CHAPTER-I
INTRODUCTION

Status of woman is a recent issue and is being considered crucial to the overall development of not only the society she belongs to, but also to the whole nation. Indeed, most of the inequalities which the feminine gender suffer in every sphere of development, whether in health, education or employment, they are a consequence of deep rooted social and cultural perceptions that consider women to be of lesser value to society than men. It has further been observed that out of all the spheres, health is the most vulnerable area, where a woman continues to be at a serious disadvantage, as even today many societies, show a preference for men’s health in the family over the health of women (Sadik, 1994).

Global estimate suggests that approximately 600,000 women die annually due to childbirth or complications of the pregnancy. Maternal mortality has gained the attention of many researchers, keeping morbidity at bay and largely ignored. The incidence of maternal morbidity, both short and long term, is not very well known (Liskin, 1992). It has been roughly estimated that for every maternal death, there are about 16 episodes of reproductive illness (Datta et al, 1980). Thus for every 600,000 women who die, there are about 9,600,000 more who suffer maternal morbidities like malnutrition, reproductive tract infections, sexually transmitted diseases, complications of pregnancy, etc. It is alarming to know that such women constitute 99 percent of world share, in the developing countries. Beside maternal morbidity and mortality, the reproductive health of young women has not been fully explored and understood all over the world, more so in developing countries and most specifically among the marginalized populations like the poor, the slum dwellers and the tribals, etc. Lack of information, social taboos, paucity of health services, low level of education and host of other socio-economic and cultural factors have been responsible for this neglected area of research, which has been very vital in recent times, more so after the International Conference of Population and Development, at Cairo. This study is, therefore, undertaken to fill some gaps in our existing knowledge.
**Background:**

In 1994, the International Conference of Population and Development (ICPD) at Cairo, Egypt showed the concern for ‘Reproductive Health Concept’. This conference drew the attention of the international community to the need for improving reproductive health care through reproductive health programs. The program recommended that ‘comprehensive and factual information and a full range of reproductive health care services including family planning should be accessible, affordable and convenient to all users’ (Potts et al, 1999). The shifting focus has been from mere population control and mortality approach to a client-based approach of addressing the reproductive health needs of individuals, couples and families.

The World Health Organization (WHO) has defined health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’. In this context, reproductive health is not merely the absence of disease or disorders of the reproductive process, rather it is a ‘condition in which the reproductive process is accomplished in a state of complete physical, mental and social well-being’. This statement further implies, that people have the ability to reproduce and that women can go through pregnancy and childbirth safely and that reproduction is carried to a healthy outcome. It also implies, that people are able to regulate their fertility without risks to their health, and that they are safe in having sex (Fathalla, 1994). The recommended reproductive health package includes – satisfying and safe sex, freedom to decide about birth, reproductive choices for men and women, access to safe and affordable abortion facilities, safe maternal services, prevention and care of reproductive health problems and special attention to adolescent’s reproductive health needs.

The attention given to adolescent’s reproductive health needs is a relatively new concept. For ages, the childbearing age i.e. of 15 – 45 years had been given more importance. The period of adolescence is generally considered a period of physical and emotional transition, rather than of ‘health problems’. In reality, most of the health problems, particularly those concerning reproductive health, emerge during this period. There are various reasons for this in today’s scenario. Among these are
the changing aspirations of the adolescents, and influence of mass media especially in
the developed nations, where the youth become aware of sexual relationships early in
life, but often, have little factual information or understanding of its biological
significance. This leads to unhealthy sexual practices and their consequence viz.
adolescence, pregnancy and motherhood; sexually transmitted diseases and
AIDS; drug and alcohol abuse, etc. This pattern is rapidly catching up the
adolescents in developing countries as well. Though, in many places birth rates are
dropping, as people marry later and also contraceptive use is on the rise, but on the
other hand sexual relations prior to marriage are increasing. In many countries, men
and women engage in pre-marital sex under strong social and peer group pressure.
Some features of modern life increase both the desire and opportunity for sexual
activity like mass media projection, breakdown of traditional families and norms,
increased migration, urbanization and modernization. About one fifth of the world’s
population is between the ages of 10 – 19 years. Thus their sexual behaviour has to
be an integral part of any reproductive health program. It is also estimated that
worldwide, some 15 million babies are born to adolescent mothers, who amount to
more than one-tenth of all births. Compared to women in their twenties, pregnant
teenagers have higher maternal and perinatal morbidity and mortality due to higher
rates of obstetric complications. The adolescent girl, who gets pregnant before she is
18, may be five times more likely to die than a pregnant woman aged 20 – 25
(Anonymous. 1996). Moreover it is an acknowledged fact that adolescent girls are
vulnerable both biologically and socially.

Compared to developed nations, in India women often marry at a very
young age and are expected to prove their fertility within a couple of years. Thus
adolescent girls in several parts of India have a double disadvantage i.e. an early
exposure to sexual activity and early child bearing due to pressure from peers and
family especially the in-laws. They are comparatively more vulnerable to
reproductive morbidity as compared to those who marry in their twenties.

The adolescence period as described by WHO ranges from 10 – 19
years, and the period from 15 – 24 years is termed as youth, whereas National Youth
Policy of Government of India, defines adolescents between 13 to 19 years and youth
between 13 to 30 years. For the present study the term ‘young people’ will be henceforth used for both adolescents and youth as described by WHO, i.e. age range from 10 to 24 years. There are approximately 1.7 billion (170 crore) people between 10 to 24 years in the world and more than 0.3 billion (30 crore) among them stay in India alone. (UNPD, 2001)

The youth are known to be the most productive group in the lower socio-economic status societies, where they start earning during the very early years of life. It is a well-known fact that when the jobs get scarce, people tend to move out of their native places. Moreover industrialization and urbanization also account for approximately 16 million people migrating each year from rural to urban areas in the developing countries, excluding China (Gardner and Blackburn, 1998). These migrants are usually clustered on the margins of the cities and culturally isolated within them. They are usually housed in temporary houses (huts, jhuggis) and are considered the society’s most vulnerable group. These people usually face disruption of their life-style, since they have to leave their support of traditional values, families, and friends and have to deal with a host of new challenges. Moreover they are different from the people in the places in which they move in with regard to socio-economic status, financial circumstances, cultural values, etc. They may also be unfamiliar with the health care agencies of that particular area. These people usually migrate to cities for better employment prospectus or to meet the demands of cities for labor work, which can be usually done by young or middle aged. Their families are usually young. Therefore, the reproductive health needs, of these young migrants deserves greater attention. Many studies indicate that migrants usually have low use of family planning methods, than the urban residents. The risk of HIV, AIDS and other STDs is also higher because they are young and their family life is often disrupted, which increases the risky sexual behaviour (Gardner and Blackburn, 1998).

Migration effect different people in different ways and upto different extent. For a variety of social and biological reasons, women are often more vulnerable than men, to problems associated with migration. Some of these reasons have their origin in the status and role of women, especially in traditional and poor
societies. Other reasons effect the unique biological character and needs of women, particularly with respect to reproduction, sexual relations and physical power (Carbello et al, 1996). Therefore the focus of this study is on the adolescents living in slum areas in and around the city of Chandigarh.

**Importance of Research:**

It is a known fact that Reproductive Health package should cover the needs of both sexes i.e., women and men. Usually, burden of ill health is borne more by women. They not only face health hazards related to pregnancy and delivery, but also have serious sequel of STDs, infertility related problems, and side-effects of various contraceptives, since most of the time it is woman who opt for a contraceptive rather than a man. As already stated some aspects of reproductive morbidity have been extensively researched, which primarily focus on the married women. However, the unmarried young females have mostly been neglected. In today’s context this segment of population needs adequate attention, keeping in view the decrease in pubertal age, increase in marriageable age and an increased risk in pre-marital sexual activities. These young women have not been given due concern, for reproductive health care, because neither the society approves of their access to sex before or outside marriage nor are they daring enough to go against the social norms and seek medical aid. It has been observed that young people, both married and unmarried had largely been left out of the recent reproductive revolution among older married women and are required to fend for themselves. The increasing proportion of adolescent population living in developing countries like India deserves due attention to their reproductive health needs. In 1999, the ICPD too after a five-year review, identified this particular group, as a vulnerable group. Thereafter the concerned member countries committed, to ‘meet the needs of adolescents and youth regarding information, counseling and high quality sexual and reproductive health services’ so as a way to encourage them to continue their education, maximize their potentials and prevent early marriage and high risk childbearing.

