A STUDY ON ECONOMIC ANALYSIS OF REPRODUCTIVE HEALTH CARE WOMEN IN NAGAPATTINAM DISTRICT

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Abstract

The reproductive health needs of married women in India are largely unmet. This study aimed to explore treatment-seeking behaviour of married women for selected reproductive health (RH) concerns in low-performing areas of Nagapttinam District and also this study highlights net effects of age on the prevalence and treatment seeking behaviour for reproductive health problems (RTIs). As part of a large community based-project, a cross-sectional survey was conducted from November 2016 to March 2017. From each of two (Mayiladuthurai and Keezhaiyur block) select study areas, 300 unmarried female married women aged 18 to above 49 years were selected for participation by multistage random sampling through household listing and were recruited into the study. Trained interviewers administered a structured questionnaire to participating married women. Descriptive and ANOVA analytic methods were used compare RH conditions and healthcare seeking behaviour of married women across rural settings. Approximately 50% of the sample (age group between 28 and 37) reported experiencing menstrual problems in the last year. The predominant problems reported by participants included: lower abdominal pain, irregular menstruation, and excessive bleeding during menstruation.

Introduction

The health of Indian women is intrinsically lined to their status in society. Women especially in the developing world including India were facing many reproductive health problems. The related issues such as abortion, childbirth, sexuality, contraception and maternal mortality. Biological, social, cultural, economical, and behavioral factors play an important role in determination of reproductive health. Problems of reproductive health are particularly acute in developing nations. Nearly 90 percent of all the births in the world occur in developing countries. Reproductive health needs, especially in developing countries and particularly in India are poorly understood and ill served. Reproductive health addresses women's health, rights, and empowerment, but in India reproductive morbidity is an outcome of not just biological factors but also of women's poverty, powerlessness and lack of control over resources as well. The magnitude of woman's reproductive health problems in India is immense, ignored and marginalized and demands immediate attention.

Statement of the Problem

The importance of understanding economic analysis of treatment seeking behavior of reproductive health problems has advanced extensively in the last decade. The study is elected to assess the economics analysis of treatment seeking behaviour of women in Nagapattinam district. Economic poverty and rapid growth of population, inadequate nutrition and crowded and in sanitary living conditions are at the root of health problems. When a large number of people live in poor household located in crowed and in sanitary surroundings.

Health seeking behaviour depends upon the severity of illness the availability of health care facilities, the access to health care services and the economic condition of the individual/household and other such factors. Thus, there is an urgent need for such studies in India which will provide useful information to health planners and policy can be formulated to improve reproductive health of women. This study attempts to analyze the levels of reproductive health related problem and treatment seeking behaviour among women in Nagapattinam district and to determine the influence of socio-economic demographic and programmatic factors on reproductive health status and treatment seeking behaviour.

It is important to note that there are significant differences reproductive health and treatment seeking behaviour and background characteristics. In the study consider the proposed analytical frame work for reproductive health problem and treatment seeking behaviour of women residing in rural areas from poor households and low socio-economic conditions may not be able to receive quality food after contraceptive services it leads to health problems. Education is one of the major factors that can reduce the mortality of women. It is expected that with an increase in their awareness about reproductive health problem methods thereby improving their reproductive health status. A better health programme

may lead to more awareness of reproductive related health problem and low levels of Reproductive morbidities.

In this context the present attempt focuses on this aspect with reference to rural and urban sector making a case study of a typical Nagapattinam district. A new quantitative measure of development has been used to assess the level of health index and house sanitation. This study gives due attention to analyses the health status and treatment seeking behaviour of women households. Further, this study aims at analyses the direct cost as well as indirect cost of health care among the women in households.

