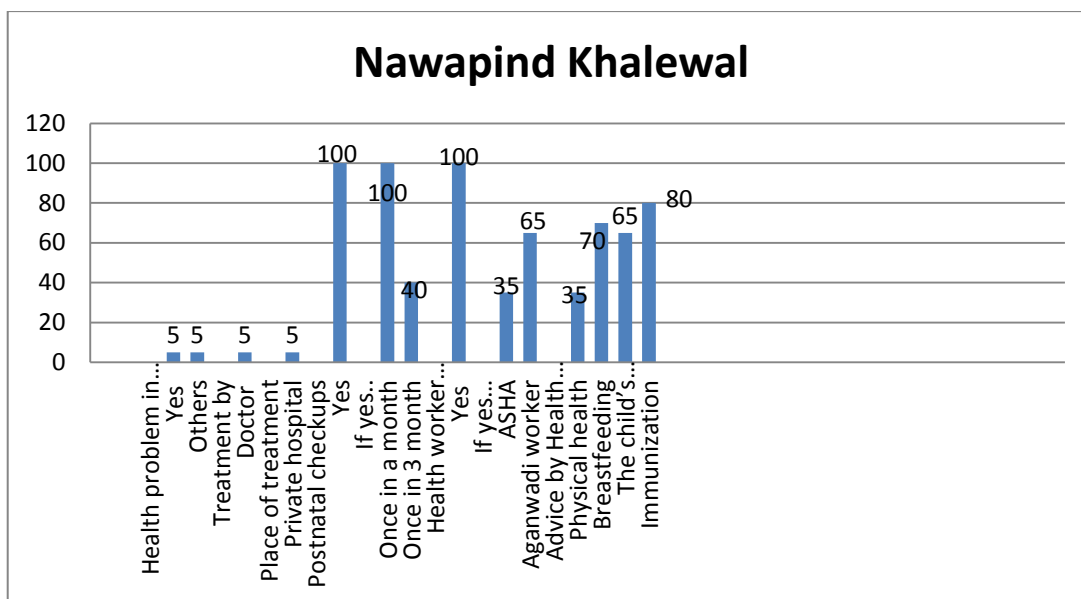


Figure 4.28.3: Distribution of Respondents by Postnatal Care in NawapindKhalewal Village

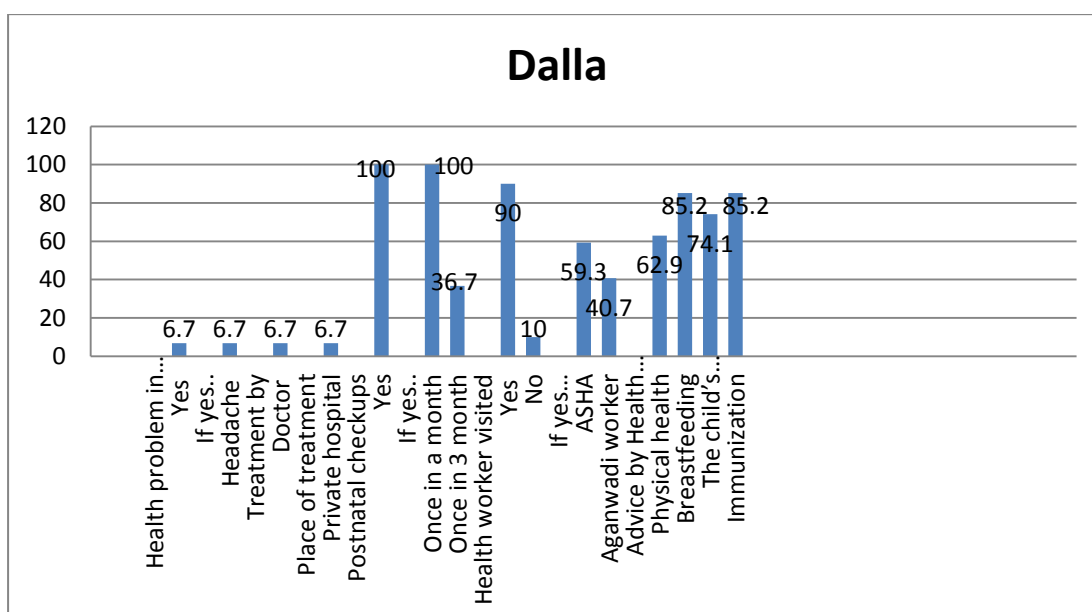


Figure 4.28.4 Distribution of Respondents by Postnatal Care in Dalla Village

All treatment was provided by doctors, with no instances of treatment by nurses. All treatments took place in private hospitals, with no treatments in government hospitals. Postnatal checkups were universally conducted across all villages, with a 100% rate. The frequency of these checkups varied, with once a month being the most common at 100%, followed by once every three months at 42.5%, and only one instance of a checkup once every six months (0.63%). Health worker visits were high across all villages, with an overall visitation rate of 88.8%. The highest visiting rate was in Nawapind Khalewal at 100%, followed by Tashpur at 91.1%, Dalla at 90%, and Hussainpur at 83.1%. The health workers visited such as ANMs (0.7%), ASHAs (54.2%), and Anganwadi workers (45.1%) and advice given by health workers covered various aspects. The advice on physical health was given to 54.2% of the individuals, breastfeeding advice was given to 88.1%, advice on the child's development and health was given to 82.4%, and immunization advice was given to 89.4%. There were no instances of advice on mood changes.

Case Study: 4

Postpartum Haemorrhage

XYZ, a 38-year-old woman, experienced severe complications during childbirth in 2015. Despite a normal delivery, she suffered excessive bleeding and inadequate postpartum care. This case study highlights the importance of proper technique during childbirth, and patient advocacy, timely intervention. Childbirth complications can be life-threatening. This case sheds light on the challenges faced by women during childbirth.

Her pregnancy progressed normally until the due date of June 12, 2015. She was admitted to the hospital for delivery, which occurred at 2:30 AM on June 12th. The delivery was conducted by a doctor by Episiotomy procedure, but complications arose afterward. She experienced uncontrolled bleeding after delivery and mentioned a wrong cut in her vaginal area during procedure. She required multiple blood transfusions due to severe bleeding.

This case serves as a reminder that childbirth complications demand vigilant monitoring, skilled care, and compassion. By studying such cases, we can improve maternal outcomes and enhance healthcare practices

BREAST FEEDING PRACTICES

Table 4.29

Distribution of Respondents based on Breast Feeding Practices

Breast feeding	Tashpur (45)	%	Hussainpur (65)	%	Nawapind Khalewal (20)	%	Dalla (30)	%	Total (160)	%
Breast feeding										
Yes	42	93.3	62	95.4	18	90	30	100	152	95
No	3	6.7	3	4.6	2	10	0	0	8	5
If no...										
Not digested	2	66.7	1	33.3	0	0	0	0	3	37.5
No excretion	1	33.3	2	66.7	2	100	0	0	5	62.5
First breast feed										
Immediately	8	19.0	14	22.6	5	27.8	10	33.3	37	24.3
After 2 hour	7	16.7	7	11.2	4	22.2	6	20	24	15.8
Within day	10	23.9	13	21	3	16.7	3	10	29	19.1
After one day	17	40.4	28	45.2	6	33.3	11	36.7	62	40.8
Squeeze before breastfeeding										
Yes	2	4.8	3	4.9	1	5.6	2	6.7	8	5.3
No	40	95.2	59	95.2	17	94.4	28	93.3	144	74.7

Table 4.29 and Figure 4.29.1 to 4.29.4 represents the breastfeeding practices in four villages: Tashpur, Hussainpur, Nawapind Khalewal, and Dalla. In Tashpur 93.3% of mothers breastfed their children, while 6.7% did not. Among those who did not breastfeed, 66.7% reported that the milk was not digested, and 33.3% reported no excretion. In Hussainpur 95.4% of mothers breastfed their children, while 4.6% did not. Among those who did not breastfeed, 33.3% reported that the milk was not digested, and 66.7% reported no excretion

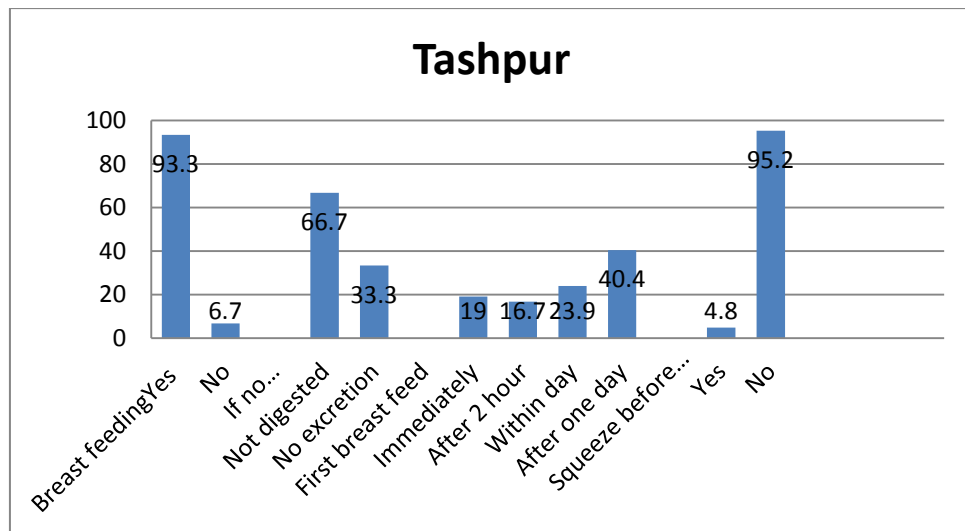


Figure 4.29.1: Distribution of Respondents based on Breast Feeding practices in Village Tashpur

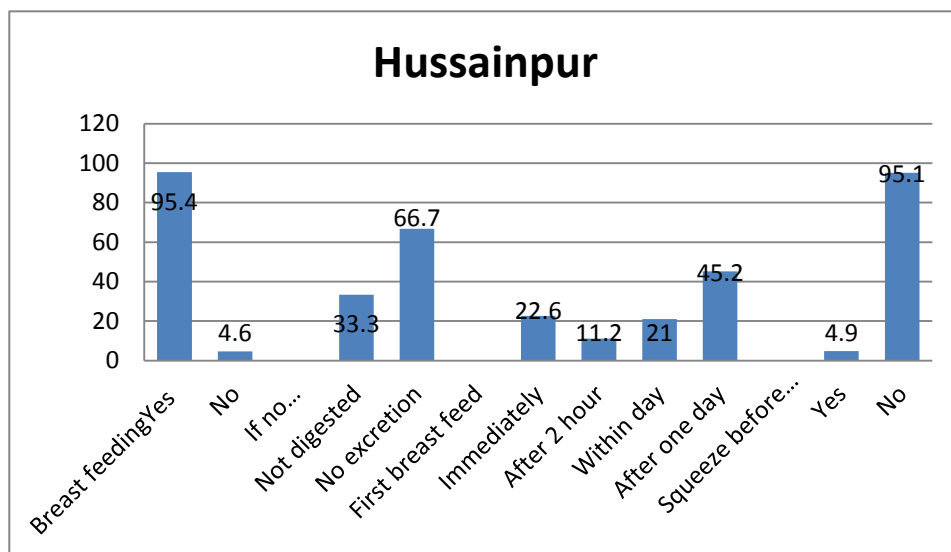


Figure 4.29.2: Distribution of Respondents based on Breast Feeding Practices in Village Hussainpur

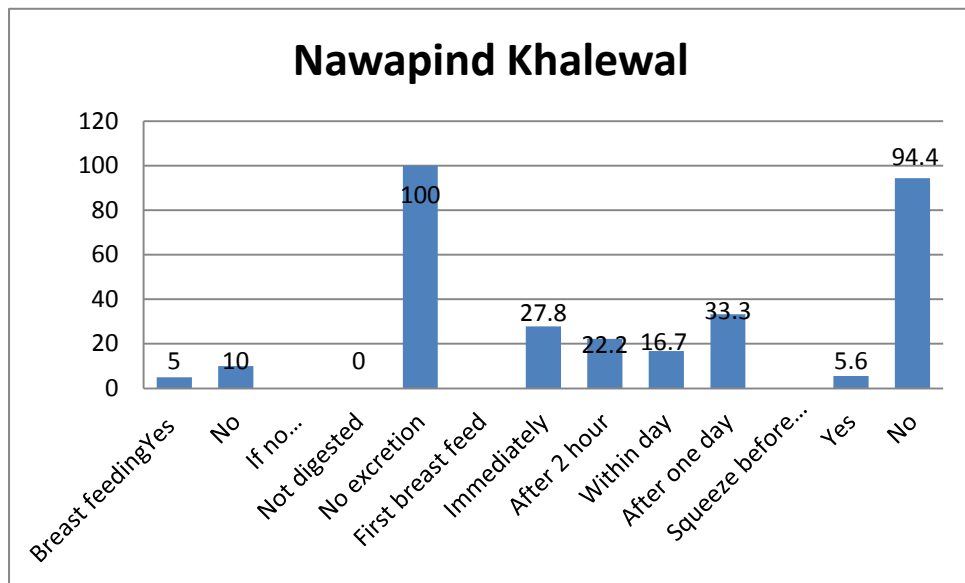


Figure 4.29.3: Distribution of Respondents based on Breast Feeding Practices in Village Nawapind Khalewal

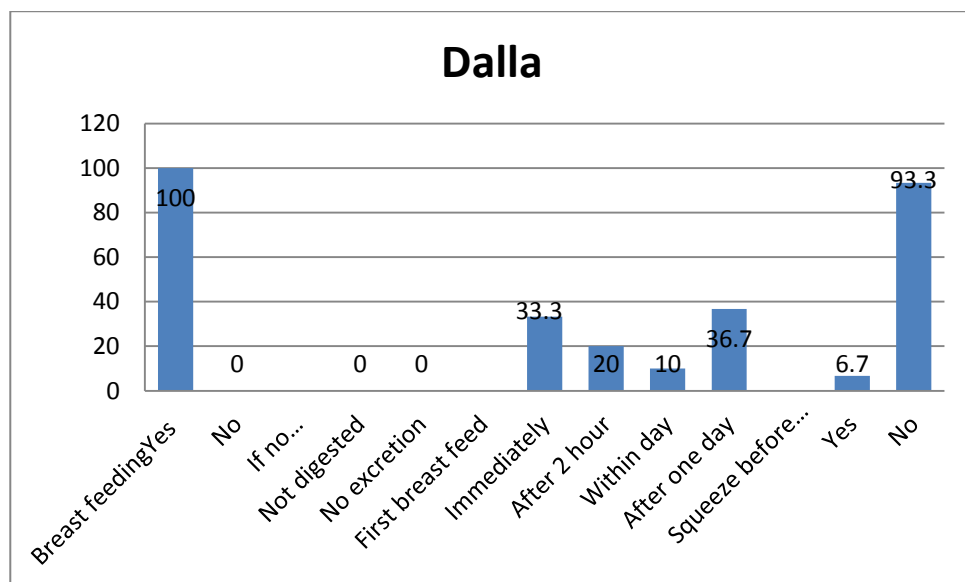


Figure 4.29.4: Distribution of Respondents based on Breast Feeding Practices in Village Dalla

In Nawapind Khalewal 90% of mothers breastfed their children, while 10% did not. All mothers who did not breastfeed reported no excretion. Dalla presents all mothers (100%) breastfed to their children.

First Breastfeed

In Tashpur only 19% of mothers breastfed immediately, 16.7% after 2 hours, 23.9% within a day, and 40.4% gave feed after one day. Hussainpur presents 22.6% of mothers breastfed immediately, 11.2% after 2 hours, 21% within a day, and 45.2% after one day. 27.8% of mothers breastfed immediately, 22.2% after 2 hours, 16.7% within a day, and 33.3% after one day in Nawapind Khalewal. In Dalla 33.3% of mothers gave breastfeed immediately to their child, 20% after 2 hours, 10% within a day, and 36.7% after one day.

Squeeze Before Breastfeeding is traditional practices is less popular among women. In all four villages, the majority of mothers did not squeeze before breastfeeding, ranging from 93.3% in Dalla to 95.2% in Tashpur and Hussainpur.

Table 4.30

Distribution of Respondent's Knowledge regarding Supplementary Food

Knowledge of supplementary food age	Tashpur	%	Hussainpur	%	Nawapind khalewal	%	Dalla	%	Total	%
4 month	29	64.4	24	36.9	9	45	18	60	80	50
5 month	9	20	4	6.2	2	10	5	16.7	20	12.5
6 monzth	3	6.7	35	53.8	9	45	6	20	53	33.1
Poor knowledge	4	8.9	2	3.1	0	0	1	3.3	7	4.4
Supplementary feed started at..										
Not started	2	4.4	5	7.7	2	10	4	13.3	13	8.1
4 month	10	22.2	20	30.8	5	25	9	30	44	27.5
5 month	23	51.2	31	47.7	11	55	10	33.3	75	46.9
6 month	10	22.2	9	13.8	2	10	7	23.3	28	17.5
Time period for breastfeeding										

Till now	6	14.3	11	17.7	2	11.1	5	16.7	24	15.8
6 month	1	2.4	0	0	0	0	0	0	1	0.7
Less than 6 month	0	0	0	0	0	0	0	0	0	0
More than 6 month	35	83.3	51	82.3	16	88.9	25	83.3	127	83.5

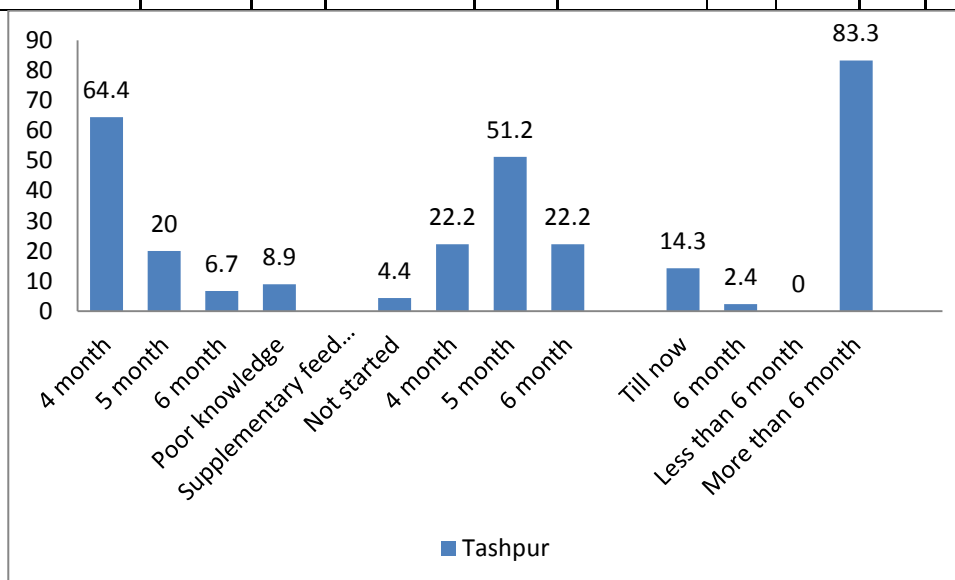


Figure 4.30.1: Distribution of Respondent's Knowledge regarding Supplementary Food in Tashpur Village