Youth usually form a large chunk of population among the semi-skilled and under-skilled workers, who migrate, to the urban areas. As their numbers are growing, they are becoming a new focus for reproductive health care programs in
developing countries. Due to displacement and migration, these youth face many risks to their health (including reproductive health), due to various factors like age, socio-economic status and difficulty in accessing health services either due to ineligibility or due to non-familiarity with the availability of these services. Women often make-up the majority of migrants from rural areas to the bigger cities, particularly in Latin America, East and Southeast Asia (Bender et al, 1993 and Pierotti, 1995). In India too, where men once dominated migratory flows, rural-to-urban migration is becoming more female-oriented (Hugo, 1992). Migration among women tends to peak at ages 15 – 24 (Brockerhoff, 1995 and Findley 1991), when it is easier to find jobs and often accompany their spouses to places of destination.

Like any other developing city, Chandigarh too is becoming a hub for such migratory population. A population of approximately three lacs out of a total of nine lacs (Census of Chandigarh, 2001) has occupied these slum dwellings in and around Chandigarh. These slums are, deprived human settlements, which are demographically, economically and environmentally vulnerable (Bose, 1995). About 64 percent of these slum-dwellers are from states where the health indices are at the lowest ebb (usually called BIMARU) as per the national statistics. As generally observed, the slum dwellers are of low socio-economic status. They live in these slums without basic amenities, leave aside the health facilities. Walia (1988) has quoted Gardiner “Poor people live, from day to day, from crisis to crisis and they seek medical care only when the disability or discomfort becomes severe enough to constitute a crisis”. This is more true for women, who hardly seek treatment, due to cultural inhibitions or due to unawareness of accessibility of health care services. The reasons can be many viz. illiteracy, poverty, powerlessness or individual perceptions of their morbidities, especially those relating to reproductive health. Most of the times, even the husbands are ignorant of their wife’s morbid state. A study was conducted in Germany, where a man was asked about what he thought of his wife’s health. To which, he replied, “If my wife wakes up in the morning that means she is well.” Another man said, “Women’s health depends on the food she eats and the pleasure she derives from her children (Haupter, 1996). Dubey, et al. (1999) in a survey for Centre for Research in Rural and Industrial Development (CRRID),
revealed that only 16.5 percent of the Chandigarh slums avail free medical aid provided to them. In a study by Gawari, et al (2002), services of government health facilities were utilized for only 24.2 percent sickness episodes by the slum dwellers. These included the three government hospitals (PGI, General Hospital and Government Medical College and Hospital) and various dispensaries located in nearby sectors. This study also indicated that rest about 76 percent used the services of private practitioners, in and around their slums. The visit to a private practitioner invariably costs a lot of money. Why they go to those places, where they have to pay for, is a matter of grave concern.

Likewise, pregnancy is considered a normal and desirable condition for a young woman in Indian society. Pregnancy is usually expected to proceed on a largely uneventful course to its ultimate conclusion. Patel (1994), in a study in rural Rajasthan described a common belief, wherein the delivery becomes more complicated and painful as more and more people, especially men, get to learn of a woman in labor. According to this belief a laboring woman’s screams may impede the delivery process. Most of the time the behaviour especially relating to reproductive health is socially and culturally learned. Whatever is observed by the girls in their families, is adopted by them when they attain womanhood. She further explains that the woman, through various customs and observations in the household and the neighborhood derives knowledge about childbearing much early in life. For instance, it is common for children to see domestic animals like cows, buffaloes, sheep and goats give birth. Young girls assist their parents in attending to laboring cattle. Children growing up with such experiences attain some basic understanding of biological reproduction. Similarly adolescent girls may observe such events in the case of their mothers, aunts, sisters and brother’s wives, even before they themselves reach the stage of delivering children, especially in those households where the home-deliveries are preferred rather than the institutional deliveries especially among the lower socio-economic strata. The investigator of the present study has come across a family where a daughter of eighteen years assisted her mother in postnatal care (The mother had delivered a son after 11 daughters in succession). In the cultural context of this part of the country, it may not be out of place to say that, a woman is well,
until she is confined to bed or goes to grave. Though Patel’s study had in detail studied the social behaviour of women in context to their health in Rajasthan, but keeping in view the cultural distinction between Rajasthan and Chandigarh, where people have migrated from various states across India, a somewhat similar study needs to be done.

WHO has also identified high maternal mortality and morbidity as a priority for health care delivery system. In India the reporting system is not considered very good, as there is a lot of under-reporting of both morbidities and mortalities. Mortality can still be traced from various hospital and vital records, but access to information on reproductive morbidity among women is difficult because of “culture of silence” as termed by Younis et al (1993), and women are expected to bear silently all matters related to reproductive health. Therefore keeping in view the high vulnerability of young people, especially the women, who are usually not very vocal in their reproductive matters be it health or sickness, the present study aims at understanding the reproductive health seeking behaviour among the young females in the slum areas of Chandigarh.

**Review of Literature:**

Review of literature is a vital aspect of any scientific research. The review involves systematic identification, location, and scrutiny and summary of written material that contains information on a research problem (Polit and Hungler, 1978). Both published and non-published literature was explored to gain insight into the selected problem under study. The review of literature in this regard will be presented in the present section under the following headings:

1) Health Seeking Behaviour - Concept and meaning
   - General health seeking behaviour
   - Reproductive health seeking behaviour
2) Reproductive Health and Reproductive Morbidity
   - Concept and meaning
   - Definition
   - Prevalence
The review of literature in this chapter pertains to broader areas of health seeking behaviour, for conceptual understanding and the extent of available information. Other relevant studies found during the review have been taken up only in the respective chapters and therefore not been reviewed here in order to avoid duplication and maintain clarity in the arguments.

1) **Health Seeking Behaviour:**

Certain people perceive specific physical symptoms such as pain, fever, nausea, etc. a condition to seek a physician for treatment while others with similar symptoms may attempt self-medication, and still others may dismiss them as not a reason to seek medical attention at all. How does the individual react and respond to the threats of personal sickness are some basic questions in medical sociology. Mechanic and Volkart (1961) described this behaviour as “the way in which symptoms are perceived, evaluated and acted upon by a person who recognizes some pain, discomfort or other signs of organic malfunction”.

Here, the illness may be viewed as a deviant social state brought about by disruption of normal behaviour through disease. Sociologists generally prefer describing illness as a social rather than a biological event because the condition of suffering denoted by illness is a subjective experience. Suchman (1965) describes disease as a medical entity that can be defined in the terms of biological, physiological and psychological functioning and illness as a social entity definable in terms of social functioning.

Illness as deviance is typically regarded as an undesirable circumstance for both the sick person and for society. For the sick person, an illness can obviously mean discomfort and temporary or permanent disruption of normal biological and social functioning. Illness can entail risk of financial hardships for the sick person’s family and for the society, illness can mean a reduction in the ability of a social group or organization to carry out its usual tasks and perform its normal social functions (Cockerham, 1986).
It was Talcott Parson (1951), who initially formulated the sociological view of illness as deviance. Parson described being sick as a disturbance in the "normal" condition of the human being, both biologically and socially. According to him the sick person adopts characteristic behaviours in accordance with the normative demands of the situation. He further enumerates the features of sick-role and postulates that (i) an individual’s illness incapacitates him / her and act as a base for exemption from normal responsibilities and obligations depending upon the nature of illness; (ii) an individual’s illness is not his or her fault and he or she needs help in order to get well; (iii) the sick person has an obligation to get well because being sick in undesirable and (iv) the sick person and those with responsibility for his welfare, have an obligation to seek technically competent help.

Thus, it can be seen that sickness is a social phenomenon, which occurs in all the societies. It has been observed that different societies have developed characteristic ways of responding to the problems of sickness. The perception of symptoms is greatly influenced by the values and customs of a community or a given social group. The further interpretation and response to the given sickness depends upon this perception.

Therefore, the decision whether or not to have any intervention by the person who is ill is neither simple nor is the prerogative of the afflicted person alone. To quote Kleinman (1988) “Illness is first engaged in lay society where the sick person and the family draw from paradigms of every day practical knowledge and culturally approved management strategies that they learned locally as part of being socialized into shared competencies as members of a local cultural system”. These play important role in determining the bodily complaints of a sick person and also help in choosing institutional setting of care. Every society has an array of such institutional setting of care with varied intervention modalities. The use of such modalities of care by a particular person is determined partially by particular cultural belief and value system, which is shared by all the community members.
**Concept of Health Seeking Behaviour:**

The behaviour of an individual who seeks help from a particular agency of the community has been discussed by various authors using different names. Gater had used the term “pathways to psychiatric care” (Gater 1991), Kulka et al (1981) used the term “help seeking” and Mechanic (1992) mentioned the term “care seeking”. The term Health Seeking Behaviour used in this study is broadly similar to what is described above.