Review of Literature

A life course approach to reproductive health: Theory and methods

A life course approach examines how biological (including genetics), behavioural and social factors throughout life, and across generations (Kuh D et al, 2003), act independently, cumulatively and interactively to influence health. A life course approach to reproductive health asks a range of questions that are relevant to the development of health policy. For example, does birth weight influence the age of menarche and of menopause? Does maternal stress during pregnancy influence the development of polycystic ovary syndrome in female offspring? What is the influence of childhood growth on age at menopause and is this modified by adult body size? Could the link between reproductive health and other chronic diseases be due to a common set of factors that affects them both and, if so, when and what is the best way to intervene? What is the impact of grandmother's fertility rate on that of the granddaughter's? Would preventing maternal gestational diabetes provide the most cost effective means of reducing the risk of gestational diabetes in the offspring? At the heart of this life course perspective lies a theoretical framework that assumes and tests for a temporal ordering of exposure variables and their inter-relationships with the outcome measure, both directly and through intermediary (mediating or modifying) variables(Khu D et al, 2003, Ben-Shlomo et al, 2002).

Garg et al., (2001) reported the perceived reproductive morbidity and health care seeking behaviour among women in an urban slum. This study estimates the prevalence of various Reproductive Tract Infections in females in a slum of Delhi. All ever married women in the reproductive age group were interviewed by a pre-designed and pre-tested interview schedule. As many as of 62.3 per cent reported one or more problems in the past six months. The risk factors like genital hygiene and abortions were significantly associated with reproductive morbidity. Only 27.8 per cent consulted a health facility for management. The authors recommended effective services for RTIs/STIs coupled with an awareness generation for the better utilisation of these services in the urban slums

Sharma and Sahay (2001) attempted to understand the experience of menstruation in the socio-cultural context of an urban Indian slum in Delhi. Observations were gathered as part of a larger study of reproductive tract infections in women in Delhi, using both qualitative and quantitative methods. The qualitative phase consisted of 52in-depth interviews, three focus group discussions and five key informant interviews. In the quantitative phase, inferences were drawn from 380 respondents. Mean age at menarche was 13.5.Onset of menarche is associated with physical maturity and the ability to marry and reproduce. However, a culture of silence surrounds menarche, an event which took the women interviewed almost by surprise. Most were previously unaware that it would happen and the information they were given was sparse. Menstruation is associated with taboos and restrictions on work, sex, food and bathing, but the taboos observed by most of the women were avoidance of sex and not participating in religious practices, the taboo on not going into the kitchen, which had been observed in rural joint households, was not being observed after migration from rural areas due to lack of social support mechanisms. There is a clear need to provide information to young women on these subjects in ways that are acceptable to their parents, schools and the larger community, and that allow them to raise their own concerns. Education on these subjects should be envisaged as a long-term, continuous process, beginning well before menarche and continuing long after it.

Joseph et al., (2002) attempted to find out the preferences of women belonging to a sub-urban community of Bangalore city either for home deliveries or institutional deliveries and try to correlate the relationship between the factors such as the educational status and socio-economic status of women and their preferences. In addition, the influence of the place of delivery on the care of the newborn and infant was also investigated in this study. The study revealed that (i) educated parents and families belonging to a higher socio-economic status preferred hospital deliveries; (ii) difference in the acceptance of ante-natal care between these two groups was not significant; and (iii) children born in hospitals

found to have a better chance of being breast-fed within the first 30 minutes of delivery and were also more likely to be fully immunized in time as compared to those delivered at home.