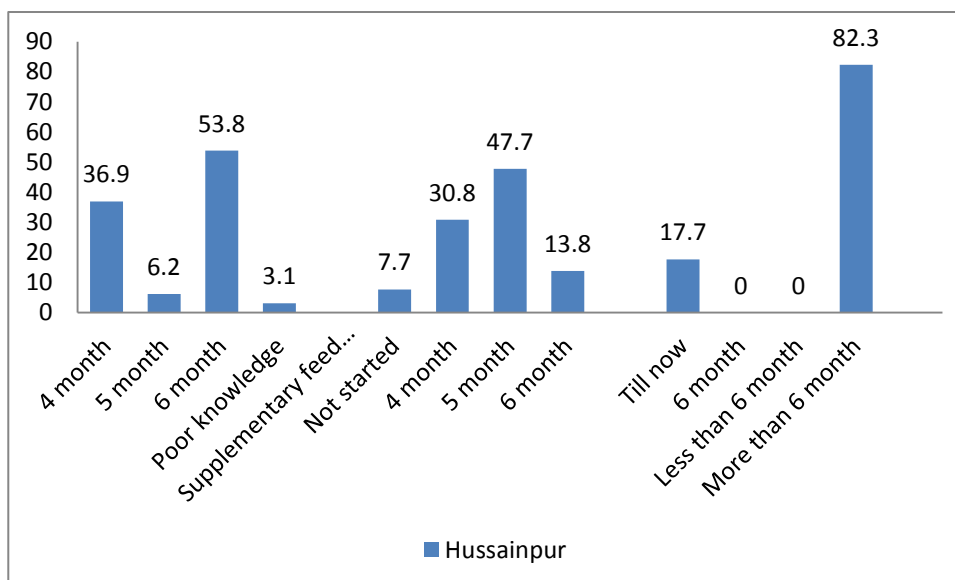


Figure 4.30.2: Distribution of Respondent's Knowledge regarding Supplementary Food in Hussainpur Village

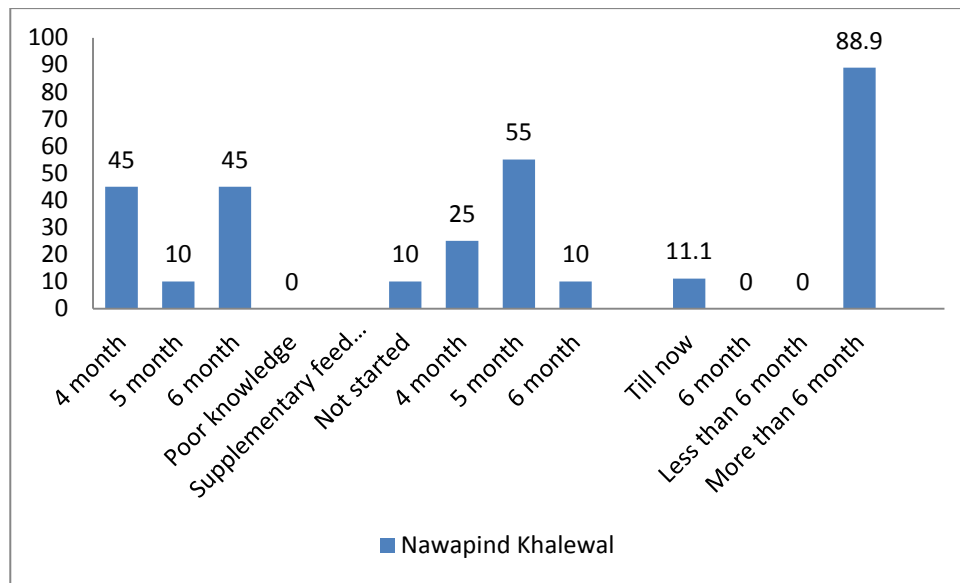


Figure 4.30.3: Distribution of Respondent's Knowledge regarding Supplementary Food in Nawapind Khalewal Village

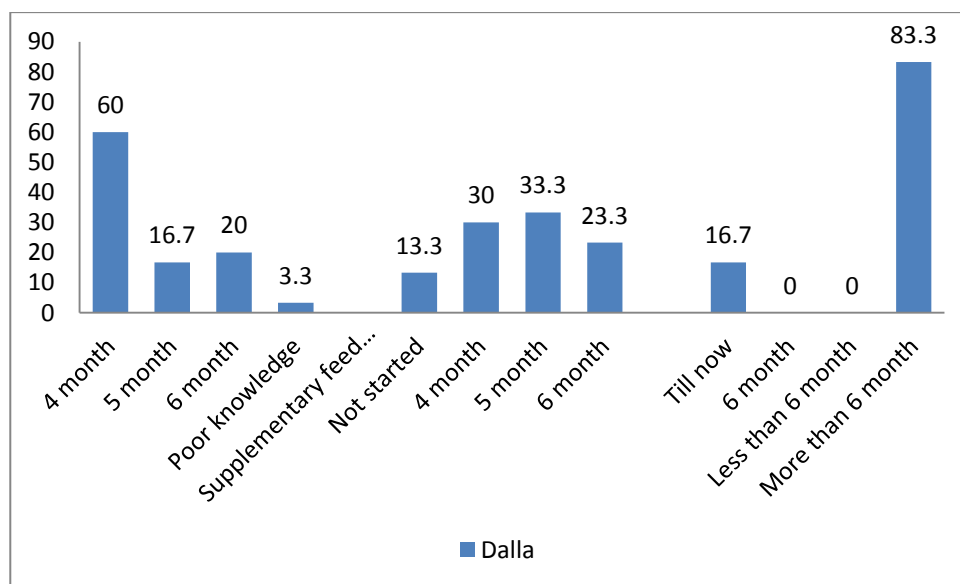


Figure 4.30.4: Distribution of Respondent's Knowledge regarding Supplementary Food in Dalla Village

Table 4.30 and Figure 4.30.1 to Figure 4.30.4 represent the respondent's knowledge of supplementary food age, the initiation of supplementary feeding, and duration of the breastfeeding period across four villages: Tashpur, Hussainpur, Nawapind Khalewal, and Dalla.

In terms of knowledge of supplementary food age, the majority of respondents in Tashpur (64.4%), Nawapind Khalewal (45%), and Dalla (60%) gained this knowledge by the time their children were four months old. However, in Hussainpur, the majority (53.8%) gained this knowledge when their children were six months old. Across all villages, the percentage of respondents with poor knowledge was relatively low, with the highest being 8.9% in Tashpur. Regarding the initiation of supplementary feeding, the majority of respondents in Tashpur (51.2%), Hussainpur (47.7%), and Nawapind Khalewal (55%) started this when their children were five months old. In contrast, in Dalla, the majority (30%) started this when their children were four months old. The percentage of respondents who had not started supplementary feeding was relatively low across all villages, with the highest being 13.3% in Dalla.

As for the breastfeeding period, the overwhelming majority of respondents in all four villages (83.3% in Tashpur, 82.3% in Hussainpur, 88.9% in Nawapind Khalewal, and 83.3% in Dalla) reported breastfeeding for more than six months. The percentage of respondents who were still breastfeeding is relatively low across all villages, with the highest being 17.7% in Hussainpur. Very few respondents reported breastfeeding for only six months, with the highest percentage being 2.4% in Tashpur.

CHILD CARE

Table 4.31

Distribution of Respondents by Child Care Practices

Child care	Tashpur	%	Hussainpur	%	Nawapind Khalewal	%	Dalla	%	Total	%
	(45)		(65)		(20)		(30)			
Knowledge regarding..										
Diarrhoea	45	100	65	100	20	100	30	100	160	100
Danger signs of Pneumonia ..yes	44	97.8	64	98.5	20	100	30	100	158	98.8

No	1	2.2	1	1.5	0	0	0	0	2	1.2
ORS	45	100	65	100	20	100	30	100	160	100
Knowledge source										
Health worker	41	91.1	54	83.1	20	100	27	90	142	88.8
Other TV/Books/ Friends	4	8.9	11	16.9	0	0	3	10	18	11.2
Knowledge given regarding...										
Diarrhoea	41	100	49	90.7	20	100	27	100	137	90.1
ORS	41	100	49	90.7	20	100	27	100	137	90.1
Danger signs of pneumonia	2	4.9	7	13	0	0	3	11.1	12	7.9

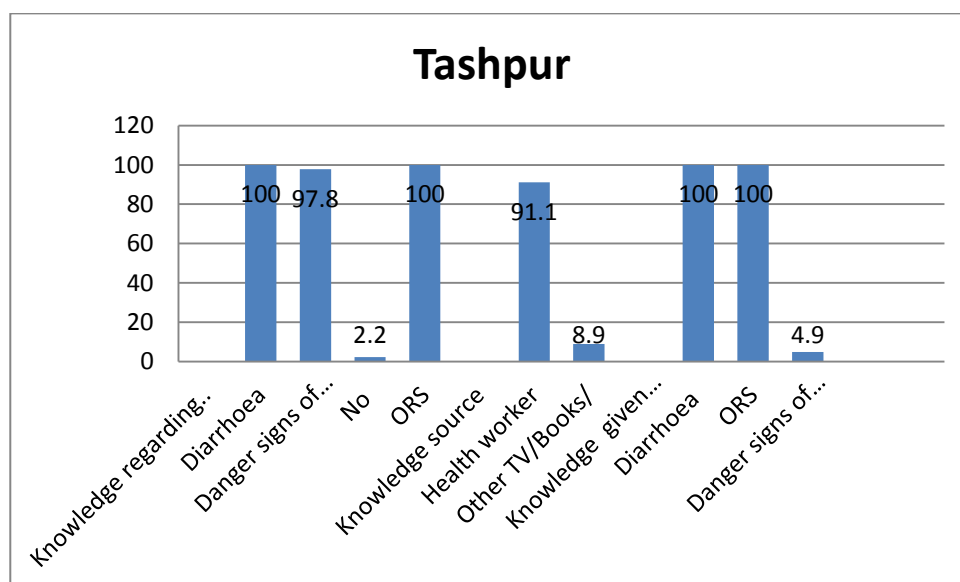


Figure 4.31.1: Distribution of Respondents by Child Care in Tashpur Village

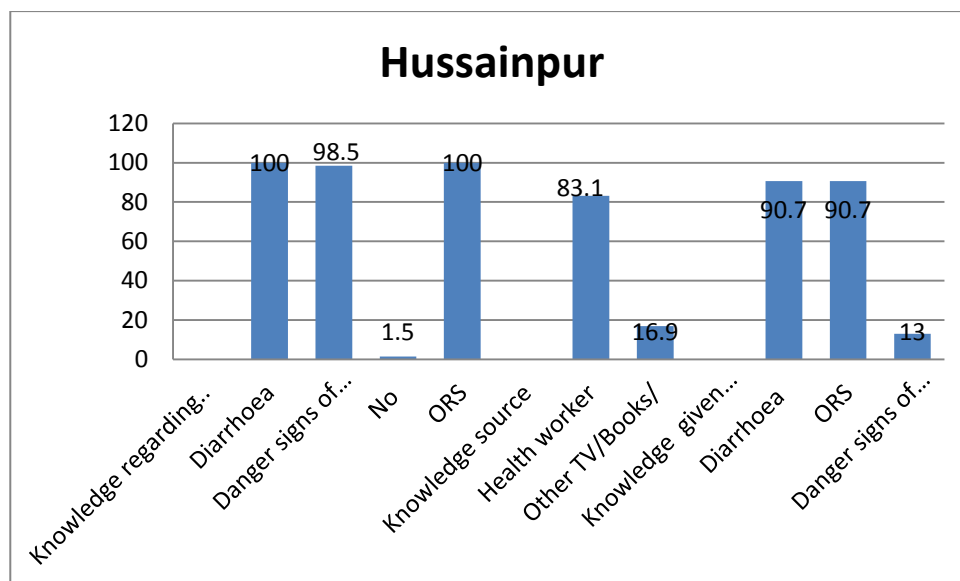


Figure 4.31.2: Distribution of Respondents by Child Care in Hussainpur Village

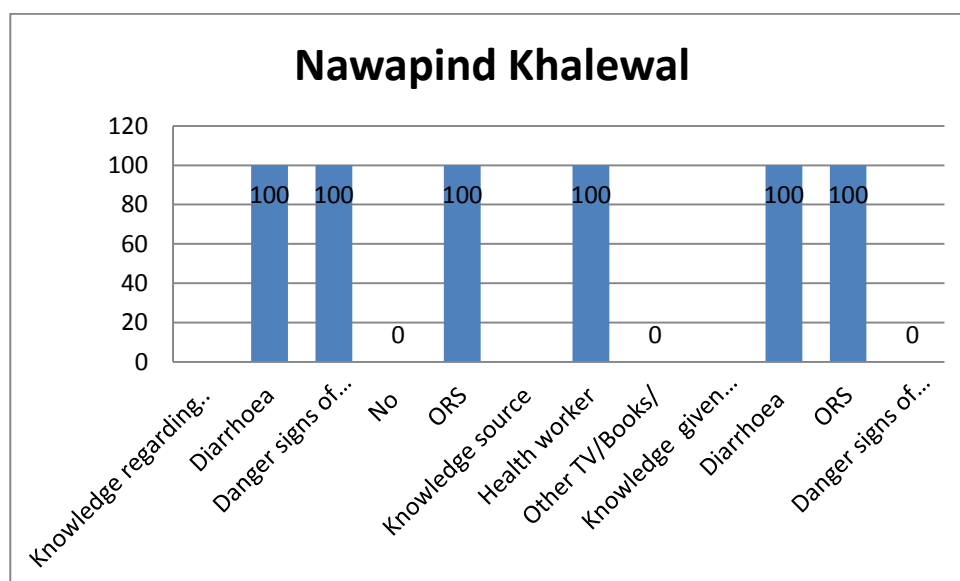


Figure 4.31.3: Distribution of Respondents by Child Care Practices in Nawapind Khalewal Village

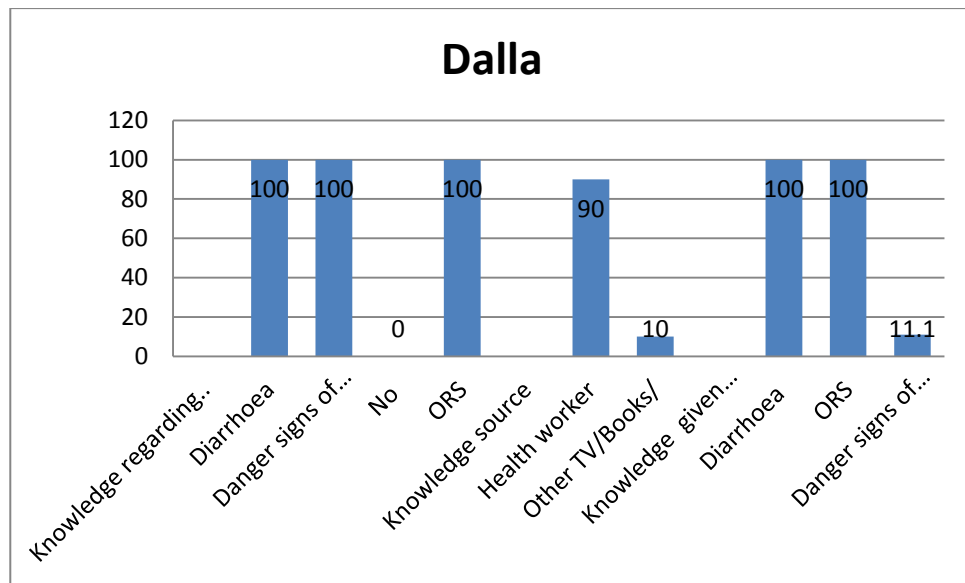


Figure 4.31.4: Distribution of Respondents by Child Care in Dalla Village

The data presents in the Table 4.31 and Figure 4.31.1 to 4.31.4 represents the knowledge and awareness regarding child care practices in four villages: Tashpur, Hussainpur, Nawapind Khalewal, and Dalla. Across all villages, there is universal knowledge (100%) about diarrhoea and Oral Rehydration Solution (ORS). While in case of Pneumonia, The majority of respondents are aware of the danger signs of pneumonia, with 97.8% in Tashpur (44 respondents), 98.5% in Hussainpur, 100% in Nawapind Khalewal and 100% in Dalla. Only a small percentage (1.2% overall) indicated no knowledge of these signs. The primary source of knowledge is health workers, with 91.1% in Tashpur, 83.1% in Hussainpur, 100% in Nawapind Khalewal and 90% in Dalla. Other sources such as TV, books, and friends account for the remaining knowledge source. The knowledge given regarding diarrhoea and ORS is high, with 100% in Tashpur, Nawapind Khalewal, Dalla and 90.7% in Hussainpur. The knowledge given regarding the danger signs of pneumonia is relatively low, with 4.9% in Tashpur, 13% in Hussainpur, and 11.1% in Dalla. No knowledge was given in Nawapind Khalewal.

Table 4.32**Distribution of Child Illness History among Respondents**

Child illness history	Tashpur	%	Hussainpur	%	Nawapind khalewal	%	Dalla	%	Total	%
Diarrhoea	9	20	5	7.7	1	5	3	10	18	11.3
Pneumonia	1	2.2	1	1.5	0	0	0	0	2	1.2
Other illness	2	4.4	0	0	0	0	3	10	5	3.1
Total	12	26.7	6	9.2	1	5	6	20	25	15.6
Treatment										
Government hospital	4	33.3	2	33.3	0	0	0	0	6	24
Private hospital	8	66.7	4	66.7	1	100	6	100	19	76
Present illness										
Fever, cough, cold	0	0	3	4.6	0	0	0	0	3	1.9
Others	0	0	1	1.5	0	0	1	3.3	2	1.3
Total	0	0	4	6.2	0	0	1	3.3	5	3.1
Treatment										
Government hospital	0	0	0	0	0	0	0	0	0	0
Private hospital	0	0	4	100	0	0	1	100	5	100
Complete Immunization										
Yes	45	100	65	100	20	100	30	100	160	100
No	0	0	0	0	0	0	0	0	0	0

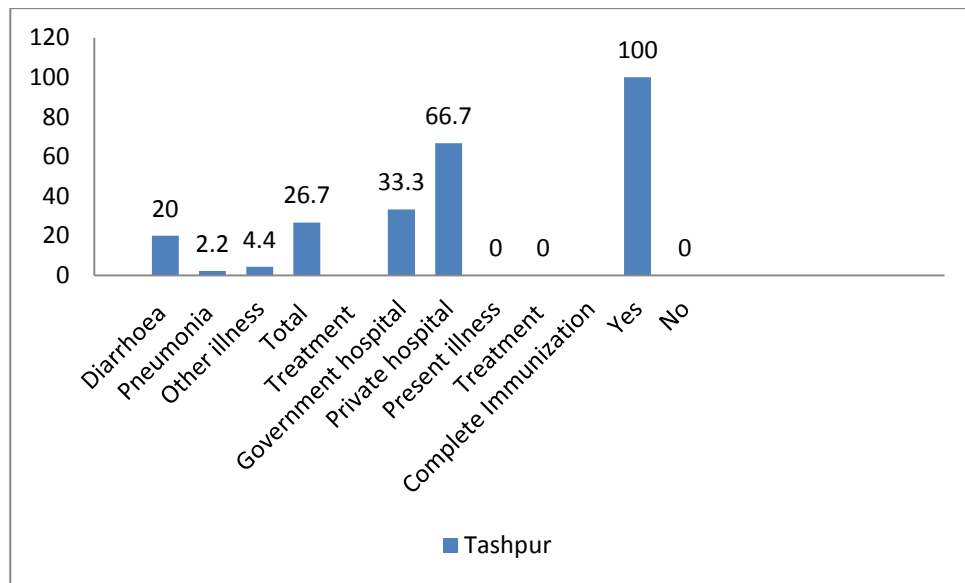


Figure 4.32.1: Distribution of Child Illness History among Respondents in Tashpur Village