Tuckett (1976) reasons out that one reason why some people in the community can have quite severe symptoms and still not consult a doctor is that, these people can tolerate considerable pain, and the disruption that pain can cause in their lives. He further states that sometimes, this tolerance is made easier, by the fact that many conditions have a gradual onset and is therefore easier to adapt than those with a dramatic onset.

Lehtinen and Vaisanen (1978) referring to Purola et al (1974) state that every individual has his/her own concept of health. However, it is not that, one’s own concept of health is a creation solely of a single person, but it also includes influence of sources like the social forces, operating in the society, to which the individual belongs. The same disease does not necessarily produce identical subjective state of illness in all individuals, and on the other hand subjects with identical experiences of illness do not necessarily follow the same pattern when resorting to medical aid. A number of factors have been identified which determine as to what type of care facility should be utilized by the person in need of treatment, e.g. to what extent one knows about a disease, its treatment, apprehension of the disease in the mind of the individual, modalities of treatment and socio-demographic and ethical factors.

The Health Seeking Behaviour may be viewed here as behaviour of a person who is under some morbid state of the reproductive process which leads her or her relatives to make sequential contacts with various helping agencies available in the community with the objective of getting rid of that state.
There are large number of care giving agencies or helping agencies in the community e.g. general practitioner, registered medical practitioner, traditional healer (Hakim, Vaid, Unani medics, yoga, Homeopaths, Naturopaths, Acupuncturist), religious faith healers, Magico-therapist or Specialist or other paramedical health worker like nurses, traditional birth attendants, etc. (Misra, 1994). In addition to this there are various government hospitals, dispensaries and centres that cater to the need of various morbid states among the population. The question, which arises, is to what has prompted a host of experts to study the pathway to health care or treatment seeking behaviour of the individual and/or her family.

One of the most potent reasons is perhaps to understand why a person in distress is not in a position to reach an appropriate care giving agency or vice-versa and why he/she chooses to seek a particular agency.

It has been observed that the genesis of some kind of illness in a member of a family is not to be automatically taken as some kind of illness which requires that person to be taken to an appropriate professional for intervention. Instead, this pathological state of illness is not only shared by the person who is afflicted by it but by the family in specific and community in general. The folkways, mores, taboos, values, belief system are all specific to that community and shared by all of the members of the community and also the person who is ill. So, the cultural impact or influence on the patient, family and the community is tremendous (Pilowsky 1993). This, in fact, helps the community in determining the genesis of the illness and also guides as to who is best suited to take care of it in the community. Help seeking behaviour starts from this point. There are other reasons, which force the community to go to other treatment agencies, which to an expert, may seem undesirable. For example, most people in developing countries live in rural areas or in such appalling slum conditions in and around big cities, that they do not have access to modern treatment facilities. Poor socio-economic status or social backwardness in our setting is also a factor, which inhibits people from consulting proper medical facilities. Some authors have reported that even those communities, which are cut off from the mainstream because of social or geopolitical reasons, have
developed very elaborate self-sustaining systems, which include health care as well. Their attitude encourages them to develop elaborate structure of faith healing, traditional healing or other mode of help giving facilities.

Another important factor that impinges upon the competing system of medical health care is other alternative methods because of certain reasons. In countries where modern health services are relatively inaccessible, the population has to fall back upon the more readily available popular substitutes. These may be of the nature of witchcraft, exorcism as astrological remedies of religious ceremonies. These in turn reinforce magico-mystical notions and foster mistrust and rejection of professional health services even when they may be available.

**General Health Seeking Behaviour:**

A major approach to the study of health care seeking behaviour has been its correlation with socio-economic status. Until recently it was generally believed that lower class persons tended to underutilize the health services because of financial costs and/or subculture of poverty that failed to emphasize the importance of good health. The major premise of this approach is the vicious circle that, poverty breeds illness and illness in turn accelerates poverty.

Earl Koo’s (1967) in his study, ‘The health of Regionvilla’ helped establish that lower class person are less likely than others to recognize various symptoms requiring medical treatment and that these beliefs contribute to differences in actual use of services. This premise was supported by the conclusions of the surveys by National Center for Health Statistics in 1960 and 1965. But since 1968, studies conducted by Bellin and Gerger (1972), Bice et al (1972), Monteiro (1973), Sparer and Okada (1974), Galvin and Faw (1975) have confirmed that it can be no longer assumed that lower income persons underutilize physician services. Lois Monterio (1973) after comparing the 1968 NHS with a sample of Rhode Island residents concluded that:

1. When an illness is present there is an equal tendency among all socio-economic status groups to see a physician.
b) When an illness is present, lower socio-economic group tends to report higher utilization, if ‘free’ health care is available, otherwise low socio-economic persons show about the same level as upper socio-economic group who have no free health care facilities.

c) Therefore higher rates of demand for physician and the availability of publicly financed care resulted in an increased use of medical care seeking behaviour by the poor.

Khare (1963) in his study in North Indian village observed that higher castes follow and seek ideas embodied in great tradition while lower castes largely seek explanation for their ailments, in spirits and ghosts and in superhuman factors. Valunjkar and Chaturvedi, (1967) have discussed the religious aspects of concepts of disease and its causation and stated that basic principle of Hinduism of ‘Karma’ and re-birth plays a vital role. Their studies have confirmed that health and illness is perceived as reward and punishment for one’s action in previous birth. This study has brought out the cultural attributes of the concept of health and sickness in different situations, but has hardly attempted to show any variation in health behaviour on the basis of caste or socio-economic status.

Madan (1969), who studied people’s preference for modern and traditional system of medicine in a U.P. town, is probably made one of the first few studies in which an attempt has been made to examine any relationship between the preferences and the socio-economic status variables. His study concluded that four-fifth of the interviewers had a first preference for allopathy and that people did not differentiate between system of medicine, on sex or age variable.

McBroom (1970) suggests that the inverse relationship between socio-economic status and indicators of illness may be due to certain methodological idiosyncrasies. e.g. using prevalence rates instead of incidence rates or to the possibility that ill persons are more likely to be downwardly mobile or different in reporting illness. Kadushin (1964) also claims that lower status persons in health survey may over-report, perhaps due to the tendency to express anxiety in physical terms.
Dhillon and Srivastava (1972) attempted to explore as to how people perceive illness and what they did when they fall sick. This sociological study, conducted in an urban community with a view to investigate the curative behaviour among the urban dwellers, showed some interesting results. People consider illness as an episode only, if it is accompanied either by fever or pain or a person is incapacitated from taking care of himself. It also showed that there is a greater concern for the health of the earning members, and the head of the family, then for other members in the family. It was further observed that the curative behaviour is influenced by the way the people perceive illness. Except for ‘serious’ and ‘abrupt’ illness, there is invariably a time lag between perceived onset of illness and seeking medical care. It was found that home medication is almost invariably tried at least during the initial stages of illness, which varies between ‘modified food’ to ‘taking medical remedies’. On the question, “How did the people make a choice of source of seeking medical care?” it was found that people have mental grading of physical ailments, based on ‘how expensive’ and ‘how good’ a physician or clinic is. Like Madan, Dhillon also confirmed that allopathic system was most popular both in terms of the system actually tried and the system of preference. The study also revealed that extra family consultations were not common in the initial stages of illness for decision making on medical care.

Most of the available data indicate that medical care seeking behaviour is generally low, among males than females and it increases with age. Taylor et al., (1975) attempted to establish a relationship between physical symptoms and medical care seeking behaviour for persons less than 65 years. He also concluded that men were less likely to see a doctor when they needed to, than women and that visits to a physician were 5.5 among females and 4.3 among males per year.

Chuttani and Nayak, (1976) in her survey of health service utilization has indicated that awareness about the existence of Primary Health Center (PHC) decreases with distance of PHC and same is true with the utilization aspect also. About 51 percent of those who utilized the PHC services were dissatisfied either due to no relief from the treatment availed or due to impersonal behaviour of medical and
This study was conducted in seven PHC’s across four states of India.

Eric Ram and Datta, (1976) in their study on medical care of rural people and its relationship with education level in fifty-two villages observed that about one-fifth of the households did not take medical help even for major illness of their family members. But those who took medical help liked to get it from an allopathic doctor even if the patients had to travel a long distance. The study showed that education and income seem to have direct effect on expenditure of medical care. This study also attempted to draw some relationship between variables, and showed that once the demonstrative effect of allopathic medicine is experienced either by the patient or by any other member of the family, the preference goes for allopathic system of medicine.