A study by Barua & Kurz (2001) revealed that in India, married adolescent girls of ten delay seeking treatment for reproductive tract infections. Sexual matters may be " shrouded in a culture of silence, embarrassment, shame and blame". The study also showed that married adolescents with abnormal vaginal discharge, itching, bad odour or pain during sex were more likely to talk to husbands, but they were, however, reluctant and expected their wives to seek care themselves. In a study by Prasad et al,(2005) on 451 married girls and women aged 16-22 in Tamil Nadu, showed that more than half had experienced a gynaecological problem or urinary tract infection, but few had sought treatment. Laboratory tests confirmed that 38 percent women had a reproductive tract infection (RTI), including 15 percent who had sexually transmitted disease (STI). Of those who had experienced gynaecological problems, almost two third (65 percent) had sought no treatment, citing lack of a female health care provider in the community, lack of privacy at the health centre, distance from home, or lack of concern over symptoms. Women often consider many symptoms as normal and do not seek treatment until discomfort is quite high. This is particularly true for young married women, who usually experience low social status in their husband's household and their community. Even if who sought treatment, majority went to unqualified private practitioners, followed by home-based remedies. Balasubramanian (2005) showed that care-seeking behaviour for reproductive morbidity was very low among adolescent girls. The care-seeking was found to be fairly high for abnormal vaginal discharge and very low for menstrual irregularities and skin diseases. One more study in rural Tamil Nadu by Rural Women's Social Education Centre (2000)assessed prevalence of reproductive tract infections among married adolescents and found 59 percent reported one or more gynecological problems and only 35 percent sought any treatment. The majority were going to traditional or unqualified practitioners for such treatment. In the marital place, girls are treated quickly for the illnesses interfering with domestic work and are expected to conceive in the first year of marriage. Menstrual disorder and symptoms of reproductive tract infections of untreated. Husbands made the decisions whether their wives could seek care and mothers-in-law sometimes influence these decisions; girls have neither decision making nor influencing power. A study on married adolescents by Prasad (2005) in Tamil Nadu showed that young women are embarrassed to talk about their gynaecological complications, as they believe that nobody talks about such illnesses.30 The study revealed that in fact there is a chain of communication of symptoms of gynecological complications adolescent women were suffering with. They first discuss their problems with mothers-in-laws or sisters-in-laws who then communicate this to their fathers-in- law/brothers-in-law and ultimately either fathers-in-law/brothers-in-law or husbands accompany women to the doctor. Knowledge about the source of treatment among adolescent women was also found to be limited. Though young married adolescents contribute enormously to the domestic economy, they often do not have an independent income to pay for their health services even in an emergency (Bruce, 2003).

Research Gap

The review of the literature which deals with the issues pertaining to treatment seeking behavior of womens' reproductive health problem, its necessity, its importance, discrepancies between the blocks, poor and rich, different age group women's and also among different religious groups suggests that women's have been suffering for long time in India. There are intra household discrepancies in resource allocation, not only in poor households, but also in rich households, where womens' are seeking behavior of private and public health care, since they are groomed only to get early married. However, perception change is taking place of late though only in small circle, but neglect of women's reproductive problem is still practiced. In this context, from the various studies concerning treatment seeking behavior of women reproductive problem, it is observed that so far no researchers has attempted to study the behavioural aspect of the womens' interims of their opinions regarding their treatment seeking beheaviour of reproductive problem. Women beliefs and practices on menstruation and also different religious practices on menstruation and knowledge regarding various aspects of menstruation and menstrual hygiene. Hence to fill this research gap, this research forms the core objective of probing into the question of treatment seeking behavior.

Objectives of the Study

1. To study the influence of women reproductive age group on the Symptoms of Reproductive Problem.
2. To estimate the direct cost of the reproductive problem affected population.

Hypotheses

H1: Direct cost of reproductive cases is closely associated with age.

Research Methodology

This study has been conducted in Nagapattinam District, Analysis to help the planners to identify the socio-economic causes and associated reasons behind their economics analysis of treatment seeking behaviour of women.

Study Area

Nagapattinam District is a coastal district of Tamil Nadu state in southern India, According to 2011 census, Scheduled Castes and Scheduled Tribes populated district and also backward district in Tamil Nadu state.

Sampling Design

The Nagapattinam district comprises 8 Taluks, 11 Blocks and 497 Villages. As regards the hierarchy of administrative arrangement, there are 3 Municipalities, 10 Town Panchayats and 433 Village Panchayats in the district. Among the villages were selected from the district by sub-dividing 11 blocks into three strata of more or less similar population size on the basis of the female literacy. Eleven blocks were arranged in ascending order of female literacy. Female literacy was considered for such stratification since it has an influence on women's health and exposure to knowledge. The percentage of female literacy in 11 blocks was between 40 and 68. The blocks were divided into two strata in a manner that the total populations in each of these groups were almost similar. Then one block was selected from each of these two strata. While selecting the blocks, care had been taken to get adequate representation of their distance from the district headquarter, Nagapattinam. The essence behind such selection was that, the closer the block to the district headquarter, better is the level of development and the vice versa. In the first strata (Mayiladuthurai block), the female literacy was between 54.1 and 59 percent and in the second strata (Keezhaiyur block), it was between 40 and 54 percent.