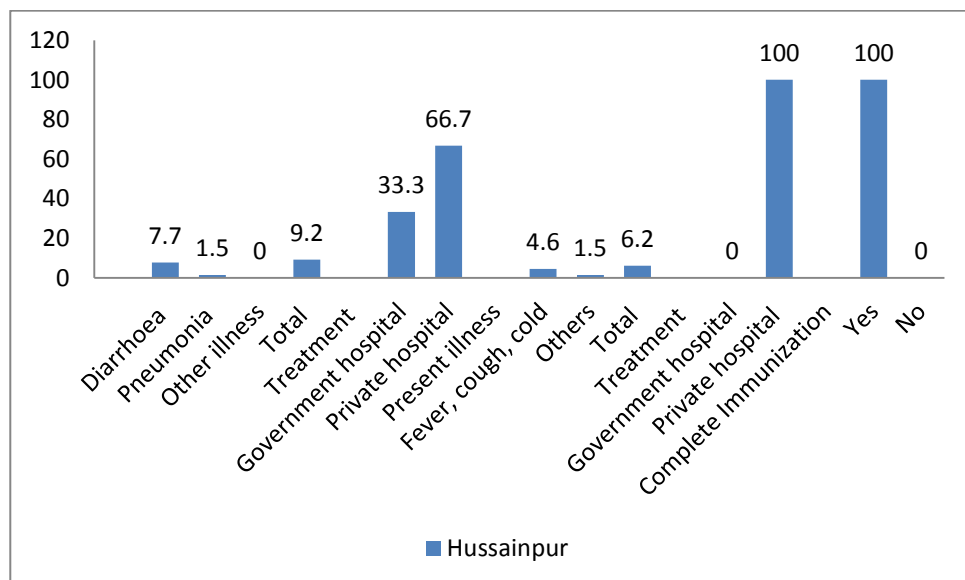


Figure 4.32.2: Distribution of Child Illness History among respondents in Hussainpur Village

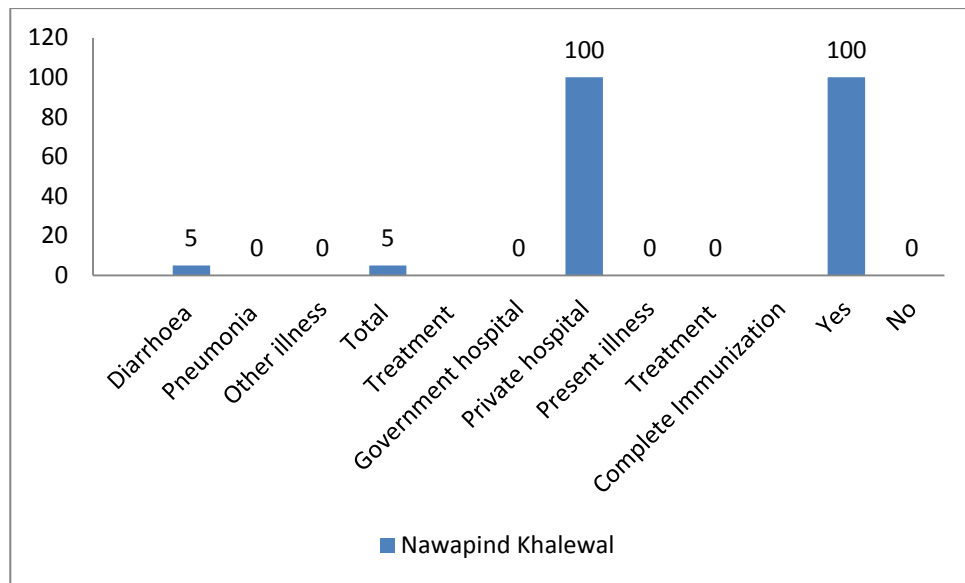


Figure 4.32.3: Distribution of Child Illness History among respondents in Nawapind Khalewal Village

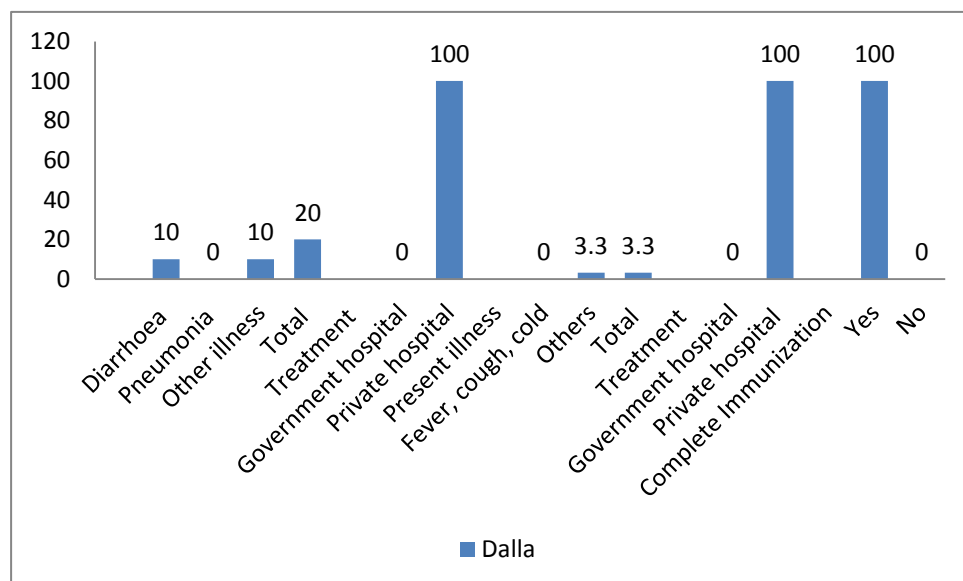


Figure 4.32.4: Distribution of Child Illness History among respondents of in Dalla Village

In Table 4.32 and Figure 4.32.1 to Figure 4.32.4 represents Distribution of Respondents by their Child Illness History of in four Villages.

Child Illness History in Tashpur: The highest reported illness was diarrhoea (20%), followed by other illnesses (4.4%), and pneumonia (2.2%). In Hussainpur diarrhoea was the most common illness (7.7%), with pneumonia and other illnesses not reported. In Nawapind Khalewal diarrhoea was reported in 5% of children, with no cases of pneumonia or other illnesses. In Dalla diarrhoea and other illnesses were reported in 10% of children each, with no cases of pneumonia. In all four villages, the majority of treatments for these illnesses were sought from private hospitals (ranging from 66.7% in Tashpur and Hussainpur to 100% in Nawapind Khalewal and Dalla).

Present Illness

In Hussainpur 4.6% of children were reported to have fever, cough, and cold, and 1.5% reported other illnesses and in Dalla 3.3% of children reported other illnesses, with no cases of fever, cough, and cold.

Immunization

In all four villages, 100% of children were reported to have complete immunization, indicating a strong adherence to immunization programs in these areas.

KNOWLEDGE ABOUT IDEAL GAP BETWEEN CHILDREN

Table 4.33

Distribution of Respondents based on their knowledge for Ideal Age Gap between Children

Ideal Gap Knowledge	Tashpur (45)	%	Hussainpur (65)	%	Nawapind Khalewal (20)	%	Dalla (30)	%	Total	%
3 years	31	68.9	49	75.4	13	65	25	83.4	118	73.8
Not Adequate knowledge	14	31.1	16	24.6	7	35	5	16.6	42	26.2

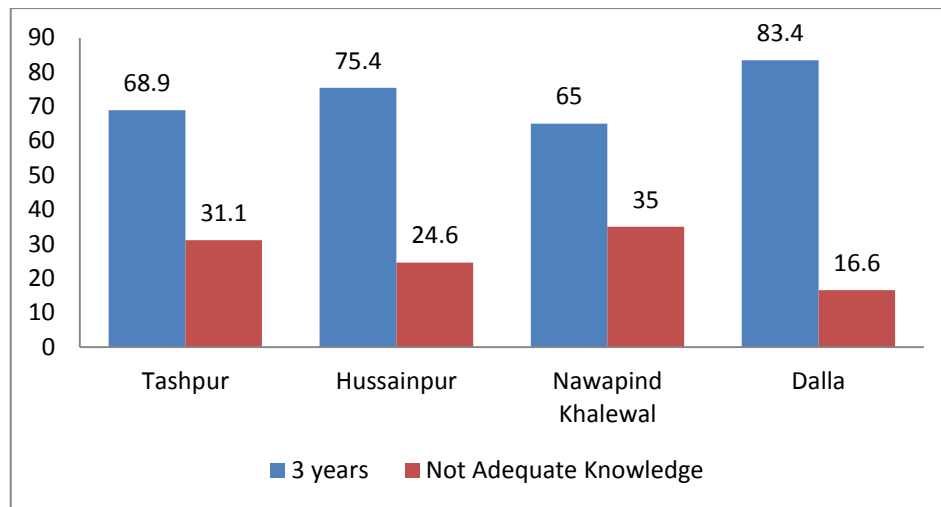


Figure 4.33: Distribution of Respondent's Knowledge as per Ideal Age Gap between Children

Table 4.33 and Figure 4.33 represents the knowledge for gap between children among women. In Tashpur, 68.9% of respondents have desired knowledge and 31.1% of women do not know. In Hussainpur majority of women have good knowledge at 75.4% and 24.6% of women have poor knowledge. Nawapind Khalewal has 65% have accurate knowledge, while 35% do not know the ideal gap between children. Dalla stands at 83.4%, indicating actual knowledge and 16.6% do not have adequate knowledge.

KNOWLEDGE ABOUT CONTRACEPTIVES AND FAMILY PLANNING METHODS

Table 4.34

Distribution of Respondent's Awareness Regarding Contraceptive Methods

Methods	Awareness regarding contraceptives								Total	
	Fashpur (45)	%	Hussainpur (65)	%	Nawapind khalewal (20)	%	Dalla (30)	%	No.	%
Female Sterilization	45	100	65	100	20	100	30	100	160	100
Male Sterilization	45	100	65	100	20	100	30	100	160	100
Pills	45	100	65	100	20	100	30	100	160	100
IUD/ Copper T	45	100	64	98.4	20	100	30	100	159	99.3
Male Condom	45	100	65	100	20	100	30	100	160	100
Female Condom	1	2.2	3	4.6	1	5	0	0	5	3.1
Birth patches	1	2.2	3	4.6	1	5	0	0	5	3.1
Rhythm Method	19	42.2	37	56.9	11	55	22	73.3	89	55.6
Withdrawal	45	100	65	100	20	100	30	100	160	100

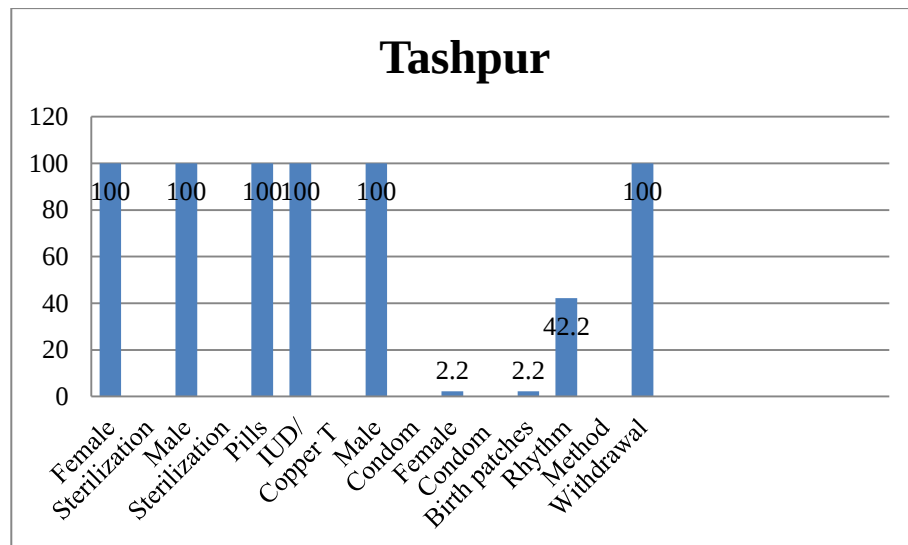


Figure 4.34.1: Distribution of Respondent's as per the Awareness of Contraceptive in Tashpur Village

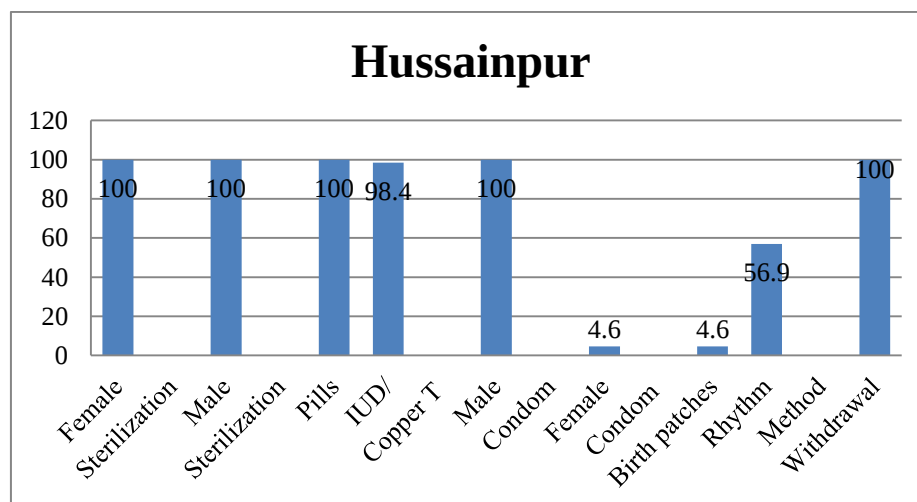


Figure 4.34.2: Distribution of Respondent's as per the Awareness of Contraceptive in Hussainpur Village

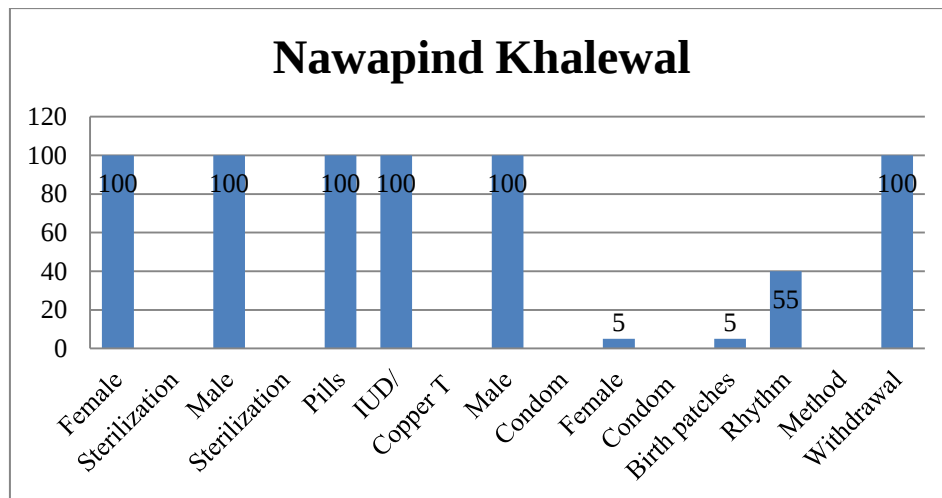


Figure 4.34.3: Distribution of Respondent's as per the Awareness of Contraceptive in Nawapind Khalewal Village

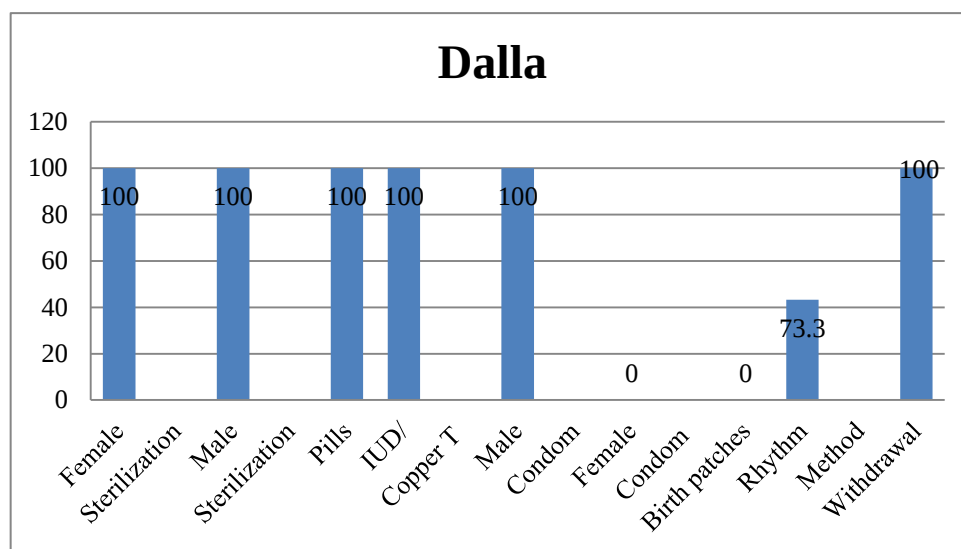


Figure 4.34.4: Distribution of Respondent's as per the Awareness of Contraceptive in Dalla Village

The data in Table 4.34 and Figure 4.34.1 to 4.34.4 represents the awareness regarding various contraceptive methods across four villages: Tashpur, Hussainpur, Nawapind Khalewal, and Dalla. Female Sterilization, male Sterilization, male condom, pills, and withdrawal methods show 100% awareness across all four villages, indicating a universal understanding of these contraceptive methods. IUD/Copper -Tshows a high

awareness level, with 100% in Tashpur, Nawapind Khalewal, and Dalla. However, in Hussainpur, the awareness is slightly lower at 98.4%. Female Condoms and birth patches awareness is relatively low, with only 2.2% in Tashpur, 4.6% in Hussainpur, 5% in Nawapind Khalewal and no awareness in Dalla. Rhythm method has a higher level of awareness compared to female condoms and birth patches. In Tashpur, 42.2% are aware of this method, 56.9% in Hussainpur, 55% in Nawapind Khalewal, and 73.3% in Dalla.