Bhatnagar (1978) in his study on 3 villages in Patiala (Punjab) on ‘community responses to health’ attempted to delineate the prevailing concept of health in rural Punjab, and identified the health needs of the people. In addition to this, the study also assessed people’s perception towards various health care agencies available in the community. The major emphasis was to describe the practices and beliefs prevailing in the community. However, it did not attempt to show any meaningful relationship between various variables, nor did it assess people’s perception about health and sickness.

Trakroo (1980) in a study in four rural villages of Haryana, found that women and children have comparatively higher incidence of sickness, than males. The decision to opt for remedial measures outside the house rested with male members, particularly head of the household, followed by the husband. He concluded that socio-economic status is the most potent determining social factor in determining the treatment-seeking behaviour. The findings revealed that the respondents belonging to upper socio-economic status group were more likely to take early and accurate decision to seek medical care.
It is also true that symptoms of disease, which are recognized by the medical profession as signs of disease, as reasons to be taken to the doctor, must first be perceived as a problem by the individual, then defined as something to be taken to the doctor, and then actually taken there. This process of recognition, definition and action is usually influenced in a powerful way by members of the individual’s family or others in a position close to him (Suchman and Phillips, 1958).

Trakroo (1980) suggested that treatment-seeking behaviour is a product of a series of variables broadly classified as:

i) Socio-demographic – age, sex, caste, education.
ii) Socio-economic – occupation, land holding, cattle, wealth, social status.
iii) Socio-psychological – potential influence of primary social networks of family, neighborhood, friendship circle, personality attributes of the diseased, ill or sick person.
iv) Socio-cultural – beliefs, attitudes and value orientations.
v) Geographic – accessibility of health facility.
vi) Organizational – availability of the service facility.

Each of these variables would not only influence the medical care seeking behaviour but also to a large extent influence the individual’s perception and action on:

i) Assessing his/her health, diseases, illness or sickness.
ii) Whether he/she should seek health restoring activities and attempt at seeking medical care out of the various alternatives available to him/her.
iii) Where he/she should go for seeking medical care when he/she has various alternatives available.

In a study conducted by Vendor-Stuyt et al (1996) in rural Guatemala, it was found that high utilization of health services for the treatment of child illness is directly proportional to occupational status of mother and overall level of socio-economic development of the area. The mothers sought medical assistance for their babies below five years only, when they perceived a worsening of clinical condition in another study by Perez et al, in Mexico in 1996.
Pandey and Tiwari (1996) who studied the socio-cultural characteristics of health seeking behaviour of tribal population in Jabalpur found that 70 percent of them went to the tribal doctor (Gunia) for their ailment. They did not have faith in modern medicine and were superstitious, so there was under-utilization of the health facilities. Poverty and ignorance were considered to be the main cause for non-utilization. In 1996, Pandey et.al. studied another tribal population of Madhya Pradesh and found that 47 percent of them preferred their tribal practitioner. Economic constraints were the biggest cause for not utilizing the health-services.

Kumar et al, (1997) reported 76 percent of deliveries conducted by trained birth attended (TBA) in villages, where no health center was available and if Primary Health Center (PHC) was available nearby, lesser number of deliveries were conducted by TBAs. According to his study, availability of health centers in the vicinity of the village definitely influenced the health-seeking behaviour of the women folk.

Jaramillo, E. (1998) studied the paths followed and the barriers experienced by patients for the health care service, for pulmonary tuberculosis symptoms. Result showed that culture based explanations, stigma attached to the disease and the poor qualities of health care services are strong barriers to early diagnosis. Steen and Mazonda (1999) estimated that 52 percent of patients tried one or more alternative treatments before starting special treatment for pulmonary tuberculosis in Botswana. Even after starting modern medicine, 47 percent of the patients visited or planned to visit a traditional healer or a faith healer.

Another study by Grover (1999) concluded that chronic chest symptomatics showed preference for home remedies first, and then they sought treatment from outside. Eighty-one percent of them took home treatment and 67 percent of those who had taken treatment from outside were persuaded by their family members, friends or relatives to do so. Still 18.7 percent patients never sought any treatment, since they perceived the chest-related symptoms to be of no significance.
Thus from the literature reviewed so far for the health seeking behaviour, it can be seen that it depends upon not a single variable, but many interdependent variables like socio-demographic, economic, psychological, cultural, administrative and organizational. These may influence both the perception and the action of health seeking behaviour of the people who suffer and their caretakers.

**Reproductive Health Seeking Behaviour:**

Many people can have serious symptoms but still may not consult a doctor, because they have more toleration power (Tuckett, 1976). Going by the past experiences women often have been found to fall in this category, where they have profound tolerance. Many women consider most of these reproductive morbidities to be normal and a part of their destiny and so may not seek treatment or may not report these symptoms to health care-workers. Since, health seeking behaviour or treatment seeking behaviour depends upon the perception of the individual, therefore when individual think it is normal or perceive it to be non-serious she does not seek treatment. Even if these symptoms are perceived to be abnormal or pathological, they may still not seek treatment out of guilt or shame. Sometimes, they are believed to be punishment of their deeds (WHO, 1989). Moreover India largely has a male dominant society, in which the females mostly remain within the confines of the family. Even if they go out for work it is either a male (father, brother, husband) or an older lady who is expected to take decisions on affairs connected with the younger one’s in the family. Another reason for not seeking treatment is considered to be shyness. There is scarcity of female doctors in the rural areas. Traditions and customs inhibit rural women from talking to or getting examined by male doctors for gynaecological or sexual disorders. Hence, there is under-reporting of such symptoms (Bang et al.1989). This is at extreme level in case of poor people.

Tahzib (1983) did a survey of gynaecologic morbidity in Nigeria. Out of 800 women, not a single woman reported any such morbidity. They needed their husband’s permission to visit a clinic or hospital, and if husbands refused or were not available, treatment became impossible. Even, to have advice from male traditional healers, the crisis had to be severe.
Walia (1988) studied the utilization of health services during pregnancy in rural population of Haryana and found that 70 percent of the women took no treatment for complaints like diarrhoea, constipation, vomiting, aches, edema and vaginal infection considering them, the normal problems of pregnancy. The rest, who did take the treatment, preferred the private practitioners to the government health services.

In Bang’s study (1989), while 92 percent of women were found on examination to have a gynaecological problem, only 55 percent of them, reported having problem, themselves. Anemia and hypertension related with pregnancy were considered normal. Inspite of knowing about vaginal discharge as an abnormal sign, women did not know where to go for treatment. They went to the ‘witch doctor’ for sterility.

Pingala (1992) found the prevalence of vaginal discharge among 21.6 percent of women in a resettlement colony, but 55 percent had, had no treatment due to shyness and unawareness of the center of treatment. In the same setting, Gauri (1994) surveyed women of 15-44 years of age and found that 37 percent took no treatment at all for low backache. This was usually associated with maternal morbidity and one-fourth of these women did not seek treatment due to various reasons like shyness, illiteracy, and low socio-economic status or did not know where to go and whom to consult.

Crabbe, et al (1996) concluded that in large towns in Cameroon, the utilization of formal health services for STD related complaints is low and the high cost of treatment in this sector may play an important role in the choice of care opinions. Higher education was also a factor for choice of formal sector.

Patel and Khan (1996), in a study done in rural Uttar Pradesh, found that 77 percent of the ever married women who were in their reproductive age reported at least one symptom indicating reproductive health disease. Only 28 percent of them had taken treatment or consulted a health provider, while mostly had relied on private medical practitioners.
In Zambia, Faxelid, et al. (1998) interviewed patients attending STD clinics in urban and rural settings. Most of these patients experienced symptoms for one to two weeks before they came to the clinic. During this period, 60 percent of the urban and 50 percent of the rural had taken some kind of medicine. Market places, private practitioners, friends and relatives were common treatment sources, and 10 percent had received medicine from traditional healers.

IIPS and ORC Macro (2000) for NFHS-2, collected information regarding any antenatal problems for two most recent pregnancies preceding the survey. The most commonly reported problems were excessive fatigue (43%), anaemia (27%), swelling of the legs, body or face (26%), blurred vision (22%) and convulsions (14%). The survey further revealed that only 65 percent women had antenatal checkups. About 78 percent of women who were pregnant for the first time received tetanus toxoid in comparison to 56 percent women who had fourth or fifth pregnancy. The iron and folic acid supplementation was received by almost 58 percent. Only 34 percent of these women reported an institutional delivery.