After the selection of the blocks, two villages were selected from each of these three blocks. For each block, villages were arranged in ascending order of proportion of Caste population, which is an indicator of development. Four sub-divisions were made from this arrangement, confirming similar population size from each of these four sub-divisions. Then one village was selected from each of these four sub-divisions, taking care that the villages were not closely spaced, to confirm sample distribution over a larger geographical area. Thus two villages were selected from one block. Similar procedure was followed for selection of villages in other blocks.

After the selection of the villages, all the households in the selected villages were listed. During listing, the households with at least one eligible woman, i.e. 18-45 years married woman were identified. Seventy Five households in each of these villages were selected by multistage random sampling after house listing in each village. One eligible woman was randomly selected from each household. Thus seventy five respondents were selected from each of the villages. Respondents of the study were married women. In order to take care of non-response due to various reasons, an extra 10% of respondents were included in the sample. That is, 320 respondents were selected for the interview. Totally, 300 respondents completed the interview and 20 respondents declined to participate in the interview.

Data collection and survey instruments:

Data collection was done in 2017. All members of the selected households were listed. For each listed person, information was collected on age, sex, relationship to the head of the household, marital status, and education. The study included both the quantitative as well as qualitative techniques. A structured questionnaire was developed for the quantitative study. The questionnaires were translated into local language. Draft questionnaires were pilot tested with 10 eligible women in two villages that were not part of the study and necessary modifications were made. Qualitative techniques include Group Discussions and In-depth Interviews. Focus Group Discussions were conducted before the quantitative phase of data collection to get issues related to marriage as well as the common reproductive problems prevalent in the community. After the quantitative data collection, in-depth interviews were conducted for respondents to get more detail insight about important issues related to reproductive health. In-depth interviews were also carried out for the service providers to confirm the prevalence of reproductive problems and treatment-seeking behaviour among married women.

Data Analysis

Data were entered and analyzed using SPSS software version 20. Categorical variables were presented as frequencies and percentages. Bi-variate analysis involved the use of the Chi-square test for assessing the

significance of associations between treatment seeking behavior of women and socio-demographic variables.

Table 1: Area wise age levels of sample respondents

Age	Mayiladuthurai Block		Keezhaiyur Block		Total
	Manakudi	Mannampandal	Ettukudi	Thirupoondi	
18-22	8	11	7	10	36
	(22.20)	(30.60)	(19.40)	(27.80)	(100.0)
	[2.7]	[3.7]	[2.3]	[3.3]	[12.0]
23-27	5	11	19	19	54
	(9.30)	(20.40)	(35.20)	(35.20)	(100.0)
	[1.7]	[3.7]	[6.3]	[6.3]	[18]
28-32	24	18	17	13	72
	(33.30)	(25.0)	(23.60)	(18.10)	(100.0)
	[8]	[6]	[5.7]	[4.3]	[24]
33-37	22	19	22	18	81
	(27.20)	(23.50)	(27.20)	(22.20)	(100.0)
	[7.3]	[6.3]	[7.3]	[6]	[27]
38-42	12	10	5	6	33
	(36.40)	(30.30)	(15.20)	(18.20)	(100.0)
	[4]	[3.3]	[1.7]	[2]	[11]
Above 42	4	6	5	9	24
	(16.70)	(25.0)	(20.80)	(37.50)	(100.0)
	[1.3]	[2]	[1.7]	[3]	[8]
Total	75.0	75.0	75.0	75.0	300.0
	(25)	(25)	(25)	(25)	(100)
	[25]	[25]	[25]	[25]	[100]

The distribution of the sample respondents on the basis of their area and age level is presented in Table 1.

The table shows that among the 300 sample respondents, 36(12 percent) belong to the age group of 18-22 years, 54 (18 per cent) come under the age group of 23-27, 72 (24 per cent) belong to the age group of 28-32, 81 (27 percent) belong to the age group of 33-37 years, and 24 respondents (8 per cent) come in the age group of above 42 years.

