

**Health Literacy among Rural Women with Special Reference
to Community Health Centers of Madhya Pradesh: A Study**

THESIS

Submitted for the Degree of

DOCTOR OF PHILOSOPHY

IN

LIBRARY AND INFORMATION SCIENCE

Supervisor

Prof. SHILPI VERMA

Head, DLISc, BBAU

**BABASAHEB
BHIMRAO
AMBEDKAR
UNIVERSITY**



Submitted by

GULAB DEVI

Research Scholar

Department of Library and Information Science

(School for Information Science and Technology)

Babasaheb Bhimrao Ambedkar University

(A Central University)

Vidya Vihar, Raebareli Road, Lucknow- 226 025, Uttar Pradesh

Enrolment No-968/17

Year 2020

DECLARATION

I hereby declare that thesis entitled “**Health Literacy among Rural Women with Special Reference to Community Health Centers of Madhya Pradesh: A Study**” Submitted by me for the award of the Degree of Doctor of Philosophy in Library and Information Science to the Department of Library and Information Science, Babasaheb Bhimrao Ambedkar University, Lucknow is an outcome of my own efforts and is an original work. The contents of this thesis did not form a basis for the award of any previous degree to anyone else. It is also undertaken that thesis is essentially free from all kinds of plagiarism.

I hereby also undertake that the thesis submitted by me to Babasaheb Bhimrao Ambedkar University, Lucknow satisfies all the requirements as stipulated in the Doctor of Philosophy (Ph.D) regulations -1999 as amended in 2013 and it is fit for submission and evaluation for the award of the degree of Doctor of Philosophy in Library and Information Science of the University.

Date: 25.9.2020

Place: BBAU, Lucknow


GULAB DEVI

Research Scholar
Department of Library and Information Science
Babasaheb Bhimrao Ambedkar University
Vidya Vihar, Raebareli Road, Lucknow-226025 (U.P.)

CERTIFICATE

This is to certify that the thesis titled “**Health Literacy among Rural Women with Special Reference to Community Health Centers of Madhya Pradesh: A Study**” Submitted by **Ms. Gulab Devi** is an original research work and has not been previously submitted in part or full for the award of any other degree or diploma to this or any other university.

The thesis submitted to Babasaheb Bhimrao Ambedkar University Lucknow satisfies all the requirements as stipulated in the *Doctor of Philosophy (Ph.D) regulations-1999 as amended in 2013* and it is fit for submission and evaluation for the award of the degree of Doctor of Philosophy of the University.

Date: 25.9.20



Supervisor



Head of Department

HEAD
पुस्तकालय एवं सूचना विज्ञान विभाग
Department of Library & Information Science
बाबासाहेब भिमराव अम्बेडकर विश्वविद्यालय
Babasaheb Bhimrao Ambedkar University
विद्या विहार, रायबरेली रोड,
Lucknow-226 025 (उ.प्र.)
Lucknow-226025 (U.P.)

ACKNOWLEDGEMENT

First and foremost, I would like to thank God who has given courage, serenity and motivation to complete this study.

There are many people whom I would like to acknowledge for enabling me to stand at the significant milestone of completing doctorate degree. With great pleasure, I consider myself lucky to have Prof. Shilpi Verma, Professor and Head, Department of Library and Information Science Babasaheb Bhimrao Ambedkar University, Lucknow as my research work supervisor. I offer her heartfelt gratitude for her innumerable guidance, help, support, affection and encouragement throughout the research study. Her precious guidance helped me in all the time of research, from the stage of planning research to analyzing results, discussions and compilation of the thesis. .

I am deeply thankful to Professor M. P. Singh, Professor, Department of Library and Information Science for his valuable suggestions, ideas and all kind of support that enriched my thesis.

Words are not enough to express my sincere thanks to Professor K. L. Mahawar, Professor, Department of Library and Information Science, BBAU, Lucknow, for his great support, valuable and crucial suggestions.

I am deeply thankful to Professor M.P. Singh, Department of Library and Information Science for his valuable suggestions, ideas and kind of support that enriched my thesis.

I am highly thankful to Dr. Vineet Kumar and Dr. Sharad Sonkar, faculty members of the Department of Library and Information Science, BBAU for their encouragement, cooperation and valuable suggestions for the study.

I am thankful to Mr. Amit Sahu, Ms. Shreya Gupta Ms. Neha Kanojia, and all the research scholars of the department for their kind support and help.

I will be failing if I do not express my gratitude to my sister Ms. Rekha Choudhary, brothers and sister-in-laws. I am deeply obliged for her/his care and sustained efforts that helped me to achieve my target.

I am very much thankful to my loving parents (Mr. Amar Das Choudhary and Mrs. Muuni Bai) for their immense support, affection, sacrifices which helped me to carry out this work. At last but not the least I would like to extend my special thanks to my near and dear ones who gave me encouragement and enlightened my research work.

Thank you all once again.


Gulab Devi

<u>TABLE OF CONTENTS</u>	Page No.
<ul style="list-style-type: none"> • Declaration • Certificate • Ph.D. Course Work Certificate • Acknowledgement • List of Tables • List of Figures • List of Images • Abbreviations • Preface 	i ii iii iv vii-xii xiii-xiv xv-xv xvi-xx xxv-xxiii
CHAPTER-1 : INTRODUCTION	1-20
CHAPTER-2 : REVIEW OF LITERATURE	21-43
CHAPTER-3 : PROFILE OF HEALTH COMMUNITY CENTERS	45-93
CHAPTER-4 : DATA ANALYSIS AND INTERPRETATION	94-438
CHAPTER-5 : FINDINGS, CONCLUSIONS AND SUGGESTIONS	439-453
APPENDICES	
<ul style="list-style-type: none"> • BIBLIOGRAPHY 	i-iv
<ul style="list-style-type: none"> • QUESTIONNAIRE FOR MEDICAL PROFESSIONAL 	v-xiii
<ul style="list-style-type: none"> • QUESTIONNAIRE FOR RURAL WOMEN 	xiv-xxx

LIST OF TABLES

Table no	Name of Table	Page No
Table 4.1	Sample of Gwalior	95
Table 4.1.1	Types of Category/ Population	95
Table 4.1.2	Family's Monthly Income	96
Table 4.1.3	Education Levels of Rural Women	97
Table 4.1.4	Marital Status of women]	98
Table 4.1.5	Occupation of the rural women's husband	99
Table 4.1.6	Housing and Living Status of rural women	100
Table 4.1.7	Awareness about Health Literacy	102
Table 4.1.8	Reasons for Non- Awareness about Health Literacy	103
Table 4.1.9	Provision of Health Information, Resources, and Services by CHC	104
Table 4.1.10	Awareness, Source and Uses of immunization	104
Table 4.1.11	Availability and Accessibility of Health Care Services by CHC	106
Table 4.1.12	Access to the Satisfactory Road Network in Rural Areas	108
Table 4.1.13	Barriers to Health Treatment	109
Table 4.1.14	Awareness about nutritious diet taken by Rural Women	111
Table 4.1.15	Reasons for Non-Awareness of Nutritious diet by Rural Women	112
Table 4.1.16	Chosen Places for Delivery of their Child by Rural Women	113
Table 4.1.17	Awareness about Contraception	114
Table 4.1.18	Use of Contraception by Rural Women	115
Table 4.1.19	Reasons for not using Contraception by Rural Women	116
Table 4.1.20	Health Information received by Rural Women	117
Table 4.1.21	Treatment taken during pregnancy by Rural Women	118
Table 4.1.22	Types of Hospitals preferred by Rural Women	119
Table 4.1.23	Availability of Medical Staff in CHC	120
Table 4.1.24	Satisfaction level with CHC Staff	121
Table 4.1.25	Aspects of visiting to CHC by Rural Women	123
Table 4.1.26	Social Empowerment status of Rural Women	124
Table 4.2	Sample of Shivpuri	127
Table 4.2.1	Types of Category/ Population	128
Table 4.2.2	Family's Monthly Income	130
Table 4.2.3	Education Levels of Rural Women	131
Table 4.2.4	Marital Status of women	131
Table 4.2.5	Occupation of the rural women's husband	132
Table 4.2.6	Housing and Living Status of rural women	133
Table 4.2.7	Awareness about Health Literacy	136
Table 4.2.8	Reasons for Non- Awareness about Health Literacy	137
Table 4.2.9	Provision of Health Information, Resources, and Services by CHC	138
Table 4.2.10	Awareness, Source and Uses of immunization	139
Table 4.2.11	Availability and Accessibility of Health Care Services by CHC	140
Table 4.2.12	Access to the Satisfactory Road Network in Rural Areas	142
Table 4.2.13	Barriers to Health Treatment	143

Table 4.2.14	Awareness about nutritious diet taken by Rural Women	145
Table 4.2.15	Reasons for Non-Awareness of Nutritious diet by Rural Women	146
Table 4.2.16	Chosen Places for Delivery of their Child by Rural Women	146
Table 4.2.17	Awareness about Contraception	147
Table 4.2.18	Use of Contraception by Rural Women	148
Table 4.2.19	Reasons for not using Contraception by Rural Women	148
Table 4.2.20	Health Information received by Rural Women	149
Table 4.2.21	Treatment taken during pregnancy by Rural Women	150
Table 4.5.22	Types of Hospitals preferred by Rural Women	151
Table 4.2.23	Availability of Medical Staff in CHC	152
Table 4.5.24	Satisfaction level with CHC Staff	155
Table 4.2.25	Aspects of visiting to CHC by Rural Women	156
Table 4.2.26	Social Empowerment status of Rural Women	158
Table 4.3	Sample of Indore	164
Table 4.3.1	Types of Category/ Population	164
Table 4.3.2	Family's Monthly Income	165
Table 4.3.3	Education Levels of Rural Women	166
Table 4.3.4	Marital Status of women	167
Table 4.3.5	Occupation of the rural women's husband	168
Table 4.3.6	Housing and Living Status of rural women	169
Table 4.3.7	Awareness about Health Literacy	172
Table 4.3.8	Reasons for Non- Awareness about Health Literacy	173
Table 4.3.9	Provision of Health Information, Resources, and Services by CHC	173
Table 4.3.10	Awareness, Source and Uses of immunization	174
Table 4.3.11	Availability and Accessibility of Health Care Services by CHC	176
Table 4.3.12	Access to the Satisfactory Road Network in Rural Areas	178
Table 4.3.13	Barriers to Health Treatment	178
Table 4.3.14	Awareness about nutritious diet taken by Rural Women	181
Table 4.3.15	Reasons for Non-Awareness of Nutritious diet by Rural Women	181
Table 4.3.16	Chosen Places for Delivery of their Child by Rural Women	182
Table 4.3.17	Awareness about Contraception	183
Table 4.3.18	Use of Contraception by Rural Women	184
Table 4.3.19	Reasons for not using Contraception by Rural Women	185
Table 4.3.20	Health Information received by Rural Women	186
Table 4.3.21	Treatment taken during pregnancy by Rural Women	187
Table 4.3.22	Types of Hospitals preferred by Rural Women	188
Table 4.3.23	Availability of Medical Staff in CHC	190
Table 4.3.24	Satisfaction level with CHC Staff	192
Table 4.3.25	Aspects of visiting to CHC by Rural Women	193
Table 4.3.26	Social Empowerment status of Rural Women	195
Table 4.4	Sample of Dewas	198
Table 4.4.1	Types of Category/ Population	198
Table 4.4.2	Family's Monthly Income	200
Table 4.4.3	Education Levels of Rural Women	201

Table 4.4.4	Marital Status of women	202
Table 4.4.5	Occupation of the rural women's husband	202
Table 4.4.6	Housing and Living Status of rural women	204
Table 4.4.7	Awareness about Health Literacy	207
Table 4.4.8	Reasons for Non- Awareness about Health Literacy	208
Table 4.4.9	Provision of Health Information, Resources, and Services by CHC	209
Table 4.4.10	Awareness, Source and Uses of immunization	211
Table 4.4.11	Availability and Accessibility of Health Care Services by CHC	213
Table 4.4.12	Access to the Satisfactory Road Network in Rural Areas	215
Table 4.4.13	Barriers to Health Treatment	217
Table 4.4.14	Awareness about nutritious diet taken by Rural Women	220
Table 4.4.15	Reasons for Non-Awareness of Nutritious diet by Rural Women	221
Table 4.4.16	Chosen Places for Delivery of their Child by Rural Women	222
Table 4.4.17	Awareness about Contraception	223
Table 4.4.18	Use of Contraception by Rural Women	224
Table 4.4.19	Reasons for not using Contraception by Rural Women	224
Table 4.4.20	Health Information received by Rural Women	226
Table 4.4.21	Treatment taken during pregnancy by Rural Women	228
Table 4.4. 22	Types of Hospitals preferred by Rural Women	228
Table 4.4. 23	Availability of Medical Staff in CHC	229
Table 4.4.24	Satisfaction level with CHC Staff	230
Table 4.4.25	Aspects of visiting to CHC by Rural Women	232
Table 4.4.26	Social Empowerment status of Rural Women	234
Table 4.5	Sample of Ujjain	237
Table 4.5.1	Types of Category/ Population	237
Table 4.5.2	Family's Monthly Income	239
Table 4.5.3	Education Levels of Rural Women	249
Table 4.5.4	Marital Status of women	240
Table 4.5.5	Occupation of the rural women's husband	241
Table 4.5.6	Housing and Living Status of rural women	242
Table 4.5.7	Awareness about Health Literacy	243
Table 4.5.8	Reasons for Non- Awareness about Health Literacy	245
Table 4.5.9	Provision of Health Information, Resources, and Services by CHC	246
Table 4.5.10	Awareness, Source and Uses of immunization	247
Table 4.5.11	Availability and Accessibility of Health Care Services by CHC	249
Table 4.5.12	Access to the Satisfactory Road Network in Rural Areas	251
Table 4.5.13	Barriers to Health Treatment	252
Table 4.5.14	Awareness about nutritious diet taken by Rural Women	253
Table 4.5.15	Reasons for Non-Awareness of Nutritious diet by Rural Women	254
Table 4.5.16	Chosen Places for Delivery of their Child by Rural Women	255
Table 4.5.17	Awareness about Contraception	257
Table 4.5.18	Use of Contraception by Rural Women	258
Table 4.5.19	Reasons for not using Contraception by Rural Women	259
Table 4.5.20	Health Information received by Rural Women	259
Table 4.5.21	Treatment taken during pregnancy by Rural Women	260

Table 4.5.22	Types of Hospitals preferred by Rural Women	262
Table 4.5.23	Availability of Medical Staff in CHC	262
Table 4.5.24	Satisfaction level with CHC Staff	264
Table 4.5.25	Aspects of visiting to CHC by Rural Women	265
Table 4.5.26	Social Empowerment status of Rural Women	267
Table 4.6	Sample of Mandsour	270
Table 4.6.1	Types of Category/ Population	270
Table 4.6.2	Family's Monthly Income	271
Table 4.6.3	Education Levels of Rural Women	272
Table 4.6.4	Marital Status of women	273
Table 4.6.5	Occupation of the rural women's husband	274
Table 4.6.6	Housing and Living Status of rural women	275
Table 4.6.7	Awareness about Health Literacy	277
Table 4.6.8	Reasons for Non- Awareness about Health Literacy	278
Table 4.6.9	Provision of Health Information, Resources, and Services by CHC	279
Table 4.6.10	Awareness, Source and Uses of immunization	281
Table 4.6.11	Availability and Accessibility of Health Care Services by CHC	282
Table 4.6.12	Access to the Satisfactory Road Network in Rural Areas	283
Table 4.6.13	Barriers to Health Treatment	284
Table 4.6.14	Awareness about nutritious diet taken by Rural Women	285
Table 4.6.15	Reasons for Non-Awareness of Nutritious diet by Rural Women	286
Table 4.6.16	Chosen Places for Delivery of their Child by Rural Women	288
Table 4.6.17	Awareness about Contraception	289
Table 4.6.18	Use of Contraception by Rural Women	290
Table 4.6.19	Reasons for not using Contraception by Rural Women	291
Table 4.6.20	Health Information received by Rural Women	293
Table 4.6.21	Treatment taken during pregnancy by Rural Women	295
Table 4.6.22	Types of Hospitals preferred by Rural Women	297
Table 4.6.23	Availability of Medical Staff in CHC	299
Table 4.6.24	Satisfaction level with CHC Staff	301
Table 4.6.25	Aspects of visiting to CHC by Rural Women	302
Table 4.6.26	Social Empowerment status of Rural Women	304
Table 4.7	Sample of Satna	307
Table 4.7.1	Types of Category/ Population	308
Table 4.7.2	Family's Monthly Income	309
Table 4.7.3	Education Levels of Rural Women	310
Table 4.7.4	Marital Status of women	311
Table 4.7.5	Occupation of the rural women's husband	312
Table 4.7.6	Housing and Living Status of rural women	313
Table 4.7.7	Awareness about Health Literacy	316
Table 4.7.8	Reasons for Non- Awareness about Health Literacy	317
Table 4.7.9	Provision of Health Information, Resources, and Services by CHC	318
Table 4.7.10	Awareness, Source and Uses of immunization	320
Table 4.7.11	Availability and Accessibility of Health Care Services by CHC	321

Table 4.7.12	Access to the Satisfactory Road Network in Rural Areas	322
Table 4.7.13	Barriers to Health Treatment	
Table 4.7.14	Awareness about Nutritious diet taken by Rural Women	325
Table 4.7.15	Reasons for Non-Awareness of Nutritious diet by Rural Women	326
Table 4.7.16	Chosen Places for Delivery of their Child by Rural Women	327
Table 4.7.17	Awareness about Contraception	328
Table 4.7.18	Use of Contraception by Rural Women	329
Table 4.7.19	Reasons for not using Contraception by Rural Women	330
Table 4.7.20	Health Information received by Rural Women	331
Table 4.7.21	Treatment taken during pregnancy by Rural Women	332
Table 4.7.22	Types of Hospitals preferred by Rural Women	333
Table 4.7.23	Availability of Medical Staff in CHC	334
Table 4.7.24	Satisfaction level with CHC Staff	337
Table 4.7.25	Aspects of visiting to CHC by Rural Women	338
Table 4.7.26	Social Empowerment status of Rural Women	340
Table 4.8	Sample of Sagar	344
Table 4.8.1	Types of Category/ Population	345
Table 4.8.2	Family's Monthly Income	346
Table 4.8.3	Education Levels of Rural Women	347
Table 4.8.4	Marital Status of women	348
Table 4.8.5	Occupation of the rural women's husband	348
Table 4.8.6	Housing and Living Status of rural women	350
Table 4.8.7	Awareness about Health Literacy	353
Table 4.8.8	Reasons for Non- Awareness about Health Literacy	354
Table 4.8.9	Provision of Health Information, Resources, and Services by CHC	354
Table 4.8.10	Awareness, Source and Uses of immunization	356
Table 4.8.11	Availability and Accessibility of Health Care Services by CHC	357
Table 4.8.12	Access to the Satisfactory Road Network in Rural Areas	359
Table 4.8.13	Barriers to Health Treatment	360
Table 4.8.14	Awareness about nutritious diet taken by Rural Women	362
Table 4.8.15	Reasons for Non-Awareness of Nutritious diet by Rural Women	364
Table 4.8.16	Chosen Places for Delivery of their Child by Rural Women	364
Table 4.8.17	Awareness about Contraception	365
Table 4.8.18	Use of Contraception by Rural Women	366
Table 4.8.19	Reasons for not using Contraception by Rural Women	368
Table 4.8.20	Health Information received by Rural Women	369
Table 4.8.21	Treatment taken during pregnancy by Rural Women	370
Table 4.8.22	Types of Hospitals preferred by Rural Women	370
Table 4.8.23	Availability of Medical Staff in CHC	371
Table 4.8.24	Satisfaction level with CHC Staff	374
Table 4.8.25	Aspects of visiting to CHC by Rural Women	375
Table 4.8.26	Social Empowerment status of Rural Women	377
Table 4.9	Sample of Gandhinagar	382
Table 4.9.1	Types of Category/ Population	382
Table 4.9.2	Family's Monthly Income	383
Table 4.9.3	Education Levels of Rural Women	384

Table 4.9.4	Marital Status of women	384
Table 4.9.5	Occupation of the rural women's husband	385
Table 4.9.6	Housing and Living Status of rural women	386
Table 4.9.7	Awareness about Health Literacy	388
Table 4.9.8	Reasons for Non- Awareness about Health Literacy	389
Table 4.9.9	Provision of Health Information, Resources, and Services by CHC	389
Table 4.9.10	Awareness, Source and Uses of immunization	390
Table 4.9.11	Availability and Accessibility of Health Care Services by CHC	391
Table 4.9.12	Access to the Satisfactory Road Network in Rural Areas	393
Table 4.9.13	Barriers to Health Treatment	394
Table 4.9.14	Awareness about nutritious diet taken by Rural Women	395
Table 4.9.15	Reasons for Non-Awareness of Nutritious diet by Rural Women	395
Table 4.9.16	Chosen Places for Delivery of their Child by Rural Women	396
Table 4.9.17	Awareness about Contraception	397
Table 4.9.18	Use of Contraception by Rural Women	398
Table 4.9.19	Reasons for not using Contraception by Rural Women	398
Table 4.9.20	Health Information received by Rural Women	399
Table 4.9.21	Treatment taken during pregnancy by Rural Women	401
Table 4.9.22	Types of Hospitals preferred by Rural Women	401
Table 4.9.23	Availability of Medical Staff in CHC	402
Table 4.9.24	Satisfaction level with CHC Staff	403
Table 4.9.25	Aspects of visiting to CHC by Rural Women	405
Table 4.9.26	Social Empowerment status of Rural Women	406
Table 4.10	District wise data analysis	408
Table 4.10.1	Types of Category/ Population	409
Table 4.10.2	Family's Monthly Income	409
Table 4.10.3	Education Levels of Rural Women	410
Table 4.10.4	Marital Status of women	410
Table 4.10.5	Occupation of the rural women's husband	412
Table 4.10.6	Housing and Living Status of rural women	413
Table 4.10.7	Awareness about Health Literacy	414
Table 4.10.8	Reasons for Non- Awareness about Health Literacy	415
Table 4.10.9	Provision of Health Information, Resources, and Services by CHC	416
Table 4.10.10	Awareness, Source and Uses of immunization	416
Table 4.10.11	Availability and Accessibility of Health Care Services by CHC	418
Table 4.10.12	Access to the Satisfactory Road Network in Rural Areas	419
Table 4.10.13	Barriers to Health Treatment	419
Table 4.10.14	Awareness about nutritious diet taken by Rural Women	421
Table 4.10.15	Reasons for Non-Awareness of Nutritious diet by Rural Women	421
Table 4.10.16	Chosen Places for Delivery of their Child by Rural Women	422
Table 4.10.17	Awareness about Contraception	423
Table 4.10.18	Use of Contraception by Rural Women	423
Table 4.10.19	Reasons for not using Contraception by Rural Women	424
Table 4.10.20	Health Information received by Rural Women	425
Table 4.10.21	Treatment taken during pregnancy by Rural Women	426

Table 4.10.22	Types of Hospitals preferred by Rural Women	426
Table 4.10.23	Availability of Medical Staff in CHC	427
Table 4.10.24	Satisfaction level with CHC Staff	429
Table 4.10.25	Aspects of visiting to CHC by Rural Women	431
Table 4.10.26	Social Empowerment status of Rural Women	432