Singh et al, (1999) found dysmenorrhoea as the most commonly reported menstrual problem among 40.7 percent of the adolescent schoolgirls in rural Haryana. This was followed by irregular menses (23%) of which only 5.3 percent consulted a doctor and 22.4 percent took over the counter medications from chemists.

Walraven et al, (2001), warns that provision of services itself do not overcome the ‘culture of silence’ surrounding reproductive health disorders. In his study among women in rural Gambia, he found 70 percent of the women having at least one reproductive disorder. But only 26 percent reported it to the field worker, while 53 percent reported to a gynaecologist. Out of these, only 39-45 percent had sought treatment for the reproductive health disorders barring 61 percent for infertility and 54 percent for genital ulcers.

A community based study on reproductive health, fertility and related care seeking behaviour was studied among a sample of women of childbearing age, living in streets of Calcutta by Ray et al in 2001. Besides, the quite common
conditions like leucorrhoea (28.5%), menstrual irregularities (12.3%), infertility (2.5%) and STDs (1.3%) were also reported. But most of these illnesses (three-fourth) were uncared for, and the remaining one-fourth sought treatment from government institutions, private agencies or even from untrained practitioners (quacks). The reproductive behaviour of street dwelling women were characterized by early marriage, teenage pregnancies and scarce use of contraceptives, as well as frequent abortions (2.8%). Very few pregnant women received adequate antenatal care (3.8%). Coverage of tetanus toxoid immunization (68.5%) and proper iron and folic acid supplementation (16.7%) were also poor. Though, 71 percent respondents received antenatal care from government health institutions, while home delivery (i.e., on street) was a common practice and conducted mostly by untrained birth attendants (51.8%).

Best (2002), reported that self-reporting of gynecological symptoms was high among women of Kohn-Kaen in northeast Thailand. The 70 percent of surveyed subjects had reported such symptoms over the previous two years, and 58-71 percent of these complaints were recurrent.

In yet another study by Gulati et al, (2003), in the Delhi slums, it was found that 80 percent of the women received antenatal care during their pregnancy, which is astonishingly very high in comparison to other studies. And almost all of them (79.4%) had tetanus toxoid. The assisted delivery by doctor or trained dai had been reported by only 47 percent of the women.

The literature reviewed shows a mixed trend of health seeking behaviour for reproductive health problems among the respondents. Most of the women preferred to keep silent about their problems relating to reproductive processes, in-spite of the fact that prevalence of these problems has been found to be quiet high. Therefore, when even reporting is not done, treatment seeking is very scarce, since most of these problems are considered due to evil deeds, that is why, many women keep on suffering in silence.
Reproductive Health and Reproductive Morbidity – Concept and meaning

Reproductive health covers a whole range of conditions and processes that include health, sexual development, reproduction and fertility regulation. World Health Organization defines reproductive health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease’ or infirmity in all matters relating to the reproductive system and to its functions and processes.

It has been estimated that in developing countries the burden of reproductive ill health among women of reproductive age is far greater than the burden from tuberculosis, respiratory infections, vehicle injuries, homicide and violence. It accounts for almost 36 percent of the total disease burden among women (Khanna, 1997).

The working group of WHO in 1989, adopted the definition of reproductive morbidity as ‘any morbidity or dysfunction of the reproductive tract, or any morbidity which is a consequence of reproductive behaviour including pregnancy, abortion, childbirth or sexual behaviour, and may also include morbidities of psychological nature’. Subsequently three categories of reproductive morbidities have been suggested as shown in the figure – 1.1 below:

Figure – 1.1

WHO CLASSIFICATION OF REPRODUCTIVE MORBIDITY

REPRODUCTIVE MORBIDITY

- Obstetric Morbidity [OM]
- Gynecological Morbidity [GM]
- Contraceptive Morbidity [CM]

- Direct OM
- Indirect OM
- Psychological OM

- Direct GM
- Indirect GM
- Psychological GM

- Temporary
- Permanent

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A. Obstetric Morbidity – It is morbidity in women, resulting from any cause related to or aggravated by the pregnancy or its management. This further can be of three types:

i) Direct Obstetric Morbidity: It results from the complications of the pregnant status (pregnancy, labor or puerperium), from interventions, omissions, incorrect treatments or from a chain of events resulting from any of the above. This can either be temporary morbidity which occur during pregnancy and within 42 days of delivery e.g. antepartum haemorrhage, postpartum haemorrhage, eclampsia or it can be a permanent morbidity e.g. rectovaginal fistula, vesicovaginal fistula, urinary or faecal incontinence, pelvic inflammatory disease, dyspareunia, secondary infertility, etc.

ii) Indirect Obstetric Morbidity: It results from previous existing disease, which gets aggravated by the physiologic effect of pregnancy e.g. anaemia, malaria, hepatitis, tuberculosis, malnutrition, etc. Such morbidity may occur at any time and may continue beyond the reproductive period.

iii) Psychological Obstetric Morbidity: It includes puerperal psychoses (baby blues), suicide, or strong fear of pregnancy and childbirth, and may be the consequence of obstetric complications, obstetric interventions, cultural practices (such as isolation during labor and delivery), or coercion to have abortion or denial of abortion, etc.

B. Gynaecologic Morbidity – This category includes any condition, disease or dysfunction of the reproductive system which is not related to pregnancy, abortion or childbirth, but may be related to the sexual behaviour. This again is of three types:

i) Direct Gynaecologic Morbidity: It includes the reproductive cancer, premenstrual syndrome, endocrinial disorders, sexually transmitted diseases (STDs) and their sequel, cervical-cancer, pelvic inflammatory
disease (PID), secondary sterility, Acquired Immuno Deficiency Syndrome (AIDS)) and reproductive tract infections (RTIs), etc.

ii) Indirect Gynaecologic Morbidity: It includes primarily traditional practices like circumcision, genital mutation, etc.

iii) Psychological gynaecology morbidity: The psychologic disorders associated with STDs, infertility, traditional practices, dyspareunia fistulae, etc. comes under this category.

C. Contraceptive Morbidity – Any condition which results from efforts (other than abortion) to limit fertility, whether they are traditional or modern methods.

Prevalence of various reproductive health morbidities:

For many years, the knowledge regarding various aspects of maternal mortality is readily available, but maternal morbidity has been largely ignored. The main reason being that though definition of maternal mortality is quite clear, the maternal morbidity somehow could not be given a definite shape due to overlapping of the categories discussed above.

Dutta, et al (1980) conducted one of the earliest studies to measure morbidity among pregnant women in Rajasthan in India, which quotes 15 obstetric morbidities for each maternal death. Kapil (1990) quotes 20 mothers suffering from impaired health for every maternal death.

Another study by Li, et al. (1982) in a Chinese town found 37 percent of the pregnant ladies having some illness during pregnancy. About 21 percent had difficult labor and 6 percent complained of postpartum complications.

Bang, et al (1989) found 92 percent of the rural respondents reporting at least one gynaecological condition among childbearing women, in Maharashtra with an average of 3.5 conditions per women.

Subsequent to Bang’s study, where gynaecological morbidity was very high four studies were undertaken in Maharashtra, Gujarat and West Bengal by Latha
et al (1997). These were population based, but were independent of each other. The gynaecological morbidity found is shown in Table – 1.1:

Table – 1.1

<table>
<thead>
<tr>
<th>Gynaecological condition</th>
<th>West Bengal (N=395)</th>
<th>Gujarat (N=293)</th>
<th>Baroda (N=548)</th>
<th>Bombay (N=715)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Menstrual Problem</td>
<td>32.7</td>
<td>58.9</td>
<td>58.0</td>
<td>60.7</td>
</tr>
<tr>
<td>2. Excessive Discharge</td>
<td>50.1</td>
<td>57.0</td>
<td>22.4</td>
<td>30.8</td>
</tr>
<tr>
<td>3. Childlessness</td>
<td>3.3</td>
<td>2.7</td>
<td>1.8</td>
<td>5.0</td>
</tr>
<tr>
<td>4. Prolapse Uterus</td>
<td>6.1</td>
<td>2.4</td>
<td>1.1</td>
<td>2.7</td>
</tr>
<tr>
<td>5. Lower Backache</td>
<td>5.3</td>
<td>29.7</td>
<td>24.1</td>
<td>39.3</td>
</tr>
</tbody>
</table>

♦ Women reporting any morbidity
♦ Mean number of morbidities among women


Thus it is evident that leading causes of morbidity are menstrual problems (33%-59%), excessive discharge (22%-57%), followed by lower backache (5%-39%) in the above studies.