Age group-wise, among the 36 respondents who come under 18-22 years age group, 8 (22.2 per cent) are in Manakudi village, 11(30.6 per cent) are in Mannampandal village from Mayiladuthurai block, 7(19.4 per cent) are in Ettukudi village and 10 (27.8 per cent) are in Thirupoondi village from Keezhaiyur block; in the case of the 54 respondents who fall in the age group of 23-27, 5 (9.3 per cent) are in Manakudi village, 11(20.4 per cent) are in Mannampandal village from Mayiladuthurai block, 19(35.2 per cent) are in Ettukudi village and 19 (35.2 per cent) are in Thirupoondi village from Keezhaiyur block; out of the 72 respondents who are in the age group of 28-32, 24 (33.3 per cent) are in Manakudi village, 18(25 per cent) are in Mannampandal village from Mayiladuthurai block, 17(23.6 per cent) are in Ettukudi village and 13 (18.1 per cent) are in Thirupoondi village from Keezhaiyur block; in the case of the 81 respondents who come under the age group of 33-37 years, 22 (27.2 per cent) are in Manakudi village, 19(23.5 per cent) are in Mannampandal village from Mayiladuthurai block, 22(27.2 per cent) are in Ettukudi village and 18 (22.2 per cent) are in Thirupoondi village from Keezhaiyur block; out of the 33 respondents who are in the age group of 38-42, 12 (36.4 per cent) are in Manakudi village, 10(30.3 per cent) are in Mannampandal village from Mayiladuthurai block, 5(15.2 per cent) are in Ettukudi village and 6 (18.2 per cent) are in

Thirupoondi village from Keezhaiyur block; and among the 24 respondents who come under the age group of above 42 years, 4 (16.7 per cent) are in Manakudi village, 6(25 per cent) are in Mannampandal village from Mayiladuthurai block, 5(20.8 per cent) are in Ettukudi village and 9 (37.5 per cent) are in Thirupoondi village from Keezhaiyur block . The area-wise age group of the sample respondents indicates that the share of those who come under the age group of 33-37 years is 27 per cent overall, which is 50.7 per cent in Mayiladuthurai block and 49.3 per cent in Keezhaiyur block, while share of those who are 28-32 years of age is 24 per cent overall, which is 58.3 per cent in Mayiladuthurai block and 41.7 per cent in Keezhaiyur block. Thus, the proportion of middle age respondents is higher in Mayiladuthurai block than in Keezhaiyur block.

Table 2 shows the mean and standard deviation of the symptoms of reproductive problem with respect to the respondents' age. ANOVA was performed to identify the existence of mean difference among the different age groups of the respondents. Among the eight variables of symptoms, all variables of symptoms do not have a significant outcome. The insignificant outcomes occurred for Abdomen pain at the time of menstruation (F = 1.071; P = 0.376), Irregular Menstruation (F = 1.143; P = 0.337), Excessive bleeding at the time of menstruation (F = 1.475; P = 0.198), Less bleeding at the time of menstruation (F=.675;P = 0.643), Occurrence of menstruation in less quantity and at unpredictable time (F = .375; P = 0.865), Failure to Menstruate (F = 1.044; P = 0.392), Closure to menstruation (F = 1.622; P = 0.154), and Low level of Hemoglobin in the blood (F = .716; P = 0.612) . This shows that the respondents do not differ with respect to their age towards various symptoms of reproductive problem.