Table 4.35. Source of awareness about contraceptive methods among Respondents in Tashpur Village

Village – Tashpur Contraceptive Methods	TV/newspaper/ Books/ Magazines	%	Friends/ husband / Neighbours	%	ASHA/ANM/CH C/ PHC/Sub centre	%	Total	%
Female Sterilization	45	100	0	0	0	0	45	100
Male Sterilization	45	100	0	0	0	0	45	100
Pills	29	64.5	16	35.5	0	0	45	100
IUD/ Copper T	37	82.2	3	6.7	5	11.1	45	100
Male Condom	29	64.5	14	31.1	2	4.4	45	100
Female Condom	1	2.2	0	0	0	0	1	2.2
Birth patches	1	2.2	0	0	0	0	1	2.2
Rhythm Met Hod	5	11.1	6	13.3	8	17.8	19	42.2
Withdrawal	2	4.4	43	95.6	0	0	45	100

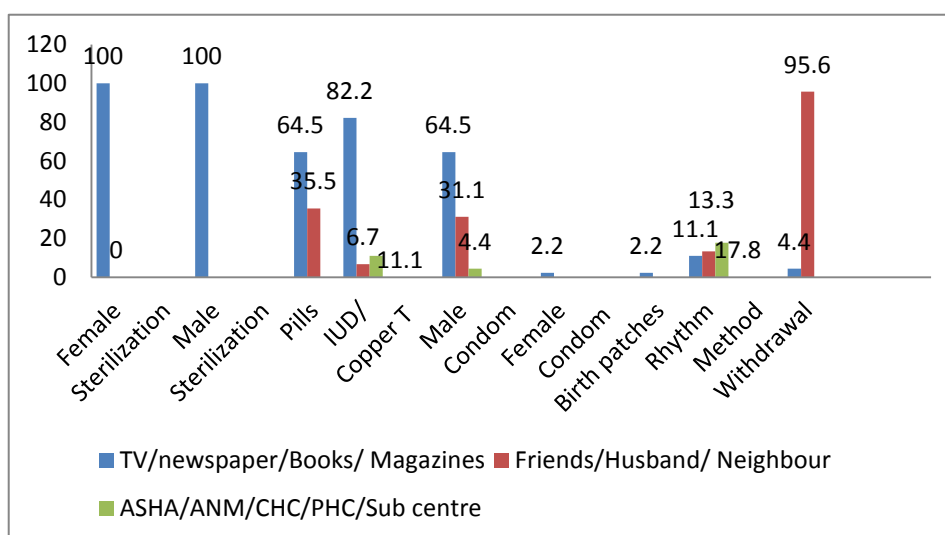


Figure 4.35: Source of awareness about contraceptives methods among respondents in Tashpur Village

Table 4.36

Source of awareness about contraceptive methods among respondents in Hussainpur Village

Village – Hussainpur Methods	TV/newspaper/ Books/ Magazines	%	Friends/ husband / Neighbours	%	ASHA/ANM/CH C/ PHC/Sub centre	%	Total	%
Female Sterilization	65	100	0	0	0	0	65	100
Male Sterilization	65	100	0	0	0	0	65	100
Pills	46	70.8	19	29.2	0	0	65	100
IUD/ Copper T	48	73.8	9	13.9	7	10.8	64	98.4
Male Condom	44	67.7	18	27.7	3	4.6	65	100
Female Condom	3	4.6	0	0	0	0	3	4.6
Birth patches	3	4.6	0	0	0	0	3	4.6
Rhythm Method	7	10.8	23	35.4	7	10.8	37	56.9
Withdrawal	2	3.1	63	96.9	0	0	65	100

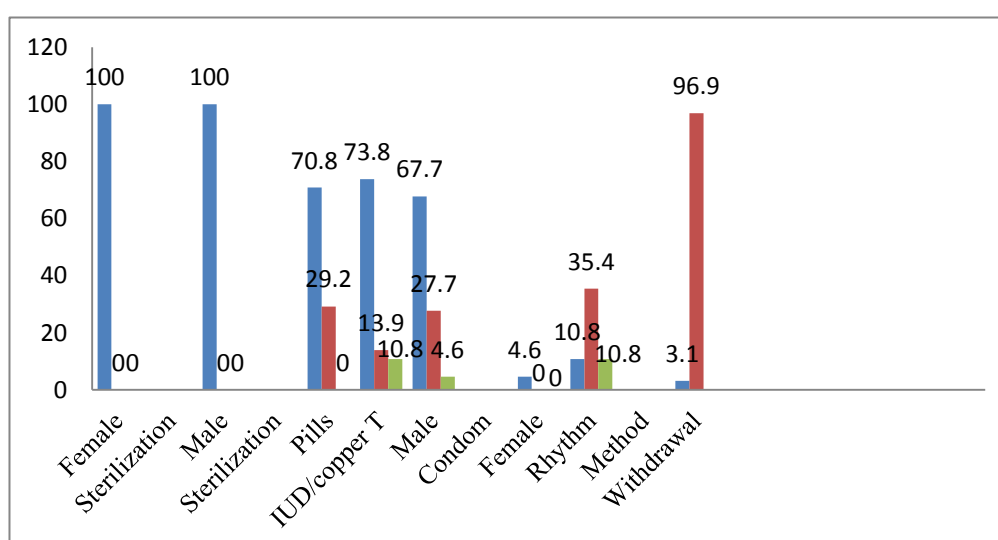


Figure 4.36: Awareness of Contraceptives among respondents in Hussainpur Village

Table 4.37- Source of awareness about contraceptives methods among respondents in Nawapind Khalewal Village

Village – Nawapind Contraceptives Methods	TV/newspaper/ Books/ Magazines	%	Friends/ husband / Neighbours	%	ASHA/ANM/CH C/ PHC/Sub centre	%	Total	%
Female Sterilization	20	100	0	0	0	0	20	100
Male Sterilization	20	100	0	0	0	0	20	100
Pills	15	75	5	25	0	0	20	100
IUD/ Copper T	12	60	5	25	3	15	20	100
Male Condom	12	60	7	35	1	5	20	100
Female Condom	1	5	0	0	0	1	1	5
Birth patches	1	5	0	0	0	1	1	5
Rhythm Method	6	30	5	25	2	10	11	55
Withdrawal	1	5	19	95	0	0	20	100

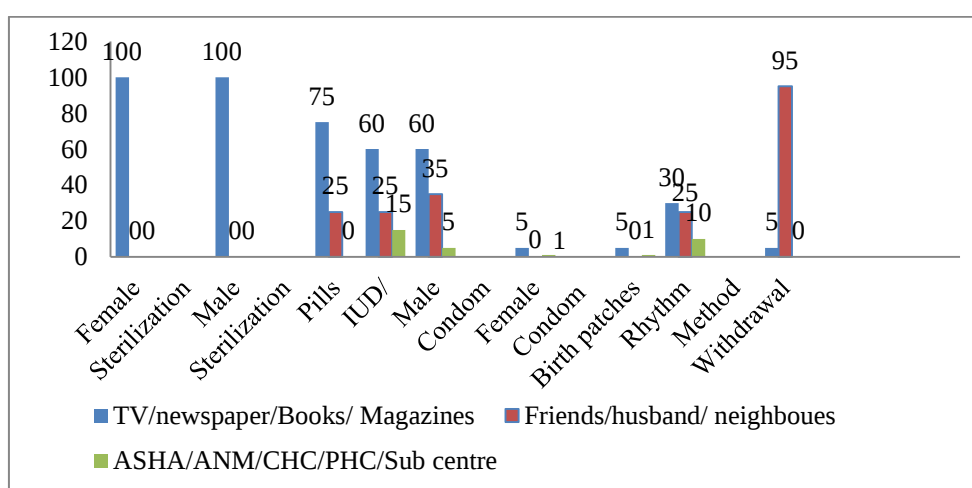


Figure 4.37: Awareness of Contraceptives among respondents in Nawapind Khalewal Village

Table 4.38**Source of awareness about contraceptives among respondents in Dalla Village**

Village – Dalla	TV/newspaper/B ooks/ Magazines	%	Friends/ husband / Neighbours	%	ASHA/ANM/C HC/ PHC/Sub centre	%	Total	%
Female Sterilization	30	100	0	0	0	0	30	100
Male Sterilization	30	100	0	0	0	0	30	100
Pills	21	70	9	30	0	0	30	100
IUD/ Copper T	16	53.4	13	43.3	1	3.3	30	100
Male Condom	17	56.7	8	26.6	5	16.7	30	100
Female Condom	0	0	0	0	0	0	0	0
Birth patches	0	0	0	0	0	0	0	0
Rhythm Method	6	20	16	53.4	0	0	22	73.3
Withdrawal	1	3.3	29	96.7	0	0	30	100

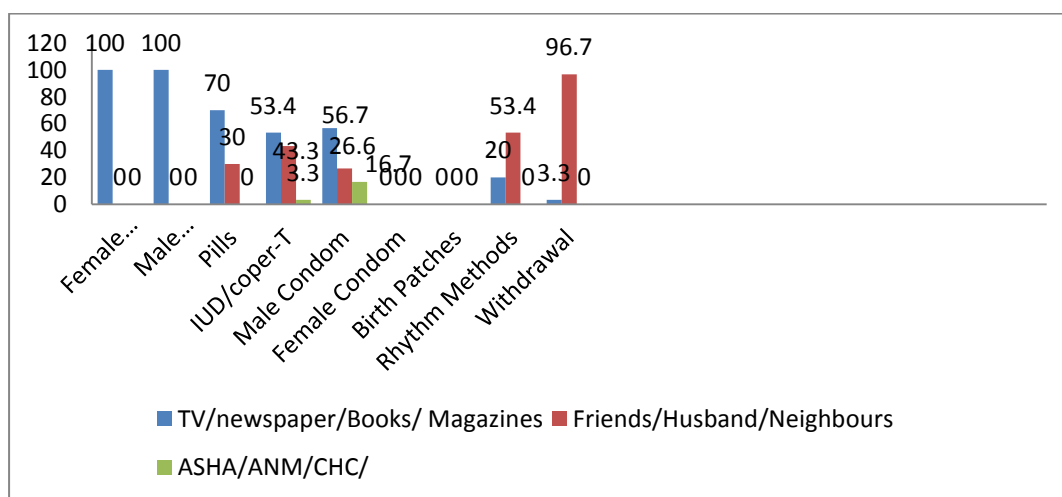
**Figure 4.38: Source of awareness about contraceptive among respondents in Dalla Village**

Table 4.35 highlights the sources of awareness about contraceptive methods among respondents in Tashpur Village. For female and male sterilization, 100% of respondents gained awareness through TV/newspapers/books/magazines. For pills and male condoms, 64.5% relied on TV/newspapers, 35.5% and 31.1% on friends/neighbors, and 4.4% (male condom) on ASHA workers, respectively. Awareness of IUD (Copper T) was primarily from TV/newspapers (82.2%), followed by ASHA workers (11.1%). Methods like female condoms and birth patches had minimal awareness (2.2% from TV/newspapers). For the withdrawal method, 95.6% relied on friends/neighbours, while 42.2% learned about the rhythm method from combined sources.

Table 4.36 highlights the sources of awareness about contraceptive methods among respondents in Tashpur Village. For female and male sterilization, 100% of respondents gained awareness through TV/newspapers/books/magazines. For pills and IUD 70.8% and 73.8% relied on TV/newspapers, 29.2% and 13.9% on friends/neighbours, and 10.8% (IUD) on ASHA workers. Methods like female condoms and birth patches had minimal awareness (4.6% and 4.6% from IV/newspapers). For male condom primary source is TV i.e 67.7%. For the withdrawal method, 96.9% relied on friends/neighbors, while 35.4% learned about the rhythm method from combined sources. These trends indicate TV/newspapers/books as the dominant source, with significant contributions from friends and ASHA workers for specific methods.

Table 4.37 highlights the sources of awareness about contraceptive methods among respondents in Nawapind Khalewal Village. For female and male sterilization, 100% of respondents relied on TV/newspapers/books/magazines. Awareness of pills was sourced from TV/newspapers (75%) and friends (25%), with 100% total awareness. For IUD (Copper T) and male condoms, 60% of respondents relied on TV/newspapers, while ASHA workers contributed 25% and 35%, respectively. Awareness of female condoms and birth patches was minimal, at only 5% each from TV/newspapers. The rhythm method was known to 55%, primarily through ASHA workers (25%) and TV/newspapers (30%). The withdrawal method had complete awareness (100%) through friends/neighbors (95%).

Table 4.39

Use of Contraceptives by Respondents

Use of contraceptive by respondent	Tashpur (45)	%	Hussainpur (65)	%	Nawapind Khalewal (20)	%	Dalla (30)	%	Total (160)	%
Yes	10	22.2	11	17	1	5	10	6.7	19	11.9
No	35	77.8	54	83	19	95	28	93.3	141	88.1
If yes...Pills	2	20	5	45.5	0	0	0	0	0	0
IUD/ copper T	1	10	1	9.0	1	100	2	20	5	3.1
Female condom	0	0	0	0	0	0	0	0	0	0
Birth patches	0	0	0	0	0	0	0	0	0	0
Rhytham method	0	0	0	0	0	0	0	0	0	0
Female sterllization	7	70	5	45.5	0	0	8	80	20	12.5

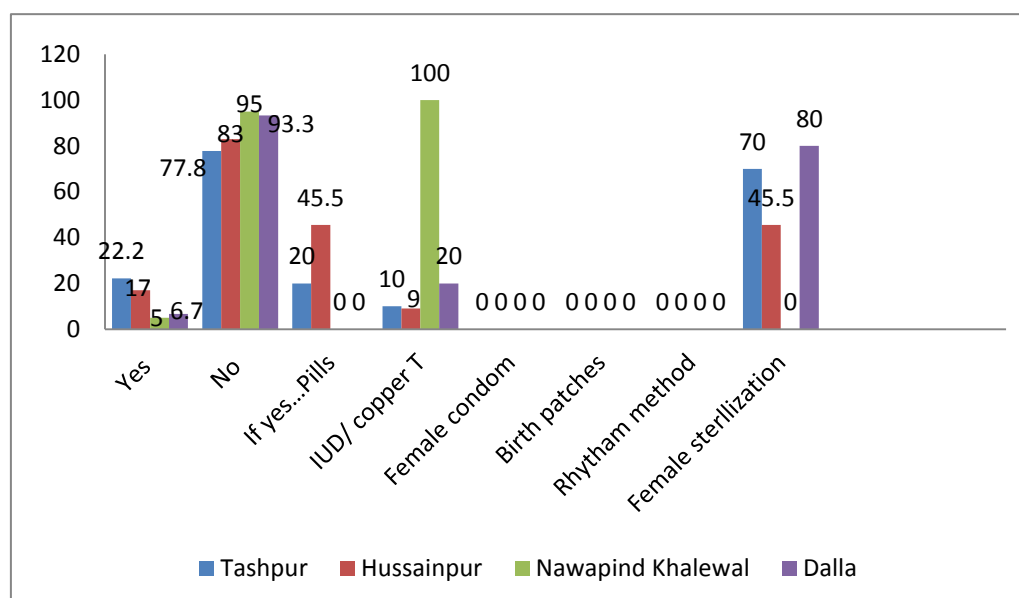


Figure 4.39: Use of Contraceptives by Respondents

In Tashpur, out of 45 respondents, 22.2% reported using contraceptives. Among those who used contraceptives, 20% used pills, 10% used IUD/Copper T, and a significant 70% had undergone female sterilization. In Hussainpur, 17% of respondents are using contraceptives. The preferred methods were pills (45.5%) and female sterilization (45.5%), with a small percentage (9%) using IUD/Copper T. In Nawapind Khalewal, contraceptive usage was the lowest among the four villages, with only 5% respondents reporting usage. The only method used in this village was IUD/Copper T. In Dalla, 6.7% of respondents are using contraceptives. No one reported using pills or IUD/Copper T. Instead, a significant 80% of those who used contraceptives had undergone female sterilization. These findings suggest that while contraceptive usage varies across villages, female sterilization is the most common method where contraceptives are used. However, a significant majority of respondents across all villages do not use contraceptives. This could indicate a need for increased awareness and accessibility of various contraceptive methods in these areas.

Table 4.40

Use of Contraception by Respondent's Husband

Use of contraceptive by respondent's husband	Tashpur (45)	%	Hussainpur (65)	%	Nawapind Khalewal (20)	%	Dalla (30)	%	Total (160)	%
Male condom	3	15.8	14	45.2	3	23.1	3	20	23	29.5
Male sterilization	0	0	0	0	1	7.7	0	0	1	1.3
Withdrawal	16	84.2	17	54.8	9	69.2	12	80	54	69.2
Total	19	100	31	100	13	100	15	100	78	100

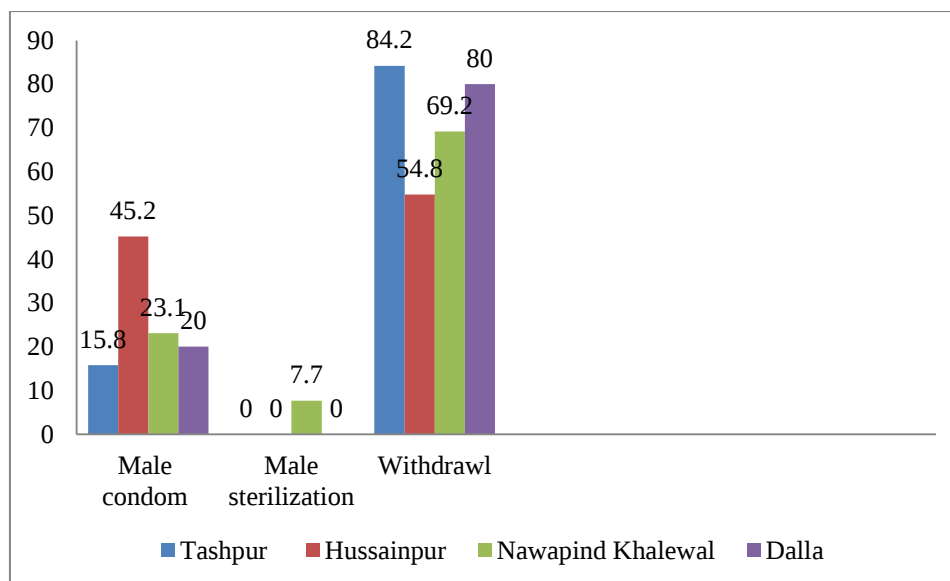


Figure 4.40: Use of Contraception by Respondent's Husband

The data in Table 4.40 and Figure 4.40 indicates the Use of Contraception by Respondent's Husband in the Tashpur, Hussainpur, Nawapind Khalewal, Dalla Villages. In Tashpur, the use of male condoms is at 15.8%, while male sterilization is not practiced. The withdrawal method is the most common contraceptive method, used by 84.2%. In Hussainpur, the use of male condoms is significantly higher at 45.2%, making it the most used contraceptive method in this village and the withdrawal method is used by 54.8%. In Nawapind Khalewal, the use of male condoms and male sterilization is at 23.1% and 7.7% respectively. The withdrawal method is the most common contraceptive method, used by 69.2%. Dalla represents the use of male condoms is at 20%, while male sterilization is not practiced. The withdrawal method is the most prevalent contraceptive method, used by 80% of the respondents.

Table 4.41**Exploring Contraceptive Source Preferences among Respondents**

Source of contraceptive	Tashpur (45)	%	Hussainpur (65)	%	Nawapind Khalewal (20)	%	Dalla (30)	%	Total (160)	%
Government hospital/ dispensary	8	61.5	7	28	2	40	10	77	27	49.1
Private hospital/ chemist shop	5	38.5	18	72	3	60	3	23	28	60.9
Total	13	100	25	100	5	100	13	100	55	100

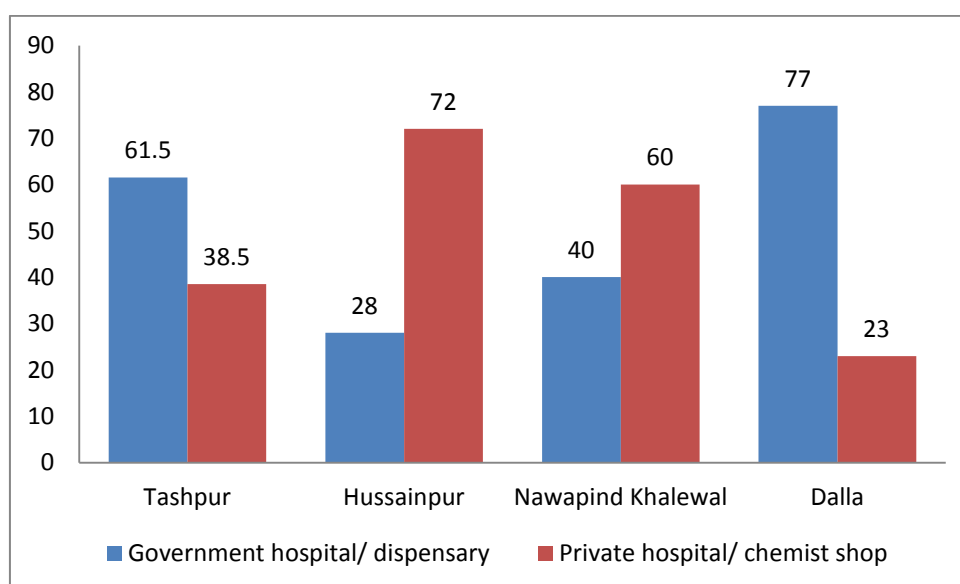
**Figure 4.41: Exploring Contraceptive Source Preferences among Respondents**

Table 4.41 and Figure 4.41 indicates the sources of contraceptives in respondents of four villages. The sources are categorized into two: Government hospital/dispensaries and private hospital/chemist shops. In Tashpur, the majority of contraceptives, 61.5%, are sourced from government hospitals or dispensaries, while 38.5% are obtained from private hospitals or chemist shops. In contrast, Hussainpur shows that a significant 72% of contraceptives are taken from private hospitals or chemist shops, and only 28% are obtained from government hospitals or dispensaries. This suggests a

greater preference for private healthcare services in Hussainpur. In Nawapind Khalewal, the distribution is evenly split with 60% of contraceptives sourced from private hospitals or chemist shops, and 40% from government hospitals or dispensaries. This indicates a balanced utilization of both private and public healthcare services in the village. Dalla shows the highest reliance on government services among the four villages, with 77% of contraceptives sourced from government hospitals or dispensaries and only 23% from private hospitals or chemist shops.