Two other studies on a small sample size had been carried out in Chandigarh on various specific gynaecological diseases. Pingala (1992) found the prevalence of vaginal discharge among 21.6 percent women in a resettlement colony and in the same setting, Kumari (1996) found 7.6 percent of women aged above 15 years having prolapse of the uterus.

Liskin (1992) while discussing maternal morbidity in developing countries, reports approximately 27, 18, 7.5 and 7 percent uterine prolapse in Columbia, Pakistan, Philippines and Syria respectively. It also reports 2-10 percent of women, younger than 25 years having prolapse uterus, due to early marriage and childbearing.

Kumar et al, (1995) reported 45.2 percent of rural women in Haryana suffering from 153 episodes of illnesses in the maternity period with an average of 1.5 episodes per women. About 93 percent had symptoms of excessive bleeding, fits,
prolonged labour, etc. This study was conducted on women who had delivered in the past two years at the time of study.

A major baseline survey was done in 1995-1996 among 13,000 households in seven districts of Bihar, Rajasthan and Madhya Pradesh by the Center for Operations, Research and Training (CORT), in order to understand the morbidity patterns among women as related to their gynaecological problems. In this survey, 5 problems were prompted to the respondents and they were asked to state whether they had faced any of them in the last three months. Women who reported at least one problem varied from 19 to 30 percent, whereas those who had three or more problems ranged from 1.3 to 6.7 percent.

Harlow and Campbell, (2000) had compiled studies on menstrual dysfunction among women in developing countries. The study had shown that 28-57 percent of Indian women, 56 percent of Turkish women and 25-58 percent women of other nine developing countries reported dysmenorrhea as a leading menstrual problem.

Hirozawa (2001) conducted a study in rural Gambia for reproductive health problems among women of 15-54 years of age. It was observed that 70 percent of the women had at least one reproductive disorder. Out of these 47 percent had reproductive tract infections, 55 percent were anaemic, 10 percent had pelvic tenderness, whereas about 10 percent were found to be infertile.

Bhatia and Clealand (2001) in a study estimated that the reproductive ill health accounted for half of all illness days and for 31 percent for curative health expenditure. The study states that, 1990 Global Burden of Study estimated 27.4 percent of disability – adjusted life years lost in Indian women aged 15 – 44 years were attributable to reproductive ill health.

A study was conducted by Barua in Maharashtra in 2001 to gain insight into whether and how the reproductive health needs of 15 – 19 years married women are met, especially for gynaecological problems, family planning and perceived fertility problems. It was found that they were quickly treated for illnesses
interfering with domestic work and were expected to conceive in the first year of marriage. Often menstrual disorders and reproductive tract infections go untreated. Household work and silence due to embarrassment related to sexual health problem were the strongest factors influencing the care seeking. It was the husbands who decided whether their wives could seek care and mother-in-laws usually influenced these decisions; women had neither decision-making power nor could they influence the decision.

In rural women of Gambia, West Africa, 70 percent women had at least one reproductive organ disorder. Reproductive tract infections accounted for 47.3 percent problems, menstrual dysfunction for 34 percent and infertility 9.8 percent of the total morbidities. Most commonly reported symptoms by the women themselves were menstrual problems, abnormal vaginal discharge and vaginal itching (Walraven, et al 2001).

Defining morbidity has been one of the biggest problems in researching reproductive illness. Misclassification is quite common. Many conditions that are obstetric in origin are categorized as gynaecological problems. Illnesses are variously and inconsistently categorized as conditions, complications or complaints. Moreover, perception of what constitutes ‘morbidity’ also varies. Researchers tend to focus on complications that are measurable and potentially life threatening such as hypertension or bleeding. The so called ‘minor complaints’ of pregnancy like nausea, vomiting, backache, fatigue are rarely addressed even though these conditions may significantly impair women’s well being and their ability to work. Conversely, women may not view some complications of pregnancy as illness. Swelling of hands and face may be an ominous sign, to health workers, but only a few women may regard such an occurrence as illness. Much of the morbidities are under-reported if they are perceived to be normal conditions, if they are associated with shame or if they are asymptomatic (WHO, working group 1989).

In many societies, a majority of the women go through pregnancy and childbirth without any assistance from formally trained health care providers. Thus most illness, rarely come to the attention of health care providers.
From the literature reviewed so far it can be concluded that treatment seeking behaviour is determined not only by perceptions of the individual, but also includes cultural forces, socio-demographic aspects and the perceptions of the family and community in which the individual exists.

Not much literature could be found on all the reproductive health problems together in a study. Various studies conducted, had varied settings (rural, urban), varied socio-economic status (rich, poor and sometimes not mentioned) and varied reproductive problem definitions, thereby making the comparison data across them a difficult task.

**Gaps in Research:**

After reviewing the literature, it was found that:

(i) Most of the studies have evaluated the utilization of health services, which made their attempts secondary to health seeking behaviour in nature.
(ii) Most of the studies were done on general health seeking behaviour and very few were directed toward reproductive health seeking behaviour except few recent ones.
(iii) Most of the studies were only on few aspects of reproductive health e.g. pregnancy, STD’s, AIDS and hardly any had included all the aspects of reproductive morbidity.
(iv) None of the studies were found to deal with young females as the target group. Most of them were married women or elderly women, though few were adolescent.
(v) Very few studies were directed towards reproductive health seeking behaviour of females in low socio-economic conditions, like slums.

**Rationale for the Proposed Study:**

The treatment-seeking behaviour for reproductive health in slums is comparatively a new area, where not much has been done, though many authors have recently felt that reproductive health needs of the migrants need attention, more so in the developing countries. A few aspects which usually have been researched are pregnancy and its related problems, STDs, AIDS, etc. Hardly any study has been
found which dealt with young people’s reproductive health seeking behaviour in India and that too especially in the low socio-economic conditions like slums. Most of the studies evaluated the utilization of health services, rather than going deeper into the dynamics of why and why not. Moreover, the researcher had been working in a resettlement colony, where she came across many women who took reproductive health problems in their routine stride, and never thought of consulting experts. Rainwater (1968) suggested that the poor had a distinctive culture. They usually hold their bodies in low esteem and had relatively low levels of scientific knowledge about medicine events. For them, poor health is just a situation, when social functioning becomes physically impaired.

Therefore, to understand the reproductive health needs and gain knowledge of the perceptions of the young females of the slums, the present study has been proposed. It may provide valuable insight for the health care decision-makers so as to provide reproductive health care to these socially downtrodden and economically weaker section people who moved to the cities for better life. Moreover, the health of females, especially the reproductive health and the health care system must be seen from beyond medical point of view, because health is very much dependent upon socio-economic and cultural conditions. The problem of reproductive health as well as the health care system reflects the production relations and the broader social-order based upon it. Hence, it is important to understand the role of social factors and value systems to study the reproductive health of the women. Therefore, the present study is an attempt in that direction.

Objectives:

The study is proposed with the following broad objectives:

1) To enumerate the prevalence of reproductive health morbidities among young females of slums in Chandigarh.

2) To study the perceptions of these young females about their reproductive health needs.
3) To gain in-depth insight into their attitude, beliefs and knowledge relating to reproductive health problems, and to examine their consistency and inconsistency with prevailing practices.

4) To correlate the factors influencing the perceptions, practices and reproductive health treatment seeking behaviour of the respondents.

5) To identify issues pertaining to improvement in reproductive health services.

Hypotheses:

Patterns of general health seeking behaviour, revealed by several studies would serve as guidelines to propose specific hypothesis during the course of this study. Thus in the descriptive part, these hypothesis will be subjected to empirical test in the context of reproductive health seeking behaviour among the young females. The main hypotheses for the study are:

1) Reproductive health seeking behaviour would vary among literate and illiterates. It is assumed that the educated women have more self-confidence and awareness about the health care facilities. They may be more vocal than women with no education and hence may decide, about availing required reproductive health services.

2) Reproductive health seeking behaviour would vary among the migrants and non-migrants. The migrants are likely to avail lesser health facilities than the non-migrants, who may be aware of the health infrastructure available in, and around slums. Thus there may be a variation in seeking the reproductive health care services.

3) The economic status of the family would make the difference in seeking reproductive health services. The costs of the reproductive health services may not be within the reach of very poor families, since some cost is always attached while seeking treatment, and hence they may not be using the available services.