LIST OF FIGURES

Figure no.	Figure Headings	Page no.
Fig. 4.1.14	Awareness about full nutrition diet taken by rural women	111
Fig. 4.1.15	Reason for not aware full nutrition diet by rural women	113
Fig.4.1.17	Awareness about contraception	115
Fig. 4.1.21	Treatment taken during pregnancy by rural women	118
Fig 4.2.7	Awareness about health literacy	136
Fig. 4.3.12	Access to satisfactory road network is rural areas	179
Fig. 4.3.17	Awareness about contraception	185
Fig. 4.3.19	Reason for not use contraception by rural women	186
Fig.4.3.21	Treatment during pregnancy	189
Fig. 4.4.7	Awareness about health literacy	207
Fig. 4.4.9	Providing health information, resources and services by CHC	210
Fig.4.4.12	Satisfactory road network	286
Fig. 4.4.14	Full nutrition diet taken by rural women	220
Fig. 4.4.15	Reason for not taken full nutrition diet by rural women	221
Fig. 4.4.17	Awareness about contraception	223
Fig. 4.4.19	Reason for not use contraception by rural women	225
Fig. 4.5.9	Providing health information, resources and services by CHC	247
Fig. 4.5.12	Access to satisfactory road network is rural areas	247
Fig 4.5.14	Awareness about full nutrition diet taken by rural women	251
Fig. 4.5.15	Reason for not aware full nutrition diet by rural women	253
Fig 4.5.17	Awareness about contraception	257
Fig 4.5.18	Using contraception by rural women	258
Fig. 4.5.19	Reason for not using concentration	259
Fig. 4.5.21	Treatment taken during pregnancy by rural women	261
Fig. 4.6.7	Awareness about health literacy	277
Fig. 4.6.9	providing health information, resources and services	281
Fig 4.6.14	Awareness about full nutrition diet taken by rural women	288
Fig. 4.6.15	Reason for not aware full nutrition diet by rural women	289
Fig. 4.6.17	Awareness about contraception	291
Fig. 4.6.18	Using contraception by rural women	292
Fig. 4.6.21	Taken treatment during pregnancy by rural women	295
Fig. 4.7.7	Awareness about health literacy	313
Fig.4.7.17	Awareness about contraception	323
Fig. 4.7.18	Using contraception by rural women	326
Fig. 4.7.21	Treatment taken during pregnancy by rural women	330
Fig. 4.8.14	Awareness about full nutrition diet taken by rural women	350
Fig.4.8.17	Awareness about contraception	363
Fig.4.8.18	Using contraception by rural women	364
Fig. 4.9.5	Occupation of the rural women's husband	383

LIST OF IMAGES

S.N.	Image no	Headings of Images	Pages no
1.	3.1	Rural women in CHC hospital	50
2.	3.2	Information for rural women	52
3.	3.4	The rural women with her new born baby	53
4.	3.5	Rural women during post- natal treatment	54
5.	3.5	Image- Rural Women in Hospital	57
6.	3.6	Image of Mohana CHC	58
7.	3.7	Image of Bhitwar CHC	60
8.	3.8	Image of Kolaras CHC	64
9.	3.9	Image of Narwar CH	65
10.	3.10	Image of Pohari CHC	66
11.	3.11	Image of Band CHC	67
12.	3.12	Image of Khurai CHC	70
13.	3.13	Image of Khurai CHC	71
14.	3.14	Image of Shahgarh CHC	72
15.	3.15	Image of Shahgarh CHC	73
16.	3.16	Image of Shahgarh CHC	75
17.	3.17	Rural women pre-natal treatment in CHC	76
18.	3.18	Image of Majhgawan CHC	77
19.	3.19	Image of Rural women in CHC	78
20.	3.20	Image of Rampur Baghelan CHC	79
21.	3.21	Image of Medical shop of Uchehra CHC	80
22.	3.22	Image of Ghatia CHC	81
23.	3.23	Image of instruction for rural women by CHC	82
24.	3.24	Image of instruction for rural women by CHC	83
25.	3.25	Image of instruction for rural women by CHC	84
26.	3.26	Image of Bagli CHC	86
27.	3.27	Image of Bagli CHC	86
28.	3.28	Image of Kannod CHC	87
29.	3.29	Image Sonkachha CHC	89
30.	3.30	Image of Sanwad CHC	92
31.	3.31	Image of family planning	90
32.	3.32	Image of Tondkhurd CHC	87
33.	3.33	Image of Depalpur CHC	88

LIST OF ABBREVIATIONS

ANC	Ante-Natal Care
ANM	Auxiliary Nurse Midwife
APHC	Additional Primary Health Center
ARC	ASHA Resource Center
ARSH	Adolescent Reproductive Sexual Health
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha, Homeopathy
BMO	Block Medical Officer
BPHC	Block PHC
BPM	Block Programme Manager
CAH	Community Action for Health
CHC	Community Health Center
CMO	Chief Medical Officer
CMOH	Chief Medical Officer Health
DH	District Hospital
DHAP	District Health Action Plan
DPM	District Programme Manager
DPMU	District Programme Manager Unit
DTC	District Training Center
DWCD	Department Women & Child Development
EDL	Essential Drug List
FP	Family Planning
FRU	First Referral Unit
GNM	General Nursing Midwife
HMIS	Health Management Information System
HMRI	Health Management & Research Institute
HR	Human Resource
HRD	Human Resource Development
HRIS	Human Resource Information System
HSC	Health Sub-center

LIST OF ABBREVIATIONS

ANC	Ante-Natal Care
ANM	Auxiliary Nurse Midwife
APHC	Additional Primary Health Center
ARC	ASHA Resource Center
ARSH	Adolescent Reproductive Sexual Health
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha, Homeopathy
BMO	Block Medical Officer
BPHC	Block PHC
BPM	Block Programme Manager
CAH	Community Action for Health
CHC	Community Health Center
CMO	Chief Medical Officer
CMOH	Chief Medical Officer Health
DH	District Hospital
DHAP	District Health Action Plan
DPM	District Programme Manager
DPMU	District Programme Manager Unit
DTC	District Training Center
DWCD	Department Women & Child Development
EDL	Essential Drug List
FP	Family Planning
FRU	First Referral Unit
GNM	General Nursing Midwife
HMIS	Health Management Information System
HMRI	Health Management & Research Institute
HR	Human Resource
HRD	Human Resource Development
HRIS	Human Resource Information System
HSC	Health Sub-center

ICDS	Integrated Child Development Scheme
ICTC	Integrated Counseling and Testing Center
IDSP	Integrated Disease Surveillance Project
IEC	Information Education Communication
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IMR	Infant Mortality Rate
IPD	In Patient Department
IPHS	Indian Public Health Standards
ISO	International Organization for Standardization
IUCD	Intra-uterine Contraceptive Device
JPHN	Junior Public Health Nurse
JSSK	JananiShishuSurakshaKaryakram
JSY	JananiSurakshaYojana
LHV	Lady Health Visitor
LL	LR Labour Room
LSAS	Life Saving Anaesthesia Skills
LT	Laboratory Technician
MCTS	Mother and Child Tracking System
MDG	Millennium Development Goals
MDR	Multi-drug Resistant (TB)
MIS	Management Information System
MHW	Male Health Worker
MMR	Maternal Mortality Ratio
MMU	Mobile Medical Unit
MO	Medical Officer
MoHFW	Ministry of Health & Family Welfare
MOIC	Medical Officer In-charge
MoU	Memorandum of Understanding
MPW	Multi-purpose Worker
MTP	Medical Termination of Pregnancy
NFHS	National Family Health Survey

NGO	Non-Government Organisation
NHSRC	National Health Systems Resource Center
NICU	Neonatal Intensive Care Unit
NIHFW	National Institute of Health & Family Welfare
NPCB	National Programme for Control of Blindness Programme
NRC	Nutritional Rehabilitation Center
NRHM	National Rural Health Mission
NSSK	NavjatShishuSurakshaKaryakram
NSV	Non-scalpel Vasectomy
NUHM	National Urban Health Mission
NVBDCP	National Vector Borne Disease Control Programme
OPD	Out Patient Department
PCPNDT	Pre-Conception and Pre Natal Diagnostic Techniques (Prohibition of Sex-selection) Act – 1994
PHC	Primary Health Center
PHN	Public Health Nurse
PHN	Public Health Nurse
PIP	Programme Implementation Plan
PMU	Programme Management Unit
PPP	Public Private Partnership
PRI	Panchayati Raj Institutions
PWD	Public Works Department
RCH	Reproductive and Child Health
RDK	Rapid Diagnostic Kit
RGSEAG	Rajiv Gandhi Scheme for Empowerment of Adolescent Girls
RHFWTC	Regional Health & Family Welfare Training Center
RHP	Rural Health Practitioner
RKS	RogiKalyanSamiti
RKSK	RastriyaKishorSwasthyaKaryakram
RMP	Rural Medical Practioner
RMSCL	Rajasthan Medical Services Corporation Limited

RNTCP	Revised National Tuberculosis Control Programme
RSBY	RashtriyaSwasthyaBimaYojana
SBA	Skilled Birth Attendant
SDH	Sub Divisional Hospital
SHC	Sub Health Center
SHSRC	State Health Systems Resource Center
SIHFW	State Institute of Health and Family Welfare
SIMS	Softline Intelligent Micro Systems
SNCU	Special Newborn Care Unit
SPMU	State Programme Management Unit
STG	Standard Treatment Guideline
TB	Tuberculosis
VHND	Village Health and Nutrition Day
VHSNC	Village Health and Sanitation and Nutrition Committee
WHO	The World Health Organization

Preface

The Community Health Center (CHC), the third tier of the network of rural health care institutions, was required to act primarily as a referral center (for the neighboring PHCs, usually 4 in number) for the patients requiring specialized health care services. The objective of having a referral center for the primary health care institutions was two-fold; to make modern health care services accessible to the rural people and to ease the overcrowding in the district hospitals. The CHCs were accordingly designed to be equipped with: four specialists in the areas of medicine, surgery, pediatrics and gynecology; 30 beds for indoor patients; operation theatre, labour room, X-ray machine, pathological laboratory, standby generator, etc., along with the complementary medical and Para-medical staff. At the instance of Planning Commission, the Programme Evaluation Organization undertook the study to evaluate the functioning of the Community Health Centers (CHCs) and their effectiveness in bringing specialized health care services within the reach of rural people. Both secondary and primary data were required to be analyzed to test the various hypotheses relating to the above mentioned objectives of the study. While the information available in published sources was obtained and used wherever necessary, the major part of the data, required for the study, was generated through a sample survey of 41 CHCs spread over the 09 sample districts of Madhya Pradesh selected for the study.

The findings of the Study are as follows:

- (a) Given the other relevant factors, the services of a CHC are likely to be used less intensively, if:
 - (i) its geographical coverage is very large;
 - (ii) it has inadequate medical staff, particularly the specialists; and
 - (iii) the mean distance of the PHCs from the CHC is longer.
- (b) Some CHCs have been approved without sanctioning all the posts of specialists. Only 30 per cent of the required posts of the specialists were found to be in position. More than 70 per cent of the sample CHCs is running either with one specialist or without any specialist.
- (c) There is a mis-match between medical specialist's vis-a- equipment/facilities/ staff, leading to sub-optimal utilization of resources. The over- all productivity of the public health services can substantially be improved if this mis-match as well as thin spread of resources is avoided.
- (d) Only two out of 31 CHCs were found to have been used as referral centers to some extent. As many as 11 CHCs have not attended any referral case, while the remaining 18 have been

used sub-optimally with an average of 206 cases per year. The constraints to utilization of the services of CHCs relate to inadequacies of infrastructure, medical and paramedical staff, and more importantly, the mis-match of various inputs.

(e) Notwithstanding the existing limitations in the services delivery system, a large majority of the households expressed their strong preference for public health care system as against the private facilities. The findings tend to suggest that CHCs have not made any significant contributions towards realization of the intended objectives even after about two decades of their establishment. The study has been able to identify a set of key factors that has contributed to the poor performance of CHCs. It is hoped that the findings of the study will be useful to the planning/ implementing agencies in introducing the necessary corrective steps for improving the services delivery system.

Chapter-1 is “Introduction”. This chapter begins with a brief introduction of the health literacy, definition, research problem, hypotheses, need, scope, objective and research methodology used in the study.

Chapter-2 is “Review of Literature” deals with the important published literature including journals articles, published articles, books, and health websites relevant in in study earlier studies related to health literacy.

Chapter-3 is “Profile of Community Health Center of Madhya Pradesh”. This chapter provides the brief profile of Community Health Center (CHC) and their function covered in the study.

Chapter -4 is “Data Analysis and Interpretation”. This chapter presents the tabulations, statistical analysis, interpretation and graphical representation of the collected data from Community Health Center (CHC).

Chapter -5 is “Findings, Conclusion and Suggestions” presents the summary of the findings of the study and draws overall conclusion. A few suggestions have been given at the end for further research.

INTRODUCTION

1.0 Concept of Health Literacy

Our earliest scriptures define education as that which liberates, that provided the instruments for independence from lack of knowledge and domination. In the modern world, it could naturally include the capability to read and write, since that is the main instrument of learning. Hence the vital importance of women's education includes women's literacy.

This approach also understands the problem of authority and also how social structures affect access to and use of health information, as indicated by the promotion of rural women's health. Health literacy encourages empowerment, which in turn is vital in achieving the internationally agreed goals for health and development as well as beginning to emerging threats such as pandemic influenza, climate change, and non-communication diseases.

The term 'health and literacy', form an underlying concept that evolved from the 1970s to one that has captured the attention of a wide variety of disciplines, notably education and health care, but also library science, public health, and mental health. F. Butt encompasses the totality of the concept that is constructed in Health literacy. An evaluation of the concept of health literacy using the approach of concept/dimensional analysis, clear know-how of the concept is important, as health literacy has implications that are complete and affect each of man or woman and the whole society.

1.1 Historical background of Health Centers in India.

The first detailed descriptions of health information system for compliant accurate and timely information on vital statistics, causes of deaths and morbidity data, nutrition, smoking utilization of alcohols and illicit drugs for the planning of health services in British India was given by Sir Joseph Bhore in his detailed reports of "Health Survey and Development Committee", submitted to the government of India in 1946.

Health literacy could be defined as little more than an understanding of health information and instructions. In 1974, Simonds coined the term "health literacy".

The National Family Planning Programme was first time launched in 1951, laying the foundation of the Health Management and Evaluation System (HMES) in India. In 1960, the Ministry of Health and Family Planning, Government of India, annually fixed contraceptive method-specific targets, laying the foundation of the Health Management Information and Evaluation System (HMIES) in India.

In 1964 - 67, the systematically developed family planning management information and evaluation system (MIES) was launched to monitor not only activities but supplies, training, human resources, finance, etc. It assisted the implementation, monitoring, and evaluation (M&E) at various levels. In 1986 - 1985, the major changes were introduced in the forms of HMIS version 1.0, which was implemented on the basic pilot in four states, namely Gujarat, Haryana, Maharashtra, and Rajasthan, to reduce beneficiary registered members to 13, consolidate reporting formats and incorporating private hospital reporting that provided material, child health, and family planning services. In 1986 - 1988, compatible HMIS (version 2.0) was developed in association with the National Information Center (NIC) under the ninth year plan. Its piloting began in 1989 in 4 of the same above state (Govt. of India, 1992). It was extended in a phased manner in 13 states in 1990- 1995.

In 1992, well - made and user - friendly new reporting formats were introduced under the Child Survival and Safe Motherhood Program (Govt. of India, 1994), combined reporting formats for family planning maternal and child health - a new target - free HMIS 1 approach was initially launched in April 1996 in four districts on a basic pilot (Sangwan & mary, 1999) but the same was abandoned shortly afterward. During that time, various states such as Andhra Pradesh, Maharashtra, West Bangel, Himachal, Gujrat, Rajasthan, Panjab, and Haryana were piloting their health information system (Devey, 1995).

Madhya Pradesh is one of the Republic of India's largest states. The State is categorized by a complex social structure, a predominantly rural economy, a difficult and inaccessible terrain, and distribute settlements all over vast areas that together position severe challenging problems to delivery methods for health. Madhya Pradesh has a population of about 7.33 crores (approx.), which is around 6% of the country's population. According to the form of the viewpoint of per capita income, literacy, urbanization, infrastructure, and other indicators of growth, Madhya Pradesh belongs to

the country's category of less developed regions. Infrastructure, and other indicators of growth, Madhya Pradesh belongs to the country's category of less developed regions.

1.2 Impact of Health Policies in Madhya Pradesh

In 2005, the National Rural Health Mission launched the Janani SurakshaYojana, which emphasizes institutional deliveries, to reduce high levels of maternal and neonatal mortality. The program provides transport, financial support and incentives for Accredited Social Health Activists (ASHA) to encourage mothers to pursue institutional delivery. The scheme is fully sponsored by the central government and implemented in all states and territories of the Union (UTs), with a particular focus on low - performing states. Madhya Pradesh's performance until 2008 after JSY was introduced is summarized below with secondary source support.

It is observed that institutional deliveries have changed dramatically from 2005 - 06 onwards. The number of institutional deliveries in Madhya Pradesh is growing vastly. NRHM's evaluation study in 7 states, 2011, indicated the referral transport services viz in Madhya Pradesh. In all the first referral units (FRU), Janani Express Vehicles are functional. Although Janani SurakshaYojana's progressive scheme was successful in bringing mothers to the institutions, the state still lacks the facilities required to ensure safe birth & medical care for children.

The trend in health and nutrition expenditure per capita shows that health expenditure in Madhya Pradesh and Bihar has always remained low compared to other EAG states. Various studies observe that various factors reduce government health spending. Also analyzed that, after the Fiscal Responsibility, Budget Management Act (FRBM) has been enacted in all states, states are left with very little scope to increase public sector allocations such as health and education. 'The FRBM Act enforces the government to reduce fiscal and revenue deficits by either raising revenue resources or restructuring/cutting overall public spending. To achieve MDG and other development goals, increased spending on health infrastructure and human resources is necessary for the state.

Health literacy means more than reading pamphlets and making successful prescriptions. Health optimizing rural women's access and ability to use health information effectively is also part of women empowerment.

1.1.1 A Brief Introduction of Health Literacy

Health literacy is a concept with multiple, contested definitions. The working definition to be used throughout this study is that developed by the Institute of Medicine (IOM) in 2004 (Institute of Medicine, 2004): Health literacy is an individual's ability to obtain, process, and understand basic health information and services sufficiently to make appropriate health decisions. This definition captures basic, functional health literacy (i.e. 'functional health literacy') and is perhaps the most commonly used in the clinical, epidemiological, and psychological literature on health literacy.

The term 'health literacy' was coined by Scott Simonds in 1974 in a paper in support of health education as social policy, according to which students should leave human health literature in the same way as in academic disciplines (Ratzan, 2001; Simonds, 1974). Health Literacy work has been growing slowly throughout the 1990s, partly as a result of the introduction of several measuring instruments for health literacy in the United States. The National Assessment of Adult Literacy was published and included. Over the last decade, health literacy research has expanded to create a broad global sector, aimed at refining the concept and measurement of the term, generating prevalence estimates of low health literacy, and exploring its antecedents and health outcomes in a variety of contexts and populations.

1.1.2. Defining Health Literacy

Health literacy has multiple definitions that are challenged among researchers and across disciplines. Considering 'Health Literacy' as a research field is considering an intersection of clinical, epidemiological, academic, health promotion, and psychological fields.

On the other hand, there has been a lack of research in the field of health information literacy that has applied a comparative perspective to explore the nature of ways in which people use knowledge to learn about health. Ultimately, there is a lack of understanding of the different ways that people experience education in health information, or in other words, the different ways that data consumers consider having health information.

Access-evaluation, interpretation, and implementation of various parameters of health information related to health care, disease prevention, and dissemination of health information in the knowledge world.

Accessing: involves recognizing needs for health information, identifying likely sources of information, searching, finding, and obtaining information on health;

Evaluation: includes determining the value and applicability of the information. This requires the ability to interpret, sort, and analyze data on health;

Understanding: includes the study, understanding, and access to health information;

1.2 Some important definitions of Health Literacy

Health literacy generally refers to individuals 'quality of gaining access to, understanding the use of the information in ways that promote and maintain good health'.

According to WHO (1998), health promotion glossary "health is ' psychological and social skills that verify human beings 'ability to access health information in ways that encourage and maintain good health."

According to the American Medical Association Foundation (1999), defines Health Literacy as "the ability to acquire process and understand the basic health information and services necessary to make suitable health decisions and follow the standard of care instructions."

Nutbeam (2006), defines health literacy as " This has resulted in the development of 'outcomes' structures from health procedures that illustrate and explain the association between health promotion actions, health social factors and ensuing health outcomes health literacy."

According to the Patient Protection and Affordable Care Act of 2010. defines "Health Literacy as the degree to which an individual can obtain, communicate, process, and understand basic health information and services to make appropriate health decisions."

1.4 Overview of Women's Health Literacy of Madhya Pradesh (MP)

Women make 50% of the population and contribute to the economy of the state in a significant mode. Despite their contribution, the women, in general, suffer from various kinds of deprivations. The position of women in society is the result of typical social background. The stylized role assigned to her in the families puts the woman to positive disadvantages in life due to which they are not able to realize their potential in life. Although rural women are fifty per cent of the population their contribution to themselves and society is not satisfactory. They sincerely suffer from intra family neglect and poverty. Women lag behind the male population on almost all the socio-economic indices. Rural women have poor access to all essential services like health, education, food, drinking water, and sanitation. This makes their position still more exposed. Women are represented in diverse social, economic, and geographical locations. Due to these differences, their problems are also varied and unique. To improve their condition a planned intervention capable of responding to their differentiated needs is required. The eleventh plan recognizes this unique requirement and predicts that the health center of women must be utilized to solve their problems. The participatory approach is emphasized to give control of women over the programs meant for their improvement.

The gender perspective incorporated in the plan have a multipronged approach, they must;

- Provide women with basic entitlements;
- Prioritize economic empowerment;
- An environment free of violence against women;
- Representation at the highest level of policymaking;
- Strengthening institutional mechanisms for gender mainstreaming and Effective policy Implementation;

1.4.1 To achieve the Health vision and goals of the state, the following strategies implemented:

1.4.1.1 EQUITY

Poor women are commonly known to have the worst factors of health and Madhya Pradesh was an exception. Other aspects of assets moreover have anything to do with income and health. In general Madhya Pradesh's access to health care and health status, urban disparity gender disparity, and disparity due to lack of education are geographically disparities in providing education at all places.

1.4.1.2 Income inequity

Income affects both access to healthcare and health conditions. The rate of infant mortality is double and the rate of child mortality in poor families is more than five times of non-poor. The analysis also reveals that the rich were using the private sector hospitals more, but rural women are also using even more of the public provision.

1.4.1.3 Gender Inequity

Women play a prominent and key role in maternal and community health decisions. Mortality rates for girls except for during early development are higher than for boys.

1.4.1.4 Rural-urban Inequity

Public spending on healthcare in rural areas would be less than one-third of the per capita spent on urban areas. IMR is significantly greater in rural areas than in urban areas. More than 86% of deliveries were at home in rural areas, compared with 50% in urban areas.

1.4.1.5 Education Inequity

National Family Health Survey (NFHS) data clearly showed that the level of education of mothers directly affects the use of health services. The health sector can contribute greatly to addressing the unfair situation for access to health and health social position.

The health sector has the ambition to improve economic and geographic equity as well as coverage of the population for access to effective and good quality health care.

The health sector has the ambition to improve economic and geographic equity as well as coverage of the population for access to effective and good quality health care through new strategies described below.

1.5 Status of Women in Madhya Pradesh

Even though it is well-known fact that the condition of women in the state is far from a satisfactory level, the state government is fully determined to improve their standard of life. The government is also taking steps to open up all the opportunities to women so that can realize their potential. To draw a comprehensive picture of the situation of women in MP an array of the temporal and spatial behavior of social indicators is used to bring in the cultural, social, political, environmental, and developmental context of the region.

1.5.1 Demography

The female population of the state is 49 % of the total population of the state. The life expectancy of women is 56.7 years, which is lower than that of the males. The All India life expectancy for the period 1998-2002 for the male is 61.6 and female is 63.3, whereas the life expectancy for the same period for Madhya Pradesh for the male is 57 and for females, it is 56.7 years. (Source: RGI). This fact is enough to explain the status of the health of women in Madhya Pradesh. This indicates the deeper malaise responsible for the worse situation of women.

1.5.2 Sex Ratio

The sex ratio of the new state of MP has improved in 2001 (920) since the last decade (912), for the second time since 1901. The sex ratio of new Madhya Pradesh is below the national average of 933. Although there has been an improvement in the overall sex ratio of 2001, 14 districts of the total 45 districts in the State records sex ratio less than 900. With Morena recording the lowest at 822 in 2001 (808 in 1991).

1.6 Health and Nutrition Scheme for Women's by Madhya Pradesh Government

a) Janani Suraksha Yojana:

This scheme is being implemented by the Health Department of Madhya Pradesh. The scheme aims for the safe delivery of babies so that Mortality Rate can be reduced.