Table 4.42

Awareness of Reproductive Tract Infections/Sexually Transmitted Diseases among Respondents

Awareness of Reproductive Tract Infections/ Sexually Transmitted Diseases	Tashpur (45)	%	Hussainpur (65)	%	Nawapind Khalewal (20)	%	Dalla (30)	%	Total (160)	%
Yes	1	2.2	2	3.1	2	10	0	0	5	3.1
No	44	97.8	63	96.9	18	90	30	100	155	96.9
Sources of information										
Radio/TV	0	0	0	0	0	0	0	0	0	0
Books/Newspaper / Magazine	1	100	2	100	1	50	0	0	4	80
friends	0	0	0	0	0	0	0	0	0	0
Health worker ANM/ASHA	0	0	0	0	0	0	0	0	0	0
Doctor	0	0	0	0	1	50	0	0	1	20

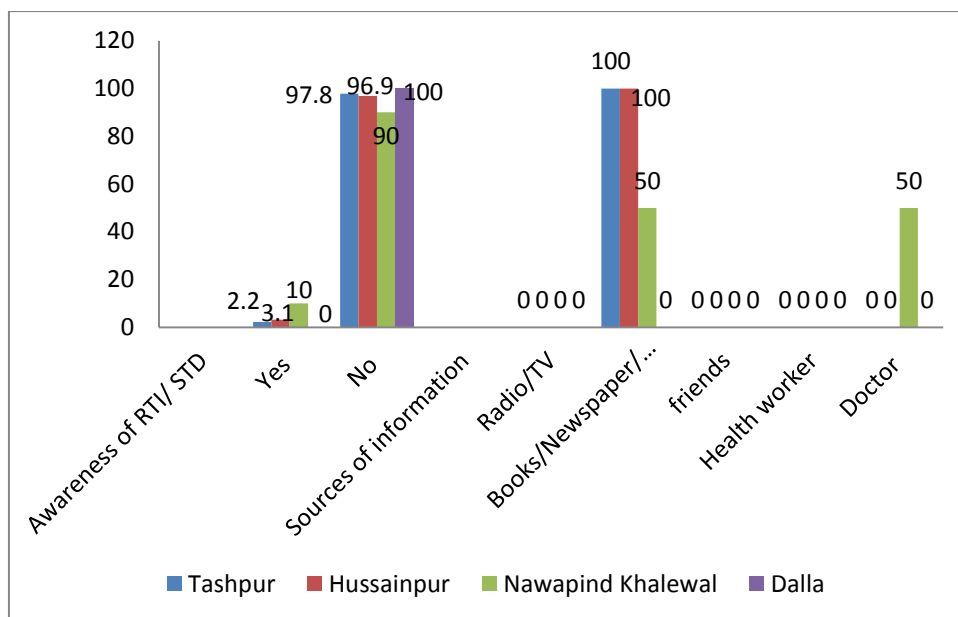


Figure 4.42: Awareness of Reproductive Tract Infections/Sexually Transmitted Diseases among Respondents

Table 4.42 and Figure 4.42 represent awareness of RTIs/ STDs and the sources of information in respondents of four villages: Tashpur, Hussainpur, Nawapind Khalewal, and Dalla. In Tashpur, out of 45 respondents interviewed, only 2.2% were aware of RTI/STD. The sole source of information for this group was Books/Newspapers/Magazines. In Hussainpur, with a sample size of 65, a slightly higher percentage of individuals (3.1%) were aware of RTI/STD. All of these individuals cited Books/Newspapers/Magazines as their source of information. Nawapind Khalewal had the highest percentage of RTI/STD awareness at 10%, with 20 respondents interviewed. Half of these informed individuals learned about RTI/STD from Books/Newspapers/Magazines, while the other half gained their knowledge from Doctors. In Dalla, none of the 30 were aware of RTI/STD.

Table 4.43**Awareness of HIV/AIDS among Respondents**

HIV/AIDS	Tashpur (45)	%	Hussainpur (65)	%	Nawapind Khalewal (20)	%	Dalla (30)	%	Total (160)	%
Awareness of HIV/ AIDS										
Yes	42	93.4	63	96.9	20	100	30	100	155	96.9
No	3	6.6	2	3.1	0	0	0	0	5	3.1
Sources of information										
Radio/TV	39	92.8	58	92.1	20	100	30	100	155	96.9
Books/Newspaper/ Magazine	6	14.3	7	11.1	4	20	4	13.3	21	13.5
Friends	37	88.1	43	68.2	12	60	14	46.7	106	68.4
Health worker ANM/ASHA	7	16.7	5	7.9	5	25	7	23.3	24	15.5
Doctor	1	2.3	2	3.1	0	0	0	0	3	1.9
Knowledge regarding mode of transmission										
Yes	42	93.4	63	96.9	20	100	30	100	155	96.9
No	3	6.6	2	3.1	0	0	0	0	5	3.1
If yes..										
Heterosexual intercourse	42	93.4	63	96.9	20	100	30	100	155	96.9
Homosexual intercourse	12	28.6	26	41.3	7	35	9	30	54	34.9
Infected needle/ blades	42	93.4	63	96.9	20	100	30	100	155	96.9
Mother to child	42	93.4	63	96.9	20	100	30	100	155	96.9
Blood transfusion	42	93.4	63	96.9	20	100	30	100	155	96.9

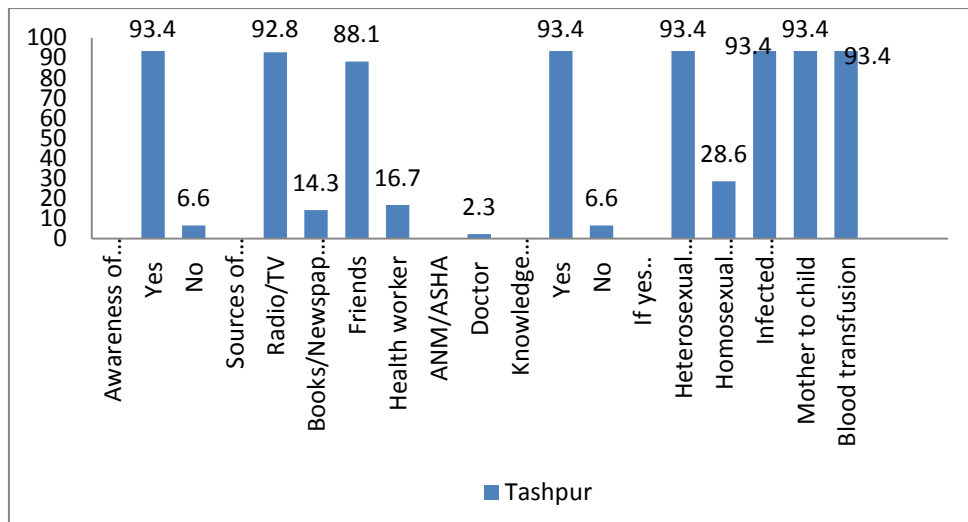


Figure4.43.1: Awareness of HIV/AIDS among Respondents in Tashpur Village

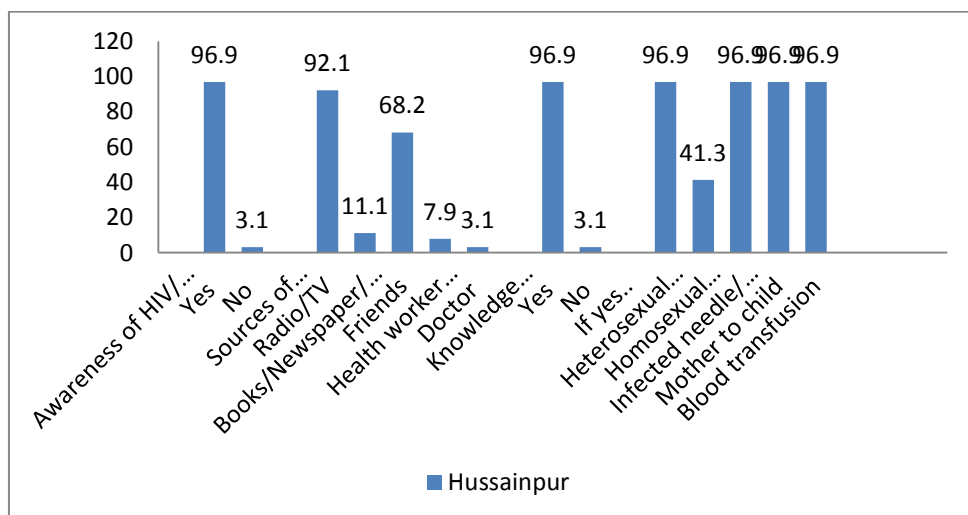


Figure4.43.2: Awareness of HIV/AIDS among Respondents in Hussainpur Village

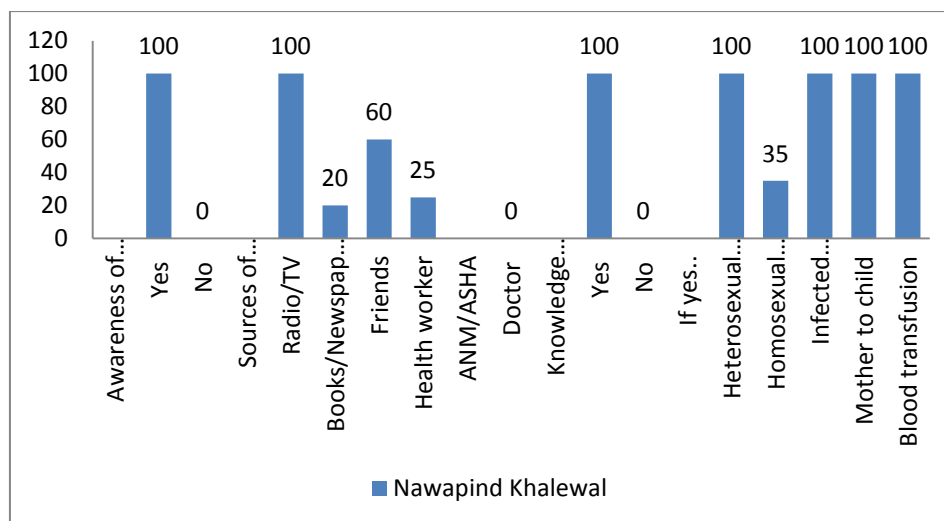


Figure4.43.1: Awareness of HIV/AIDS among Respondents in Nawapind Khalewal Village

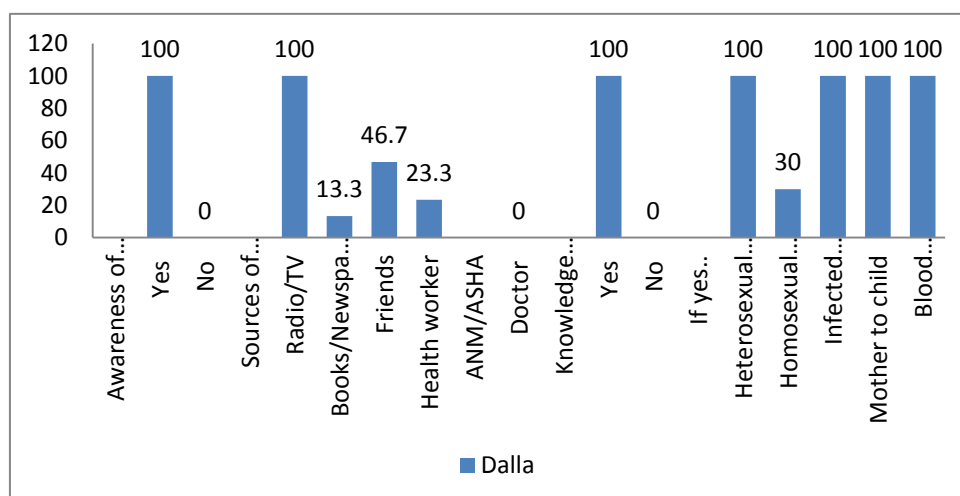


Table 4.43.4: Awareness of HIV/AIDS among Respondents in Dalla Village

The data presented in Table 4.43 and Figure 4.43.1 to Figure 4.43.4 reflects the awareness of HIV/AIDS among respondents from four villages. In Tashpur, 93.4% of the population is aware of HIV/AIDS, while 6.6% are not. The primary sources of information are Radio/TV (92.8%), friends (88.1%), and Books/Newspaper/Magazine (14.3%). Health workers and doctors contribute to 16.7% and 2.3% of the information source, respectively. In Hussainpur, the awareness is slightly higher at 96.9%, with

only 3.1% unaware. The majority get their information from Radio/TV (92.1%) and friends (68.2%). Books/Newspaper/Magazine, health workers, and doctors contribute to 11.1%, 7.9%, and 3.1% of the information source, respectively. In Nawapind Khalewal, all respondents (100%) are aware of HIV/AIDS. All of them get their information from Radio/TV and 60% from friends, Books/Newspaper/Magazine and health workers contribute to 20% and 25% of the information sources respectively. In Dalla, similar to Nawapind Khalewal, all respondents (100%) are aware of HIV/AIDS. All of them get their information from Radio/TV, and 46.7% from friends. Books/Newspaper/Magazine and health workers contribute to 13.3% and 23.3% of the information source, respectively. In terms of knowledge regarding the mode of transmission, 96.9% of the total population is aware. The known modes of transmission include heterosexual intercourse (96.9%), infected needle/blades (96.9%), mother to child (96.9%), blood transfusion (96.9%), and homosexual intercourse (34.9%).

Discussions

- The findings of this study highlight several important aspects of health seeking behaviour among women in rural Punjab. Firstly, the results indicate that women with higher education and economic status are more likely to utilize health care services. However, the study also reveals that even among less educated women, sound economic status also follow the proper care.
- The study also highlights the importance of husband's education level in influencing treatment preference either government or private and family planning decisions.
- The results also indicate that reproductive health issues are common among women in four villages. The overall preference for government and private hospitals is more and allopathy is more consistent. However, the finding that RMP doctors are the most preferred option in two villages (Hussainpur and Nawapind Khalewal).
- The study's findings on antenatal care are reliable but folic acid consumption is low. The high miscarriage rate in Tashpur village is a cause for concern.

- The results also highlight the role of health workers in providing advice on institutional delivery and antenatal care. The finding that majority of women had their antenatal checkup on time.
- The study's finding that majority of women received treatment for postnatal care from private hospitals rather than government hospitals,
- The results also highlight the importance of breastfeeding and the challenges faced by some mothers. The finding that majority of mothers initiated breastfeeding immediately.
- The study's findings that majority of women are aware of the appropriate age for introducing supplementary food.
- The results also highlight the importance of awareness about contraception. There is low awareness to birth patches and female condom due to their education and withdrawal method is more common due to their husband autonomy.
- The finding that majority of women are aware of the danger of HIV/AIDS but awareness about other reproductive health issues such as RTIs and STDs is low.

SUMMARY

A vivid examination of Women's Health Seeking Behaviour in context of reproductive and child health in Punjab reveals that Attainment of medical services in relation to reproduction: antenatal and post natal care, childbirth, gap between child-birth, child health, use of contraception, seeking professional help for gynaecological abnormalities and So the women respondents are not in a position to decide the utilization of services by her. It is found out that the control of family planning and usages of necessary contraception in the hands of husbands of the respondents, Punjab being a highly patriarchal society. In HSB minor visible change found due to women's educational attainment, government interventions or women financial independence. Government Intervention and the awareness wave created by Feminist Movements divulges that the women reproductive health is affected due to the lack of family planning and methods of family planning for the issue of high degree of gender discrimination.

In this scenario, women empowerment as an ideal construct is the ultimate agenda to make women realize their human rights of equality, and sexual & reproductive rights, which can mitigate the ongoing problems of women health, hazards related to child birth and child health.

CHAPTER V

SUMMARY AND CONCLUSION

The study of women's health-seeking behaviour holds significant importance. Preventing and curing diseases depend more on behaviour than medicine, it is essential to examine whether Indian women can adopt health-favourable behaviour. The unequal health status of women is a global issue, and despite efforts towards a common standard of living outlined in the Universal Declaration of Human Rights. Women continue to suffer from poor health worldwide. In Indian society, socio-cultural norms relegate women to a lower position in the gender hierarchy, depriving them of the freedom to make choices related to food consumption and health-related behaviour. In addition, they are expected to uphold the honour of their husbands through their actions. From a young age, girls are taught that their own desires and needs are secondary to those of their family and husband. Women rely on their male counterpart for access to healthcare as well as decision-making related to their health, including choosing a doctor, treatment location, and types of medication (Allopathy or other). Consequently, they face barriers not only to healthcare services but also to their freedom.

Health-seeking behaviour is a complex phenomenon that significantly impact on the well-being of an individual, family, and community. In the context of reproductive and child health in Punjab, our study delved into central aspects such as present reproductive problems and their treatment preference, antenatal care and postnatal care behaviour, child care seeking behaviour, and awareness and use of family planning methods and awareness regarding RTIs and STDs. The primary purpose of our study was to explore health-seeking behaviour patterns among rural women in Punjab. By examining specific dimensions related to reproductive and child health, aimed to contribute to the existing knowledge base and identify the required recommendations. Understanding how women seek healthcare services during crucial life stages is essential for designing effective interventions and improving health outcomes. In the present study, 160 rural women were included as sampled respondents from villages of Tashpur, Hussainpur, Nawapind and Dalla of Kapurthala and Jalandhar districts of Punjab.

THE MAJOR FINDINGS

Understanding the demographic background of the participants is essential in contextualizing the findings of the study, as factors such as age, education, socioeconomic status, and family structure can significantly impact health-seeking behaviour, especially in the terms of reproductive and child health. This analysis also allows us to understand how different segments of the population experience health services differently and how this may influence their reproductive and child health outcomes. The sample for this study consisted of 160 women, all of whom were between the ages of 15 and 49 years, with at least one child. Age distribution shows that 6.3 % of the women were between the ages of 15-24. 40% were between 25-34 years. 53.7 % were between 35-49 years. This shows a balanced representation across various stages of reproductive age. The age distribution provides a broad spectrum of experiences within the reproductive cycle. Women aged 15-24 are typically at the early stages of motherhood and may still be exploring maternal health services for the first time, while women aged 25-34 are more experienced with reproductive and child health practices. The women in the 35-49 age group, often in the later stages of their reproductive years, are likely to have experienced multiple pregnancies and may have a wealth of personal health-seeking experiences. Religion and caste reveals 81.3% of the women identified as Sikh. 15.6 % identified as Hindu and 3.1% are muslims. A majority (71.9%) belonged to the scheduled caste (SC) or other backward classes (OBC). Caste and religion can often intersect with socioeconomic and health-seeking behaviors in India, making these findings relevant to the analysis. Caste plays a major role in access to healthcare in rural India, with marginalized castes often facing discrimination and exclusion from mainstream health services. These women may have more limited access to healthcare, both due to economic constraints and social barriers related to caste-based discrimination. Education is a significant factor in determining access to and understanding of reproductive and child health. 4.4 % of the women were illiterate. 26.8 % had received primary, middle and high school education. 38.1% had completed secondary education. 26.9 % had completed higher education or beyond. The data reveals that the majority of the women had basic or no formal education, which may hinder their ability to engage with healthcare providers, understand medical instructions, and recognize the importance of timely health

interventions. Women with higher education levels are more likely to seek health services and adopt preventive health behaviors, as education is closely tied to health literacy. However, even among less educated women, sound economic status plays an important role in promoting proper care. Educational qualification of the respondent's husband does matter, as he is the one who is going to take the decisions related to family planning. The research discloses that majority of the respondent's husbands have completed education up to secondary level only. In the terms of occupation 61.2% of the women were housewives. 22.5 % were employed in public and private sectors and 16.3% were engaged in local labor or small businesses. The fact that majority of the women were housewives highlights the traditional gender roles prevalent in the region. Being a housewife often means having limited autonomy and financial independence, which can restrict a woman's ability to seek healthcare. Women working in labor may also face challenges, such as time constraints and physical exhaustion, which limit their ability to access health services, particularly if these services are located far from their homes. 55% of the participants came from families who have low socio-economic status. 33.8% belonged to lower-middle-income households. Only 11% reported belonging to middle class status. The economic profile of the participants demonstrates that a significant proportion of the women come from financially disadvantaged background. This economic strain could delay or prevent access to essential maternal health services, such as antenatal care or institutional deliveries, which are essential for preventing complications. The significant proportion of nuclear families (46.9 %) in the sample is an interesting demographic feature and 53.1% lived in joint family setting. Family structure plays a key role in reproductive health decision-making, and the prevalence of nuclear families suggests that the women may have more direct influence on household decisions compared to those in joint family settings. Women in nuclear families may have more direct decision-making power regarding their health compared to those in joint families, where decisions are often made by senior family members and husbands particularly in rural areas. The menarche age distribution indicates a trend where the majority of women experienced menarche between the ages of 13-14 years, with variations observed across four villages and average marriage is 18-21year of age group (40%) followed by 22-25 (39.3%) are revealed. The number of children is

primary element for understanding their reproductive history and experiences with antenatal and postnatal care. 39.4% of women had one child. 45% had two children. 15.6 % had three or more children.