Table 2: Influence of Age of the Respondents on the Symptoms of Reproductive Problem

Symptoms		Age of the Respondents						Total (n=300)
		18-22 Years (n=36)	23-27 Years (n=54)	28-32 Years (n=72)	33-37 Years (n=81)	38-42 Years (n=33)	Above 42 Years (n=24)	
Abdomen pain at the time of menstruation	Mean	3.5	3.06	3.18	3.02	3.33	3.04	3.16
	SD	1.159	1.172	1.142	1.245	1.291	1.083	1.191
Irregular Menstruation	Mean	3.61	3.04	3.19	3.19	3.27	3.17	3.22
	SD	1.153	1.132	1.146	1.108	1.353	1.09	1.156
Excessive bleeding at the time of menstruation	Mean	2.92	2.94	3.01	2.78	3.42	2.88	2.96
	SD	1.131	1.172	1.144	1.245	1.251	1.035	1.185
Less bleeding at the time of menstruation	Mean	2.64	2.98	2.76	2.8	3.03	2.92	2.84
	SD	0.961	1.236	1.068	1.1	1.311	1.283	1.14
Occurrence of menstruation in less quantity and at unpredictable time	Mean	2.92	2.8	3.03	2.91	2.79	2.83	2.9
	SD	1.131	1.105	1.15	1.086	1.083	1.049	1.102
Failure to Menstruate	Mean	2.42	2.56	2.71	2.78	2.61	2.29	2.62
	SD	1.156	1.144	1.168	1.118	1.171	1.16	1.149
Closure to menstruation	Mean	2.44	2.61	2.82	3	2.55	2.63	2.74
	SD	1.054	1.204	1.191	1.351	0.905	1.135	1.199
Low level of Hemoglobin in the blood	Mean	2.56	2.65	2.86	2.83	2.52	2.88	2.74
	SD	1.182	1.276	1.214	1.202	1.228	1.393	1.232

		Sum of Squares	df	Mean Square	F	Sig.
Abdomen pain at the time of menstruation	Between Groups	7.592	5	1.518	1.071	.376
	Within Groups	416.728	294	1.417		
	Total	424.320	299			
Irregular Menstruation	Between Groups	7.620	5	1.524	1.143	.337
	Within Groups	391.860	294	1.333		
	Total	399.480	299			
Excessive bleeding at the time of menstruation	Between Groups	10.265	5	2.053	1.475	.198
	Within Groups	409.255	294	1.392		
	Total	419.520	299			
Less bleeding at the time of menstruation	Between Groups	4.404	5	.881	.675	.643
	Within Groups	383.916	294	1.306		
	Total	388.320	299			
Occurrence of menstruation in less quantity and at unpredictable time	Between Groups	2.303	5	.461	.375	.865
	Within Groups	360.697	294	1.227		
	Total	363.000	299			
Failure to Menstruate	Between Groups	6.885	5	1.377	1.044	.392
	Within Groups	387.795	294	1.319		
	Total	394.680	299			
Closure to menstruation	Between Groups	11.538	5	2.308	1.622	.154
	Within Groups	418.182	294	1.422		
	Total	429.720	299			
Low level of Hemoglobin in the blood	Between Groups	5.458	5	1.092	.716	.612
	Within Groups	448.262	294	1.525		
	Total	453.720	299			

Table 3: χ^2 Results of Age versus Direct cost of reproductive cases

Cost of Input	Age of the Respondents						Total Cost (n=300)
	18-22 (n=36)	23-27 (n=54)	28-32 (n=72)	33-37 (n=81)	38-42 (n=33)	Above 42 (n=24)	
Doctor fee	6613.63 (12.00)	7058.82 (19.80)	7134.14 (24.10)	7011.11 (26.00)	5868.42 (9.20)	7300 (9.00)	6900.56 (100)
Medicine	7005.55 (11.90)	7510.18 (19.10)	7106.94 (24.10)	6878.39 (26.20)	6507.57 (10.10)	7727.08 (8.70)	7089.33 (100)
LAB Fees	6686.11 (12.50)	6655.55 (18.70)	6522.22 (24.50)	6168.51 (26.00)	5557.57 (9.60)	6979.16 (8.70)	6400.83 (100)
Transport	5423.61 (12.10)	5681.48 (19.00)	5554.86 (24.70)	5242.59 (26.20)	4724.24 (9.60)	5672.91 (8.40)	5395.66 (100)
Room Rent	6227.27 (12.80)	6191.17 (19.70)	6170.72 (23.60)	6066.66 (25.50)	5421.05 (9.60)	6233.33 (8.70)	6079.54 (100)
Bribe Tips	488 (10.30)	513.888 (15.60)	578.571 (27.20)	554.237 (27.50)	569.230 (12.40)	488.235 (7.00)	542.922 (100)
Food	4077.77 (13.00)	4081.48 (19.50)	3648.61 (23.30)	3652.46 (26.20)	3354.54 (9.80)	3879.16 (8.20)	3765.16 (100)
Others	2570.83 (12.00)	2660.18 (18.60)	2680.55 (25.00)	2462.96 (25.90)	2524.24 (10.80)	2450 (7.60)	2569.33 (100)
Total	33950 (12.30)	35274 (19.10)	33539.58 (24.20)	32074.07 (26.10)	29616.67 (9.80)	35512.5 (8.50)	33231.67 (100)