Under Janani SurakshaYojana (JSY) the government provides a cash incentive for pregnant mothers to have institutional births as well as pre- and ante-natal care. Transport is made available to pregnant women under 'Parivahan Yojana'. During the last two and a half years, more than ten lakh women have taken the benefit of Janani SurakshaYojana. The scheme has proved to be a success in urban as well as rural areas. Under the scheme a sum of Rs. 1400 is given to pregnant women in rural areas and Rs.1000 in urban areas. The person who brings the pregnant woman to the hospital for delivery is given Rs. 600 in the rural areas and Rs. 200 in the urban areas.

b) Prasooti Sahayata Yojana:

This scheme is being implemented by the labour department, Madhya Pradesh. Under this scheme, pregnant women working as a construction worker receives the benefit of 50% of the 12- week wage and a total of Rs 1000/-, to meet the delivery expenditure. Women can benefit twice in a lifetime form this scheme.

c) Mangal Divas:

This scheme was being implemented by the Department of Women and Child Development, Madhya Pradesh. A new Mangal Diwas scheme is launched under the nutrition program during the Eleventh Five Year Plan. With the help of the Department of Health and Family Welfare, every Tuesday programs such as Janmdin, Ann Prasan, Godbharais, and Kishori scheme are being organized with small function under this scheme.

d) Project Shaktiman:

Tackling prevalent infant mortality among women and children remains the biggest most essential challenge before the state government, especially in tribal groups. To reduce the percentage of malnutrition in the tribal area, a project called “Project Shaktiman” has been launched separately by the WCD department in 39 tribal clusters, identified from 19 tribal Dominated districts. A mapping exercise was performed to selected 38 blocks with such a high percentage of tribal population having malnutrition among children (0-5 years). This project would help to prevent and reduce malnutrition rates in young children, reduce IMR and MMR through an incorporated approach, reduce anemia among girls and adults, promote awareness of personal hygiene, safe

drinking water, sanitation, and also optimize the coverage and consumption of sufficient iodized salt and vitamin etc.

e) Rashtriya Maternity Benefits Yojana this scheme is being implemented by the Madhya Pradesh Department to promote poor economic conditions for pregnant women. Gram Panchayats is authorized to provide a sum of Rs 300 on receipt of application as financial supports to pregnant women.

f) Deen Dayal Mobile Health Clinic: Deen Dayal Mobile Hospital Yojana was launched in May 2006 in Madhya Pradesh to increase health services coverage for the flung region that is not easy to access and where SC/ST population is largely focused. The program aims to improve access and accessibility of quality healthcare for people living in remote locations, particularly for poor, women and children.

g) Deen Dayal Antyodaya Upchar Yojana the scheme launched in September 2004 aims to provide medical treatment for all categories of patients belonging to BPL families under the scheme in the financial year; a family is given medical check-up and treatment worth up to Rs 20,000. A health card is given to each beneficiary family in which the details of the family are entered. Card entries are also made by admitted to a hospital on a patient undergoing treatment.

h) Ladli Laxmi Yojana the purpose of this scheme implemented since 2006 is to lay some foundation for the future of girls by improving their educational status and to bring about a positive change in the social approach to a girl's birth. Under the scheme, national saving certificate worth Rs 6,000 are purchased every year by the state government on behalf of a girl after her birth even after the amount reached Rs 30,000 the girl covered by the scheme gets Rs 2000 on class VI admission, Rs 4000 on class IX admission and Rs 7500 on class XI admission, during her studies in class XI and XII, she received Rs 200 per month. When the girl reached the age of 21 and has not married before the age of 18 the amount in a lump sum that comes to Rs 1 lakh is paid to her.

i) Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG)

The scheme focused particularly to young girls of age group 11 to 18 years. Nutrition and non-nutrition components are two major components of the scheme School girls aged 14 years and young girls aged 14 to 18 are given Home Ration or Hot

Cooked Meal. In the non- nutrition components, IFA supplementation, health check-up, referral services, nutrition and health education, family welfare counselling and guidance, adolescent reproductive sexual health, child care practices, life skill education, and vocational training are provided to out of school adolescent girl aged between 11 to 18 years.

j)Some National Health Organisations: The Ministry of Women and Child Development are headed by Smt. Smriti ZubinIrani, Minister Mr. Ram Mahohar Mishra; the Secretary, and Mr. A.B. Joshi and Mr. Ali Raza Rizvi special secretary of the Ministry of Women and Child Development. The ministry activities are carried out through seven officers. Under its agencies, the ministry has autonomous institutions.

1. The National Institute of Public Cooperation and Child Development (NIPCCD)
2. The National Commission for Women (NCW)
3. The National Commission for Protection of Child Rights (NCPCR)
4. The Central Adoption Resource Agency (CARA)
5. The Central Social Welfare Board (CSWB)
6. The Rashtriya Mahila Kosh (RMK)

Schemes for Women Empowerment

- ❖ Scheme for Beti Bachao Beti Padhao
- ❖ One-Stop Center Scheme
- ❖ Women Helpline Scheme
- ❖ Reintegration of Trafficked Victims and Commercial Sexual Exploitation.
- ❖ The Working Women Hostel
- ❖ SWADHAR Greh-A Women in Difficult Circumstances Scheme
- ❖ Support to Training and Employment Programme for Women (STEP)
- ❖ NARI SHAKTI PURASKAR
- ❖ The Awardees of Rajya Mahila Samman & Zila Mahila Samman
- ❖ The Mahila Police Volunteers
- ❖ The Mahila E-Haat

- ❖ The Mahila Shakti Kendras (MSK)
- ❖ NIRBHAYA

1.8 Need for Significance of the Study

1. To identify the language barriers, literacy, and communication in health care.
2. To identify the role of Health Literacy in reducing health disparities.
3. To identify the Health literacy need of rural women.
4. To identify the Health literacy need of professionals.

1.9 Statement of the Problem

As researchers the factors for investigation that contribute to health disparities and unnecessary healthcare costs, one element receiving increased attention is health literacy. Health literacy is the ability to obtain, process, and appropriately act on health information (Nielsen-Bohlman, Panzer, and Kindig). Low health literacy has been found to contribute to poorer health outcomes (De Walt et al.; Kalichman et al.; Lindau et al.) and increased costs to the healthcare system (Howard, Gazmararian, and Parker; Weiss and Palmer).

Hence the researcher has chosen the topic based Health Literacy among Rural Women with special reference to the Community Health Center (CHC) of MP. For the aforesaid purpose, the study is being conducted on the Community Health Center of Central India of Madhya Pradesh i.e. 42 Community Health Center out of 338 Community Health Center of Madhya Pradesh has been selected.

1.10 Objectives of the Study

1. To find out the key problems in accessing health-related information by the rural women of Madhya Pradesh.
2. To determine the effectiveness of data collation and analysis work done in health community centers of Madhya Pradesh.
3. To study the relationship between literacy and health status of the rural women of Madhya Pradesh.

4. To identify the awareness of health literacy of rural women in health care in Madhya Pradesh.
5. To study the quality of life of the rural women of Madhya Pradesh.
6. To know, how rural women use information.

1.11 Hypotheses

Hypotheses are considered as an important instrument in research. The main purpose of hypotheses is to suggest a new experiment and observations. It can say hypotheses are the tentative answer of the proposal made by the researcher at the beginning of the study. M. R. Cohan and E. Nagge have described the function of hypotheses as follows:

1. The function of hypotheses is to direct our search for the order amongst facts.
2. It is of considerable advantage. It is a systematic inquiry that begins with a suggested explanation or solution of the difficulty, which are originated in it. Something in the subject matter and our previous knowledge suggest such a tentative explanation to us.

Based on the above points, the researcher has framed the following hypotheses for the present study:

1. The growth of health literacy in health information center of Madhya Pradesh is not satisfactory.
2. There is a lack of trained, qualified professionals to provide the health care at Community Health Center.
3. There is no significant relationship between literacy and the quality of life of rural women.

1.12 Scope of the Study

The scope of the study is limited to the Community Health Centers of Madhya Pradesh. They are divided into five Zones of Madhya Pradesh North Zone (Gwalior and Shivpuri), East Zone (Ujjain and Mandsaur), West Zone (Satna and Sagar), Central Zone (Bhopal only) and the South Zone (Indore and Dewas). The community health Centers located in selected cities of Madhya Pradesh are studied under this study.

The list is given below:

S.No	Zone	Blocks	Name of CHC		
1.	Central Zone	Bhopal	Gandhinagar		
2			Berasia		
3	North Zone	Gwalior	Bhitarwar		
4			Mohana		
5		Shivpuri	Badarwas		
6			Karera		
7			Khaniadhana		
8			Kolaras		
9			Narwar		
10			Pichhore		
11			Pohari		
12			East Zone	Mandsaur	Malhargarh
13					Sitamau
14	Shamgarh				
15	Ujjain	Ghatia,			
16		Tarana			
17	West Zone	Sagar	Banda		
18			Gadakota		
19			Devari		
20			Jaisinagar		
21			Kesli		
22			Kurai		
23			Maalthona		
24			Rahatgarh		
25			Shahgarh		
26			Surkhi		
27			Satna	Amarpatan	
28		Devrajnagar			
29		Nagod			
30		Majhgawan			
31		Mukundpur			
32		Rampur Baghelan			
33	Uchehera				
34	South Zone	Dewas	Bagli		
35			Kannoad		
36			Khategaon		
37			Sonkachh		
38			Toankkhurd		
39		Indore	Depalpur		
40			Sanwer		
41			Manpur		
42			Mhow		

1.13 Methodology of the Study

Research is an inquiry or a deep and careful investigation especially searching for new facts in any branch of knowledge. The research design refers to a plan, blueprint, or guide for data collection and interpretation, sets of rules that enable the investigator to conceptualize and observe problems under study". The appropriateness of the study mainly depends on the research design chosen for the study. It is a way for solving, the research problems in a well-organized and systematic manner. For conducting research, proper planning of research is most important, upon which the whole study depends.

Research Method-The study is mainly descriptive study, however; it is based on the quantitative technique of research. The research implies quantitative measures and the use of statistical analysis. The formulation of the research problem is based on the critical appropriation of review of literature, in-depth discussion with the medical professional, and a pilot study. The research process mainly involves data collection, data processing, and data analysis. However, proper identification and formulation of the research problem, hypotheses, and selection of research tools, collecting data, data processing, and data analysis are important research processes. The present study attempts to examine the health issue of rural women in Madhya Pradesh.

1.13.1 Research Method used in the Study-There are no. of research methods available based on the sample, scope, and nature of the study. The research method used in the study is the survey method; to justify the objective of the study this method is most appropriate. The data of Community Health Center is collected in the study through the survey method.

1.13.2 Data Collection tool and Technique used in the study- As the survey method is used for the study. The data is collected with the help of a Questionnaire, Interview, Observation, and Literature review method for the study.

1.13.2.1 Questionnaire

The questionnaire is meant for a set of questions developed in an organized and ordered manner for gaining information from rural women about a given problem.

The questionnaire used in the study is, prepared after the comprehensive literature search and discussion. Both open and closed-ended questions are included in the questionnaire, distributed among all selected rural women related to various Zones of the Madhya Pradesh. The personal interviews of the selected rural women of various Zones in MP help in the proposed study.

There are only two questionnaires for the data collection used in this study;

1. Questionnaire for Medical Professional
2. Questionnaire for Rural Women.

1.13.2.2. Interview:

An interview is a technique to get the information with the respondent on the face to face basis. It helps the researcher in getting more correct information on sensitive issues. The interview method supplements the questionnaire method in a very effective manner.

1.13.2.3 Observation:

Various articles, books, online and print journals, Websites, different health websites were also consulted to know the various studies done related to the selected research topic.

1.14 Sampling and Size of the Sample

Community Health Center (CHC) is extending across India and also Madhya Pradesh. A total of 42 Community Health Center (CHC) dealing with various health disciplines are present in Madhya Pradesh. The Community Health Center (CHC) is divided into 5 Zones: Central, Northern, Southern, Eastern and Western Zone of Madhya Pradesh. Two Community Health Center (CHC) are covered and taken as a sample from every Zone.

1.15 Data Collection and Analysis:

The study is descriptive and based on mainly primary data collected from the field survey. Besides the collection of primary, secondary and relevant literature has been collected from published and documented sources, including the internet sources.

Previous surveys, reports, studies, and research work have done reviewed critically to get the inside of the topic. The field survey is critically conducted in selected Community Health Center (CHC) in Madhya Pradesh selected for field survey. The analysis of the data is done based on research findings of selected Community Health Center (CHC).

1.16 Limitation of the Study

The present study had several limitations that might have restricted the generalization of the finding of the study. The study is mainly based on the questionnaire. In the questionnaire method, there may be a possibility of the wrong answer by the respondents.

Chapterization of the theses

The study is presented in Five Chapters

Chapter-1 is “Introduction”. This chapter begins with a brief introduction of health literacy, definition, research problem, hypotheses, need, scope, objective, and research methodology used in the study.

Chapter-2 is “Review of Literature” deals with the important published literature including journal articles, published articles, books, and health websites relevant in earlier studies related to health literacy.

Chapter-3 is “Profile of Community Health Center of Madhya Pradesh”. This chapter provides a brief profile of the Community Health Center (CHC) and its function covered in the study.

Chapter -4 is “Data Analysis and Interpretation”. This chapter presents the tabulations, statistical analysis, interpretation, and graphical representation of the collected data from the Community Health Center (CHC).

Chapter -5 is “Findings, Conclusion, and Suggestions” presents a summary of the findings of the study and draws an overall conclusion. A few suggestions have been made at the end for further research.

References

- index @ www.cdc.gov. (n.d.). Retrieved from
<https://www.cdc.gov/healthliteracy/learn/index.html>
- 25348be432aa91dc2b4a681351d67b6fa0fc3734 @ www.asha.org.(n.d.). Retrieved
from <https://www.asha.org/slp/healthliteracy/>
- what-is-health-promotion @ www.who.int. (n.d.). Retrieved from
<http://www.who.int/features/qa/health-promotion/en/>
- Ministry_of_Women_and_Child_Development @ en.wikipedia.org.(n.d.). Retrieved
from https://en.wikipedia.org/wiki/Ministry_of_Women_and_Child_Development
- Errors @ www.mp.gov.in.(n.d.). Retrieved from
<http://www.mp.gov.in/web/guest/Women-Child-Development1> Accessed on
04/04/2019
- PageNotFound @ www.ais.up.ac.za.(n.d.). Retrieved from
<http://www.ais.up.ac.za/med/scm870/nutbeam.PDF> Accessed on 19/03/2018
- da39a3ee5e6b4b0d3255bfef95601890afd80709 @ madhyapradesh.pscnotes.com.(n.d.).
Retrieved from <https://madhyapradesh.pscnotes.com/mppcs-mains-social-sector/health-services-preventive-and-curative-health-programmes-in-india-m-p-with-an-emphasis-on-children-and-womens-health-issues-related-to-availability-of-curative-health-to-all/> Accessed on 04/04/2019
- index @ www.mpswc.nic.in. (n.d.). Retrieved from <http://www.mpswc.nic.in/>
- Errors @ www.mp.gov.in.(n.d.). Retrieved from
<http://www.mp.gov.in/web/guest/Women-Child-Development1>
- 95fcc2c28a31acb3efc3d2d3c6b1f35a3a48489f @ environicsindia.in.(n.d.). Retrieved
from <http://environicsindia.in/2018/11/15/womens-health-schemes-in-madhyapradesh/>
- index @ www.cdc.gov. (n.d.). Retrieved from
<https://www.cdc.gov/healthliteracy/learn/index.html>
- www.asha.org. (n.d.). Retrieved from <https://www.asha.org/slp/healthliteracy/>
- what-is-health-promotion @ www.who.int. (n.d.). Retrieved from
<http://www.who.int/features/qa/health-promotion/en/>

REVIEW OF LITERATURE

2.0 Introduction

The intended purpose of this chapter is to examine the literature related to health literacy and providing an insight into some of the outstanding and crucial issues hindering the growth of health literacy in the Community Health Centre. There is a strong need to address these issues to provide greater visibility and training to the medical staff and women.

A literature review allows the researcher to examine the issues in-depth and to understand the different aspects of the problem. Several studies have been carried out on the use of the internet and web technology for various purposes in general and in particular.

It is difficult to cite all literature being published either in print or electronic form. The review on health literacy resources and services is made on online resources, Pub-med, NML, Emerald, Elsevier Science, JSTOR, Open Access e-journal like Directory of Open Access Journal (DOAJ), Open Access Journal Search Engine (OAJSE), Google Scholar, etc. These studies under review offered in-depth insights on the issue of health literacy among rural women in the CHC of Madhya Pradesh.

In this Chapter literature review, Most of the existing research in the area of health literacy consists of studies related to information search strategies of rural women, AASHA use of CHC and internet, Library, health websites, as a source of information for gathering data.

2.1 History of Health Literacy

‘Health Literacy’ was first implemented by Scott Simonds (Simonds, 1974), according to Ratzan (Ratzan, 2001). While this is undoubtedly true, the use of the word by Simonds was also very different from current. Also, Simonds made a case for school health education with the hope that not only would pupils be taught in the normal subjects of the curriculum, but that they might become as ‘literate’ in health as they were in history and science, for example. ‘Health literacy’ subsequently gained more limited technical significance. Health Literacy work grew slowly throughout the 1990s, partly prompted by the introduction of several health literacy measurement instruments in the United States. The United States in 2003 National Adult Literacy

Survey was published and included a nationally representative survey of American health literacy for the first time. Such surveys' titles material and geographical scope have changed somewhat over the years;

The most recent survey, called the Survey of Adult Skills (OECD, 2013a), was conducted between 2008 and 2013 by the OECD Program for the International Assessment of Adult Skills (PIAAC). The OECD has a well-developed concept and operationalization of literacy, as adopted in this survey (OECD, 2013a):

2.2 Type of Health Literacy

Nutbeam, who was instrumental in this redefinition process, reflected very honestly on the shortcomings of the narrow definition of health literacy alluded to above (Nutbeam, 2000). However, many times, the often significant gap between 'awareness' and 'learning' has been part of the philosophy of psychology and education. Nutbeam, however, aims to broaden the concept of health literacy to include the many emotional, cultural, and environmental factors affecting health choices and health-related behavior. Health literacy is the cognitive and social skills that assess individuals' motivation and ability to access, interpret, and use knowledge in ways that encourage and maintain good health. Health education means more than reading pamphlets and making appointments effectively. Health education is crucial to prosperity by enhancing people's access to health information and their ability to use it effectively.

1. *Basic/functional literacy-*

This is considered to be equivalent to the narrow definition of 'traditional.' It is characterized by 'sufficient basic literacy skills to be able to function effectively in everyday situations.'

2. *Communicative/interactive literacy-*

'More advanced cognitive and literacy skills that, together with social skills, can be used to actively participate in everyday activities, to obtain information and to derive meaning from different modes of communication, and to apply new information to changing circumstances.'

3. *Critical literacy-*

'More advanced cognitive skills that can be used, together with social skills, to critically analyze information and to use this information to exercise greater control over life events and situations.'

Emily J. Hauenstein, Rachael S. Clark & Elizabeth I. Merwin. (2019). The research is on Modeling Health Disparities and Outcomes in Disenfranchised Populations. The study explained the complexity of obtaining health care in a rural setting, the Health Disparities, and Outcomes (HDO) model has been revised and updated using emerged theoretical models of adversity and inequity.

Hamidreza, Mohaddes and Hakkak, et al. (2019). The entire study on Health Literacy Level and Related Factors among Pregnant Women Referring to Bojnord Health Centers in 2017. It has been described that health is a vital and changeable factor in improving access to health information, communication with health care providers, and health care system orientation. The purpose of this was therefore to determine the level of health literacy and its associated factors among pregnant women referring to Bojnord health centers in 2017.

Tabish, S.A. (2019). The study that the health streams every aspect of the human race, whether it is Culture, Religious Beliefs, and other aspects. The launch of the National Health Security Scheme (NHPS) on 25 September 2018, shows it is the largest insurance plan in the world, covering 40 health centers in India. With this, the inter-disciplinary approach to health care has been working and the health system has been working effectively.

Hosking, Sarah M. et al. (2018). The research on health literacy in a population-based sample of Australian women: a cross-sectional profile of the Geelong Osteoporosis Study. The study described a recently developed multidimensional health literacy tool that measured multiple factors of health literacy. The objective of this study was to use a multidimensional tool, the Health Literacy Questionnaire (HLQ), to determine the health literacy profile of a randomly selected population-based sample of Australian women.

Kaur, Navdeep. (2018). The study highlighted on the Impact of photo novel interventions among people with low levels of health literacy. It has described a growing momentum across different disciplines to use photonovels to communicate information among people with low health literacy levels. The aim of the study was information professionals; scientists, researchers, and clinicians can use photonovels to communicate information related to health.

Nirmala, Devi. (2018). Research has described the Impact of Health Sector Reforms on Utilization of Health Care Services in Rural Assam (India). It was described to analyze the impact of the health reforms on the pattern of use of health care services and to identify factors disturbed health care facilities' choice based on a cross-section study in rural Assam. The study relied on a household survey conducted in Nagaon and Assam district of Nalbari during 2014-15 to identify the factors affecting access to public health care facilities.

Sarah M. Hosking. et al. (2018). The study shows Health literacy in a population-based sample of Australian women: a cross-sectional profile of the Geelong Osteoporosis Study. This study aimed to conclude the health literacy profile of a randomly selected, population-based sample of Australian women expended a multidimensional tool, the Health Literacy Questionnaire (HLQ). The conclusions of the study were the outline of this population-based cohort of women demonstrated relations between low health literacy and low SES, lower levels of education, collective age, and anthropometric and lifestyle risk issues for chronic disease.

Solhi, Mahnaz, et al. (2018). The study highlighted entitled on Effect of Health Literacy Education on Self-Care in Pregnant Women. It was described that during January-June 2016, the current randomizes controlled clinical trial took place at two comprehensive health service canters in Paksasht (Province of Tehran, Iran). As a data collection tool, the author developed a dedicated questionnaire on self-care and health literacy during pregnant 40 women.

Yilmazel, Gulay. (2018). The research throws light on Health Literacy, Mammogram Awareness, and Screening among Tertiary Hospital Women Patients, The objective of this study was to determine the level of health literacy, awareness of mammograms, and screening among women patients in tertiary hospitals. A cross-sectional study with 519 patients between 40 and 69 aged was conducted. The questionnaire for data collection was applied to women patients as well as including demographic characteristics, health behaviors, mammogram awareness, and screening.

Honghui Rong,1 Xin Cheng, and et.al.(2017). Survey of health literacy level and related influencing factors in military college students in Chongqing, China. This study aimed to investigate the HL and related associate factors in military college students in Chongqing, China. Data were obtained with the Chinese Citizen Health

Literacy Questionnaire (2012 edition) from 3183 military college students aged 16–28 years at Chongqing in December 2015.

Khajouei R, Salehi F.(2017). This is study about Health Literacy among Iranian High School Students. This descriptive cross-sectional study was conducted at high schools in Kerman. Data concerning 3 dimensions of health literacy (health knowledge, health skills, and health behaviors) were collected from 312 students using an adapted version of a valid and reliable questionnaire developed by the Ministry of Health of China. Data analysis was performed by descriptive statistics and chi-square analysis using SPSS version 22.

Kowsalya, Raju, and Manoharan, Shanmugam. (2017). The present study highlighted that a healthy lifestyle and heavy expenditure of nutritious food can provide people with excellent health throughout their lives. Although India's government has made several attempts to enhance women's health status, the main issues connected with implementing suitable measures are poverty, gender discrimination, and analphabetism in the population.

Stephanie MacLeod, MS, and et.al. (2017). The study highlights the impact of inadequate health literacy on patient satisfaction, healthcare utilization, and expenditures among older adults. The study revealed that inadequate health literacy (HL) was associated with impaired healthcare choices leading to poor quality-of-care. The primary purpose was to estimate the prevalence of inadequate HL among two populations of AARP_ Medicare Supplement insured's and to describe the impact on patient satisfaction, preventive services, healthcare utilization, and expenditures. Surveys were mailed to the insured in 10 states. Multivariate regression models were used to identify characteristics and adjust outcomes.

Subramanyam, N and Krishnamurthy, M (2017). Analyzed the bibliographical and full-text sources in medical science. In study Bibliographical Database and Usage among Medical Professionals at Ramaiah Medical College was analysed. They highlight the importance of database use among Medical Professionals, their frequency of use, the purpose of use were studied. An important tool for gathering data collection for this was the questionnaire. This study found different types of the medical databases used by Medical Professionals.

Tiraki, Zeliha&Yılmaz, Medine. (2017). The study highlighted the Cervical Cancer Knowledge, Self-Efficacy, and Health Literacy Levels of Married Women. The purpose of the study (descriptive and relational) study was to investigate the relationship between knowledge of cervical and self- effectiveness and levels of health literacy among married women aged 18-65. The aim of the study was the level of health literacy among lower literate, a graduate of primary school, and advanced participant.

Gauguly, Anirban, and Nandi, Saiket. (2016). Using Statistical Forecasting to Optimize Staff scheduling in Health care Organizations. The objective of this article was therefore to increase the traction of this important, but sparsely discussed the concept of time series forecasting in health organizations. The purpose of this articles was to demonstrate the typical steps involved in applied forecasting techniques in inpatient care. This demonstration involved the use of statistical techniques like analysis of variance (ANOVA).