Understanding these demographic variables is important for designing health interventions that are tailored to the needs of these women, addressing the unique challenges they face in seeking care for themselves and their children.

The findings revealed that the most common reproductive issue related to menstrual health was abdominal pain, affecting 94.1% of those with abnormalities, followed by backache (58.8%). Irregular menses and over bleeding were less common, affecting 26.5% and 14.7% respectively. There were no reports of less bleeding, failure to menstruate, or menopause across the villages. The prevalence of PCOD (33.3%) and fibroids is generally low. Leucorrhoea (16.7%) is less common. 9.4% cases of anaemia were found. In terms of treatment preference, the majority of Tashpur (53.3%) and Hussainpur (42.4%) residents prefer private hospitals, while a significant proportion of Nawapind Khalewal (58.3%) prefers RMP doctors and Dalla (68.4%) residents prefer government hospitals. RMP Doctors are the second most preference in Hussainpur (30.3%) followed by Tashpur (20%). Overall, government hospitals are the most preferred (36.7%), followed by private hospitals (34.2%) and RMP Doctors (29.1%). This data suggests a strong inclination towards allopathy and a mixed preference for treatment facilities across the all village. Allopathy dominates with a 96.2% preference, followed by Homeopathy (2.5%) and Ayurvedic (1.3%). These preference are associated with, such as accessibility, cost, and quality of care.

Findings revealed that the average child bearing age is 55.6% in the 20 to 24 years of age group and Tashpur has a high miscarriage rate at 66.7%.

It is evident from the findings that all pregnancies were registered in all four villages, indicating a 100% registration rate. Majority of respondents (98.1%) in all villages had their first checkup within the first three months of pregnancy. Very few reported to hospitals after 3rd month of pregnancy due to lack of awareness for their pregnancy. This data shows that a strong adherence to early antenatal check-ups across all villages Private hospitals were slightly more preferred (55.6%) than government hospitals (44.4%) for pregnancy checkups. It underscores the importance

of early antenatal care and the role of both private and government facilities in providing this care. Major findings revealed that 18.8% respondents had a less than 4 antenatal checkups history and 13.3 % women did not take iron and folic acid during pregnancy due to lack of knowledge. They do not have awareness folic acid is necessary for their foetus development. The present data highlights the health workers played a significant role in all villages, for advice on institutional delivery (100%), also provided antenatal care advice with a particular focus on antenatal diet and institutional delivery, when respondents were pregnant. These findings inform approximately half of the women had suffered from nausea and vomiting during their pregnancy time, 11.2% of women had pregnancy anaemia, 10.6% and 11.9% of respondents reported visual disturbances and hypertension respectively. Private hospitals were favoured by a significant proportion (70.5%) of pregnant women. In summary, across all villages, doctors played a vital role in delivery care. Private hospitals were favored, and the mode of delivery varied. The present findings revealed the accessibility to healthcare facilities and informed decision-making during childbirth. Approximately 86.9% of deliveries were conducted by doctors, 8.7% and 4.4% of deliveries were handled by nurses and dais respectively. The majority (64.4%) of deliveries occurred in private hospitals. Around 26.2% of deliveries took place in government hospitals, only 1.3% of deliveries happened in nursing clinics and 8.1% of deliveries occurred at home. The highest proportion (42.5%) of deliveries involved caesarean sections. The study findings indicate that the overall stillbirth rate (3.1%) is relatively low. However, it remains essential to focus on specific factors, including timely healthcare access, effective labor management, and placental health, to further reduce the occurrence of stillbirth. While examining postnatal care it is found that approximately 3.8% of women reported health problems during the first six weeks after childbirth and highlights the Postpartum hemorrhage (0.6%) case reported in Hussainpur village. Most of the women received treatment, 5.6% from doctors, private hospitals were the preferred place for seeking postnatal care (5.6%). All women (100%) participated in regular postnatal checkup. Health workers visited 88.8% of the women and primarily provided advice related to physical health (54.2%), breastfeeding (88.1%), immunization (89.4%) and the child's development and health (82.4%) but mood changes were not commonly addressed. These findings

highlight the importance of ASHA and aganwadi workers engagement and the need for targeted interventions to improve postnatal care and health-seeking behaviour among women in these areas. The collected data sheds light on 95% women practiced breastfeeding in these rural areas and the timing of the first breastfeed. It also underscores the challenges faced by some mothers (5%), such as digestion and excretion issues. Most of the mothers initiated breastfeeding immediately after birth (24.3%), some delayed it by a few hours (15.8%), (19.1%) practiced within a day, and Significant number of women started breastfeeding after one day(40.8%).Very few mothers practiced squeeze their breasts before breastfeeding which is 5.3%. The data revealed that breastfeeding is common in these rural areas, with most mothers chosen to breastfeed their infants. However, there are variations in timing and practices. Maternal confidence, psychological preparedness and social support are the causative factors. Efforts to educate mothers about immediate breastfeeding initiation and proper techniques could further improve breastfeeding rates. Additionally, addressing these concerns related to digestion and excretion may contribute to better breastfeeding outcomes. When it comes to knowledge and practices related to supplementary feeding and breastfeeding for their, the data revealed significant propotion. 50% of women are aware of the appropriate age for introducing supplementary food and 4.4% have a poor knowledge. There is significant variation in knowledge across villages. Tashpur has the highest awareness, while Hussainpur has the lowest. Education levels may play a potential role. Respondents with higher education rates tend to have better awareness. Access to health programmes and community awareness campaigns can impact the knowledge. While there is universal knowledge about diarrhoea and ORS (100%) in all participants, the knowledge given regarding the danger signs of pneumonia is significantly lower at 98.8%. The primary source of knowledge is health workers, indicating the importance of these professionals in distributing health information in community. Results provides the past and present health status of children in these villages, highlighting the occurrence of diarrhea was common(11.3%) than pneumonia(1.2%) and the reliance on private hospitals for treatment and 100% of children were reported to have complete immunization, indicating a strong adherence to immunization programmes in these areas. In cases of present illness fever-related symptoms are more common. It

revealed that the women (26.2%) do not have an adequate knowledge gap ideal gap between children. It is interpreted that though majority of women respondent have awareness related to contraception they do not know different types contraceptive methods such as intrauterine devices (IUDs) or contraceptive loops (99.3%) and birth patches (3.1%) and female condom (3.1%) remained limited. Female sterilization emerged as the most widely recognized method, followed by oral contraceptive pills and condoms. However, it became evident that the complexity of explaining and demonstrating these methods make challenges. Health workers, including Auxiliary Nurse Midwives (ANMs) and Accredited Social Health Activists (ASHAs), expressed difficulties in educating women about these techniques due to their technical nature and the need for precise administration. Additionally, the cost associated with certain contraceptive devices may contribute to the lack of awareness. This shows the patriarchal nature of dominance over women. Indian society completely discards male sterilization but it has accepted female sterilization instead. It is evident from the findings that only 11.9% women respondents are reported using contraceptives. Among these, no one reported using female condoms, birth patches, or the rhythm method. The most common method was female sterilization (12.5%), followed by pills (0%) and IUD/Copper T (3.1%). The majority of respondents (88.1%) reported not using any contraceptives. The finding suggests that while contraceptive usage varies across villages, female sterilization is the most common method where contraceptives are used. While studying the respondent's husband's reproductive behaviour, it is found out that the use of male condoms is at 29.5%, male sterilization is at 1.3%, and the withdrawal method is the most common contraceptive method, used by 69.2% of the respondents. Most of the respondents (60.9%) get contraceptives from private hospital or chemist shop. This data provides valuable insights into the contraceptive practices across these villages, highlighting the predominance of the withdrawal method and the varying usage rates of male condoms. However, a significant majority of respondents across all villages do not use contraceptives. This could indicate a need for increased awareness and accessibility of various contraceptive methods in these areas. While some contraceptive methods like sterilization, pills, and withdrawal method are universally understood across all villages, awareness regarding others like the female condom and

birth patches are significantly low. The study discloses that the sampled women respondents are well aware of the danger of the mode of transmission and effect of HIV/AIDS. The knowledge regarding the mode of transmission of is HIV/AIDS 96.9%. The known modes of transmission include heterosexual intercourse (96.9%), infected needle/blades (96.9%), mother to child (96.9%), blood transfusion (96.9%), and homosexual intercourse (34.9%). The study reveals that 96.9% women respondents are aware of the danger of HIV/AIDS across the four villages. The primary sources of information are broadcasted national health advertisements related to the same on Radio/TV (96.9%), friends (68.4%), and Books/Newspaper/Magazine (13.5%). Health workers and doctors contribute to 15.5% and 1.9% of the information source, respectively. On the other hand only 3.1% respondents have a complete knowledge regarding RTIs and STDs. This necessitates a need for targeted educational interventions to increase awareness of less-known contraceptive methods, and RTIs and STDs.

Understanding the healthcare-seeking behaviour of women is important for providing basic healthcare services and formulating strategies to improve their access to healthcare. Policymakers have long grappled with the challenge of addressing the health-seeking patterns of Indian women, which are influenced by factors such as their low social status, poverty, vulnerability during childbirth, and lack of knowledge and empowerment. Education has become an essential facilitator, as women with higher levels of education show greater awareness and active participation in antenatal and postnatal services. Employment status had a two fold impact: women in paid jobs tended to navigate health systems on their own, whereas those involved in unpaid domestic work often depended on male or older family members for permission and mobility. Family decision-making and the husband's role further complicate this, as many women lack autonomy over their health, including contraceptive use, which is often disregarded by male partners who show limited concern for female health needs. The research indicates that women have limited use of government health care services despite their close proximity to health care services centres. To address this issue, policymakers should refocus maternal and child health services to empower Anganwadi Workers (AWWs) to serve as role models and advocates for women's health. This study helps to understand how the

healthcare behaviour of women would change if barriers such as information and knowledge were no longer obstacles. By studying the health-seeking behaviour of women, the research seeks to shed light on key motivational gaps and pave the way for further studies. The findings of the study suggest that simply possessing knowledge and awareness is not sufficient to encourage women to seek healthcare from the government sector. The influence of patriarchal family structures, where men often make decisions on matters of family planning and healthcare, limits women's ability to prioritize their health independently.

5.2. Recommendations to Enhancing Health Seeking Behaviour and Survival for Women and Child

Outlined below are three strategies aimed at enhancing the accessibility and quality of healthcare, as well as raising awareness among women. Each of these solutions is elucidated through varying approaches and case studies.

1. Integrating Health Education into Formal Curriculum: Introducing modules on reproductive and child health in school curriculum especially for girls in secondary education can lay the foundation for informed health decisions in adulthood. Adult literacy programmes that incorporate basic health awareness can also prove effective in reaching women who did not benefit from formal education earlier.

2. Promoting Women's Economic Empowerment: Empowering women economically can significantly influence their health-seeking decisions. Implementing income-generating programmes and self-help groups with microfinance support may foster independence and increase prioritization of health needs. Financial literacy campaigns tailored for women in marginalized communities could also enhance their ability to manage health-related expenses effectively.

3. Promotion of Tele-medicine/Tele-health: This involves addressing patients' needs using remote technology. Telemedicine enables rapid access to remote medical expertise through telecommunication and information technology, thereby reducing the cost of service delivery and enhancing healthcare access. Given the scarcity of doctors and hospitals in rural areas, telemedicine solutions should be introduced as a compelling option that would allow women to directly

interact with specialist doctors, even when located in distant regions. With the increasing penetration of the internet, telemedicine can be leveraged to expand health access.

4. Awareness regarding Digital Health System: It is also known as e-health should be enforced in rural areas, as it offers network oriented health services through various online platforms. These services are accessible through mobile applications and are part of the digital India program. For example, the Vaccine Tracker app helps parents track their children's immunization status. Furthermore, the Kilkari mobile app initiative delivers audio messages about pregnancy, childbirth, and child care directly to families and parents. These programs have significantly benefited women in remote villages and rural areas who have smartphones and can access these facilities.

5. Mobile Medical Units: With technological advancements, mobile medical vans have evolved into health system, allowing for greater speed and efficiency in providing healthcare services. These mobile medical units should be introduced to rural areas to reduce the fear, cost and hesitation related to transport. These vans can raise awareness, ensure preventive vaccinations, and encourage regular medical check-ups among the rural women.

6. Effective Community Health Initiatives: These should be introduced to rural areas for the overall development of maternal health status. The NHM workers are not taking care of informing women related to adequate knowledge of antenatal and postnatal childbirth, disease such HIV/AIDS or proper family planning. Evaluation units should be put up at least in every block to securitize the effectiveness of these NHM workers. The slogan "Healthy Women, Healthy World" underscores the pivotal role women play as guardians of family health, consequently contributing significantly to the well-being of their communities. It is the shared responsibility of all involved parties to ensure that women receive quality health care.

7. NGO and Corporate intervention: N.G.Os and corporate bodies should approach the group of rural women along with their ethical responsibility in improving healthcare services for women in remote areas, as outlined in the National Health Policy. The government should address policy making,

implementation, monitoring, evaluation, training, and research related to better maternal health of rural women. Notably, numerous NGOs and corporate entities are actively involved in healthcare, either through direct engagement with target groups or by advocating for healthcare reforms. However, challenges in women's health persist, underscoring the necessity for sustained commitment from the government, NGOs, CSR, and families, as well as a conducive policy environment and targeted resources to achieve the overarching goal of addressing women's health issues.

SUMMARY

In summary, maintenance and promotion of health is generally connected with primary care and awareness, knowledge and practice by individual, family and community. The optimum level of fulfilling both productive and reproductive role of women is overall well-being of society.

Education is often seen as the cornerstone of human resources, but it's equally important for health workers such as NHM workers to collaborate with folk media, involve religious leaders, traditional healers, and other health professionals to empower rural women in India. By providing rural women with the right information and access to healthcare, they can take better care of themselves, their families, and their communities. Understanding cultural nuances will enable us to educate rural women more effectively. It's essential for social workers, and health professionals to be mindful of the cultural dynamics of the communities they serve, as culture plays a significant role in women's health, impacting families and society as a whole. Neglecting the influence of culture in our work limits our ability to connect with and aid families and children, and culturally insensitive practices can even harm the clients.

REFERENCES

- Ade A., Revati S., & Kulkarni A. (2014). Reproductive health profile and health seeking behaviour among Muslim women of urban slum of Raichur, Karnataka. *International journal of research in health sciences*, 2(2), 444-448.
- Adler, N. E., et al. (2016). Socioeconomic status and health: The challenge of the gradient. *American Psychologist*, 71(8), 1-15.
- Agarwal, A. K., Mishra, J., Verma, P. K., Mahore, R., & Verma, R. (2014). Knowledge, attitudes, and treatment-seeking behaviour related to reproductive tract infections (RTIs) and sexually transmitted infections (STIs) among married women attending Suraksha Clinic in North Madhya Pradesh, India. *Journal of Reproductive Health*, 1(1), 1-10.
- Agus, Y., Horiuchi, S. Factors influencing the use of antenatal care in rural West Sumatra, Indonesia. *BMC Pregnancy Childbirth* 12, 9 (2012). <https://doi.org/10.1186/1471-2393-12-9>
- Ahmed, S.M., Abd-El Rahman, T.A., & Masoed, E.S. (2013). "Mothers' awareness and knowledge of under five years children regarding immunization in Minia city Egypt." *Life Science Journal*, 10(4), 1224-1232
- Aigbokhaode, A. Q., Isah, E. C., & Isara, A. R. (2023). Health seeking behaviour among caregivers of under-five children in Edo State, Nigeria. *South Eastern European Journal of Public Health*, 3, 52.
- Akibu, M., Tsegaye, W., Megersa, T., & Nurgi, S. (2018). Prevalence and Determinants of Complete Postnatal Care Service Utilization in Northern Shoa, Ethiopia. *Journal of pregnancy*, 8625437. <https://doi.org/10.1155/2018/8625437>
- Al-Ateeq, M. A., & Al-Rusaies, A. A. (2015). Health education during antenatal care: the need for more. *International journal of women's health*, 7, 239-242.
- Ali, Y.A., Akhtar, A.Q., Malik, M.A., Hasan A (2004) .Factors affecting utilization of Antenatal Care among women in urban slum areas of Islamabad. *Rawal Medical Journal*, 9(4), 71-75.
- Allendorf K. (2010) The quality of family relationships and use of maternal health-care services in India. *Stud Fam Plann*, 41(4), 263-76.

- Andersen, R. M., et al. (2014). Changing the US health care system: Key issues in health services policy and management. Jossey-Bass, 4th Edition.
- Anderson JG. Health services utilization: framework and review. *Health Services Research*. 1973 ;8(3):184-199. PMID: 4593850; PMCID: PMC1071757.
- Andersson-Ellström, A., & Milsom, I. (2002). Knowledge about the prevention of sexually transmitted diseases: a longitudinal study of young women from 16–23 years of age. *Sexually transmitted infections*, 78(5), 339-341.
- Andre, FE, Booy, R, Bock, HL, Clemens, J, Datta, SK. et al. (2008). Vaccination greatly reduces disease, disability, death and inequity worldwide. *Bulletin of the World Health Organization*, 86 (2), 140-146. Retrieved from <http://dx.doi.org/10.2471/BLT.07.040089>
- Angelillo, I. F., Ricciardi, G., Rossi, P., Pantisano, P., Langiano, E., & Rossano, F. (1999). Mothers and vaccination: knowledge, attitudes, and behaviour in Italy. *Bulletin of the World Health Organization*, 77(3), 224-229.
- Apter, D., & Vihko, R. (1983). Early menarche, a risk factor for breast cancer, indicates early onset of ovulatory cycles. *The Journal of clinical endocrinology and metabolism*, 57(1), 82–86. <https://doi.org/10.1210/jcem-57-1-82>
- Awasthi, M. S., Awasthi, K. R., Thapa, H. S., Saud, B., Pradhan, S., & Khatry, R. A. (2018). Utilization of Antenatal Care Services in Dalit Communities in Gorkha, Nepal: A Cross-Sectional Study. *Journal of pregnancy*, <https://doaj.org/article/d631f5f5a2c348a0bb0131074c52da88>
- Aziz Ali, Sumera & Dero, Aftab & Savera, Aziz & Ali, Gulshan. (2018). Factors-affecting-the-utilization-of-antenatal-care-among-pregnant-women-a-literaturereview. *Journal of Pregnancy and Neonatal Medicine*, 2(2), 41-45. https://www.researchgate.net/publication/328043592_Factors-affecting-the-utilization-of-antenatal-care-among-pregnant-women-a-literature-review
- Bajaj, A., Latha, P., & Sharma, U. (2017). A Study to Assess the Knowledge and Attitude among Primigravidae Mothers Regarding Safe Reproductive Child Health in a Selected Hospital of Moga, Punjab. *International Journal of Health Sciences and Research*, 7(6), 262-265
- Balarajan, Y., Selvaraj, S., & Subramanian, S. V. (2011). Health care and equity in India. *The Lancet*, 377(9764), 505-515.