4) Reproductive health seeking behaviour would also vary among working and non-working females. Working females are usually self-dependent and therefore can decide for themselves, whereas the non-working may have to ask for approval of her husband or father (in case of unmarried), for seeking the services. Moreover,
the working women may have access to money, which non-working are usually deprived of. Further, the working group comes in contact with a wider social group and may thus exchange information regarding reproductive health services and seeks them accordingly.

5) The respondent’s family type may significantly influence the treatment-seeking behaviour of the respondents. The family structure may alter the decisions for seeking reproductive health services. The joint families may give females a wider social context for discussing their reproductive health needs. The senior females in the joint families may impose their decisions on younger females or may help them to decide the treatment to be taken, whereas in nuclear families the women may decide on their own, about the pathways to seek care for problems concerning reproductive health.

6) Reproductive health services seeking behaviour would also differ among different castes in the society, as the status of women may differ in lower and upper castes.

**Operational Definition:**

1) **Menstrual Problems:** These refer to the problems experienced by the females during their menstrual cycle. Eight types of problems have been included for this study:

   (a) **Premenstrual Syndrome:** It is the combination of symptoms experienced by some women prior to the onset of each menstrual cycle. Major symptoms include headache, fatigue, low back pain, engorged or painful breasts, mood swings, binge eating, crying spells, etc.

   (b) **Dysmenorrhoea:** It is painful menstruation.

   (c) **Polymenorrhoea:** It refers to the shortened menstrual cycle from the usual 28 days.

   (d) **Menorrhagia:** It means more than normal bleeding at the time of regular menstrual cycle.

   (e) **Oligomenorrhoea:** It means less than normal bleeding at the time of menstrual cycle.
(f) **Metorrhagia:** This refers to appearance of blood between the regular menstrual periods.

(g) **Amenorrhoea:** It means absence of menstrual bleeding for 1 – 12 months after normal menarche. It can be due to emotional upsets, pregnancy or breast-feeding.

(h) **Irregular periods:** It is irregular menstrual cycle. Sometimes it may be shortened and other times it may be lengthened than the usual 28 days.

2) **Vaginal Discharge:** It is usually termed ‘leucorrhoea’ or ‘safed pani’ (white discharge) by the women, which is excreted from the female genital organs and when in excess suggests some reproductive morbidity e.g. pelvic inflammatory disease. The discharge may cause itching, redness, burning or edema at the perineal area.

3) **Lower Backache:** It is a symptom and not a specific entity. It refers to the pain at the lower end of the back, which may or may not radiate to buttocks, thighs, calves, etc. It is quiet common in reproductive age group. Lower backache is also one of the symptom of pelvic inflammatory disease.

4) **Prolapse of uterus:** It results from stresses of child bearing due to stretched and weakened support to the uterus. For the purpose of this study, prolapse of uterus will be considered if a woman says that she has a feeling of something coming out of the vagina, through various local terminologies.

5) **Urinary Problem:** This problem is experienced in the females in the form of incontinence of urine, dribbling of urine while coughing or sneezing, frequent urge to pass urine, difficulty or pain while passing urine. These are usually clinical manifestations of vaginal fistula, which may have occurred because of tissue damage resulting from injury sustained during delivery.

6) **Antenatal Problems:** These are the problems experienced by women during their antenatal period (pregnancy) e.g. nausea, vomiting, swelling of hands/feet, etc.

7) **Postnatal Problems:** These are the complications, which are manifested by women within 42 days of delivery, abortion or termination of pregnancy.
8) **Contraceptive Problems:** This refers to those symptoms, which are experienced by women while using a contraceptive.

9) **Conception Problem:** Usually referred to as infertility, wherein woman is unable to conceive in one year of unprotected intercourse during her married life.

10) **Perception:** Is hereby referred as an individual’s representation of reality. Perception is usually always right according to the individual’s thought.

11) **Migrants / Non-Migrants:** For the purpose of this study all the respondents who were not born in Chandigarh will be termed as migrants and those, whose birthplace is within the Chandigarh Municipal Corporation limits will be termed as non-migrants.

**Conceptual Framework:**

Death in contrast to sickness is a clear and measurable event, where as sickness is in part a subjective experience and the extent to which people recognize the symptoms of sickness to be worthy of attention and then define them. Symptoms are usually perceived, evaluated and acted upon by different people in varied social situations. It is being realized by sociologists nowadays that sickness is far beyond the biological or medical deviation, because health is also dependent upon social, economic and cultural conditions. For example whether, a woman experience pregnancy, birth control or any other reproductive aspect as stressful and traumatic is partially due to the ways in which she is socially organized. For example in some cultures, childbirth is one of the worst pains a human being can undergo, where as in some communities women continue to work in the fields until the child is just about to be born, thus showing no distress. Her husband on the other hand gets into the bed and groans as though he has labour pains. Sometimes the husband stays in the bed with the baby to recuperate from the childbirth ordeal, and the woman goes to the field to work (Melzack, 1973). Therefore the reproductive morbidity categorized by the WHO needs another aspect of morbidity i.e. sociological morbidity, since reproductive health in reality is influenced by many determinants active in the society.
Conceptualization utilizes, forms of conjectures whereby meaning can be attached to otherwise unrelated facts. Conceptual framework formalize the thinking process so that other may read and know the frame of reference basic to the research problem (Charter, 1975). The conceptual model to be used for the proposed study is a combination of three models, which are:


As per Health Belief Model, the health behaviour is determined by the extent to which a person sees a problem as having both serious and high probability of occurrence. It is a psychological model that attempts to explain and predict health behaviours by focusing on the attitudes and beliefs of individuals. The key variables of this model are as follows:

(i) **Perceived Threat:**
   - Perceived susceptibility: Influenced by subjective perception of risk of getting a health problem.
   - Perceived severity: Feelings concerning the seriousness of getting a health problem, which can be medical, clinical or social.

(ii) **Modifying Factors:** Demographic, socio-psychological and structural variables that effect the individual’s perceptions.

(iii) **Cues to Action:** Events, which can be motivating factors, which motivate people to take action. These can be:
   - Internal e.g. physical symptoms of a health problem.
   - Environmental e.g. media publicity, advise from others, personal knowledge of someone affected by same health problem, etc.
(iv) **Perceived Benefits**: The believed effectiveness of strategies designed to reduce the threat of problem.

(v) **Perceived Barriers**: The potential negative consequence that may result from taking particular health actions, including physical, psychological and financial demands.

The Health Belief Model assumes that human behaviour is dependent upon two primary variables: 1) The value placed by a person upon a particular outcome and 2) The person’s belief that a given action will result in that outcome. Thus, this model suggests that action taken by an individual is due to an individual’s perception of being personally susceptible to that particular problem and also perception of having serious implications of that problem. This perception is affected by some modifying factors. Rosenstock, further assumes that despite recognition, that action is necessary, a person may still not be sufficiently motivated to do some thing, if perceived barriers to action are more than the perceived benefits. Therefore, a stimulus in the form of an action cue is required to ‘trigger’ the appropriate behaviour.

The Health Belief Model has been widely used for preventive health behaviour, such as, Vaccination against influenza (Leventhal et al, 1960); Taking of penicillin prophylaxis for heart diseases (Heinzelman, 1962); The seeking of dental care (Kegeles, 1963); Determining frequency of breast self examination (Champion, 1990); Belief intervention on breast self examination performance (Champion and Scott, 1993), etc. The limitation of this model is that it has been applied mostly to preventive situations and not curative behaviour, in which the behaviour studied is voluntary. Obviously, many people who seek health services are motivated to take action by appearance of clear and definite symptoms. The ‘perceived seriousness’ and ‘cues of action’ of this model has been modified and utilized in the conceptual frame work for the present study. The original Health Belief Model by Rosenstock is shown in Figure 1.2 on the following page.
The second Model of Mechanic has formulated a general theory of help seeking, in which he lists ten variables that ultimately decides the decision to seek medical care. These are:

(a) Visibility and recognizibility of symptoms.
(b) Extent to which symptoms are perceived as serious.
(c) The extent to which they disrupt the activities.
(d) The frequency and persistence of symptoms.
(e) Tolerance threshold of the individual.

(f) Available information, knowledge and cultural assumptions.
(g) Basic needs leading to denial.
(h) Other needs competing with illness responses.
(i) Competing interpretations to the recognized symptoms.
(j) Availability of treatment resources, physical proximity, psychological and monetary costs of taking action.