Jean P. Shipman, Erica Lake, and Alice I. Weber. (2016).The study is on improving health literacy. It was revealed, that Utah University has established various partnerships to improve health literacy and health outcomes among patient population, employees, and members of the community. Health science libraries were key members of these partnerships. The finding of the study was partnerships and outreach efforts lead to better awareness of the importance of health literacy by institutional staff.

Kimberly A. Kilfoyle, et al. (2016). Entitled study on Health Literacy and Women's Reproductive Health: A Systematic Review. The goal of the study was to identify, investigate, and synthesize research on the relationship between health literacy and the knowledge, behaviors, and outcomes of the reproductive health of women. A total of 34 articles were included in this review and met the eligibility criteria. It was founded that two authors of the study used a standardized form to abstract data from articles. Abstract data arranged in table format were reviewed and summarized.

Pramanik, Auditi. (2016). The study highlightes Patients' Perception of Services Quality of Healthcare Services in India: A comparative study on Urban and Rural study. It's compared, therefore, an attempt to measure the perception of patients regarding quality of health care services in India along with a comparative study on

Urban and Rural hospitals. The objects of this study was to understand the current trend of health care services in India through literature and questionnaire surveys. Data were collected from 368 patients who were then hospitalized or already discharged.

Rajawat, Kumkum (2016). in their work-study of the Information Communication Technology (ICT) based Library & Information Services in Pharmacy College 31 Pharmacy College Libraries in Rajasthan an appraisal revealed that automation status, Audio-Video, E-journals, and different classification using by pharmacy library as well as catalog code. Most of the libraries using CSIR. INFLIBNET and INDEST-AICTE. The data were collected by using a questionnaire.

Tiwari, V.K. at al. (2016). studied Standard, Framework, and Practices in Health Management Information and Evaluation System (HMIES) in Australia and India. They reveal in this article, efforts were made to compare information collection and government systems, its standardization, and the extent of utilization for decision-making in Australia and India.

Vilella, Karina Duarte. (2016). done research on The Association of Oral Health Literacy and Oral Health Knowledge with Social Determinants in Pregnant Brazilian Women. The objective of the study was to evaluate oral health literacy (OHL) in pregnant women and their association with determinates and knowledge in infant eating habits and oral hygiene.

Cuili Wang, Robert L Kane, DongjuanXu&QingyueMeng. (2015). The study is on Health literacy as a moderator of health-related quality of life responses to chronic disease among Chinese rural women. This study described research conducted on a health survey of 913 rural poor women aged 23-57 in northwest China. The result of the study show the low health literacy group was 1.33 times more likely that the high health literacy group to have a chronic disease.

M. Muniyandi, and et. al. (2015).The study conducted on Health literacy on tuberculosis amongst a vulnerable segment of the population: special reference to the Saharia tribe in central India. It has highlighted Health literacy on tuberculosis, regard to prevention, diagnosis, and treatment. This study helps to assess the health literacy of TB among one of the vulnerable tribal groups (*Saharia*) in central India. The tools for data collection for the study were used short term questionnaire. Data entry was

done by using the Census and Survey Processing System (*CSPro*) software package version 5.0 (cspro.software.informer.com/s.o, USA).

Rubenstein, Ellen L. (2015). The study on health information and health literacy: Public library practices, challenges, and opportunities. In their work out a study of 18 libraries in two public library systems in central Oklahoma was conducted. The project sought to gain an in-depth understanding of how libraries are contributing to health information access and health literacy. The three aspects of the study: library personnel's perspectives on the roles and responsibilities of libraries about health information and literacy, how staff assisted patrons with health questions, and how they defined health literacy.

Taha H. Musa, Wei Ping-min, and PuYuepu. (2015). the study reveals on 'Review: Health literacy intervention and their consequences'. The study explained health literacy, different kinds of disease, definition, intervention, and their consequence level, teaching, method among different community children and adults. The aim of the study was to find status of research progress towards health literacy.

Win M. Oo, Pa P. Soe & Kay T. Lwin. (2015). The study entitled on Status and determinants of health literacy: a study among the adult population in selected areas of Myanmar. This research has described identified health literacy status and determinates, and affiliating health literacy with health risk behaviors among Myanmar's population. The aim of the study is health literacy and also associated with an increased risk of health with behaviors that presented health risks such as smoking, betel chewing, and not regular exercise.

K. M. Mazor, et.al. (2014). does study on Health Literacy and Pap Testing in Insured Women. The study revealed that research founded an association between health literacy and participation in cancer screening. The purpose of this study was to examine the relationship between participation in cervical cancer screening. The relationship between health literacy and devotion to evidence-based references for Pap testing was examined, splendid multivariate logistic regression models. Data from 527 women aged 40 to 65 were analyzed and are reported here. Of these 527 women, 397 (75 %) were up to date with Pap testing.

Mazor, K. M. et al. (2014). The study is on Health Literacy and Pap Testing on Insured Women. The study revealed that several studies have identified a link

between health literacy and screening active participation. The Cancer Message Literacy Test- Listening and the Cancer Message Literacy Test- Reading were used to evaluate health literacy.

Yee, Lynn M. & Simon, Melissa A. (2014). The study describes The Role of Health Literacy and Numeracy in Contraceptive Decision-Making for Urban Chicago Women. The study highlighted, low functional health literacy and numeracy have known associations with poor health outcomes, and the family planning population has investigated these health disparity markers. Literacy and numeracy were evaluated using REALM-7 and a validated scale of 3 question scale of urban Chicago women.

Kamalapur, S. M., & Reddy, S. (2013).The Present study analyses Nutrition and women's health in India. It has also been mentioned in this study that how many doses have declined in the average of girls in different years in India, it has also been seen that many of the girls' health-related issues have been highlighted, including girls' sex ratio, abortion, etc.

Lam, Yukyan, Broaddus, Elena T & Surkan, Pamela J. (2013). The article was on Literacy and healthcare-seeking among women with low educational attainment: analysis of cross-sectional data from the 2011 Nepal demographic and health survey. It highlighted research and suggested that literacy plays a key role in mediating relationships among women in developing countries between formal education and care-seeking. The result of the study was an improvement for socio-demographic covariates; literacy was associated with certain aspects of health care seeking.

Michael J. Ormshaw, Leena T. Paakkari, Lasse K. Kannas, (2013). Measuring child and adolescent health literacy: a systematic review of the literature. This study was conducted to compile, analyze, and describe the methodology and measurement of childhood/adolescent health literacy. Design/methodology/approach – Six online databases (ERIC, PubMed, CINAHL, Biomed Central, Web of Science, and Sports Discuss), were systematically searched to identify the English language, peer-reviewed articles, and published between 1980 and April 2011.

Sahak, Mohd Dasuki. (2013). The study was conducted on the study to investigate the usage of library science among Medical Health Science, (FPSK), University Putra Malaysia (UPM) from July 2009 until April 2010. It is aimed also to investigate the

usage of resources and facilities between male and female students. The instrumentation for data collection used was a questionnaire.

Sentell, Tetine. Et al. (2013). The research on Health Literacy, Health Communication Challenges, and Cancer Screening among Rural Native Hawaiian and Filipino Women. This study revealed that there was limited information about the pathways of health information and the challenges of health communication about cancer screening in Native Hawaiians and Filipinos women groups. The finding of the study had discussed the 2010 National Health Literacy Action Plan.

Houshyari, AsefehBadiey. (2012). the study focused on Medical Education and Information and Communication Technology. The study reveals that Teaching and learning medicine particularly has gone under profound changes due to computer technologies, and medical schools around the world have invested heavily either in new computer technologies or in the process of adapting to this technological revolution. This descriptive survey study was designed to assess medical students' computer and Internet skills and their attitude toward ICT.

Khatri, Ajay B, and Choukhande, Vaishali G.(2012). ^[5] The study conducted on Indigenous Knowledge Web Resources in India with Special Reference to Ayurvedic Resources. The finding of the study was conducted that some portal was established by the Indian Government such as TKDL, AYUSH research portal, and DHARA. The study was to highlight the importance, features, structure, content, and facilities of the portal.

Pagán, José A. et al. (2012).The study on Health Literacy and Breast Cancer Screening among Mexican American Women in South Texas. This reveals that this study analyzes the role of functional health literacy in the behavior and adherence of Hispanic women to mammography. The of the study used survey data from 722 Mexican American Women aged 40 and over in the Lower Rio Grande Valley of Texas in 2008 were used to estimate models of logistical regression to assess the role of functional health literacy in mammography screening behavior and adherence.

Williams E. Nwagwu& Monday Ajama. (2011). They have researched Women's health information needs and information sources: a study of a rural oil palm business community in South-Western Nigeria. The study uses data collected through focus group discussion (FGD) and a questionnaire to attend to health information needs,

sources, and information-seeking behavior of women living in a rural palm plantation community in Nigeria. The FGD revealed that women relied on traditional health information sources; they practiced self-medication based on prior diagnosis and only visited hospitals when their diseases went out of hand.

Hae-Ra Han, Jiyun Kim, and Miyong T. Kim. (2010). Measuring Health Literacy among Immigrants with a Phonetic Primary Language: A Case of Korean American Women. The study explored protocol was approved by the Organized Review Board. Trained research staff approached potential participants to briefly introduce themselves and the study. Research staff then asked whether they were interested in participating in the study. Korean women 18 years of age or older and who are able to read and write Korean were eligible to participate. For those who were interested and eligible, a detailed description of the study was given. A total of 99 KA women were enrolled in the study. Informed consent was obtained from each participating woman.

Hae-Ra Han, Jiyun Kim, Miyong T. Kim & Kim B. Kim (2010). It was a study on Measuring Health Literacy among Immigrants with a Phonetic Primary Language: A Case of Korean American Women. The need to understand health literacy among ethnic minority groups with limited English skills is growing rapidly in the US, and finding valid and useful health tools for certain linguist minorities is difficult. The purpose of this study to validate the Korean translation of the Rapid Estimate of Adult Medicine Literacy (REALM) and Adult Short Form (S-TOFHLA) Functional Health Literacy Test.

Olatokun, Wole Michael. (2010). The study explained that Indigenous Knowledge of Traditional Medical practitioners in the treatment of sickle cell anemia. The study examined the information-seeking behavior of traditional medical practitioners on anemia. The cluster sampling technique was used to select 160 traditional medical practitioners from the study population. The study reveals a different level of medical education.

U.C., S., & K.B., S. (2010). The study described the position of Indian women and their contribution to their family is often ignored; the health of Indian women is linked to their position in the society. And they were considered as a financial burden; especially in rural areas, this attitude hurts their health status. In poor health, negative results have been found not only for women but also for their children and other

family members. This condition has been researched in India by focusing on the issues of five major women, including the main include: maternal and child health; Cruelty against women; Nutrition status; Uneven treatment of girls and boys; and the quality of care. It revealed that it is based on data drawn from the National Family Health Survey (NFHS-1, NFHS-2 NFHS-3), which includes the period from 1993-2006, and figures were taken from the Indian Sample Registration System and National Crime Research Bureau.

OlatokunWole M & Ayanbode O F. (2009). The research on ‘Use of indigenous knowledge by women in a Nigerian rural community’. It also aimed to find out how sustainable development in Ogun state has been positively affected by rural women’s use o indigenous knowledge. The research design of the survey was adopted. Data were collected using a structured by the interviewer and analyzed were carried out using frequencies and percentages distributions. The findings of the study reveal that most of the rural women were farmers and illustrate, but have extensive knowledge of traditional medicine.

Keleher, Helen & Hagger, Virginia. (2007). The study was titled as to the Department of Health Science, School of Primary Health Care, Monash University International Diabetes Institute. This study described to reviews the progress made in Australia on primary health care since health literacy was included in the health goals of Australia in the mid-1990s. Considerable research has been conducted on mental literacy, and research was underway with CALD communities on chronic disease self-management, included health literacy.

Freedman, Hadssa. (1985). The survey on the ‘A survey of the use of Washington Hospital Medical Library’. The study aimed to identify the users and non- users of the library, role as a multidisciplinary library serving the information needs of all kinds of users such as hospital staff and students as well as analyzed to establish priorities for the future development of the library and their satisfaction. The collection of data was a questionnaire-based survey.

The literature presented some valuable guidance and methods to support the aims and objectives of the study. It was observed in analyzing existing research that there is a lack of information on health literacy, lack of research on the impact of health information literacy on healthcare costs, and health outcomes in Madhya Pradesh.

Sustained research is needed to advance understanding of inadequate men and women's health literacy status in Madhya Pradesh.

The concept of health literacy is presented above reviews, which represents the essence of the definitions given in the literature of this concept. The review recognized health literacy, information literacy, or more specific health information literacy as an alternative approach to health information research that is relevant to the general public's teaching of health information. Most specifically, in the dimensions of healthcare data, navigation, disease prevention, and health promotion, it can also help the profession. The analysis showed the important concept of data-seeking, critical thinking, decision-making, problem-solving, interaction, and awareness along with a multitude of different skills related to social, financial, and cognitive skills that help in understanding health information in the healthcare context. Some of the suggestions from different organizations include allocating more resources to provide instruction in health literacy and developing effective interventions to avoid medical errors due to low literacy levels, building partnerships between literacy, Language access advocates, and the establishment of quality standards and health literacy measures that have been accepted by the general medical community. It also offers a study of the successful application of health information literacy in a variety of settings, i.e. the medical environment, different health contexts, healthcare settings, daily life at home, in the community, at the workplace, in the healthcare system, on the marketplace, and in the political arena. The literature on health information systems and practices regarding health care information shows that the programs for health information shared the results of cooperation.

References

- Salawu, A. S., Asaolu, S. O., & Sowemimo, O. A. (2014). Transmitted helminths among school-aged children in Saki , Oyo State , Nigeria. *Journal of Public Health and Epidemiology*, 6(12), 417–423. <https://doi.org/10.5897/JPHE2014.0664>
- Han, H. R., Kim, J., Kim, M. T., & Kim, K. B. (2011). Measuring health literacy among immigrants with a phonetic primary language: A case of Korean American women. *Journal of Immigrant and Minority Health*, 13(2), 253–259. <https://doi.org/10.1007/s10903-010-9366-0>
- Hosking, S. M., Brennan-Olsen, S. L., Beauchamp, A., Buchbinder, R., Williams, L. J., & Pasco, J. A. (2018). Health literacy in a population-based sample of Australian women: A cross-sectional profile of the Geelong Osteoporosis Study. *BMC Public Health*, 18(1). <https://doi.org/10.1186/s12889-018-5751-8>
- Indexed, D. (2019). Impact of Health Sector Reforms on Utilization of Health Care Services in Rural Assam (India, 2019(1), 1–14.
- Lam, Y., Broaddus, E. T., & Surkan, P. J. (2013). Literacy and healthcare-seeking among women with low educational attainment: Analysis of cross-sectional data from the 2011 Nepal demographic and health survey. *International Journal for Equity in Health*, 12(1), 1–12. <https://doi.org/10.1186/1475-9276-12-95>
- Mazor, K. M., Williams, A. E., Roblin, D. W., Gaglio, B., Cutrona, S. L., Costanza, M. E., ... Field, T. S. (2014). Health Literacy and Pap Testing in Insured Women. *Journal of Cancer Education*, 29(4), 698–701. <https://doi.org/10.1007/s13187-014-0629-7>
- Mobley, S. C., Thomas, S. D., Sutherland, D. E., Hudgins, J., Ange, B. L., & Johnson, M. H. (2014). Maternal health literacy progression among rural perinatal women. *Maternal and Child Health Journal*, 18(8), 1881–1892. <https://doi.org/10.1007/s10995-014-1432-0>
- Nwagwu, W. E., & Ajama, M. (2011). Women’s health information needs and information sources: A study of a rural oil palm business community in South-Western Nigeria. *Annals of Library and Information Studies*, 58(3), 270–281.
- Olatokun, Wole M., & Ayanbode, O. (2009). Use of indigenous knowledge by women in a Nigerian rural community. *Indian Journal of Traditional Knowledge*, 8(2), 287–295.
- Olatokun, Wole Michael. (2010). Indigenous knowledge of traditional medical practitioners in the treatment of sickle cell anemia. *Indian Journal of Traditional Knowledge*, 9(1), 119–125.

- Oo, W., Soe, P., & Lwin, K. (2015). Status and determinants of health literacy: a study among adult population in selected areas of Myanmar. *International Journal of Community Medicine and Public Health*, 2(3), 318–322. <https://doi.org/10.18203/2394-6040.ijcmph20150489>
- Pagán, J. A., Brown, C. J., Asch, D. A., Armstrong, K., Bastida, E., & Guerra, C. (2012). Health literacy and breast cancer screening among Mexican American women in South Texas. *Journal of Cancer Education*, 27(1), 132–137. <https://doi.org/10.1007/s13187-011-0239-6>
- Salawu, A. S., Asaolu, S. O., & Sowemimo, O. A. (2014). Transmitted helminths among school-aged children in Saki , Oyo State , Nigeria. *Journal of Public Health and Epidemiology*, 6(12), 417–423. <https://doi.org/10.5897/JPHE2014.0664>
- Sentell, T., Dela Cruz, M. R., Heo, H. H., & Braun, K. L. (2013). Health literacy, health communication challenges, and cancer screening among rural native Hawaiian and Filipino women. *Journal of Cancer Education*, 28(2), 325–334. <https://doi.org/10.1007/s13187-013-0471-3>
- Shipman, J. P., Lake, E., & Weber, A. I. (2016). Improving health literacy: health sciences library case studies. *Reference Services Review*, 44(2), 206–214. <https://doi.org/10.1108/RSR-03-2016-0022>
- Tiraki, Z., & Yilmaz, M. (2018). Cervical Cancer Knowledge, Self-Efficacy, and Health Literacy Levels of Married Women. *Journal of Cancer Education*, 33(6), 1270–1278. <https://doi.org/10.1007/s13187-017-1242-3>
- Vilella, K. D., Alves, S. G. A., de Souza, J. F., Fraiz, F. C., & Assunção, L. R. da S. (2016). The Association of Oral Health Literacy and Oral Health Knowledge with Social Determinants in Pregnant Brazilian Women. *Journal of Community Health*, 41(5), 1027–1032. <https://doi.org/10.1007/s10900-016-0186-6>
- Wang, C., Kane, R. L., Xu, D., & Meng, Q. (2015). Health literacy as a moderator of health-related quality of life responses to chronic disease among Chinese rural women. *BMC Women's Health*, 15(1), 1–8. <https://doi.org/10.1186/s12905-015-0190-5>
- Yee, L. M., & Simon, M. A. (2014). The role of health literacy and numeracy in contraceptive decision-making for urban Chicago women. *Journal of Community Health*, 39(2), 394–399. <https://doi.org/10.1007/s10900-013-9777-7>
- Yilmazel, G. (2018). Health Literacy, Mammogram Awareness and Screening Among Tertiary Hospital Women Patients. *Journal of Cancer Education*, 33(1), 89–94. <https://doi.org/10.1007/s13187-016-1053-y>

- Subramanyam, N., & Krishnamurthy, M. (2017). Bibliographic Data Bases and Usage among Medical Professionals at Ramaiah medical college: a study. *International Journal of Digital Library Services*, 7(01), 85–92.
- Sahak, M. D., & Masrek, M. N. (2014). Library Usage of Medical Students: A Comparative Analysis of First-Year and Third Year Students in University Putra Malaysia. *Procedia - Social and Behavioral Sciences*, 129, 127–132.
- Rajawat, K. (2016). Information Communication Technology (ICT) Based Library & Information Services in Pharmacy. *International Journal of Digital Library Services*, 6(4), 75–87.
- Perera, P. (2009). A Study on the pattern of usage of library facilities at the Medical Library, The University of Peradeniya. *Journal of the University Librarians Association of Sri Lanka*, *Journal of the University Librarians Association of Sri Lanka*, 9(0).
- Tyagi, Sunil, and Passi, Sunil Kumar. (2013). Library Usage Patterns in the National Medical Library (NML) of India: A Case Study. *International Research: Journal of Library & Information Science*, 3(1), 196-209.
- Khatri, A. B., and V. G. C. (2012). Special Reference to Ayurvedic Resources. *International Journal of Digital Library Services. International Journal of Digital Library Services*, 2(3), 1–50.
- Srinivasulu, P., & Reddy, V. P. (2010). A Survey of Medical College Libraries in Andhra. *Library Philosophy and Practice (e-journal)*, 391.
- Philip, Kathryn James. (2017). Librarian Joint Mediated Outreach on Health and Legal Information Provision in Select Communities in AkwaIbom State, Nigeria. (2017). *Library Philosophy and Practice (e-journal)*. 1618.
- Mairaj, M. I. (2012). Applications of information and communication technologies in libraries in Pakistan. *JMLA*, 100(3), 218–222
- Rubenstein, Ellen L. (2015). Health information and health literacy: Public library practices, challenges and opportunities. *Wiley Online Library* 52(1), 1–7.
- Houshyari, A. B., Bahadorani, M., Tootoonchi, M., Jacob, J., Gardiner, Z., & Roberto, A. (2012). Medical Education and Information and Communication Technology, *Jouranl of Education and Health Promotion*, 3(1), 1–9.

Freedman, Hadssa. (1985). A survey of the use of Washington Hospital Medical Library .*Health Libraries Reviews*, 2, 69-78.

M. Muniyandi, V.G. Rao, J. Bhat, R. Yadav, R.K. Sharma, and M.K. Bhondeley.(2015). Health literacy on tuberculosis amongst vulnerable segment of population: special reference to Saharia tribe in central India. *Indian Journal of Medical Research*,141(5), 640–647.

Tiwari, V.K.and et.al. (2016). Standard, Framework and Practices in Health Management Information and Evaluation System (HMIES) in Australia and India. *Journal of Health Management*: 18(1).70-83.

Gauguly, Anirban and Nandi, Saiket. (2016). Using Statistical Forecasting to Optimize Staff scheduling in Health care Organizations. *Journal of Health Management*: 18(1), 70-83.

HonghuiRong,Xin Cheng and et.al.(2017).Survey of health literacy level and related influencing factors in military college students in Chongqing, China: A cross-sectional analysis.*PLoS One*.2(5).

Khajouei R ,Salehi F.(2017). Health Literacy among Iranian High School Students.*Pub med*; 41(2), 215-222.

Pramanik, Auditi. (2016). Perception of Services Quality of Healthcare Services in India: A comparative study on Urban and Rural study. *Journal of Health Management*: 18(2), 205-217.