Barbhuiya, F. (2014). Millennium Development Goals (MDGs) and Maternal Health in India: The Long Road Ahead. *Social work*, 5(1), 1-9.

Beggs, B., Koshy, L. & Neiterman, E. (2021). Women's Perceptions and Experiences of Breastfeeding: a scoping review of the literature. *BMC Public Health* **21**, 2169

Berkman, L. F., et al. (2014). *Social epidemiology*. Oxford University Press.

Beson, P., Appiah, R. & Adomah-Afari, A. (2018). Modern contraceptive use among reproductive-aged women in Ghana: prevalence, predictors, and policy implications. *BMC Women's Health* **18**,157 <https://doi.org/10.1186/s12905-018-0649>

Bhandari, P. (2023, June 22). Triangulation in Research | Guide, Types, Examples. Scribbr. Retrieved from <https://www.scribbr.com/methodology/triangulation/>

Bhasin, S., Shukla, A. & Desai, S. (2020). Services for women's sexual and reproductive health in India: an analysis of treatment-seeking for symptoms of reproductive tract infections in a nationally representative survey. *BMC Women's Health*, **20**, 156. Retrived from. <https://doi.org/10.1186/s12905-020-01024-3>

Bhattacharyya, A.; Chakraborty, R.; Raj, T.; Comprehensive Knowledge about HIV/AIDS among Women of Reproductive Age in India. *Epidemiologia* **2023**, *4*, 492-504. <https://doi.org/10.3390/epidemiologia4040041>

Biro, F. M., Pajak, A., Wolff, M. S., Pinney, S. M., Windham, G. C., Galvez, M. P., & Teitelbaum, S. L. (2018). Age of menarche in a longitudinal US cohort. *Journal of pediatric and adolescent gynecology*, 31(4), 339-345.

Bolarinwa, O. A., Ahinkorah, B. O., Seidu, A. A., Ameyaw, E. K., Saeed, B. Q., Hagan Jr, J. E., & Nwagbara, U. I. (2021, April). Mapping evidence of impacts of COVID-19 outbreak on sexual and reproductive health: a scoping review. In *Healthcare* (Vol. 9, No. 4, p. 436). MDPI.

Breslow, L. (2006). Health measurement in the third era of health. *American Journal of Public Health*, 96(1), 17-19. <https://doi.org/10.1186/s12889-021-12216-3>

Cabrera, J. P. (2018). Maternal Role Attainment Theory: Promoting Maternal Identity and Family Health. *International Journal of Childbirth Education*, 33(2).

"District Census Hand Book – Jalandhar"(PDF). Census of India. Registrar General and Census Commissioner of India.

Canelón SP, Boland MR.(2020) A Systematic Literature Review of Factors Affecting the Timing of Menarche: The Potential for Climate Change to Impact Women's Health. *International Journal of Environmental Research and Public Health*,17(5),1703. <https://doi.org/10.3390/ijerph17051703>

Census 2011. (n.d.). Jalandhar City Population Census 2011-2021 | Punjab. Retrieved from https://www.census2011.co.in/census/city/8-jalandhar.html#google_vignette

Census of India 2011: Jalandhar, Punjab. (n.d.) Retrieved from <https://www.census2011.co.in/data/town/800166-jalandhar-punjab.html>

Chandhiok, N., Singh, K. H., Sahu, D., Singh, L., & Pandey, A. (2015). Changes in exclusive breastfeeding practices and its determinants in India, 1992–2006: analysis of national survey data. *International breastfeeding journal*, 10(1), 1-13.

Chaudhary A, Satija M, Sharma S, Singh S, Girdhar S. (2017). Reproductive behaviour of newly married women in rural Punjab, India: A longitudinal study. *J Family Med Prim Care*, 6(3),568-573. doi: 10.4103/2249-4863.213948. PMID: 29417010; PMCID: PMC5787957.

Child Marriage India. (2019, February 18) Childlineindia.org.in. <https://web.archive.org/web/20190218193152/http://childlineindia.org.in/child-marriage-india>.

Chirwa E, Malata A, Norr K. (2011).HIV prevention awareness and practices among married couples in Malawi. *Malawi Med J*, 23(2):32-7. doi: 10.4314/mmj.v23i2.70745. PMID: 23074809; PMCID: PMC3627691.

Climate-Data.org. (n.d.). *Kapurthala climate: Weather Kapurthala & temperature by month*. Retrieved from <https://en.climate-data.org/asia/india/punjab/kapurthala-51395/>

Cox, B.D. Phillimore, P. M. Blaxter, A.J.L. Buckle , The Health and Lifestyle Survey, Health Promotion Research Trust, London, (1987). *Journal of Social Policy*, 17(4), 562–564. doi:10.1017/S0047279400017141

Culture – Government of Punjab, India. (n.d.). <https://punjab.gov.in/culture/>

Daniel,B., &Gill, K. (2021). A descriptive study to assess the postnatal care practices of mothers selected from different cultures, Ludhiana, Punjab. *IJCRT*, 9(3), 435-442.

- Dhillon, P., Singh, G., Ram, F., Kumar, P., & Saggurti, N. (2021). Increasing role of abstinence and infecundity in non-use of contraceptive methods in India. *Journal of Biosocial Science*, 53(2), 167-182.
- Dieterich, C. M., Felice, J. P., O'Sullivan, E., & Rasmussen, K. M. (2013). Breastfeeding and health outcomes for the mother-infant dyad. *Pediatric Clinics of North America*, 60(1), 31-48.
- Dr K. Evang, (1967) The Position of the Medically Trained Person in the Administration of Health Services. *International Review of the Red Cross*, 7(75), 339–340. doi:10.1017/S002086040008267X
- Dutta, D. C., & Konar, H. (2018). DC Duttas textbook of obstetrics: including perinatology and contraception. New Delhi, India: Jaypee.
- Fathalla, M. F. (1993). Contraception and women's health. *British medical bulletin*, 49(1), 245-251.
- Geta, M.B., & Yallew, W.W. (2017). Early Initiation of Antenatal Care and Factors Associated with Early Antenatal Care Initiation at Health Facilities in Southern Ethiopia.
- Ghosh, R., Mozumdar, A., Chattopadhyay, A., & Acharya, R. (2021). Mass media exposure and use of reversible modern contraceptives among married women in India: An analysis of the NFHS 2015–16 data. *PloS one*, 16(7), e0254400.
- Gwande K. B., Srivastava A. S., Kumar P. (2018). Reproductive tract infection and health seeking behaviour: a cross sectional community based study. *International journal Community Med Public Health*, 5(4), 1524-1528
- Hall, M. A., et al. (2002). Trust in physicians and medical institutions: What is it, can it be measured, and does it matter? *The Milbank Quarterly*, 79(4), 613-639.
- Haque, Md. A., Hossain, Md. S. N., Chowdhury, M. A. B., & Uddin, Md. J. (2018). Factors associated with knowledge and awareness of HIV/AIDS among married women in Bangladesh: evidence from a nationally representative survey. *SAHARA-J: Journal of Social Aspects of HIV/AIDS*, 15(1), 121-127. <https://doi.org/10.1080/17290376.2018.1523022>
- Hasan, M.N., Tambuly, S., Trisha, K.F. et al. Knowledge of HIV/AIDS among married women in Bangladesh: analysis of three consecutive multiple indicator cluster

surveys (MICS). *AIDS Res Ther* **19**, 68 (2022). <https://doi.org/10.1186/s12981-022-00495-8>

History of jalandhar , <https://www.jalandharonline.in/city-guide/history-of-jalandhar>
History of kapurthala, <https://www.kapurthalaonline.in/city-guide/history-of-kapurthala>

Hossain, M., Mani, K. K., Sidik, S. M., Shahar, H. K., & Islam, R. (2014). Knowledge and awareness about STDs among women in Bangladesh. *BMC public health*, 14(1), 1-7.

Husmillo, M. (2013). Maternal role attainment theory. *International Journal of Childbirth Education*, 28(2), 46-49.

Ibarra-Nava, I., Choudhry, V. & Agardh, A. Desire to delay the first childbirth among young, married women in India: a cross-sectional study based on national survey data. *BMC Public Health* **20**, 350 (2020). <https://doi.org/10.1186/s12889-020-8402-9>

International Institute for Population Sciences (IIPS) and ICF. (2017). National Family Health Survey (NFHS-4), 2015-16: India. Mumbai: IIPS.

Islam, M. M., & Masud, M. S. (2018). Determinants of frequency and contents of antenatal care visits in Bangladesh: Assessing the extent of compliance with the WHO recommendations. *PloS one*, 13(9), e0204752.

<https://doi.org/10.1371/journal.pone.0204752>

Islam, M.A., Sathi, N.J., Abdullah, H.M. *et al.* Factors Affecting the Utilization of Antenatal Care Services During Pregnancy in Bangladesh and 28 Other Low- and Middle-income Countries: A Meta-analysis of Demographic and Health Survey Data. *Dr. Sulaiman Al Habib Med J* **4**, 19–31 (2022). <https://doi.org/10.1007/s44229-022-00001-2>

Janz, N. K., & Becker, M. H. (1984). The health belief model: A decade later. *Health Education Quarterly*, 11 (1), 1-47.

Jones, Chrissie and Heath, Paul (2014) Antenatal immunization: concepts and challenges. *Human Vaccines and Immunotherapeutics*, 10 (7), 2118-2122. (doi:10.4161/hv.29610).

Karlsen, S., Say, L., Souza, JP. *et al.* The relationship between maternal education and mortality among women giving birth in health care institutions: Analysis of the cross

- sectional WHO Global Survey on Maternal and Perinatal Health. *BMC Public Health* 11, 606 (2011). <https://doi.org/10.1186/1471-2458-11-606>
- Kashyap, S., Spielman, A. F., Ramnarayan, N., et al. (2022). Impact of family-centered postnatal training on maternal and neonatal health and care practices in district hospitals in two states in India: A pre–post study. *BMJ Open Quality*, 11, e001462doi:10.1136/bmjoq-2021-001462.
- Kaur, A., Sagar, N., & Mamta. (2018). Comparison of Health Seeking Behaviour among Antenatal Women Residing in Selected Rural and Urban Areas. *International Journal of Health Sciences & Research*, 8(5), 186-191
- Kaur, R., Bisht, N., Dhillon, A., & Kumar, S. (2019). A Study of Knowledge, Attitude, and Practice of Contraception in Reproductive Age Group in Amritsar District of Punjab. *Journal of Medical Science And Clinical Research*, 7(11). DOI: 10.18535/jmscr/v7i11.26
- Kaur, R., Kaur, K., & Kaur, R. (2018). Menstrual hygiene, management, and waste disposal: practices and challenges faced by girls/women of developing countries. *Journal of environmental and public health*.
- Kaur, V. (2015). A Study to Assess the Knowledge among Mothers of Under Five Children Regarding Immunization in Selected Villages of Punjab. *International Journal of Nursing Education*, 7, 119. doi:10.5958/0974-9357.2015.00087.2
- Kishore, J., et al. (2013). Health-seeking behaviour among residents of Delhi, India: A qualitative study. *BMC Public Health*, 13(1), 1-11.
- Know Punjab – Government of Punjab, India. (n.d.). <https://punjab.gov.in/know-punjab>
- Krol, K. M., & Grossmann, T. (2018). Psychological effects of breastfeeding on children and mothers. *Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz*, 61(8), 977-985. <https://doi.org/10.1007/s00103-018-2769-0>
- Kumar, G., Choudhary, T.S., Srivastava, A. et al. (2019). Utilisation, equity and determinants of full antenatal care in India: analysis from the National Family Health Survey 4. *BMC Pregnancy Childbirth* 19,327<https://doi.org/10.1186/s12884-019-2473-6>
- Mahajan, N., & Kaur, B. (2021). Utilization of Postnatal Care among Rural Women in Punjab. *Indian J Community Med*, 46(1), 126–129.

- Mainous, A. G., et al. (2004). Factors influencing physician referrals of patients to specialists. *Family Medicine*, 36(6), 431-437.
- Malik, M., Girotra, S., Roy, D., Basu, S. (2023). Knowledge of HIV/AIDS and its determinants in India: Findings from the National Family Health Survey-5 (2019–2021). *Population Medicine*, 5(May), 13. <https://doi.org/10.18332/popmed/163113>
- Mani, G., Annadurai, K., & Danasekaran, R. (2013). Healthcare seeking behaviour for symptoms of reproductive tract infections among rural married women in Tamil Nadu-a community based study. *Online journal of health and allied sciences*, 12(3 (3)). Retrived from <https://www.ojhas.org/issue47/2013-3-3.html>
- Marphatia, A. A., Ambale, G. S., & Reid, A. M. (2017). Women's marriage age matters for public health: a review of the broader health and social implications in South Asia. *Frontiers in public health*, 5, 269.
- McGuigan, M., & Larkin, P. (2024). Laid-back breastfeeding: knowledge, attitudes and practices of midwives and student midwives in Ireland. *International breastfeeding journal*, 19(1), 13. <https://doi.org/10.1186/s13006-024-00619-y>
- Meleko, A., Geremew, M., & Birhanu, F. (2017). Assessment of child immunization coverage and associated factors with full vaccination among children aged 12-23 months at Mizan Aman Town, Bench Maji Zone, Southwest Ethiopia. *International Journal of Pediatrics*, 2017, 7976587. doi:10.1155/2017/7976587.
- Mercer, R. T. (1981). A theoretical framework for studying factors that impact on the maternal role. *Nursing research*, 30(2), 73-77.
- Ministry of Health & Family Welfare. (2017). National Health Policy. Retrived from <https://main.mohfw.gov.in/sites/default/files/9147562941489753121.pdf>
- Mohammed, A., Tsegaye, W., Megersa, T., & Nurgi, S. (2018). Prevalence and determinants of complete postnatal care service utilization in Northern Shoa, Ethiopia. *Journal of Pregnancy*, 2018, 8625437. <https://doi.org/10.1155/2018/8625437>
- Moscrop, A. (2013). 'Miscarriage or abortion?' Understanding the medical language of pregnancy loss in Britain; a historical perspective. *Medical Humanities*, 39, 98–104. doi:10.1136/medhum-2012-010284.
- Mutowo, J., Yazbek, M., van der Wath, A., & Maree, C. (2021). Barriers to using antenatal care services in a rural district in Zimbabwe. *International Journal of Africa Nursing Sciences*, 15, 100319. <https://doi.org/10.1016/j.ijans.2021.100319>

- Muttreja, P., & Singh, S. (2018). Family planning in India: The way forward. *The Indian journal of medical research*, 148(Suppl 1), S1.
- Nandwani, M., Thokchom, S., Rehman, J. (2015). A Comparative Study to assess the Health-seeking behaviour and Level of Satisfaction of Reproductive and Child Health (RCH) Services among Working and Non-working Women in Reproductive age group of Selected Areas of Imphal West District, Manipur. *International Journal of Science and Research (IJSR)* ISSN (Online): 2319-7064
- Narayana, Rajeshwari & Siddalingappa, Hugara & Mishra, Banani. (2016). Assessment of utilization of antenatal care services by mothers attending immunization sessions at a primary health centre in Mysore district, Karnataka, India. *International Journal of Community Medicine and Public Health*. 2561-2565. 10.18203/2394-6040.ijcmph20163072.
- National Health Systems Resource Centre, 2021 <https://qps.nhsrindia.org/national-quality-assurance-standards>
- Newton, J. N., Briggs, A. D., Murray, C. J., Dicker, D., Foreman, K. J., Wang, H., & Davis, A. C. (2015). Changes in health in England, with analysis by English regions and areas of deprivation, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. *The Lancet*, 386(10010), 2257-2274.
- Nlanjana, S., et al. (2013). “Factors affecting the healthcare-seeking behaviour of mothers regarding their children in rural Darjeeling district.” *Journal of Health Sciences Research*, 8(11), 25-30.
- Nutbeam, D. (2000). Health literacy as a public health goal: A challenge for contemporary health education and communication strategies into the 21st century. *Health Promotion International*, 15(3), 259-267.
- Okech, T. C., Wawire, N. W., & Mburu, T. K. (2011). Contraceptive use among women of reproductive age in Kenya’s city slums.
- Pachauri, S. (2014). Priority strategies for India's family planning programme. *The Indian journal of medical research*, 140(Suppl 1), S137.
- Pandey, B., & Shukla, D. (2018). Perceptions and practices about menstrual hygiene among women of reproductive age group (15-49 years) attending out-patient department of CIMS, Bilaspur Chhattisgarh. *International Journal Of Community*

Medicine And Public Health, 5(7), 3074–3078. <https://doi.org/10.18203/2394-6040.ijcmph20182650>

Papadimitriou, A. (2016). The evolution of the age at menarche from prehistorical to modern times. *Journal of pediatric and adolescent gynecology*, 29(6), 527-530.

Pathak, P. K., Tripathi, N., & Subramanian, S. V. (2014). Secular trends in menarcheal age in India-evidence from the Indian human development survey. *PLoS One*, 9(11), e111027.

Paul, R. A. V., Kalidas, P., Sujatha, K., Senthilkumar, S. K., & Sreesupria, A. (2017). A study on health seeking behaviour among married reproductive age group women in a rural area. *IOSR JDMS*, 16, 811. <https://www.iosrjournals.org/iosr-jdms/papers/Vol16-issue3/Version-13/B1603130811.pdf>

Paul, V. K., Sachdev, H. S., Mavalankar, D., Ramachandran, P., Sankar, M. J., Bhandari, N., & Kirkwood, B. (2011). Reproductive health, and child health and nutrition in India: meeting the challenge. *The Lancet*, 377(9762), 332-349.

Penchansky, R., & Thomas, J. W. (1981). The concept of access: Definition and relationship to consumer satisfaction. *Medical Care*, 19(2), 127-140.

Perez-Escamilla, R., et al. (2023). Breastfeeding: Crucially important, but increasingly challenged in a market-driven world. *The Lancet*, 401(10375), 472–485 <https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736%2822%2901932-8.pdf>

Population Research Centre. (2020-21). *Dynamics of Health Care Services in India*. Retrieved from <https://timesofindia.indiatimes.com/city/chandigarh/rising-hysterectomies-worry-health-experts/articleshow/90023293.cms>

Prusty, R. K., & Unisa, S. (2013). Reproductive tract infections and treatment seeking behaviour among married adolescent women 15-19 years in India. *International Journal of MCH and AIDS*, 2(1), 103.