Mechanic explains that these determinants operate at two distinct levels: other-defined and self-defined. This is where the private sphere and the public sphere formulate the action of the individual. Thus it can be said that help seeking is a culturally and socially learned response apart from the psychological, physical and biological need. The model has been applied in studying the concept of illness behaviour in a few studies like, Relevance of group atmosphere and attitudes for the rehabilitation of alcoholics (Mechanic, 1961); Perception of parental responses to illness (Mechanic, 1963); The influence of mothers on their children’s health attitudes and behaviour (Mechanic, 1964); Correlates of frustration among British practitioners (Mechanic, 1970), etc. The levels where the individual determines to taking action i.e. the Self-determined and Other-determined have been utilized for the present study.

The third model, which has been used for the conceptual framework, is of Shireen Jejeebhoy (1997). According to this there are two types of determinants, which ultimately decide the outcome of reproductive health. These are the background determinants and the intermediate determinants. The background determinants include the social, economic and cultural factors, which may have both direct and indirect influence on the reproductive health of a female. These are:

[I] Autonomy of a woman in the society which pronounces:
   (a) Her awareness of:
       - Education.
       - Good health practices.
- Disease severity.
- Her legal rights.
- Legal status of inheritance.
- Her reproductive rights.

(b) Decision making authority:
- On household purchases.
- In conditions of sickness.
- In pregnancy related behaviour e.g. how many children, after how much interval.
- On workload during pregnancy, puerperium.
- On whether to work outside the house or not.

(c) Mobility of the female whereby:
- She can go on her own to the market.
- To the health centers, unescorted.

(d) Gender disparity:
- Disparity in feeding since childhood.
- Disparity in health care facilities.
- Victim of domestic violence.
- Value of women’s health.

[II] Economic status of the female’s:
- Independent income
- Holding on the land property so that she has the purchasing capacity.

[III] Physical accessibility of the services:
- Distances within the easy reach.
- Availability of transportation.
- Affordable costs of services.
[IV] Quality of services provided makes the difference by:
- Availability of personnel.
- Accessibility of care.
- Outreach of programs.
- Access to health information.
- Access to health services.

[V] Community level indicators:
- Community involvement in safe motherhood.
- Aggregated wealth.
- Transport facilities.
- Access to water.
- Toilet facilities.

These factors provide empowerment to the woman and make her valuable to the society. Unemployment, marginilization and poverty are conditions that result in poorer health and are exaggerated by the discrimination which girls and women face throughout their life. Illiteracy is one of the most pernicious factors, which leads to harmful practices perpetuated by women themselves. They are not only unable to read and write, but are denied the information pertinent to an understanding by women, of how their body functions and how to prevent diseases, and protect themselves. Educating women and giving them access to information helps them to overcome the tragic spiral of ill health, poverty and social disintegration.
These background determinants more or less influence the intermediate determinants. The intermediate determinants further influence the reproductive health of a woman directly. These are:

[I] General health status of the females: e.g. infections, chronic diseases, prior history of complications.

[II] Nutritional status of the females: e.g. rapid or stunted growth, anemia (especially during adolescence and pregnancy).

[III] Reproductive status: including marital status, age at marriage, age at pregnancy, frequency of pregnancies, etc.

[IV] Health care behaviour: includes awareness of danger signals during pregnancy, awareness of what constitutes good health, use of available antenatal and postnatal services, use of modern labour facilities, perception of morbidities, use of safe practices and general health seeking behaviour.

The model provided by Jeejebhoy takes into consideration a more comprehensive view of women’s empowerment. It incorporates their decision taking ability, their accessibility to health care in society and their economic independence in terms of health seeking behaviour. The model also incorporates physical aspects of care and community health indicators. Therefore, it would be more comprehensive and useful to analyze health-seeking behaviour of women in this country.

Using all these three models discussed above, it has been found that any reproductive health-seeking behaviour would be influenced by a host of factors in a complex way. Thus the model in figure 1.3 is a consensus of all three models, which have been suitably modified to meet the need of the present study. The own thinking and views of the researchers have further conceptualized the linkages.
Figure - 1.3

CONCEPTUAL FRAMEWORK FOR THE PRESENT STUDY

BACKGROUND DETERMINANTS
- HEALTH STATUS
- NUTRITIONAL STATUS
- REPRODUCTIVE STATUS
- HEALTH CARE BEHAVIOUR

INTERMEDIATE DETERMINANTS
- WOMEN’S AUTONOMY
- ECONOMIC STATUS
- ACCESSIBILITY OF SERVICES
- QUALITY OF SERVICES

REPRODUCTIVE HEALTH STATUS
- MORBIDITY

BIO-SOCIAL
- BIO-PHYSICAL
- BIO-PSYCHOLOGICAL

PRIVATE SPHERE
PUBLIC SPHERE

REPRODUCTIVE HEALTH SEEKING BEHAVIOUR
The conceptual framework for the present study presented in the Figure 1.3, depicts two types of determinants, which may effect the reproductive health status of a female. The background determinants refer to the so-called socio-cultural and socio-economic factors, which determine how valuable a woman is to her family and society at large. Greater the value of fairer sex, better will be these socio-economic factors. Constraints facing women, who have consequences for maternal morbidity and mortality are manifold e.g. unequal feeding practices of a girl child, results in growth retardation and cultural norms prescribing early marriage and then immediate and repeated pregnancies further enhance the risk of reproductive morbidities. The same is true with their education. Girls, found to have lower education tend to get married earlier than those with higher education. So, once she gets married, the parenthood cycle has to start in order to secure her position in the marital home. Women also tend to refrain themselves from seeking medical care due to varied reasons of powerlessness, unawareness, non-accessibility of services, etc. The pregnant status is generally considered a normal routine affair, which every woman has to bear. The so-called decision-makers of the family do not allow the woman to seek help form any outside agency, till the condition becomes severe. Many ailments like nausea and vomiting, tiredness, fatigue, edemas of limbs are never ever considered morbidity during antenatal period. The same is true with conditions like fever and fatigue during postnatal period.

The intermediate determinants are the result of these background determinants, which further directly influence the reproductive health status of a woman. Many of the reproductive morbidities have direct link to the nutrition, general health and reproductive status e.g. a woman who has a stunted growth will most probably have a poor physical health status. Further if she gets married at an early age, she is prone to have a higher morbidity rate than her counter parts, who have a better physical health status. Moreover it can be assumed that the woman who is lowly educated, and has a lower social status in the society and is without any economic independence, will most probably shun from seeking any help from outside. This can be either due to unaffordable services or due to non-decision making power of that woman. The concepts provided by Jejeebhoy model have been suitably
modified and used for this part of the conceptual framework. Abouzahr et al. (1996) has very aptly concluded ‘Maternal morbidity is a sensitive indicator of gender inequality and it acts as a litmus test for the status of women, their access to health care and the adequacy of the health care system in responding to their needs’.

Thus, rather than a simple medical problem, poor reproductive health should be considered ultimately as a reflection of a series of social, cultural and economic circumstances. Discrepancies have reportedly been found between women’s perceptions and expressions of their needs and conditions of health and sickness (Obermeyer, 1999). The individual in a society usually reacts to his or her socially acceptable public expression in front of others. The views expressed by Mechanic have been conceptualized here to form linkages. Thus, the private sphere (which depicts how the individual perceives her condition of health or sickness) and the public sphere (which depicts how the individual is expected to express herself for a particular condition in the society) should be consistent. In case of inconsistency in these two spheres, the individual generally tends to suppress, bear and tolerate her private sphere needs. If this happens, the health problems may arise as stress, strain and other complications, inducing negative effects on the well being of an individual in the form of bio-socio-cultural, biophysical or bio-psychological symptoms. This is often seen in the case of females, who are expected not to be outspoken, and expressive, but be quiet tolerant and withdrawn, especially when it concerns anything in relation to sex and sexuality. The ‘Culture of Silence’ i.e. the culture of secrecy prevails among the Indian women which does not allow any open discussion on reproductive health even among the women themselves. Though in western countries some studies have shown that there are more women then men who seek medical aid, but in the context of developing countries it has been found just the opposite, may be because of the female inhibitions to openly discuss the matters of reproduction. Even daughters are unable to discuss reproductive health problems with their mothers, especially when they are unmarried. Therefore everything happening in regard to such matters is taken for granted and the sufferings continue. In short, a woman’s position in the society has consequences for her health, as well for her experiences as a consumer of health care. Health Belief Model by Rosenstock also states that the
human behaviour is dependent upon one’s own value and belief placed on the outcome. Therefore, since women wield less economic and political power than men, they are also more likely to be socially and psychologically dependent. The patriarchal subordination of women effects their lives in several aspects of reproductive health behaviour. This is what this study purports to assess, by the conceptual framework shown in Figure 1.3 on page 42.