Stephanie MacLeod, MS, and et.al. (2017). The impact of inadequate health literacy on patient satisfaction, healthcare utilization, and expenditures among older adults. *Elsevier*.38(4), 334-341. <http://dx.doi.org/10.1016/j.gerinurse.2016.12.003> Accessed on16/09/2018

Michael J. Ormshaw, Leena T. Paakkari, Lasse K. Kannas. (2013). Measuring child and adolescent health literacy: a systematic review of literature, *Health Education*.113 (5)433-455,<https://doi.org/10.1108/HE-07-2012-0039> Accessed on 23/01/2018

Salawu, A. S., Asaolu, S. O., & Sowemimo, O. A. (2014). Transmitted helminths among school-aged children in Saki , Oyo State , Nigeria. *Journal of Public Health and Epidemiology*, 6(12), 417–423. <https://doi.org/10.5897/JPHE2014.0664>

Han, H. R., Kim, J., Kim, M. T., & Kim, K. B. (2011). Measuring health literacy among immigrants with a phonetic primary language: A case of korean american women. *Journal of Immigrant and Minority Health*, 13(2), 253–259. <https://doi.org/10.1007/s10903-010-9366-0>

Hosking, S. M., Brennan-Olsen, S. L., Beauchamp, A., Buchbinder, R., Williams, L. J., & Pasco, J. A. (2018). Health literacy in a population-based sample of

Australian women: A cross-sectional profile of the Geelong Osteoporosis Study. *BMC Public Health*, 18(1). <https://doi.org/10.1186/s12889-018-5751-8>

- Indexed, D. (2019). Impact of Health Sector Reforms on Utilization of Health Care Services in Rural Assam (India, 2019(1), 1–14.
- Lam, Y., Broaddus, E. T., & Surkan, P. J. (2013). Literacy and healthcare-seeking among women with low educational attainment: Analysis of cross-sectional data from the 2011 Nepal demographic and health survey. *International Journal for Equity in Health*, 12(1), 1–12. <https://doi.org/10.1186/1475-9276-12-95>
- Mazor, K. M., Williams, A. E., Roblin, D. W., Gaglio, B., Cutrona, S. L., Costanza, M. E., ... Field, T. S. (2014). Health Literacy and Pap Testing in Insured Women. *Journal of Cancer Education*, 29(4), 698–701. <https://doi.org/10.1007/s13187-014-0629-7>
- Mobley, S. C., Thomas, S. D., Sutherland, D. E., Hudgins, J., Ange, B. L., & Johnson, M. H. (2014). Maternal health literacy progression among rural perinatal women. *Maternal and Child Health Journal*, 18(8), 1881–1892. <https://doi.org/10.1007/s10995-014-1432-0>
- Nwagwu, W. E., & Ajama, M. (2011). Women’s health information needs and information sources: A study of a rural oil palm business community in South-Western Nigeria. *Annals of Library and Information Studies*, 58(3), 270–281.
- Olatokun, Wole M., & Ayanbode, O. (2009). Use of indigenous knowledge by women in a Nigerian rural community. *Indian Journal of Traditional Knowledge*, 8(2), 287–295.
- Olatokun, Wole Michael. (2010). Indigenous knowledge of traditional medical practitioners in the treatment of sickle cell anemia. *Indian Journal of Traditional Knowledge*, 9(1), 119–125.
- Oo, W., Soe, P., & Lwin, K. (2015). Status and determinants of health literacy: a study among adult population in selected areas of Myanmar. *International Journal of Community Medicine and Public Health*, 2(3), 318–322. <https://doi.org/10.18203/2394-6040.ijcmph20150489>
- Pagán, J. A., Brown, C. J., Asch, D. A., Armstrong, K., Bastida, E., & Guerra, C. (2012). Health literacy and breast cancer screening among Mexican American women in South Texas. *Journal of Cancer Education*, 27(1), 132–137. <https://doi.org/10.1007/s13187-011-0239-6>
- Salawu, A. S., Asaolu, S. O., & Sowemimo, O. A. (2014). Transmitted helminths among school-aged children in Saki , Oyo State , Nigeria. *Journal of Public Health and Epidemiology*, 6(12), 417–423. <https://doi.org/10.5897/JPHE2014.0664>
- Sentell, T., Dela Cruz, M. R., Heo, H. H., & Braun, K. L. (2013). Health literacy, health communication challenges, and cancer screening among rural native Hawaiian and Filipino women. *Journal of Cancer Education*, 28(2), 325–334. <https://doi.org/10.1007/s13187-013-0471-3>

- Shipman, J. P., Lake, E., & Weber, A. I. (2016). Improving health literacy: health sciences library case studies. *Reference Services Review*, 44(2), 206–214. <https://doi.org/10.1108/RSR-03-2016-0022>
- Tiraki, Z., & Yilmaz, M. (2018). Cervical Cancer Knowledge, Self-Efficacy, and Health Literacy Levels of Married Women. *Journal of Cancer Education*, 33(6), 1270–1278. <https://doi.org/10.1007/s13187-017-1242-3>
- Vilella, K. D., Alves, S. G. A., de Souza, J. F., Fraiz, F. C., & Assunção, L. R. da S. (2016). The Association of Oral Health Literacy and Oral Health Knowledge with Social Determinants in Pregnant Brazilian Women. *Journal of Community Health*, 41(5), 1027–1032. <https://doi.org/10.1007/s10900-016-0186-6>
- Wang, C., Kane, R. L., Xu, D., & Meng, Q. (2015). Health literacy as a moderator of health-related quality of life responses to chronic disease among Chinese rural women. *BMC Women's Health*, 15(1), 1–8. <https://doi.org/10.1186/s12905-015-0190-5>
- Yee, L. M., & Simon, M. A. (2014). The role of health literacy and numeracy in contraceptive decision-making for urban Chicago women. *Journal of Community Health*, 39(2), 394–399. <https://doi.org/10.1007/s10900-013-9777-7>
- Yilmazel, G. (2018). Health Literacy, Mammogram Awareness and Screening Among Tertiary Hospital Women Patients. *Journal of Cancer Education*, 33(1), 89–94. <https://doi.org/10.1007/s13187-016-1053-y>
- Subramanyam, N., & Krishnamurthy, M. (2017). Bibliographic Data Bases and Usage among Medical Professionals at Ramaiah medical college: a study. *International Journal of Digital Library Services*, 7(01), 85–92.
- Sahak, M. D., & Masrek, M. N. (2014). Library Usage of Medical Students: A Comparative Analysis of First-Year and Third Year Students in University Putra Malaysia. *Procedia - Social and Behavioral Sciences*, 129, 127–132.
- Rajawat, K. (2016). Information Communication Technology (ICT) Based Library & Information Services in Pharmacy. *International Journal of Digital Library Services*, 6(4), 75–87.
- Perera, P. (2009). A Study on the pattern of usage of library facilities at the Medical Library, University of Peradeniya. *Journal of the University Librarians Association of Sri Lanka*, *Journal of the University Librarians Association of Sri Lanka*, 9(0).
- Tyagi, Sunil and Passi, Sunil Kumar. (2013). Library Usage Patterns in the National Medical Library (NML) of India: A Case Study. *International Research: Journal of Library & Information Science*, 3(1), 196-209.
- Khatri, A. B. and V. G. C. (2012). Special Reference to Ayurvedic Resources. *International Journal of Digital Library Services*. *International Journal of Digital Library Services*, 2(3), 1–50.
- Srinivasulu, P., & Reddy, V. P. (2010). A Survey of Medical College Libraries in Andhr *Library Philosophy and Practice (e-journal)*, 391.

- Philip, Kathryn James. (2017). Librarian Joint Mediated Outreach on Health and Legal Information Provision in Select Communities in Akwa Ibom State, Nigeria. (2017). *Library Philosophy and Practice (e-journal)*. 1618.
- Mairaj, M. I. (2012). Applications of information and communication technologies in Libraries in Pakistan. *JMLA*, 100(3), 218–222
- Rubenstein, Ellen L. (2015). Health information and health literacy: Public library practices, challenges, and opportunities. *Wiley Online Library* 52(1), 1–7.
- Houshyari, A. B., Bahadorani, M., Tootoonchi, M., Jacob, J., Gardiner, Z., & Roberto, A. (2012). Medical Education and Information and Communication Technology, *Journal of Education and Health Promotion*, 3(1), 1–9.
- Freedman, Hadssa. (1985). A survey of the use of Washington Hospital Medical Library. *Health Libraries Reviews*, 2, 69-78.
- M. Muniyandi, V.G. Rao, J. Bhat, R. Yadav, R.K. Sharma, and M.K. Bhondeley. (2015). Health literacy on tuberculosis amongst a vulnerable segment of population: special reference to Saharia tribe in central India. *Indian Journal of Medical Research*, 141(5), 640–647.
- Tiwari, V.K. and et.al. (2016). Standard, Framework and Practices in Health Management Information and Evaluation System (HMIES) in Australia and India. *Journal of Health Management*: 18(1).70-83.
- Gauguly, Anirban, and Nandi, Saiket. (2016). Using Statistical Forecasting to Optimize Staff scheduling in Health care Organizations. *Journal of Health Management*: 18(1), 70-83.
- Honghui Rong, Xin Cheng, and et.al. (2017). Survey of health literacy level and related influencing factors in military college students in Chongqing, China: A cross-sectional analysis. *PLoS One*. 2(5).
- Khajouei R, Salehi F. (2017). Health Literacy among Iranian High School Students. *Pub med*; 41(2), 215-222.
- Pramanik, Auditi. (2016). Perception of Services Quality of Healthcare Services in India. A comparative study on Urban and Rural study. *Journal of Health Management*: 18(2), 205-217.
- Stephanie MacLeod, MS, and et.al. (2017). The impact of inadequate health literacy on patient satisfaction, healthcare utilization, and expenditures among older adults. *Elsevier*. 38(4), 334-341. <http://dx.doi.org/10.1016/j.gerinurse.2016.12.003> Accessed on 16/09/2018
- Michael J. Ormshaw, Leena T. Paakkari, Lasse K. Kannas. (2013). Measuring child and adolescent health literacy: a systematic review of literature, *Health Education*. 113 (5) 433-455, <https://doi.org/10.1108/HE-07-2012-0039> Accessed on 23/01/2018

- Nutbeam, D. (2000) Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st Century. *Health Promotion International* 15, 259–267.
- Selden, C., Zorn, M., Ratzan, S. C., Parker, R. M. and Ruth, M. (compilers) (2002) *Health literacy* (bibliography online). National Library of Medicine, Bethesda, MD. Cited 13 October 2001. <http://www.nlm.nih.gov/pubs/resources.html>
- Simonds, S. K. (1974) Health education as social policy. *Health Education Monograph* , 2, 1–25. American Medical Association (1999) Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs: Health Literacy: Report of the Council on Scientific Affairs. *Journal of the American Health Association* , 281, 552–557.
- Manoharan, S. (2017). Health Status of the Indian Women - A Brief Report. *MOJ Proteomics & Bioinformatics*, 5 (3), 109–111. <https://doi.org/10.15406/mojpb.2017.05.00162>
- Kamalapur, S. M., & Reddy, S. (2013). Women Health in India: An Analysis. *International Research Journal of Social Sciences*, 2(10), 2319–3565. Retrieved from <http://www.isca.in/IJSS/Archive/v2/i10/3.ISCA-IRJSS-2013-135.pdf>
- Reddy, P. B. (2016). *Status of Women and Social Opportunities in Madhya Pradesh , India Social Science Status of Women and Social Opportunities in Madhya Department of Economics , Govt . PG College ,Shujalpur , India*. (January 2014), 1–6. <https://doi.org/10.13140/RG.2.1.4667.7520>
- Baba, Riyaz, and Jeelani, Suhail Shah. (2018). iMedPub Journals Assessment of Health Status and Monitoring of Healthcare Systems in Rural Areas of Gwalior District , Madhya Pradesh , *India Abstract*. (2018). 1–5.
- Indian, T., & Charter, H. (2007). *THE INDIAN WOMEN ' S HEALTH Women of Age Women with Disabilities Women Living in Custody of State Institutions*. (March), 1–41.
- Care, H., Reviews, C., & Sa, T. (2019). *Health Care : Current Reviews Health Reform as Political Instrument : Achieving Universal Health Coverage*. 7(1), 1–5. <https://doi.org/10.4172/2375-4273.1000239>.
- U.C., S., & K.B., S. (2010). A trend in women's health in India--what has been achieved and what can be done. *Rural and Remote Health*, 10(2), 1260. Retrieved from <http://www.embase.com/search/results?subaction=viewrecord&from=export&id=L359876997>

**PROFILE OF COMMUNITY HEALTH CENTERS OF
MADHYA PRADESH**

3.0 Introduction

India is a signatory of the 1978 Alma Ata Declaration and committed to achieving “Health to All” through the Primary Health Care approaches by 2000 AD. The establishment of primary health centers in India began as early as 1952 and has undergone several changes over the past six decades to meet the growing demand for health care services. The emphasis was on expanding the health establishment until the 11th Five Year Plan. During the Eighth and subsequent plans, however, the main focus was on consolidation and validating existing health infrastructure rather than expanding it. The aim was to improve the quality of health service by strengthening physical facilities such as the provision of essential equipment, the supply of essential drugs and consumables, and the construction of the building and staff quarters, the filling of vacant medical and paramedical staff positions and in-service staff training is provided.

3.1 National Rural Health Mission (NRHM)

The Hon’ble Prime Minister launched the National Rural Health Mission (NRHM) on 12 April 2005 to provide the rural population, especially vulnerable groups, with accessible, affordable, and quality healthcare. The Union Cabinet has vacated its decision of 01 May 2013, approving the launch of the National Urban Health Mission (NUHM) as a submission of an over-arching National Health Mission (NHM), with the National Rural Health Mission (NRHM) being the other submission of the National Health Mission. Special attention has been provided to the Empowered Action Group (EAG) state as well as the North-Eastern states. Jammu and Kashmir and Himachal Pradesh under the NRHM.

3.1.1 Indian Public Health Standards

The National Rural Health Mission (NRHM) was introduced in 2005 to reinforce the Rural Public System and has since fulfilled many hopes and expectations. The mission

aims to provide efficient service to the rural population across the nation with a unique focus on states and Union Territories (UTs), which have poor public health indices and/or poor facilities. To this end, the Indian Health Standards (IPHS) for Sub-Centers, Primary Health Centers (PHCs), Community (CHCs), Sub-District Hospitals were released in January/ February 2007 and used as a reference point for the planning and upgrading of public health facilities in the State and UTs.

3.1.2 National Health Mission (M.P)

The National Health Mission (NHM) was launched by the Hon'ble Prime Minister on 12th April 2005, to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups. The Union Cabinet vide its decision dated 1st May 2013, has approved the launch of the National Urban Health Mission (NUHM) as a Sub-mission of an over-arching National Health Mission (NHM), with the National Rural Health Mission (NRHM) being the other Sub-mission of National Health Mission. NRHM seeks to provide equitable, affordable, and quality health care to the rural population, especially the vulnerable groups. Under the NRHM, the Empowered Action Group (EAG) States, as well as the North Eastern States, Jammu, and Kashmir and Himachal Pradesh, have been given special focus. The thrust of the mission is on establishing a fully functional, community-owned, decentralized health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality. Institutional integration within the fragmented health sector was expected to provide a focus on outcomes, measured against Indian Public Health Standards for all health facilities.

3.1.2.1 State's Mission

All people living in the state of Madhya Pradesh will have the knowledge and skills required to keep themselves healthy and have equity in access to effective and affordable health care, as close to the family as possible, that enhances their quality of life, and enables them to lead a healthy productive life'. Thus, it may be observed that the State's vision has primarily two components, namely empowering the people living in the State with knowledge and skills required to keep them healthy and equity

in access to effective and affordable health care. The State of Madhya Pradesh also subscribes to the vision adopted by the National Rural Health Mission. Consequently, the adapted vision components to be pursued by the State are presented below:- Equip people with the knowledge and skills required to keep themselves healthy. Provide effective healthcare to rural population throughout the State with special focus on worst performing districts, which have weak public health indicators and/or weak infrastructure. These districts will receive special focus. These are Dindori, Damoh, Sidhi, Bedwani, Anuppur, Chhindwara, Rewa, Betul, Raisen, Seoni, Chhatarpur, Morena, and Sheopur. Raise the level of public spending on health from 0.89% GDP to 2-3% of GDP, with improved arrangement for community financing and risk pooling. Undertake architectural correction of the health system to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery in the State. Revitalize local health traditions and mainstream AYUSH into the public health system. Effective integration of health concerns through decentralized management at district, with determinants of health like sanitation and hygiene, nutrition, safe drinking water, gender, and social concerns. Address inter-district disparities. Pursue time-bound goals and publish the report to the people of the state on progress. Improve access to rural people, especially poor women and children to equitable, affordable, accountable, and effective primary health care.

3.3 Beginning of CHCs in India

The National Health Policy emphasized the provision of preventive, promotional, and drug treatment health services to individuals making a shift from medical care to health care. Primary health care delivery is the foundation of the rural health care system and is an integral part of the National Health care system. In rural areas, services are delivered through an integrated health and family welfare system network, and from time to time health programs have been restructured and reoriented to meet the National Policy objectives.

The health care system in India can be grouped into four types:

- a) The public sector, including hospitals, clinics, and health centers run by the government.

- b) Those run by non-governmental organizations (NGOs).
- c) The private informal sector, including faith healers and herbalists,
- d) The organized private sector, etc.

Studies have shown that the government was by far the prevalent source of health care such as immunization, services for family planning, and control of infectious diseases.

The number of different facilities varies from district to district due to the variations in the population in each district and also due to the differences in conformity to population norms and standards. Population standards are given below for some of the facilities;

In the past, three rounds of District Level Household and Facility Survey (DLHS), (Round-I in 1998-99, Round-II in 2002-04, and Round-III in 2007-08) have been undertaken with the main objective of providing reproductive and child health databases at the district level in India. The data from these surveys were useful in setting the benchmarks and reviewing the country's progress after RCH (Reproductive and Child Health) programs were implemented.

These surveys have been useful in evaluating, monitoring, and planning strategies for central and state governments.



3.1 Image-Rural women in CHC hospital

3.1.1 Type of Health Centers

In observation of the achievement of six years of National Rural Health Mission (2005-12), there is a felt need to focus on the achievements and improvements. It is, therefore, proposed to accomplish DLHS-4. Information on the accessibility and use of District Hospital (DH), Sub-Divisional Hospital (SDH), Community Health Center (CHC), Primary Health Center (PHC), and Sub-Health (SHS) services. India's Public Health System is a three-tiered health care system, primary, secondary, and tertiary, which aims to develop and deliver health care services to individuals and communities across the country.

1. Primary Health Care- provides preventive, restorative, and primitive services to the community, in which only common and simple afflictions are taken care of at this level.

2. Secondary Health Care- is intended to provide the community with preventive and specialized care and works as the first PHC and sub-health center referral center. Community Health Center, Sub-Divisional Hospitals, District- Hospitals work as secondary health care.

3. Tertiary Health Care-provides the community with super-specialized as well as comprehensive health care services for complex medical conditions. Medical colleges and apex health Centers function as tertiary health care.

4. Sub-center- The Sub-center is the most peripheral and first point of contact between the Primary health center and Community Health Center. Sub-center is assigned tasks related to interpersonal communication to bring about behavioural change and provide services related to maternal and child health, family welfare, nutrition, immunization, and control programs for communicable diseases. At least one Auxiliary Nurse Midwife (ANM), female worker and male health worker must be employed in each sub-center. As of March 31, 2015, there were 1, 53,655 Sub centers functioning in the country.

5. Primary Health Centers (PHCs) - PHP is the first point of contact between the Village community and the medical officer. The PHCs were planned to provide the rural population with integrated curative and preventive health care with an emphasis

on preventive and promotion aspects of health care. The PHCs are set up and maintained under the Minimum Needs Program (MNP)/ Basic Minimum Services (BMS) by state governments. According to the National Rural Health Mission (NRHM), contract provision for two additional staff nurse at PHCs. PHC's activities involve curative, preventive, promotional, and family welfare services. As of March



31, 2015, there were 25,308, PHCs functioning in the country.

3.2 Image- Information for rural women

3.1.1.2 Community Health Center (CHC)

Health care in India is delivered through a three-tier structure of health comprising the primary, secondary, and tertiary health care facilities to bring health care services within the reach of the people of both the rural and urban areas. The primary tier would have three types of health care institutions, namely, a Sub-center (SC) for a population of 3000-5000, a Primary Health Center (PHC) for 20000 to 30000 populations, and a Community Health Center (CHC) as a referral center for every four PHCs. The tertiary health care is to be provided by health care institutions in urban areas that are well equipped with sophisticated diagnostic and investigative facilities.

Since an inordinate emphasis has been laid on the establishment of curative health centers between the rural and urban areas as the majority of these centers are located in the urban areas, the people residing in the rural areas have to travel a long distance to reach the nearest curative health center for seeking relief from ailments which could

have otherwise been readily handled at the CHC level. Besides, for want of a well-established referral system, those seeking curative care tend to visit various specialized health care centers, thus further contributing to congestions, duplications of efforts, and wastage of resources.



3.4 Image of rural women with her new-born baby

Madhya Pradesh is one of the largest states of the Republic of India. The state is marked with a complex social structure, a predominantly agrarian economy, a difficult and inaccessible topography, and scattered settlements over a vast area that together poses several formidable problems to health service delivery systems. According to the 2001 census, Madhya Pradesh has a population of about 60 million, which is around 6% per cent of the country's population. Ranking 7th in terms of population size and 23rd in terms of population density among the 35 states and union territories, it is a large state with a widely dispersed population and relatively low density. For per capita income, literacy, urbanization, infrastructure facilities, and other development indicators, Madhya Pradesh belongs to the category of less developed states of the country.



3.5 Rural women during postnatal treatment

Despite the best of efforts on behalf of the Government institutions, the people of the state are not satisfied and the health status, though improved from last years, is far below when compared on the national scale (as reflected by the health indices). For every 100 rupees spent on health, rupees 75 come from private (out of pocket) sources. According to Budget, 2000-2001 (GMP) the overall spending on health care is Rs. 150 per capita. Although Government Health Expenditure has risen in absolute terms, it has by and large remained static in per capita terms. The share of salaries in non-plan health expenditure is 86.7%. However, the government is not getting fair returns on its investment in health care and there is widespread dissatisfaction with the access and quality of health care in the government health care institutions. On the other hand, there are serious questions about the economic access and quality of health care in the private sector, particularly in rural areas. The problem is compounded as the government does not have effective monitoring, surveillance, or control function about private health care.

3.1.1.3 Function and Services of Community Health Center (CHC)

The policy identifies some core issues to improve the access, quality, and coverage of health care in MP. The financing for health care is inadequate and should be increased particularly from the public sources. Further, the financing, as out of pocket payment

at the time of receiving services is regressive from an equity perspective and is also against the interest of the poor. The present management system for the government institutions is inefficient mainly due to lack of financial and managerial (e.g. management of personnel) autonomy. Thus, innovative thinking in the financing, a financing mechanism for health care, and modern management (financial, personnel) with defined autonomy, responsibility, output, and outcome orientation, will go a long way to improve the health of the people in the state of MP.

3.1.1.4 Coverage and Location of CHCs

The optimum population coverage by the rural health care institutions and their location in general and CHC as a referral center are among the significant factors that shows the accessibility of health care services to rural people. Although a CHC has prescribed the norm for population coverage, during the establishment of a CHC, no criterion as such has been set for geographical location. In this backdrop, the present chapter deals with the issues involving tangible population coverage by a CHC against the national norm, appropriate of 'population norm' as a criterion for establishment of a CHC, and implications of the uncomfortable location of a CHC on the utilization of referral services.

3.1.1.5 Population Norms and Coverage

The national standard for population coverage per sub-center as established in 1987 was 3000 for tribal areas and 5000 for plain areas, It was set at 20,000 to 30,000 per PHC and between 80,000 and 1.20 lakh per CHCs. In 1996, a sub-center served 4737 people and a PHP 28, 768 people on average at the entire India level. However, it was found that a CHCs population coverage was 2.6 lakh, which was well above the standard set for this rural health care institution.

3.1.1.6 Infrastructure at CHCs- Availability, and Adequacy

Community Health Center (CHC) is required to provide specialized health care services to rural people, in the absence of which they would be forced to spend a lot of time and economic use of such services in urban areas, to enable Community Health Center (CHC) to discharge this responsibility. It was envisaged that the Community

Health Center (CHC) would be equipped with medical specialists, Para-medical staff, and complementary infrastructure. The objective of this chapter is to assess the adequacy and availability of the country's selected Community Health Center (CHC) manpower and infrastructure. This assessment would enable everyone to place inappropriate context on the findings of the subsequent chapters dealing with the functioning and performance of the Community Health Center (CHC). To identify the gaps in the availability of manpower and other facilities, the required information was generated through a structured questionnaire that was interviewed by the sample Community Health Center (CHC).

3.1.1.7 Facilities at Community Health Center (CHC)

The various components of the Community Health Center infrastructure can be broadly categorized as appropriate groups and sub-head such as manpower, physical facilities, machinery and equipment, and medicines. While the Government of India has prescribed standards for essential facilities required at Community Health Center (CHC), the State Government concerned are making the implementation of the norms and the actual provision of such facilities. Manpower at Community Health Center includes medical specialists, paramedical staff, and support staff, while physical facilities include operation theatre, labor room, a pathology laboratory, and safe drinking water. Other essential complementary facilities, such as refrigerator, X-Ray machine, ECG apparatus, and generator, are included in the equipment.





3.5 Image- Rural Women in Hospital

3.1.1.8 Specialist

The scheme provides for four medical specialist posts, one each in Surgery, Medicine, Paediatrics, and Gynaecology. The variation between ‘required’ and ‘sanctioned’ posts is much less among the 42 Community Health Center (CHC) selected for the study. However, it is not clear how approval could be given to establishing a Community Health Center without sanctioning the posts of four specialists.

3.1.1.9 Para Medical Staff

The scheme set the standard for each Community Health Center (CHC) to be equipped with the required number of Para-medical staff such as seven Nurse Mid-Wives, one Compounder, one Laboratory Technician, and a Radiographer.

3.1.1.10 Supporting Staff

The scheme provided support staff at each Community Health Center (CHC), such as two Ward Boys posts, one Dhobi, three Sweepers, and one Aaya.