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	1500.000[a]	1135	.000
Likelihood Ratio	1022.389	1135	.993
Linear-by-Linear Association	263.208	1	.000
N of Valid Cases	300		
a. 1368 cells (100.0) have expected count less than 5. The minimum expected count is .08.			

Age is one of the deciding factors for decision making process in social institution. Age plays a vital role in the treatment of health problems and cost of treatment. Therefore, there may be an association between age of the respondents and direct cost incurred due to reproductive problem. To test the hypothesis of direct cost of reproductive diseases is closely associated with age of the respondents the χ^2 test has been applied. The table 5.51 presents the direct distribution and chi-square results of age with direct cost of reproductive diseases. The calculated χ^2 value is 1500 significant at 1 percent level, which is greater than the tabulated value. Therefore, the null hypothesis is not validated. Hence, the hypothesis of direct cost of reproductive problem is closely associated with age is validated. It implies that the age of the patients is significantly associated with the direct cost incurred for treatment of reproductive diseases. Therefore, it implies that the productive age class (33-37 years) is spent more for treatment. It is concluded that age plays a significant role in availing health care services.

Limitations of the study

From each gram panchayat the researcher selected only one village for the study, each village covering only 75 respondents out of large population. It covers only Nagapattinam district.

The present study is limited to:

1. Only to 300 rural women of four villages selected from Mayiladuthurai and Keezhaiyur blocks. So, the entire findings of the study may not be applicable in case of other rural areas of Nagapattinam district and even to other places.

2. Primary data collected from the respondents of the said areas of Mayiladuthurai and Keezhaiyur block.
3. Verbal statements of rural women regarding independent and dependent variables have considered for analysis.
4. Also, the gynaecological problems are captured on the basis of self-reported symptoms by young women. Clinically-tested data would have been more accurate to find out the reproductive health status of young women. Moreover, it would have been clear whether women are experiencing abnormal vaginal discharge due to existence of some reproductive tract infections or it is due to some psychosomatic syndrome.
5. Regarding the symptoms reported during pregnancy and post-partum complications, symptoms could not be classified under 'severe' and 'non-severe' categories. Symptoms such as painful urination, fever, severe vomiting, and abdominal pain, leg cramps could be manifestations of severe infection so it is difficult to classify them as non-severe. This is a limitation of study.
6. Limitations of temporality of the gynaecological problems and independent factors influencing the outcome have been recognized in the opening paragraph of the relevant section.

Conclusion

The National Reproductive Health Strategy of India prioritizes on safe motherhood, family planning, menstrual regulation, care for post-abortion complications, and management of STI. While both the Directorate General of Health Services and Directorate General of Family Planning implement reproductive health services through their programs on maternal and child health and reproductive, only married women truly benefit from these services. Overall, the study presented here demonstrates that treatment-seeking by married women was low for menstrual, while the vast majority of the married women opted for self-care for STI symptoms. These findings emphasize the need for improved accessibility to relevant information on RH issues. Existing health facilities should be made friendlier to improve the health status of the married women. Future research would benefit from exploring the reasons why married women prefer self-treatment, why they do not seek care from qualified professionals, and what characteristics would be ideal in friendly facilities. Taken together, these findings may assist policy-makers' efforts in improving existing health systems by establishing married women healthcare services across rural settings, ultimately aiming to improve the reproductive health status of married women in Nagapattinam District.

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