Purani, C., Patel, P., Gupta, K., Mehariya, K. M., & Holda, A. (2015). Knowledge, awareness, and practice of postnatal care among mothers. *Indian Journal of Child Health*, 2(2), 83-85. DOI: 10.32677/IJCH.2015.v02.i02.011

Rajeev S.V., Radhamani K.V. (2016). A cross-sectional study on immunization status of anganwadi children in a rural area of north Kerala, India.” *International Journal of Research in Medical Sciences*, 4(6), 2039-2043

- Ramachandra, K., Gilyaru, S., Eregowda, A., & Yathiraja, S. (2016). A study on knowledge and practices regarding menstrual hygiene among urban adolescent girls. *Int J Contemp Pediatr*, 3(1), 142-5.
- Reddy, P. M., Rineetha, T., D., Sreeharshika, & Jothula, K. (2020). Health care seeking behaviour among rural women in Telangana: A cross sectional study. *Journal of Family Medicine and Primary Care*, 9, 4778. doi:10.4103/jfmprc.jfmprc_489_20
- Salomon, J. A., Mathers, C. D., Chatterji, S., Sadana, R., Ustun, T. B., & Murray, C. J. (2003). Quantifying individual levels of health: definitions, concepts and measurement issues. *Health Systems Performance Assessment: Debate, Methods, and Empiricism*, 301-18.
- Sambamoorthi, U., Timothy, R., Wei, W., & Rajan, S. I. (2004). Antenatal Care and AIDS Knowledge among Married Women. *Economic and Political Weekly*, 39(7), 721-727.
- Sarkar, S., Danabalan, M., & Kumar, G. (2007). Knowledge and attitude on HIV/AIDS among married women of reproductive age attending a teaching hospital. *Indian Journal of Community Medicine*, 32(1), 82-83. DOI: 10.4103/0970-0218.53416.
- Seifu, B.L., Eshun, G., Tesema, G.A. et al. (2024). Comprehensive knowledge about HIV/AIDS and associated factors among reproductive age women in Liberia. *BMC Public Health* 24,619 <https://doi.org/10.1186/s12889-024-18105-9>
- Sharma D, Goel NK, Thakare MM. (2018) Prevalence of reproductive tract infection symptoms and treatment-seeking behaviour among women: A community-based study. *Indian Journal of Sexually Transmitted Diseases and AIDS*, 39(2), 79-83. DOI: 10.4103/ijstd.ijstd_97_16. PMID: 30623176; PMCID: PMC6298149.
- Sharma, A., & Kumar, B. (2022). Women's autonomy and contraceptive use: Challenges and opportunities. *Journal of Reproductive Health*, 28(3), 123-137
- Sharma, J., O'Connor, M. & Rima Jolivet, R. Group antenatal care models in low- and middle-income countries: a systematic evidence synthesis. *Report Health* 15, 38 (2018). <https://doi.org/10.1186/s12978-018-0476-9>
- Sharma, N & Sharma, S 2017, Reproductive health status of scheduled and non-scheduled castes women of Ludhiana district in Punjab, *International Journal for Intersectional Feminist Studies*, 3 (1), pp. 5-28.

- Sharma, N., Kumar, K. H. V., & Devgan, S. (2017). A study on utilization of antenatal care services in urban slums of Amritsar city, Punjab, India. *International Journal of Community Medicine and Public Health*, 4(3), 698-703
- Sharma, P., & Parthi, K. (2004). Reproductive health services in Punjab: Evidence of access for Scheduled Castes and non-Scheduled Castes. *Social Change*, 34(2), 40-65. <https://doi.org/10.1177/004908570403400204>
- Shora, T. N., Verma, A. K., Jan, R., & Gupta, R. K. (2015). Knowledge regarding antenatal care services, its utilization, and delivery practices in mothers (aged 15-49 years) in a rural area of North India. *Tropical Journal of Medical Research*, 18, 89. DOI: 10.4103/1119-0388.158401
- Shrestha, M. V., Paudel, L., Pant, S., Neupane, S., & Manandhar, N. (2017). Health seeking behaviour among women in Bhimtar, Sindhupalchowk district of Nepal. *Int J Commun Med Public Health*, 4, 1854-7.
- Singh, S., Singh, S. K., & Singh, T. B. (2015). Awareness of sexually transmitted infection (STI)/reproductive tract infections (RTI) and HIV/AIDS in STI/RTI-affected married women of rural areas of Varanasi district, Uttar Pradesh: A cross-sectional study. *Indian Journal of Sexually Transmitted Diseases and AIDS*, 36(1), 114-116.
- Singh, A., Yadav, A., & Singh, A. (2012). Utilization of postnatal care for newborns and its association with neonatal mortality in India: an analytical appraisal. *BMC pregnancy and childbirth*, 12, 1-6.
- Singh, S. (2010). Rural Health in Punjab – Needs Reforms and Investments.
- Smith, E. R., Hurt, L., Chowdhury, R., Sinha, B., Fawzi, W., Edmond, K. M., et al. (2017). Delayed breastfeeding initiation and infant survival: A systematic review and meta-analysis. *PLoS ONE*, 12(7), e0180722.
Retrieved from <https://doi.org/10.1371/journal.pone.0180722>
- Sogarwal, R & Bachani D. (2009) awareness of women about STDs, HIV/ AIDS condom use in india, lesson for preventive programme 32(3). 148-158.
- Syed, U., Asiruddin, S., Helal, M. S., Mannan, I. I., & Murray, J. (2006). Immediate and early postnatal care for mothers and newborns in rural Bangladesh. *Journal of health, population, and nutrition*, 24(4), 508.

- Tarannum, F., Khalique, N., & Eram, U. (2018). A community based study on age of menarche among adolescent girls in Aligarh. *Int. J. Community Med. Public Health*, 5, 395-400.
- Thappa, D. M., & Kaimal, S. (2007). Sexually transmitted infections in India: Current status (except human immunodeficiency virus/acquired immunodeficiency syndrome). *Indian Journal of Dermatology*, 52(2), 78.
- UNFPA India. (2021). *Analytical Series 1: Child Marriage in India - Insights from NFHS-5*. PDF
- UNICEF Executive Director Catherine Russell & WHO Director-General Dr. Tedros Adhanom Ghebreyesus. (2023, August 2). *Joint statement by UNICEF Executive Director Catherine Russell and WHO Director-General Dr. Tedros Adhanom Ghebreyesus on the occasion of World Breastfeeding Week*. UNICEF.
- Unicef. (2018). Child marriage is a violation of human rights, but is all too common. Hentaifrå <https://data.unicef.org/topic/child-protection/child-marriage>. United Nations Population Fund. (1994). Programme of Action adopted at the International Conference on Population and Development, Cairo, 5–13 September 1994 (20th Anniversary Edition)
- United Nations. (2015) *Transforming our world: The 2030 Agenda for Sustainable Development*. Retrieved from <https://sdgs.un.org/2030agenda>
- Upadhyay, M., Lata, K., Yadav, T.C. *et al.* Knowledge, Attitude and Perception of HIV/Aids Among Antenatal Women and its Correlation with their Socio-Demographic Profile: Study from a Tertiary Care Centre of Northern India. *J Obstet Gynecol India* 71, 488–494 (2021). <https://doi.org/10.1007/s13224-020-01422-5>
- Vora, K. S., Saiyed, S., & Natesan, S. (2020). Impact of COVID-19 on family planning services in India. *Sexual and reproductive health matters*, 28(1), 1785378.
- Weinert C, Burman ME. Rural health and health-seeking behaviours. *Annu Rev Nurs Res*. 1994;12:65-92. PMID: 7986579.
- WHO. (2018, February 19). Millennium Development Goals (MDGs). [https://www.who.int/news-room/fact-sheets/detail/millennium-development-goals-\(mdgs\)](https://www.who.int/news-room/fact-sheets/detail/millennium-development-goals-(mdgs))
- World Health Organization. (2000). *Definitions and indicators in family planning maternal & child health and reproductive health used in the WHO regional office for Europe* (No. EUR/00/5017822). Copenhagen: WHO Regional Office for Europe.

- Yadav, R. N., Joshi, S., Poudel, R., & Pandeya, P. (2017). Knowledge, attitude, and practice on menstrual hygiene management among school adolescents. *Journal of Nepal Health Research Council*, 15(3), 212-216.
- Yadav, R., Zaman, K., Mishra, A., Reddy, M. M., Shankar, P., Yadav, P., ... & Kant, R. (2022). Health Seeking Behaviour and Healthcare Utilization in a Rural Cohort of North India. *Healthcare*, 10(5), 757.
- Yermachenko, A., & Dvornyk, V. (2014). Nongenetic determinants of age at menarche: a systematic review. *BioMed research international*, 2014.

LIST OF APPENDICES

LOVELY PROFESSIONAL UNIVERSITY ,PHAGWARA, KAPUTHALA

SCHOOL OF HUMANITIES AND SOCIAL SCIENCES

DOMAIN OF SOCIOLOGY

REGISTRATION NO. 11720096

Confidential
(research
purpose only)

**TITLE OF THE STUDY - Health Seeking Behaviour among Women with
reference to Reproductive and Child Health in Punjab**

INTERVIEW SCHEDULE

District Block Village/ward

Respondent name: age: marital status: education: caste:

Religion. Occupation:

1.

Sr. no	Name of the family member	Age	Gender	Education	Marital Status	Occupation	Income
1.							
2.							
3.							
4.							
5.							

2. Type of Family a. Nuclear b. Extended c. others

3. Type of house possessed a. Pucca b. Semi-Pucca c. kaccha

4. What are the sources of drinking water for your household?

- a. Bore well b. Municipal/ corporation tap water c. others
5. source of cooking: gas/ kerosin oil/ coal/ firewood/ others

REPRODUCTIVE STATUS

1.Age at Menarche: 2. Age at marriage

3. Are you suffering from irregular menstruation? Yes /No
If yes, specify (problem and time).....

4. Are you currently suffering from any perennial health problem at present?
Yes/no

If yes mention from the following.....

- Abdominal pain at the of menstruation
- Irregular menstruation
- Over bleeding
- Less bleeding
- Failure of menstruate
- Anaemia
- Infertility
- Menopausal/ hysterectomy
- Breast cancer
- Others.....

5. Where do you go for treatment?

a. Private hospital b. Govt. hospital c. Local doctor (RMP) d. Not consulted (traditional method)

6. Which medicine do you usually prefer?

Allopathic/ homeopathic/ ayurvedic / others

REPRODUCTIVE HISTORY

No. of Pregnancy	Age at each pregnancy	Place of delivery	Normal/Caesarian	Who conducted the delivery	Sex of the baby	Whether the child born is alive Yes/ No	If any child dead, no. of days / week / month/ year(s)	Cause of death

Any abortion history if yesspecify with reason.....

PAST ANTENATAL HISTORY

1. Who attended your delivery at home.

a.ASHA B. DAI c.Local doctor (RMP) d. others

2. Any vaginal discharge during last pregnancy infection.(RTI). If yes, specify

.....

(excessive bleeding / white discharge)

3. Did you get vaccinated during your last pregnancy ? Yes / no

if yes , number of iron folic acid tablets

no of TT injections.....from where did you get it ?

if no specify reasons.....

4. In which month of pregnancy did you visit for first antenatal checkup?

.....

5. Did you get regular antenatal checkups during last pregnancy? Yes/No

If no, reasons,

If yes Where did you visit?

6. How many antenatal visit during last pregnancy?.....

What was the frequency of your antenatal checkup?

(a)Once a month (b) once in 3 month (c) once in 6 month (D) acc. To need

7. Did any health worker visit your home during pregnancy period? Yes / no

If yes ...who and how many visits.....

If no specify

8. Did you have performed at least one examination during pregnancy?

Weight / height / blood pressure / urine test / abdomen examination / internal examination / breast examination / ultrasound / others

9 .Did you receive any advice from health worker regarding.....

Antenatal diet / Antenatal exercises/ Danger signs / Breastfeeding /Newborn care / family planning / others (specify).....

10.Did you suffer from any health problem during your pregnancy ?

Swelling on hands and feet / paleness /visual disturbance / excessive bleeding /Hypertension /convulsions /weak or no movement of foetus /abnormal position of foetus / others (specify).....

10. (a.)Did you consult anybody for your treatment? Yes / no

If yes specify (from where and from whom)

If no specify.....

11. Were you advised by doctor or health worker for institutional delivery ? yes / no

PRESENT ANTENATAL PROFILE

1.After confirming your pregnancy did you register in PHC? Yes/No

if no specify

2.Are you going for regular antenatal checkup in present pregnancy?

Yes/No

If no,reasons, ____Long distance of PHC/ Financial problem / Lack of assistance

/ No convenient mode of transport

if yes, Give details of antenatal checkups your pregnancy.

Number of checkup.....

From where

3. Have you visited health facility and received the following

- a. Weight measured
- b. B.p checked
- c. Urine test
- d. Blood test
- e. Abdomen ultrasound
- f. Deliver date
- g. Delivery advice
- h. Nutritional advice

4 .Are you taking TT injections and folic acid tablets from PHC/Sub-center?

Yes/No

if no mention the reasons

5. Are you receiving Iron and folic Acid tablets? Yes/No

From where ANM/ Anganwadi worker /

others.....

If no mention reasons

6. Is any health worker come to your village regularly? Yes/No

ANM/ ASHA or others

POSTNATAL CARE

1.Did you experience any health problem after delivery up to 6 weeks?

High fever / lower abdominal pain / foul smelling vaginal discharge / convulsions
severe headache / others

2. Did you consult anybody for treatment ? yes / no

If yes (from where).....

If no reasons.....

3. Did the health worker visit your home after delivery ? yes/ no

if yes who has visited ?..

4.Give details of your postnatal checkups during last pregnancy?

Once a month/Once in 3 months/Once in 6 months/ According to the need /No
medical checkup

5. Were you advised postnatal care the following?

- physical health

- mood changes after giving birth
- Breastfeeding
- The child's development and health
- Vaccines for the child

AWARENESS ABOUT BREAST FEEDING

1. Did you breast feed your last child? Yes/No
if no mention.....,
2. when did you start first breastfeed to your child?
Immediately/ after one hour / within a day / others
3. Did you squeeze out the milk before breastfeeding? yes/ no
4. What is the age at supplementary feed for a baby?
5. When did you start supplementary feed to your last baby?
6. Mention traditional practices with reference to semisolid or solid feeding.
7. How long do you give breastfeeding to your baby?

CHILD CARE

1. What do you do when your child suffers from diarrhoea?
2. Has any health worker advised you about remedial measures for diarrhoea? Yes / no
If yes specify
3. Has your child suffered from diarrhoea from the last two weeks? Yes/ no
4. What did you give to your child during diarrhoea?
If it is ORS, from where did you get this packet?
5. Did you consult anybody for treatment ? yes / n
If yes (specify).....
6. Do you know about the danger signs of pneumonia? Yes ? no
If yes specify.....
7. Has any health worker told you about the danger signs of pneumonia? Yes / no
8. Is your child suffering from cough , cold , fever from last two weeks ? yes / NO
If yes , Did you consult anybody for treatment ? yes / no
If yes specify.....

9. Do you have a vaccination card or any other document (child vaccination record on it)? yes/ no

If yes mention (see from vaccination card).....

If no specify it.....

KNOWLEDGE ABOUT CONTRACEPTIVE METHODS

What is the ideal gap between children?

Do you have any Awareness about contraceptive method yes/ no

If yes specify

Temporary methods

Pills

IUD

Condoms

Female condoms

Rhythm method

Birth control patches

Withdrawal method

Traditional medicine (specify the source and ingredients)

Permanent methods

Female sterilization

Male sterilization

What are the Sources of family planning information?

- a. Friends
- b. Husband
- c. Neighbours
- d. PHC/Sub centre/ASHA/Nurse/Anganwadi worker

Are you/ your partner currently using any contraceptive method? Yes/No

If yes specify.....

from where did you get it?.....

Do you/ your partner suffer from any health problem after using it? Yes / no

If yes specify

Weakness/ body ache / cramps/ weight gain / dizziness, nausea vomiting /breast tenderness / irregular periods /excessive bleeding / spotting / white discharge / others

Did you consult anybody for treatment ? yes / no

If yes ,specify

If no ... What are the reasons for non-adoption of family planning?

- a. Wanted more children
- b. Children are god's gifts
- c. Family members disagreement
- d. Fear
- e. Not applicable

AWARENESS ABOUT RTI (Reproductive tract infection) /STD(sexually transmitted diseases) AND HIV/AIDS

Do you have any awareness regarding reproductive transmitted diseases ? yes / **no**

If yes. What are the sources of information?

Radio/ TV/ newspaper/ books / doctor / health worker / school teachers/ community friends / others

Do you know how RTI/ HIV is transmitted?

- Heterosexual intercourse
- Homosexual intercourse
- Infected Needle/ blades
- Mother to child
- Blood transfusion
- Lack of personal hygiene
- Others
- Do not know

Do you think RTI / STI/ HIV is a curable disease?

Yes/ no / do not know

During last 3 months did you have any problem?

Itching over vulva / low backache / lump in breast / pain during sexual
intercourse/pain in lower abdomen/ any involuntary passage of urine during cough or
sneeze / others

Did you consult anybody for treatment ? yes / no

If yes specify

REMARKS/ OBSERVATION



INSTITUTE OF OBJECTIVE STUDIES
(NGO in Consultative Status (Roster) with the Economic and Social Council of the United Nations)

Certificate of Presentation

Awarded to

Ms. Sharandip Kaur

Research Scholar, Lovely Professional University, Phagwara (Punjab)

She has participated and presented a paper in the
Two-Day Online International Conference
on

"Environment, Social and Religious Consequences on Human Evolution"

held on November 20-21, 2021

M. M. M.
Dr. M. Manzoor Alam
Chairman, IOS

[Signature]
Prof. Z. M. Khan
Secretary, Benarail, IOS

TWO DAY MULTIDISCIPLINARY NATIONAL CONFERENCE

On

"Recent Innovations in Sciences, Social Sciences, Humanities and Arts"

(23rd -24th March 2021)

Organized by

Govt. Degree College, Poonch

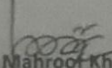


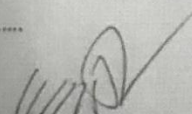
Certificate

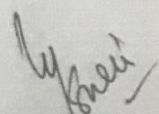
This certificate is awarded to Prof./Dr./Mr./Ms. SHARANDIP KOUR.....for
his/her ~~Invited Lecture/~~ Chairperson/Co-chairperson/ Adjudicator/Participation/
Presentation of paper(Oral/Poster)/~~Best paper presentation~~ (Oral/Poster)/ entitled
"COVID-19 Pandemic and Pregnancy".....

..... In Two Day Multidisciplinary National Conference on "Recent
Innovations in Sciences, Social Sciences, Humanities and Arts" held at Govt. Degree
College Poonch on 23rd -24th March 2021.

No.GDCP/NMD. Conf./21/ 62.....


Dr. Mahroof Khan
Organizing Secretary


Prof. Khadam Hussain
Coordinator IQAC
Convener


Prof. Mussarat Hussain Shah
Principal
Govt. Degree College
Poonch

Khandesh Bahuuddeshiya Sanshtha's College Of Engineering And Technology,

North Maharashtra Knowledge City, Jalgaon

Approved by AICTE, New Delhi, DTE Mumbai & Recognized by Govt. of Maharashtra, Affiliated to DEATU Lonere. (M.S)

(NAAC Accredited & ISO 9001:2015)

CERTIFICATE

INTERNATIONAL CONFERENCE ON RECENT TRENDS
IN SCIENCE, ENGINEERING AND TECHNOLOGY
ICRTSET-2023



ISBN: 978-93-91535-85-8



This is to certify that

Sharadip Jaur

has presented and published his/her paper titled
Knowledge, Attitude and Practice on Menstrual Hygiene among
Adolescent Girls in Kapurthala District of Punjab
during the International Conference ICRTSET-2023 held on 22 December 2023

Organized by

Civil & Electrical Engineering Department of KBS's College of Engineering and Technology,
North Maharashtra Knowledge City, Jalgaon

K7044

[Signature]
DR. S. P. AHIRRAO
PRINCIPAL
KBS, COET, NMK.

[Signature]
PROF. DURGESH. G. BARDHESI
HOD CIVIL ENGG.
CONVENER

[Signature]
PROF. KAMLESH. S. PATIL
HOD ELECTRICAL ENGG.
CO-CONVENER

[Signature]
PROF. SOHAN R. KOLHE
ACADEMIC CO-ORDINATOR
CO-CONVENER