3.1.1.11 Physical Facilities

One of the main objectives of establishing a Community Health Center (CHC) is to provide specialized health care services for both routine and referred cases. To meet this objective, the scheme envisaged that Community Health Center (CHC) should be equipped with adequate health infrastructure, including physical facilities, equipment, and medicines, in addition to manpower, so that the specialized health care services available in the Community Health center could be optimally utilized. CHCs' health infrastructure facilities are complementary, and the non-availability of one or more such facilities could adversely affect the use of health care services to be delivered in Community Health Center (CHC), even if physicians, Para-medical staff, and other staff are in position.

3.2 Vision

All people living in the Madhya Pradesh state has the necessary knowledge and skill to be healthy, and equity in accessing efficient and inexpensive healthcare, as close as feasible to the communication, which enhances their quality of life and allows living a good, productive life.

3.3 Profile of Community Health Centers of Madhya Pradesh

It has been observed that the district level disparity in the utilization of the government health facilities ranges from 100 % in every selected zone. The scope of the study is limited to the Community Health Centers of Madhya Pradesh. They will be divided into five zones of Madhya Pradesh north zone (Gwalior and Shivpuri), east zone (Ujjain and Mandsaur), west zone (Satna and Sagar), central zone (Bhopal only), and south zone (Indore and Dewas). The governments of community health Centers in selected cities of Madhya Pradesh are studied under this study.

3.3.1 North zone

North zone has four centers , Community Health Centers have been taken into account , which includes the Mohana and Bhitwarwar. Every community health center is built on the National Highway. The total population of Gwalior is 2032036 and the total

population of the rural area is 758,244, of which the total number of women is 941709.

3.3.1.1 Bhitwarwar Community Health Center, Gwalior



3.6 Image of Bhitwarwar CHC

Bhitwarwar is a town and Nagar Parishad in Gwalior district in Madhya Pradesh State, India. Dabra is the closest railway station, and Gwalior is the airport. Gwalior's length is 72 km. In Bhitwarwar Community Health Center Dr. Yashwant Sharma is working as a BMO in the same community health center and has a good experience in the medical professional. There are 04 more permanent doctors, four nurses' staff in this community health center and there are 30 beds for patients. This CHC has an ambulance 108 and one is another available for Bhitwarwar Community Health Center. The Bhitwarwar Community Center has 07 computers, 04 printers, one server, 02 scanners, and for improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs and health center continues to hold an exhibition. The Banda CHC is used to distribute pamphlets and health posters for awareness health issues to rural women in village areas in CHC the staff is less and It require more medical staff. Various types of health services are being provided in Community Health Centers, which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, Menstrual Problem, Cough, Body Pain, mother and child care, and Eye Infection, etc.

3.3.1.2 Mohana Community Health Center, Gwalior



3.7 Image of Mohana CHC

In Mohana Community Health Center Dr. Vivek Kumar is working as a BMO in the same community health center and has 1.5 years experience in the medical profession. There is 01 more permanent doctor, 01 nurse staff in this community health center and there are 30 beds for patients. This CHC has an ambulance 108 and Janni Express is available for Muhana Community Health Center. The Muhana Community Center has 02 computers, 02 printers, one server, 01 scanner, and for improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs and health center continues to hold an exhibition. The Mohana CHC is used to distribute pamphlets and health posters for awareness health issues to rural women in village areas. Fewer staff and require more medical staff. Various types of health services are being provided in Community Health Centers, which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, Menstrual Problem, Cough, Body Pain, mother and child care, and Eye Infection, etc.

3.3.2 Community Health Center of Shivpuri

The Shivpuri is bordered on the north by the districts of Morena, Gwalior, and Datia, on the east by U.P. district of Jhansi, on the west by Rajasthan district of Kota, and on the south by Guna district.

The second zone of the north is Shivpuri, which includes 07 Community Health Centers, are Bedarwas, Karera, Khaniadhana, Kolaras, Narwar, Pichhore, and Pohari. Every community health center is built on the National Highway. The district headquarter Shivpuri is situated on NH-3 (Agra-Bombay National Highway) at a 113 Km from Gwalior and 98 Km from Guna.

3.3.2.1 Bedarwas Community Health Center, Shivpuri

The Bedarwas is a town and a Nagar Panchayat in the district of Shivpuri in Madhya Pradesh. In the Community Health Center of Bedarwas of Dr. R.L. Pippal is working as a BMO and having 08 years' experience as a medical professional of the same health center. There is 01 more permanent doctor, 04 nurse staff in this community health center and there are 30 beds for patients. This CHC has an ambulance 108 available and two denoted ambulance for Bedarwas Community Health Center. The Bedarwas Community Center has 02 computers, 02 printers, one server, one scanner, one photocopies, for improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs and health center continues to hold an exhibition. The Bedarwas CHC used to pamphlets and health posters for awareness health issues to rural women in village areas. There is less the staff and require more medical staff. Various types of health services are being provided in Community Health Centers, which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, Menstrual Problem, Cough, Body Pain, Eye Infection, etc. Here, the staff's wishes for the facility should be improved.

3.3.2.2 Karera Community Health Center, Shivpuri

Karera is a municipality or Nagar Palika in the Shivpuri district of Madhya Pradesh. In the Community Health Center of Karera of Dr. Padeep Sharma is working as BMO and 13 years' experience as a medical professional of the same health center. There are 03 more permanent doctors, 05 nurses' staff in this community health center and there are 30 beds for patients. This CHC has an ambulance 108 available and two denoted ambulance for Karera Community Health Center. The Karera Community Center has 04 computers, 02 printers, one server, one scanner, one photocopy, and for improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs and health center continues to hold exhibition health orientation

program, women's motivation program. The Karera CHC is used to distribute pamphlets and health posters for awareness health issues to rural women in village areas. Various types of health services are being provided in Community Health Centers, which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, Menstrual Problem, Cough, Body Pain, Eye Infection, mother and child care, etc. Here also the staff's wish is that faculty should be improved.

3.3.2.3 Khaniadhana Community Health Center, Shivpuri

Khaniadhana is a municipality or Nagar Palika in the Shivpuri district of Madhya Pradesh. It's famous for its eight Jain temples. In the Community Health Center of Khaniadhana of Dr. Arun Jhasia is working as BMO and having 05 years' experience as a medical professional of the same health center. There are 02 more permanent doctors, 04 nurse' staff in this community health center and there are 30 beds for patients. This CHC has an ambulance 108 available and two denoted ambulance for Khaniadhana Community Health Center. The Khaniadhana Community Center has 04 computers, 04 printers, 01 servers, 01 scanners, one photocopy, and for improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs and health center continues to hold exhibition health orientation program, women's motivation program. The Khaniadhana CHC is used to LAN network for the health center office. Various types of health services are being provided in Community Health Centers, which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, Menstrual Problem, Cough, Body Pain, Eye Infection, mother and child care, etc.

3.3.2.4 Kolaras Community Health Center, Shivpuri



3.8 Image of Kolaras CHC

Kolaras is a municipality or Nagar Palika in the Shivpuri district of Madhya Pradesh. In the Community Health Center of Kolaras of Dr. Alka Trivedi is working as in-charge BMO and having 20 years' experience as a medical professional of the same health center. There are 03 more permanent doctors, 04 nurses' staff in this community health center and there are 06 beds for patients. This CHC has an ambulance 108 available and two denoted ambulance for Kolaras Community Health Center. The Kolaras Community Center has 08 computers, 08 printers, 01 server, 04 scanner, 01 LCD projectors, for improving rural women's health organizing, Center Exhibition, and Health orientation program, Women motivation programs and health center continues to hold exhibition health orientation program, women's motivation program. The Kolaras CHC is used to distribute pamphlets and health posters for awareness health issues to rural women in village areas. Various types of health services are being provided in Community Health Centers, which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, Menstrual Problem, Cough, Body Pain, Eye Infection, mother and child care, etc.

3.3.2.5 Narwar Community Health Center, Shivpuri



3.9 Image of Narwar CHC

Narwar is a town and Nagar Panchayat in the Shivpuri district in Madhya Pradesh's Indian state. Narwar is a historic town, and the Narwar Fort is just south of the Kali Sindh River, 42 km from Shivpuri. In the Community Health Center of Narwar of Dr. Sonu Jain is working as in-charge BMO and having 07 years' experience as a medical professional of the same health center. 03 more permanent doctors, 02 nurse staff in this community health center and there are 30 beds for patients. This CHC has an

ambulance 108 available and two denoted ambulance for Narwar Community Health Center. The Narwar Community Center has 05 computers, 03 printers, 01 server, 04 scanner, 01 photocopy machine, and 01 LCD projectors and for improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs and health center continues to hold exhibition health orientation program, women's motivation program. The Narwar CHC is used to distribute pamphlets and health posters for awareness health issues to rural women in village areas. Various types of health services are being provided in Community Health Centers, which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, Menstrual Problem, mother and child care, etc.

3.3.2.6 Pichhore Community Health Center, Shivpuri

Pichhore is a town and a Nagar Panchayat in the Shivpuri district in the Indian state of Madhya Pradesh. It is also connected by train from the Basai railway station 30 km away. The Community Health Center of Pichhore of Dr. Brijesh Sharma is working as in-charge BMO and has 17 years' experience as a medical professional of the same health center. There are 05 more permanent doctors, 03 nurse staff in this community health center and there are 30 beds for patients. This CHC has an ambulance 108 available and two denoted ambulance for Pichhore Community Health Center. The Pichhore Community Center have 03 computers, 02 printers, 01 servers, 01 scanner Various types of health services are being provided in Community Health Centers, which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, Menstrual Problem, mother and child care, etc.

3.3.2.7 Pohari Community Health Center, Shivpuri



3.10 Image of Pohari CHC

Pohari is a town and a Nagar Panchayat in the Shivpuri district in the Indian state of Madhya Pradesh. The Community Health Center of Pohari of Dr. Sunil Gupta is working as BMO and has 5 years' experience as a medical professional of the same health center. There are 03 more permanent doctors, 04 nurses' staff in this community health center and there are 30 beds for patients. This CHC has an ambulance 108 available and two denoted ambulance for Pohari Community Health Center. The Pohari Community Center has 03 computers, 02 printers, 01 server, 01 scanner, and fully cover with CCTV cameras all over the health center. Various types of health services are being provided in Community Health Centers, which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, Menstrual Problem, mother and child care, etc

3.4 In the West Zone

Ten (10) Health Centers covered under Sagar Community Health Centers, which include Banda, Gadakota, Devori, Jaisinagar, Kesli, Kurai, Maalthona, Rahatgarh, Shahgarh, and Surkhi. Satna also has 7 Community Health Centers, which include Amarpatan, Devrajnagar, Nagod, Majhgawan, Mukundpur, Rampur Baghelan, and Unchehra. Every community health center is built on the National Highway

3.4.1 Banda Community Health Center, Sagar

In the Community Health Center of Banda Dr. M.K. Jain is working as BMO and has 33 years' experience as a medical professional of the same health center. There are four permanent staff, three nurse staff in this community health center and there are 30 beds for patients. This CHC has an ambulance 108 available and two denoted ambulance for Banda Community Health Center. The Banda Community Center, two computers, two printers, 01 server, and 01 scanner, one photocopy, for improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs and health center continues to hold the exhibition. The Banda CHC is used to distribute pamphlets and health posters for awareness health issues to rural women in village areas. The staff is less and more staff is required in this CHC.



3.11 Image of Banda CHC

Various types of health services are being provided in Community Health Centers, which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, Menstrual Problem, Cough, Body Pain, Eye Infection, etc.

3.4.2 Gadakota Community Health Center, Sagar-

In Community Health Center, Gadakota Dr. L.S. Sakya is working as BMO In-charge of the same health center and has 12 years' experience as a medical professional. There are four more permanent doctors, three nurse staff in this community health center and for 30 beds, patients are being given training in every third month, with there is an ambulance 108 available in Gadhakota Community Center, two computers, two printers, two servers, A scanner, a photocopy, is available to work in the form of information technology products. LAN as a network in CHC is used in Administration and Entire Community Health. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs and health center continues to hold the exhibition.

Various types of health services are being provided in Community Health Centers, which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, Menstrual Problem, Cough, Body Pain, Eye Infection, etc.

3.4.2 Devori Community Health Center, Sagar

In the Community Health Center of Devori, Dhaka Dr. M.K. Jain is working as BMO and having 33 years' experience as a medical professional. There is one permanent

doctor, three nurses staff are working in this Community Health Center, and for patients capacity, 30 beds facility and health training are a facility provided here as per Government rules, there is an ambulance 108 are available in Devori Community Center. The CHC has 06 computers, three printers; 02 servers' three scanners, two photocopies, and also 13 CCTV cover all over the health center entire Community Health Center. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs and health center continues to hold the exhibition.

Various types of health services are being provided in Community Health Centers, which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, Menstrual Problem, Cough, Body Pain, Eye Infection and so no Devori CHC has also organized a workshop for rural women as per to Govt. of India.

3.4.3 Jaisinagar Community Center Health, Sagar

In Jaisinagar Community Health Center, Dr. J.S. Dhakad is working as BMO and having 28 years' experience as a medical professional. There is one more permanent doctor, four nurse staff in this community health center, and for patients bed capacity is 30, health center are given training is provided here as per Government rules, there is an ambulance 108 and Janni Express ambulance are available in Jaisinagar Community Center, three computers, two printers, one server, one scanner, one photocopy, is available to work in the form of information technology and Operating system, Email, Database Management System also used in this CHC. LAN as the network in CHC for used in Administration and Entire Community Health. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs and health center continues to hold the exhibition.

Various types of health services are being provided in Community Health Centers, which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, Menstrual Problem, Cough, Body Pain, and Eye Infection and so on. Jaisinagar CHC has also provided a workshop for rural women as per Govt. of India guidelines.

3.4.4 Kesli Community Health Center, Sagar

In Community Health Center Kesli, where Dr. Pawan Jain is working as BMO and having 22 years' experience as a medical professional. There are 05 more permanent doctors, 3 nurse staff, and 37 non-medical staff in this community health center and for patients, bed capacity is 30, the health center is providing training as per Government rules, there is an ambulance 108 are available in Kesli Community Center, four computers, four printers, one server, one scanner, one photocopy, and one fax machine is available to work in the form of information technology and Operating system, Email, Database Management System also used in this CHC. LAN as the network in CHC is used for Administration and entire Community Health. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs and health center continues to hold the exhibition.

Various types of health services are being provided in Community Health Centers, which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, Menstrual Problem, Cough, Body Pain, Eye Infection, AIDS, TB, Mother, and child care, Smoking, and Gutka, Sanitary and so no. Kesli CHC has also provided a workshop for rural women as per Govt. of India. Kesli CHC staff wishes to promote, upgrade work and increase staff in CHC.

3.4.5 Kurai Community Health Center, Sagar



3.12 Image of Khurai CHC

In Khurai Community Health Center having a good building. Dr. P.K. Jain is working as MO and having 30 years' experience as a medical professional. There is one

permanent doctor and 15 nurses staff in this community health center and 100 beds for patients; training is also being provided here on every third month, there is an ambulance 108 available in Khurai Community Center. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs and health center continues to hold the exhibition. Various types of health services are being provided in Community Health Centers, which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, Menstrual Problem, Cough, Body Pain, Eye Infection, etc. The staff is very less in comparison to the patient coming to the CHC.

3.4.6 Malthone Community Health Center, Sagar



3.12 Image of Malthone CHC

In Malthone having a small place health center and not having sufficient space for patients, especially for women delivery, and childbirth. Here Dr. Dharmendra Shrivastava having 12 years' experience in working as BMO. There is one more permanent doctor, and 15 nurse staff in this community health center and for patients 100 beds are available, training is being provided every third month, there is an ambulance 108 available in Malt hone Community Center. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs and health center continues to hold the exhibition. Various types of health services are being provided in Community Health Centers, which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, Menstrual Problem, Cough, Body Pain, Eye Infection, etc. The staff is very less in this CHC.

3.4.7 Rahatgarh Community Health Center, Sagar

The Community Health Center of Rahatgarh was established since 2006-07. There is Dr. Rajeev Raiwar is working as BMO and having 16 years' experience as a medical professional. There are two more permanent doctors, one nurse in the same CHC and bed capacity is 30 for the patient, and health training is also provided here every month, there is an ambulance 108 available in Rahatgarh Community Center. Five computers, two printers, one server (Called is Swan), one scanner, one photocopier, one LCD Projectors is available to work in the form of information technology, and the Operating system, Windows is also being used in this CHC. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs, and health center continues to hold the exhibition. Various types of health services are being provided in Community Health Centers, which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, Menstrual Problem, Cough, Body Pain, Eye Infection, etc. It has very less staff for working and lack of health facility.

3.4.9 Shahgarh Community Health Center, Sagar-



3.13 Image of Shahgarh CHC

Shahgarh Community Health Center was established since 1972. Dr. U.S. Paindey is working as a CBM and haing 25 years' experience as a medical professional. There are three more permanent doctors, four nurses and 14 non-medical staff are working in the same CHC and the bed capacity is 30 for patient and health training is being provided here every third month, there is an ambulance 108 available in Shahgarh Community Center. Five computers, three printers, one server, one scanner, one photocopier, LCD Projectors, and one fax machine is available to work in the form of

information technology and Operating system, Email, Database Management System also used in this CHC. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs, and health center continues to hold an exhibition and health training programmed are organized every month. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs, and health center continues to hold the exhibition. Various types of health services are being provided in Community Health Centers, which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, Menstrual Problem, Cough, Body Pain, Eye Infection, etc. The staff in this CHC is very less.

3.4.10 Surkhi Community Health Center, Sagar



3.15 Image of Surkhi CHC

In Surkhi Community Health Center, Dr. Sudhir Sahu is working as BM and has 08 years' experience as a medical professional. There are three more permanent doctors, five nurses and 02 non-medical staff is working in the same CHC, and training is being in every third month, there is an ambulance 108 and Janni Express available in Surkhi Community Center. This CHC has computers, printers, servers, scanner, photocopy, LCD Projectors, and fax machine is available to work in the form of information technology and Operating system, Email, Database Management System also used in this CHC. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs and health center continue to hold

an exhibition and health training programme are organized every month. Various types of health services are being provided in Community Health Centers, which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, Menstrual Problem, Cough, Body Pain, Eye Infection, etc. The staff is very less in this CHC.

3.5 Satna District and there Community Health Center

The history of the Satna district is part of the history of the region known as Baghelkhand, a very big part of which was governed by the Rewa State of the Treaty. Seven Community Health Centers in the Satna MP district have been included in the list, which includes Amarpatant, Devrajnagar, Majhgawan, Nagod, Rampur Baghelan, Mukundpur, and Uchhrahaa Health Centers.

3.5.1 Amarpatan, Devrajnagar and Mukundpur Community Health Center, Satna

Amarpatan has been built as one of the headquarters of these three for the construction of some buildings and health facilities in the community health center. Amarpatan Tehsil is bounded on the south by the Son River. Amarpattan is one of the three headquarters of the three for construction of health building in the community health center. In addition to Amarpatan, the health and other functions of both the community health centers are operated by Amarpatan. It provides information related to the health of rural women and provides health facilities in all respects.



3.16 Image of Mukundpur CHC

Dr. Bhimgopal Singh Bhadodiya as BMO and 05 MOs are working as a medical professional in these three Community Health Centers. There are three more permanent doctors and 21 nurses and 02 temporary medical staff is working in CHC and for the patient, there is 100, bed capacity and for rural women to health, training is being facility every month as per Govt. of India guidelines. There is an ambulance 108 and Janni Express available in every Community Center.



3.17 Rural women pre-natal treatment in CHC

The CHC has computers, printers, servers, scanner, photocopy, the fax machines available to work in the form of information technology and Operating system, Email, Database Management System are also used in this CHC. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs and health center continue to hold an exhibition and provided health training programs every month by CHC. Various types of health services are being provided in Community Health Centers, which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, Menstrual Problem, Cough, Body Pain, Eye Infection, etc.

3.5.2 Nagod Community Health Center, Satna

In the Nagod Community Health Center, Dr. Ravendra Kumar Patil is working as the Block Medical Officer, who has four years' experience in the medical field, there are three other doctors, 11 nurses and 40 non-medical staff working in the Nagod Community Health Center. It has post mortem Convenience is also and 40 beds for patients and 108 ambulance, buddhpratap and Janani Express ambulance rural village

are available facility as per government directives Health programs are conducted for rural women are conducted in time, Which can bring improvement in the level of rural health. . The CHC has 04 computers, two printers, two scanners, one photocopy, LAN network, and 03 CCTV to work in the form of information technology and Operating system, Email, Database Management System are also used in this CHC. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs, and health center continues to hold the exhibition. Various types of health services are being provided in Community Health Centers, which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, mother and child care, Menstrual Problem, Cough, Body Pain, Eye Infection, etc.

3.5.3 Majhgawan Community Health Center, Satna



3.17 Image of Majhgawan CHC



3.18 Image of Rural women in CHC

In the Majhgawan Community Health, Dr. Tarunkant Tripathi is working as the Block Medical Officer, who has 10 years' experience in the medical field; there are three more doctors and three nurses working in the Majhgawan. Majhgawan Community Health Center has post mortem Convenience facility also and 30 beds for patients and 108 Ambulance rural villages as per traffic and government directives Health programs are conducted for rural women which can bring improvement in the level of rural health. There have 10 computers, 05 printers, servers, 02 scanners; one LCD projector fax machine to work in the form of information technology and Operating system, Email, Database Management System also used in this CHC. Health training is being provided here every month according to Govt. health program. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs, and health center continues to hold the exhibition. Various types of health services are being provided in Community Health Centers, which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, mother and child care, Menstrual Problem, Cough, Body Pain, Eye Infection, etc. CHC also has a lack of staff.

3.5.4 Rampur Babhelan Community Health Center, Satna



3.19 Image of Rampur Baghelan CHC

In the Rampur Baghelan Community Health, Dr. R.K. Satnami is working as the Block Medical Officer, who has 20 years' experience in the medical field, there are one doctor and three nurses working in the Rampur Baghelan. Rampur Baghelan Community Health Center has 30 beds for patients and 108 Ambulance service for

rural as per traffic and government directives Health programs are conducted for rural women which can bring improvement in the level of rural health. The CHC has 05computers, 05 printers, 02 scanners; one photocoppy machine is available to work in the form of information technology and Operating system, Email, Database Management System also used in this CHC. Health training is being provided here every month according to Govt. health program. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs, and health center continue to hold the exhibition. Various types of health services are being provided in Community Health Centers, which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, mother and child care, Menstrual Problem, Cough, Body Pain, Eye Infection, Sanitary toilets etc.

3.5.5 Unchehra Community Health Center, Satna

In the Unchehra Community Health, Dr. A.K.Rai is working as the Block Medical Officer, who has a good experience in the medical field; there are five more doctors and five nurses working in the Unchehra. Unchehra Community Health Center has 30 beds for patients and 108 Ambulance services for rural villages based on traffic and government directives Health programs are conducted for rural women which can bring improvement in the level of rural health. They have 06 computers, 04 printers, 02 scanners; two photocoppy machines also are available to work in the form of information technology and Operating system, Email, Database Management System also used in this CHC. Health training is being provided every month according to Govt. health program. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs health campus, and health continues to hold the exhibition. Various types of health services are being provided in Community Health Centers, which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, mother and child care,



3.20 Image of Medical shop of Uchehra CHC

Menstrual Problem, Cough, Body Pain, Eye Infection, Sanitary toilets, Information about doctors and hospitals and family planning methods, etc.

3.6 East zone Ujjain and Mandsoor

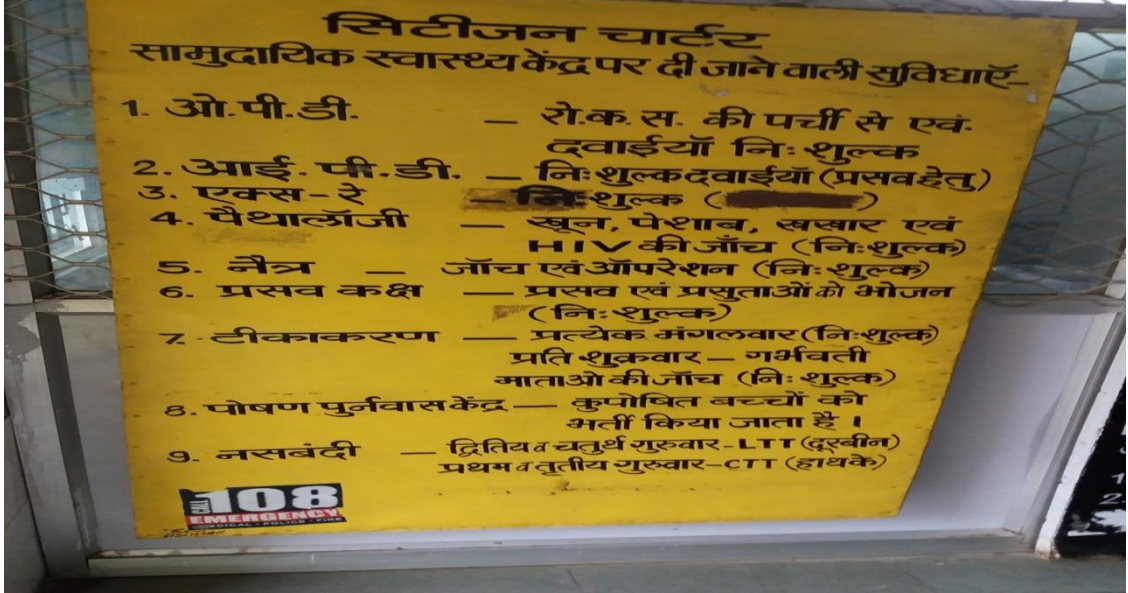
3.6.1 Ghatia Community Health Center, Ujjain

In the Ghatia Community Health, Dr. Devendra Paindya is working as the Block Medical Officer, who has 03 years' experience in the medical field, there are 01 doctor and 01 nurse working in the Ghatia. Ghatia Community Health Center has 30 beds for patients and 108 Ambulance facility rural villages as per traffic and government directives Health programs are conducted for rural women which can bring improvement in the level of rural health.



3.21 Image of Ghatia CHC

Health training is being provided every month according to Govt. health program. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs health campus, and health center continue to hold the exhibition.



3.22 Image of instruction for rural women by CHC

3.6.2 Tarana Community Health Center, Ujjain

In the Tarana Community Health, Dr. Ajay is working as the Medical Officer, who has 16 years' experience in the medical field; there are 01 doctor and 07 nurses working in the Tarana. Tarana Community Health Center has 15 beds for patients and 108 Ambulance rural villages As per traffic and government directives health programs are conducted for rural women which can bring improvement in the level of rural health. They have 04 computers, 02 printers, 02 scanners, 01 photocopy machines to work in the form of information technology and Operating system, Email, Database Management System also used in this CHC. Health training is being provided here every month according to Govt. health program. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs health campus, and health center continue to hold the exhibition. , which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, mother and child care, Menstrual Problem, Cough, Body Pain, Eye Infection, Sanitary toilets, Information about doctors and hospitals and family planning methods, etc.

3.7.0 Mandsour

3.7.1 Malhargarh Community Health Center, Mandsour



3.23 Image of Malhargarh CHC

In the Malhargarh Community Health, Dr. Naveen Mandloi is working as the Medical Officer, who has 10 years' experience in the medical field; there are 01 doctor and 06 nurses working in the Malhargarh. Malhargarh Community Health Center has 30 beds for patients and 108 Ambulance rural villages as per traffic and government directives Health programs are conducted for rural women which can bring improvement in the level of rural health. There have 04 computers, 04 printers, 01 scanner, 01 server, 02 photocopy machines to work in the form of information technology and Operating system, Email, Database Management System also used in this CHC. Health training is being provided every month according to Govt. health program. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs health campus, and health continues to hold the exhibition. , which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, mother and child care, Menstrual Problem, Cough, Body Pain, Eye Infection, Sanitary toilets, Information about doctors and hospitals and family planning methods, etc.

3.7.2 Shamgarh Community Health Center, Mandsour



3.24 Image of Shamgarh CHC

In the Shamgarh Community Health, Dr. Manish Dangarn is working as the Medical Officer, who has 05 years of experience in the medical field, there are 02 doctors and 01 nurses, and 16 non-medical staff working in the Shamgarh CHC. Shamgarh Community Health Center has 30 beds for patients and 108 Ambulance facility rural villages as per traffic and government directives Health programs are conducted for rural women which can bring improvement in the level of rural health. They have 03 computers, 02 printers, 02 scanner, 01 server, LCD projectors, 02 photocopy machines, and 16 CCTV is available to work in the form of information technology and Operating system, Email, Database Management System also used in this CHC. Health training is provided here every six months according to Govt. health program. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs health campus, and health continues to hold the exhibition. , which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, mother and child care, Menstrual Problem, Cough, Body Pain, Eye Infection, Sanitary toilets, Information about doctors and hospitals and family planning methods, etc.

3.7.3 Sitamau Community Health Center, Mandsour

In the Sitamau Community Health, Dr. Arvind Chauhan is working as the MBBS, who has 10 years' experience in the medical field, there are 02 more doctors and 05 nurse staff working in the Sitamau CHC. Sitamau Community Health Center has 30 beds for patients and 108 Ambulance rural villages as per traffic and government directives also conducted health programs that are conducted for rural women which can bring improvement in the level of rural health. There have 05 computers, 03 printers, 01 scanner, 01 server, 01 LCD projector is available to work in the form of information technology and Operating system, Email, Database Management System also used in this CHC. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs health campus, and health continues to hold the exhibition. , which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, mother and child care, Menstrual Problem, Cough, Body Pain, Eye Infection, Sanitary toilets, Information about doctors and hospitals and family planning methods, etc.

3.8 South zone (Dewas and Indore CHC)

Health Centers in selected cities of Madhya Pradesh will be studied under this study. North zone into four centers of the Gwalior Community Health Center in North Zone, Community Health Centers have been taken, which includes the Mohana and Bhitwarwar. Every community health center is built on the National Highway. The total population of Gwalior is 2032036 and the total population of the rural area is 758,244, of which the total number of women is 94,1709.

3.8.1 Bagli Community Health Center, Dewas



3.24 Image of Bagli CHC

Bagli Community Health Center has 30 beds services for patients and 108 Ambulance facilities, rural villages as per traffic, and government directives Health programs are conducted for rural women which can bring improvement in the level of rural health. They have computers, printers, scanner, are available to work in the form of information technology and Operating system, Email, also used in this CHC. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs health campus, and health continues to hold the exhibition. , which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, mother and child care, Menstrual Problem, Cough, Body Pain, Eye Infection, Sanitary toilets, Information about doctors and hospitals and family planning methods, etc.



3.25 Image of Rural women with new-born baby

3.8.2 Kannod Community Health Center, Dewas

In the Kannod Community Health, Dr. A.K. Pandey is working as the BMO, who has 20 years of experience in the medical field, there are 01 more doctor and 03 permanent nurses, 06 temporary nurse staff is working in the Kannod CHC. Kannod Community Health Center has 30 beds for patients and 108 Ambulance and Janni Express facility for rural villages as per traffic and government directives Health programs are conducted for rural women which can bring improvement in the level of rural health. They have 01 computer, 01 printer, 01 scanner, 01 server, 01 LCD projector, and 01 photocopy fax machine and 01 CCVT are available to work in the form of information technology used in this CHC.



3.26 Image of Kannod CHC

For improving rural women's health, every six-month health training program, Exhibition, Health orientation program, Women motivation programs health campus, and health center continue to hold the exhibition, which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, mother and child care, Menstrual Problem, Cough, Body Pain, Eye Infection, Sanitary toilets, Information about doctors and hospitals and family planning methods, etc.

3.8.3 Khategaon Community Health Center, Dewas

In the Khantegaon Community Health, Sarita Khurshann is working as the Staff nurse, who has 12 year's experiences in the medical field, there are 05 more nurse staff working in the Khantegaon CHC. Khantegaon Community Health Center has 30 beds for patients and 108 Ambulance facility rural villages as per traffic and government

directives Health programs are conducted for rural women which can bring improvement in the level of rural health. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs health campus, and health continues to hold the exhibition. , which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, mother and child care, Menstrual Problem, Cough, Body Pain, Eye Infection, Sanitary toilets, Information about doctors and hospitals and family planning methods, etc.

3.8.4 Sonkachha Community Health Center, Dewas



3.27 Image Sonkachha CHC

In the Sonkachh Community Health, Dr. Hemant Kumar Gupta is working as the Medical Officer, who has a good experience in the medical field; there are 02 more doctors and 03 nurses working in the Sonkachh. Sonkachh Community Health Center has 30 beds for patients and 108 Ambulance facility rural villages as per traffic and government directives Health programs are conducted for rural women which can bring improvement in the level of rural health. The CHC has computers, printers, scanners, photocopy machines, and CCTV to work and the Operating system, Email, Database Management System also used in this CHC. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs health campus, and health continues to hold the exhibition. , which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, mother and child care, Menstrual Problem, Cough, Body Pain, Eye Infection, Sanitary toilets, Information about doctors and hospitals and family planning methods, etc.

3.8.5 Tonkkhurd Community Health Center, Dewas



3.28 Image of Tondkhurd CHC

In the Tonkkhurd Community Health, Dr. Mahesh Kumar Dhakad is working as the BMO, who has 6 years' experience in the medical field; there are 03 more doctors and 04 nurse staff working in the Tonkkhurd CHC. Tonkkhurd Community Health Center has 30 beds for patients and 108 Ambulance rural villages as per traffic and government directives Health programs are conducted for rural women which can bring improvement in the level of rural health. The CHC has computers, printers, scanner, the server to work in the form of information technology and MS-office is also used in this CHC. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs health campus, and health continues to hold the exhibition. , which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, mother and child care, Menstrual Problem, Cough, Body Pain, Eye Infection, Sanitary toilets, Information about doctors and hospitals and family planning methods, etc.

3.9 Indore

3.9.1 Depalpur Community Health Center, Indore



3.29 Image of Depalpur CHC

In the Depalpur Community Health, Dr. S.K. Paincholi is working as the Block Medical Officer, who has 07 years' experience in the medical field, there are 01 doctor's staff working in the Depalpur CHC. Depalpur Community Health Center has 30 beds for patients and 108 Ambulance facility rural villages as per traffic and government directives Health programs are conducted for rural women which can bring improvement in the level of rural health. It has 01 computer, 01 printer, 01 scanner, 01 server, 01 photocopy machines, and 01 CCTV to work this CHC. Health training is being provided every six months according to Govt. health program. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs health campus, and health center continues to hold the exhibition. , which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, mother and child care, Menstrual Problem, Cough, Body Pain, Eye Infection, Sanitary toilets, Information about doctors and hospitals and family planning methods, etc. very less staff and proper space.

3.9.2 Manpur Community Health Center, Indore

In the Manpur Community Health, Dr. R.S.Tomar is working as the Medical Officer, who has 30 years' experience in the medical field; there are 04 doctors and 06 nurse staff working in the Manpur CHC. Manpur Community Health Center has 30 beds for patients and 108 and Janni Express Ambulance rural villages as per traffic and

government directives Health programs are conducted for rural women which can bring improvement in the level of rural health. The CHC has 04 computers, 04 printers, 02 scanners, 01 server, 01 LCD projectors, 01 photocopy machines to work in the form of information technology and Operating system, Email, Database Management System also used in this CHC. For improving rural women's health, Health orientation programs, Women's motivation programs health campus, and health center continue to hold the exhibition. , which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, mother and child care, Menstrual Problem, Cough, Body Pain, Eye Infection, Sanitary toilets, Information about doctors and hospitals and family planning methods, etc.

3.9.3 Mhow Community Health Center, Indore

Community Health Center was established in 1987. In the Mhow Community Health, Dr. Hansraj Verma is working as the Medical Officer, who has very good experience in the medical field, there are 02 doctors and 06 nurse permanent and 03 temporary staff working in the Mhow CHC. Mhow Community Health Center has 56 beds for patients and 108 Ambulance facility rural villages as per traffic and government directives Health programs are conducted for rural women which can bring improvement in the level of rural health. It has 04 computers, 04 printers, 02 scanners, 024 server, 02 LCD projectors, 02 photocopy, and 01 machines and 16 CCTV to work in the form of information technology and MS-Office also used in this CHC. Health training is being provided every six months according to Govt. health program. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs health campus, and health continues to hold the exhibition. , which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, mother and child care, Menstrual Problem, Cough, Body Pain, Eye Infection, Sanitary toilets, Information about doctors and hospitals and family planning methods, etc.

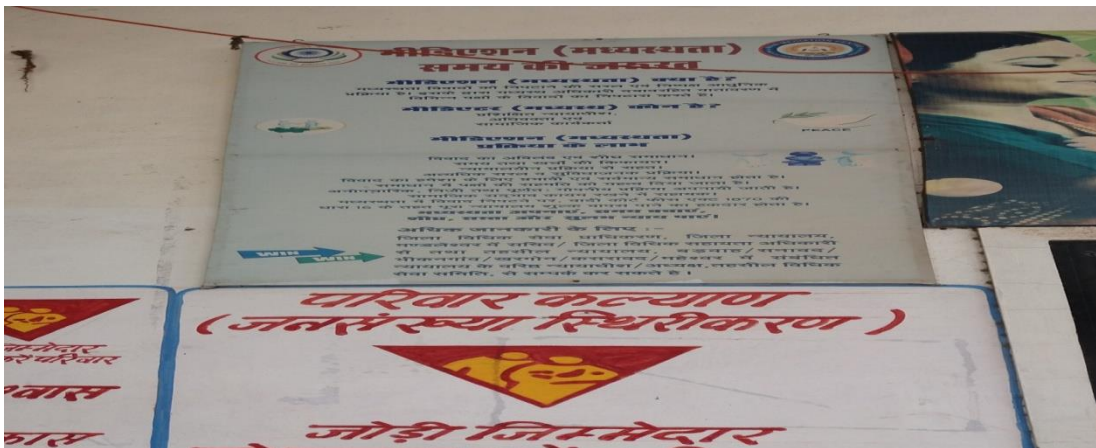
3.9.4 Sanawar Community Health Center, Indore

In the Sanawad Community Health, Dr. Manish Dangarn is working as the Medical Officer, who has 05 years experiences in the medical field, there are 04 more doctors and 75 nurses and 16 non-medical staff working in the Sanawad CHC. Sanawad

Community Health Center has 30 beds for patients and 108 Ambulance service for rural villages as per traffic and government directives Health programs are conducted for rural women which can bring improvement in the level of rural health. The CHC has 05 computers, 03 printers, 01 scanner, 01 server, 02 photocopy machines to work in the form of information technology and Operating system, Email, Database Management System also used in this CHC.



3.30 Image of Sanwad CHC



3.31 Image of Family Planning

Health training is being provided every six months according to Govt. health program. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs health campus, and health continues to hold the exhibition, which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, mother and child care, Menstrual Problem, Cough, Body Pain, Eye Infection, Sanitary toilets, Information about doctors and hospitals and family planning methods, etc.

3.10 Central Zone Bhopal

3.10.1 Gandhinagar Community Health Center, Bhopal

In the Gandhinagar Community Health, Dr. Pushparaj Thakur is working as the MO, who has 08 years experience in the medical field, there are 01 doctor and 10 nurse staff and 10 non-medical staff are working in the Gandhinagar CHC. Gandhinagar Community Health Center has 30 beds for patients and 108 Ambulance facilities as per traffic and government directives Health programs are conducted for rural women which can bring improvement in the level of rural health. The CHC has 01 computers, printers, scanner, server; LCD projectors to work in the form of information technology and Operating system, Email, Database Management System are also used in this CHC. For improving rural women's health, Center Exhibition, Health orientation program, Women motivation programs health campus, and health continues to hold the exhibition. , which mainly include Family Planning, Natal Care, Malaria Fever, Delivery Information, mother and child care, Menstrual Problem, Cough, Body Pain, Eye Infection, Sanitary toilets, Information about doctors and hospitals and family planning methods, etc.

Conclusion

This chapter gives information about Community Health Centers. Community Health Centers is playing a very important role in the field of health, especially for the improvement of the health of rural women. This chapter provides information about community health center, activities, and nature, along with information related to staff, their experience, health services, and services for women. All kinds of arrangements that are available in the Health Information Center, Community Health Centers, and Information Technology, and facilities of Health Centers of given in this chapter. Apart from this, all the Community Health Centers in this chapter are as per zone wise, and CHC falling under each zone East, West, North, South, or Central Zone, and arranged in alphabetical order.

References

- Index1 @ Nhm.Gov.in.* (n.d.). Retrieved from <https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=1249&lid=493#skip-nav> Accessed on 13.05/2018
- index @ www.nhmmp.gov.in.* (n.d.). Retrieved from <http://www.nhmmp.gov.in/> Accessed on 20.05/2018
- Chc330@Dhss.Alaska.Gov.* <http://dhss.alaska.gov/dph/HealthPlanning/Pages/primarycare/chc330.aspx>. Accessed on 20.05/2018
- Community-Health-Centres@Www.Betterhealth.Vic.Gov.Au.* <https://www.betterhealth.vic.gov.au/health/healthyliving/community-health-centres>. Accessed on 21/05/2018
- Accessed @ Satna.Nic.In.* <http://satna.nic.in/> Accessed on 21.05.2018
- Index @ Www.Npbhitarwar.Com.* <http://www.npbhitarwar.com/> Accessed on 25.05.2018
- Pohari_(Vidhan_Sabha_constituency)@En.Wikipedia.Org.* [https://en.wikipedia.org/wiki/Pohari_\(Vidhan_Sabha_constituency\)](https://en.wikipedia.org/wiki/Pohari_(Vidhan_Sabha_constituency)). Accessed on 04/06/2019
- Accessed @ satna.nic.in.* (n.d.). Retrieved from <http://satna.nic.in/> Accessed on 05./06/2019
- Pohari_(Vidhan_Sabha_constituency) @ en.wikipedia.org.* (n.d.). Retrieved from [https://en.wikipedia.org/wiki/Pohari_\(Vidhan_Sabha_constituency\)](https://en.wikipedia.org/wiki/Pohari_(Vidhan_Sabha_constituency)) Accessed on 05./06/2019
- Index1@Nhm.Gov.In.* <https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=1249&lid=493#skip-nav>. Accessed on 12/06/2019
- Index @ Www.Nhmmp.Gov.In.* <http://www.nhmmp.gov.in/> Accessed on 15/06/2019
- Kilfoyle, Kimberly A., Michelle Vitko, Rachel O’Conor, and Stacy Cooper Bailey. 2016. “Health Literacy and Women’s Reproductive Health: A Systematic Review.” *Journal of Women’s Health* 25(12): 1237–55. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5175428/pdf/jwh.2016.5810.pdf> 31/10/2018.

DATA ANALYSIS AND INTERPRETATION

Data analysis and interpretation play a pivotal role in any research because findings, testing of hypothesis and conclusion are based on data analysis. As discussed in the methodology; parts of chapter1, all the 41 Community Health Centers have been visited individually by the researcher, analysis is done based on data collected.

The scope of the study is limited to the Community Health Centers of Madhya Pradesh. They are divided into five-Zone of Madhya Pradesh North Zone (Gwalior and Shivpuri), East Zone (Ujjain and Mandsour), West Zone (Satna and Sagar), Central Zone (Bhopal only), and South Zone (Indore and Dewas).Community health Centers in selected cities of Madhya Pradesh have been studied under this study.

In the present study, few questions were asked to the respondents in all the 10 Zones in selected districts to check out the pervasiveness of health literacy among women of MP.

It was found that a large portion of women is facing problems related to this health issue, but this type of health issue is usually ignored by these women as well as by their family. First of all, because the health problem does not leave any physical marks, so it is very Good for rural women to accept that they are having any problem themselves, and secondly, rural women renew their health in a new way and they are sick and by family in very normal way they are treated with. But they are very addicted to such kind of behaviors from family members. They do not treat the sufferers anddo not seek any help from the external self-centers or do not understand this problem at all.

4.0 North Zone

Madhya Pradesh (MP) is one of India's poorest states with over 37 % of its 60 million overall populations staying below the poverty line. Scheduled Castes (SCs) and Scheduled Tribes (STs), two of the most marginalized sections, comprise 35% of the total population and a total of 60% of the poor population. Although it is well recognized that the status of women in the state is far from satisfactory, the state

government is fully determined to improve the rural women's standard of living. The government is also taking the necessary steps to open up all possibilities for rural women to realize their potential.

General Description of the Study Area

In the present study, few questions were asked to the respondents from all the 04 zones selected districts to check out the generality of health literacy of the rural women of MP. It was found that a large part of women is facing the misuse of this health issue, but this type of health issue is usually ignored by these women as well as by their families. First of all, because the health problem does not leave any physical marks, so it is very good for rural women to accept themselves. Secondly, it was seen that they do not take their health seriously and family also don't take care of them. So they are habituated to such behavior from family members. They even do not take help from primary health centers, as this does not come in their mind.

Gwalior:

Table 4.1: Sample of Gwalior

Questionnaire Distributed in CHC	Questionnaire Distributed	Questionnaire Received	Questionnaire's Analyzed
Bhitarwar	30	23	23
Mohana	30	25	25
Total	60	48	48

The above table no.4.1 shows that a total of 60 questionnaires were distributed among rural women and out of these 48 received back. It was observed that the highest response received from Mohana and the minimum is from Bhitarwar CHC.

Table 4.1.1 Types of Category/ Population

Category	Bhitarwar	Mohana	Total	Percentage
General	0	0	0	0
OBC	2 (8.69)	4 (16)	6	12.5
SC	9 (39.13)	7 (28)	16	33.33
ST	12 (52.17)	14 (56)	26	54.16
Total	23	25	48	100

	(47.92)	(52.08)		
--	---------	---------	--	--

Above table 4.1.1 shows that the type of category among rural women which shows that 54.16% rural women belong to the ST category, where 33.33% are SC and 12.5% are OBC category rural women live, which were surveyed in CHC.

Table 4.1.2 Family's Monthly Income

Income (in Rs.)	Bhitarwar	Mohana	Total	Percentage
Up to 2000	0	0	0	0
2000-4000	21 (91.30)	14 (56)	35	56
5000-10000	2 (8.69)	11 (44)	13	44
10000 - more	0	0	0	0
Total	23 (47.92)	25 (52.08)	48	100

Table 4.1.2 shows that the family's income of rural women husband in which 56% of rural women's family income is up to 2000 monthly, followed by 44 rural women are between 5000-10000 monthly family incomes.

Table 4.1.3 Education Levels of Women

Status	Bhitarwar	Mohana	Total	Percentage
Illiterate	14 (60.86)	13 (52)	27	56.25
Primary	5 (21.73)	10 (40)	15	31.25
Secondary	2 (8.69)	1 (4)	6	12.5
Higher Secondary	0	0	0	0
Graduate	0	0	0	0
Total Response	23 (47.92)	25 (52.08)	48	100

Table 4.1.3 shows that the education level of rural women in which 56.25% of rural women are illiterate, 31.25% of rural women have primary education and 12.5% of rural women only have secondary level education and none of them are graduate.

Table 4.1.4 Marital Status of Women

Option	Bhitarwar	Mohana	Total	Percentage
Married	23 (100)	25 (100)	48	100
Unmarried	0	0	0	0
Total	23 (47.92)	25 (52.08)	48	100

The table above 4.1.4 shows the marital status of rural women. It was found that 100 percent of women are married which were surveyed in CHC.

Table 4.1.5 Occupation of the Rural Women's Husband

Occupation	Bhitarwar	Mohana	Total	Percentage
Agriculture	10 (25)	12 (41.37)	22	31.88
Govt. Employee	0	0	0	0
No Employment	11 (27.5)	1 (3.44)	12	17.39
Farm Worker	1 (2.5)	1 (3.44)	2	2.90
Private	17 (42.5)	15 (51.72)	32	46.38
Driver	0	0	0	0
Business	1 (2.5)	0	1	1.45
Others	0	0	0	0
Total	40 (57.97)	29 (42.02)	69	100

Table 4.1.5 shows the occupations of rural woman's husbands in which 60.87 rural women's husbands are doing private work, while 30.43 rural women's husbands are

doing agriculture work, followed by 4.35 are farm workers and 4.35 rural women's husband are unemployed.

Table 4.1.6 Housing and Living Status of Rural Women

Variable	Categories	Bhitarwar	Mohana	Total	Percentage
Type of House	Hut	23 (100)	25 (100)	48	14.55
	Tiled	0	0	0	0.00
	Concrete	0	0	0	0.00
Ownership of House	Rented	0	0	0	0.00
	Own	23 (47.91)	25 (52.08)	48	14.55
	Others	0	0	0	0
Number of Rooms	One	17 (35.41)	16 (33.33)	33	10
	Two	5 (10.41)	9 (18.75)	14	4.24
	Three	1 (2.08)	0	1	0.30
	Four	0	0	0	0
	More than	0	0	0	0
Toilet	Not Available	14 (29.16)	6 (12.5)	20	6.06
	Available	9 (18.75)	19 (39.58)	28	8.48
Drinking water	Tap	10 (20.83)	11	21	6.36
	Hand Pump	13 (27.08)	14 (29.16)	27	8.18
Electricity	Not Available	10 (20.83)	6 (12.5)	16	4.85
	Available	17 (35.41)	18 (37.5)	35	10.61
Leisure time	Television	1 (2.08)	0	1	0.30
	Radio	0	0	0	0.00
	News paper	0	0	0	0.00
	No activity	26	12	38	11.52

		(54.16)	(25)		
Total		169 (51.21)	161 (48.78)	330	100

Table 4.1.6 shows the housing and living status of rural women, wherein 14.55 percent of rural women were living in Huts house, whereas 14.55percent of rural women have their own homes. 10% of rural women are living in a single room, whereas 4.24% rural women live in a double room, followed by 0.30% rural women living in a three-room set room. Overall 8.48% women have Toilet facility and 6.06% are not having. The drinking water facility for rural women shows that there is 6.36% women are havingtap and 8.18 arehavinghand pumps for water facility. Around 10.61% said they have electricity and 4.85 are not having electricity. Television, News Papers, and leisure activities are not at all used by them.

Table 4.1.7 Awareness about Health Literacy

Awareness Health Literacy	Bhitarwar	Mohana	Total	Percentage
Yes	8 (34.78)	7 (28)	15	31.25
No	15 (65.21)	18 (72)	33	68.75
Total	23 (47.92)	25 (52.08)	48	100

The table 4.1.7 shows that the awareness of health literacy among rural women was low. It was found that 68.75 of women were unaware of health literacy, whereas 31.25 of women were aware of health literacy.

Table 4.1.8 Reasons for Non- Awareness about Health Literacy

Reasons	Bhitarwar	Mohana	Total	Percentage
Lack of education	11 (39.28)	19 (44.18)	30	42.25
Lack of Health Information	9 (32.14)	12 (27.90)	21	29.58
Not interested	8	12	20	28.17

	(28.57)	(27.90)		
No opinion	0	0	0	0
Total	28 (39.43)	43 (60.56)	71	100

The table 4.1.8 shows that the majority of rural women i.e. 42.25% were not aware of health literacy due of lack of education, whereas of rural women 29.58% were unaware of health literacy due to of lack of health information, followed by 28.17%% were not interested in health literacy because of their some personal reasons.

Table 4.1.9 Provision of Health Information, Resources, and Services

Provision Health Information	Bhitarwar	Mohana	Total	Percentage
Yes	12 (52.17)	15 (60)	27	56.25
No	11 (47.82)	10 (40)	21	43.75
Total	23 (47.92)	25 (52.08)	48	100

The above table 4.1.9 shows that provision of Health Information, Resources, and Service provided by CHC for rural women. It was found that 56.52% rural women have access to health information, resources, and service from the CHC and 43.75% were not received it from CHC.

Table 4.1.10 Awareness, Source and Uses of Immunization

Source	Category	Bhitarwar	Mohana	Total	Percentage
Awareness about Immunization	No Awareness	8 (61.53)	5 (38.46)	13	8.67
	Yes	15 (42.85)	20 (57.14)	35	23.33
Source of Information on Immunization	Doctors	5 (50)	5 (50)	10	6.67
	Health visitors	0	0	0	0
	AASHA	22 (52.38)	20 (47.61)	42	28
	Nurse	0 (0)	2 (8)	2	1.33

Awareness about Diseases prevented by Immunization	Fully aware	0 (0)	0 (0)	0	0
	Partially aware	19 (82.60)	20 (80)	39	26
	Not aware	4 (17.39)	5 (20)	9	6
Total		73 (48.66)	77 (52.33)	150	100

Table 4.1.10 shows the Awareness about Immunization, sources of immunization information, and awareness about diseases prevented by immunization among rural women. It was found that the highest percentage of Mohana wherein 52.33% were aware about Immunization, sources of information on immunization, and aware about diseases prevented by Immunization, While 48.66% in Bhitwar were aware.

Table 4.1.11 Availability and Accessibility of Health Care Services by CHC

Variable	Categories	Bhitwarwar	Mohana	Total	Percentage
Distance to Community Health Center (in km)	1.00-5.00	0	0	0	0
	6.00-10.0	4 (4.65)	16 (17.39)	20	11.23
	11.0-15.0	16 (18.60)	7 (7.61)	23	12.92
	16.0-20.0	3 (3.49)	2 (2.17)	5	2.80
	21.0-25.0	0	0	0	0
			0	0	0	0
Reasons for visiting Community Health Centers	For free Medicine	19 (22.09)	22 (23.91)	41	23.03
	Emergency	3 (3.49)	12 (13.04)	15	8.42
	Minor Illness	0	8 (8.70)	8	4.49
	Not visiting	0	0	0	0
Visiting Private Clinic	Minor Illness	0	0	0	0
	Partially	18 (20.93)	0	18	10.11
Distance to Medical Shop(in km)	00.-.50	23 (26.74)	25 (27.17)	48	26.96
	1.00-2.00	0	0	0	0
	3.00.-more than	0	0	0	0
Total		86	92	178	100

	(48.31)	(51.68)		
--	---------	---------	--	--

The table 4.1.11 shows the availability and accessibility of Health Care Services by CHC for rural women. It was found that the overall availability and accessibility are highest among Mohana rural women with 51.68%, which was followed by Bhitwar where it was 48.31%.

Table 4.1.12 Access to the Satisfactory Road Network in Rural Areas

Road network	Bhitwar	Mohana	Total	Percentage
Yes	14 (60.86)	12 (48)	26	54.17
No	9 (39.13)	13 (52)	22	45.83
Total	23 (47.92)	25 (52.08)	48	100

The table 4.1.12 shows that the satisfactory road network in Bhitwar and Mohana CHC. Around 54.17 percent women are satisfied with road network and 45.83% are not satisfied with road network in rural areas.

Table 4.1.13 Barriers to Health Treatment

Option	Bhitarwar			Mohana			Total			Percentage
	Poor	Average	Good	Poor	Average	Good	Poor	Average	Good	
Social status	5 (5.37)	18 (29.50)	0	12 (9.91)	4 (30.76)	9 (23.07)	17 (7.94)	22 (29.73)	9 (19.15)	48 (14.32)
Self-perceived health	6 (6.45)	17 (33.33)	0	15 (12.39)	0	10 (25.64)	21 (9.81)	17 (22.97)	10 (21.28)	48 (14.32)
Not Able to pay for Medication	7 (7.52)	16 (25.39)	1 (12.5)	11 (9.09)	4 (30.76)	8 (20.51)	18 (8.41)	20 (27.03)	9 (19.15)	47 (14.02)
Not Able to afford doctor	14 (15.05)	8 (12.69)	1 (12.5)	18 (14.87)	1 (7.69)	6 (15.38)	32 (14.95)	9 (12.16)	7 (14.89)	48 (14.32)
Limited activities because of health problems	20 (21.50)	0	3 (37.5)	20 (16.52)	2 (15.38)	3 (2.15)	40 (18.69)	2 (2.70)	6 (12.77)	48 (14.32)
Monthly household income	21 (22.58)	1 (1.58)	1 (12.5)	22 (18.18)	1 (7.69)	2 (5.12)	43 (20.09)	2 (2.70)	3 (6.38)	48 (14.32)
Unable to reach out to CHC	20 (21.50)	1 (1.58)	2 (25)	23 (19.00)	1 (7.69)	1 (2.56)	43 (20.09)	2 (2.70)	3 (6.38)	48 (14.32)
Total	93 (43.46)	61 (82.43)	8 (17.02)	121 (56.54)	13 (17.57)	39 (82.98)	214 (63.88)	74 (22.09)	47 (14.03)	335 (100)

Table 4.1.13 shows that the barriers regarding health treatment faced by rural women. The poor social status, Self-perceived health, not able to pay for Medication, not able to afford doctor, limited activities because of health problems, monthly household income, Unable to reach out to CHC

were found to be the main barriers, 214 (63.88%) said it is poor, followed by 121 (56.54%) said average, followed by 93(43.46%) said good, regarding barriers for health treatment.

Table 4.1.14 Awareness about Nutritious Diet taken by Rural Women

Option	Bhitarwar	Mohana	Total	Percentage
Yes	10 (43.47)	10 (40)	20	41.67
No	13 (56.52)	15 (60)	28	58.33
Total	23	25	48	100

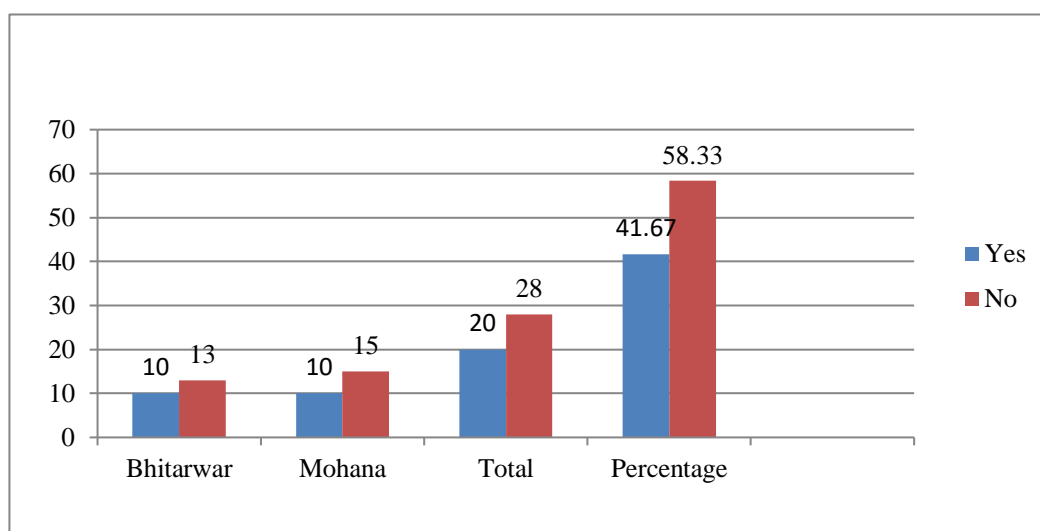


Fig. 4.1.14 Awareness about Nutritious Diet by Rural Women

The table and fig.no.4.1.14 show that the awareness about the nutritious diet taken by rural women. It was found that the 58.33% rural women were not aware of a nutritious diet.

Table 4.1.15 Reasons for Non-awareness of Nutritious Diet by Rural Women

Reasons	Bhitarwar	Mohana	Total	Percentage
Monthly Income	15 (65.21)	19 (76)	34	70.83
Not Aware	8 (34.78)	6 (24)	14	29.17
Total	23 (47.92)	25 (52.08)	48	100

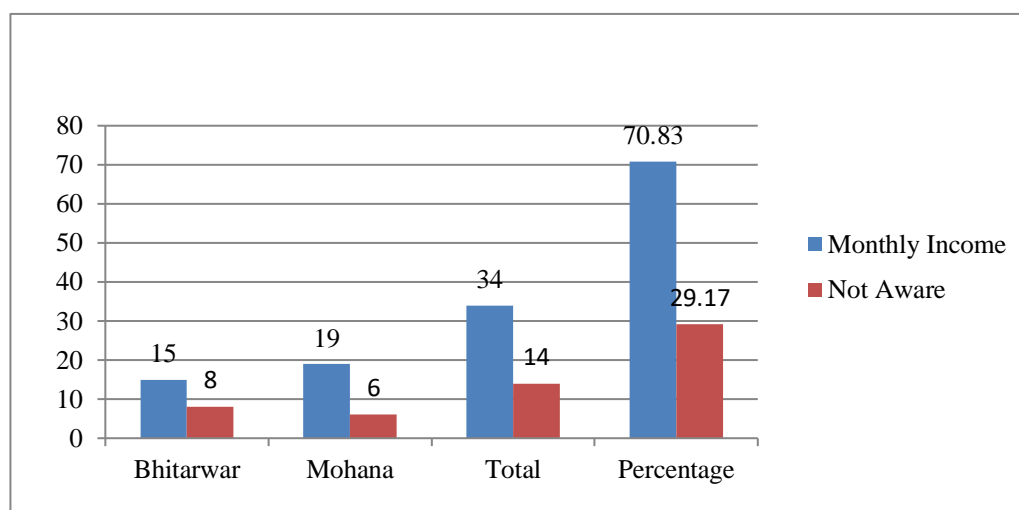


Fig. 4.1.15 Reasons for Non-awareness of Nutritious Diet by Rural Women

The table 4.1.15 shows the reasons for non-awareness about nutritious diet and foods by rural women. It found that the 70.83% of rural women were not taking nutritious diet due to lack of monthly income and the lowest 29.17% of rural women were not aware of the nutritious diet.

Table 4.1.16 Chosen Places for Delivery of their Child by Rural Women

Place of delivery	Bhitarwar	Mohana	Total	Percentage
Home	0	0	0	0
Government facility	23 (100)	25 (100)	48	100
Accredited private facilities	0	0	0	0
Other private facilities	0	0	0	0
Total	23 (47.92)	25 (52.08)	48	100

The above table 4.1.16 shows that the Chosen Places for delivery of their Child by Rural Women. It was found that 100 percent of rural women in Bhitarwar and Mohana have chosen a government facility for delivery of their child.

Table 4.1.17 Awareness about Contraception

Option	Bhitarwar	Mohana	Total	Percentage
Yes	19 (82.60)	18 (72)	37	77.08
No	4 (17.39)	7 (28)	11	22.91
Total	23 (47.92)	25 (52.08)	48	100

The table 4.1.17 shows that awareness about contraception among rural women. It was found that the 77.08% of rural women are aware about contraception all CHC. Whereas 22.91% of rural women were not aware of contraception.

Table 4.1.18 Use of Contraception by Rural Women

Use of Contraception	Bhitarwar	Mohana	Total	Percentage
Yes	1 (4.34)	6 (24)	7	14.58
No	22 (95.65)	19 (76)	41	85.41
Total	23 (47.91)	25 (52.08)	48	100

The table 4.1.18 shows the Use of Contraception by Rural Women. It was found that the 85.41% of rural women never used contraception in CHC. Whereas 14.58 percentage of rural women never used contraception.

Table 4.1.19 Reasons for not using Contraception by Rural Women

Option	Bhitarwar	Mohana	Total
Lack of information	22	12	34 (46.58)
Husband's not agree	18	8	26 (35.62)
Side effect	8	5	13 (17.81)
Total	48 (65.75)	25 (34.25)	73 (100)

The table 4.1.19 shows reasons for not using concentration by rural women. It was found the highest percentage of Bhitarwar where in rural women are not using contraception because of lack of information, husbands not agree, the side effect and the percentage is 65.75, followed by the second-highest percentage for the same belongs to Mohana which is 34.25%.

Table 4.1.20 Health Information Received by Rural Women

Option	Bhitarwar	Mohana	Total	Percentage
Community health center	20 (86.95)	22 (54.54)	42	87.5
Sub-center	0	0	0	0
Primary Health Center	0	2 (8)	2	4.17
Districts hospital	3 (13.04)	1 (4)	4	8.33
Television	0	0	0	0
Newspapers	0	0	0	0
Adult education officials	0	0	0	0
Total	23 (47.91)	25 (52.08)	48	100

The above table 4.1.20 shows that health Information received by rural women. It was found that the 87.5 percentage of rural women received from CHC, followed by 8.33 received from district hospitals, 4.17 received from Primary health center.

Table 4.1.21 Treatment taken during Pregnancy by Rural Women

Option	Bhitarwar	Mohana	Total
Yes	23 (100)	25 (100)	48
No	0	0	0
Total	23 (47.92)	25 (52.08)	48 (100)

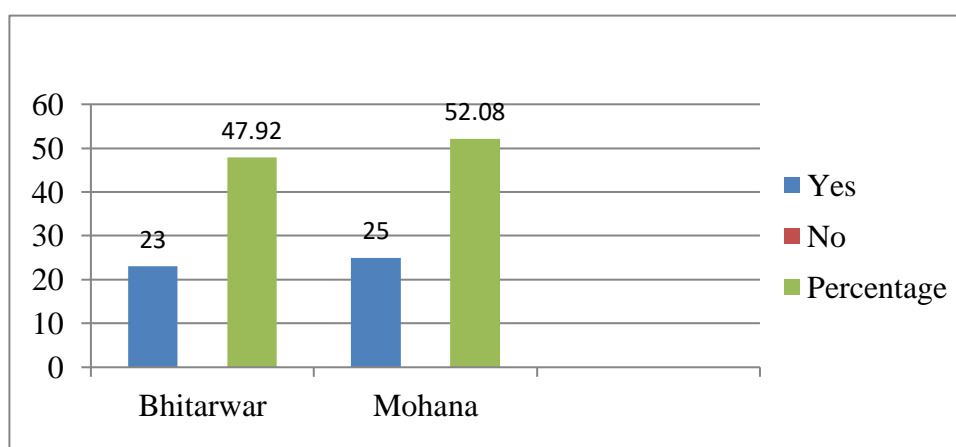


Fig. 4.1.21 Treatment taken during Pregnancy by Rural Women

The table and fig 4.1.21 show that the treatment taken during pregnancy by rural women. It was found that the 52.08 percentage of rural women in Mohana and Bhitwar has 47.92 in Bhitwar taken treatment during their pregnancy time by rural women from the CHC.

Table 4.1.22 Types of Hospitals preferred by Rural Women

Option	Bhitwar	Mohana	Total	Percentage
Community health center	23 (76.66)	29 (82.85)	48	78.69
Sub-center	0	1 (2.85)	1	1.64
Private hospital	7 (23.66)	5 (14.28)	12	19.67
Ayurvedic hospital	0	0	0	0
Traditional local health person	0	0	0	0
Total	30 (49.18)	35 (50.82)	61	100

The above table 4.1.22 shows the Types of Hospitals preferred by Rural Women in case of health issues. It was found that the 80 of rural women were preferred to CHC, followed by 18.46 private hospitals, and 1.54 of rural women were preferred sub-center in case of health needs.

Table 4.1.23 Availability of Medical Staff in CHC

Option	Bhitarwar		Mohana		Total		Percentage	
	Yes	No	Yes	No	Yes	No	Yes	No
Medical Staff								
Doctor	23 (22.11)	0	20 (18.18)	5 (5.55)	43 (19.90)	5 (2.97)	11.20	1.30
Nurse	23 (22.11)	0	23 (20.90)	2 (2.22)	46 (21.29)	2 (1.19)	11.98	0.52
Compounder	12 (11.53)	11 (14.10)	19 (17.27)	6 (6.66)	31 (14.35)	17 (10.11)	8.07	4.43
Health inspector	10 (9.61)	13 (16.66)	8 (7.27)	17 (18.88)	18 (8.33)	40 (23.80)	4.69	7.81
Health assistant (Male)	0	23 (29.48)	8 (7.27)	17 (18.88)	8 (3.70)	40 (23.80)	2.08	10.42
Health assistant (Female)	5 (4.80)	18 (23.07)	9 (8.18)	16 (17.77)	14 (6.48)	34 (20.23)	3.65	8.85
Lab technician	23 (22.11)	0	23 (20.90)	2 (2.22)	46 (21.29)	2 (1.19)	11.98	0.52
Peon	10 (9.61)	13 (16.66)	0	25 (27.77)	10 (4.62)	38 (22.61)	2.60	9.90
Total	104 (27.08)	78 (20.31)	110 (28.65)	90 (23.44)	216 (55.73)	168 (43.75)	56.25	43.75

Table 4.1.23 shows the overall availability of medical staff in CHC. It was found that the availability of nurse staff was maximum i.e. 11.98, same as followed by a lab technician with 11.98, followed by the doctor with 11.20, followed by compounder with 8.07, followed by health inspector with 4.69, followed by health assistant with 4.69 followed by health assistant female staff with 3.65 and least attended with 2.60 were availability in CHC.

It was also found that the availability of complete staff is maximum in Mohana CHC 28.65 and least in Bhitarwar CHC with 27.08.

Table 4.1.24 Satisfaction Level with CHC Staff

Option	Bhitarwar			Mohana			Total (P+G+V)			Total
	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	
Doctors	8 (13.33)	15 (19.23)	0	9 (12.32)	16 (20.77)	0	17 (12.78)	31 (20)	0	48
Nurse and Compounder	9 (15)	14 (17.94)	0	10 (13.69)	15 (19.48)	0	19 (14.28)	29 (18.70)	0	48
Labor rooms	0	23 (29.48)	0	1 (1.36)	24 (32.87)	0	1 (0.75)	47 (30.32)	0	48
Radiographers & X-Ray Machines	18 (30)	5 (6.41)	0	25 (34.24)	0	0	43 (32.33)	5 (3.22)	0	48
Lab Technician & Pathology Labs	2 (3.33)	21 (26.92)	0	3 (4.10)	22 (28.57)	0	5 (3.75)	43 (27.74)	0	48
Generators	23 (38.33)	0	0	25 (34.24)	0	0	48 (36.09)	0	0	48
Total	60 (45.11)	78 (50.32)	0	73 (54.89)	77 (49.68)	0	133 (46.18)	155 (53.82)	0	288

The data presented in table 4.1.24 shows that the overall satisfaction level with medical staff available in CHC. 78 (50.32) percentage found that the maximum rural women were satisfied in Bhitarwar, followed by 77 (49.68) percentage of rural women in Mohana are good. Whereas 73 (54.89) percentage of rural women are not satisfied with CHC staff, followed by 60 (45.11) percentage rural women are not satisfied with CHC staff (poor services).

Table 4.1.25 Aspects of Visiting to CHC by Rural Women

Aspect	Bhitarwar	Mohana	Total	Percentage
Family planning	23 (11.91)	25 (14.70)	48	13.22
Natal care Pre & Post)	23 (11.91)	25 (14.70)	48	13.22
Immunization	23 (11.91)	25 (14.70)	48	13.22
Communicable diseases	0	0	0	0
a) Malarial fever	23 (11.91)	25 (14.70)	48	13.22
b) Eye infections	11 (5.69)	8 (4.70)	19	5.23
c) Cough	13 (6.73)	12 (7.05)	25	6.89
d) Body pains	23 (11.91)	20 (11.76)	43	11.85
e) Knee pains	17 (8.80)	19 (11.17)	36	9.92
f) Problems of menopause	16 (8.29)	8 (4.70)	24	6.61
g) Cancer	2 (1.03)	3 (1.76)	5	1.38
h) Blood pressure	19 (9.84)	0	19	5.23
Total	193 (53.17)	170 (46.83)	363	100

The above table 4.1.25 shows that the overall aspect of visiting CHC by rural women. It was found that the aspect of visit to CHC is maximum 13.22 of family planning, same as followed by natal care with 13.22, followed by immunization with 13.22, followed by malaria with 13.22, followed by knee pains with 9.92, followed by cough with 6.89, followed by problems of menopause with 6.61, followed by Eye infections and Blood pressure with 5.23 and least was cancer with 1.38 were aspect for visiting CHC by rural women.

It was also found that the availability of aspect of visit to CHC is maximum CHC 53.17 in Bhitarwar and least 46.83in Mohana CHC.

Table 4.1.26 Social Empowerment Status of Rural Women

Status of Social Empowerment	Bhitarwar			Mohana			Total			Total (P+G+VG)	Percentage
	Poor	Good	V.Good	Poor	Good	V. good	Poor	Good	V.Good		
Using Toilets	10 (7.25)	13 (14.13)	0	15 (9.49)	10 (10.86)	0	25 (8.44)	23 (12.5)	0	48	10
To increase hygiene in their area	12 (8.70)	11 (11.96)	0	9 (5.69)	16 (17.39)	0	21 (7.09)	27 (14.67)	0	48	10
Steps to take safe drinking water	5 (3.62)	18 (19.27)	00	14 (8.86)	11 (11.95)	0	19 (6.41)	29 (15.76)	0	48	10
Family planning methods	4 (2.90)	19 (20.65)	0	14 (8.86)	11 (11.95)	0	18 (6.08)	30 (16.30)	0	48	10
Supporting equal status for women	22 (15.94)	1 (1.09)	0	15 (9.49)	10 (10.86)	0	37 (12.5)	11 (5.97)	0	48	10
Securing the rights for Women	21 (15.22)	2 (2.17)	0	14 (8.86)	11 (11.95)	0	35 (11.82)	13 (7.06)	0	48	10
Voicing against social injustice	20 (14.49)	3 (3.26)	0	17 (10.75)	8 (8.69)	0	37 (12.5)	11 (5.97)	0	48	10
Supporting widow remarital	17 (12.32)	67 (7.61))	0	22 (13.92)	3 (3.26)	0	39 (13.17)	9 (4.89)	0	48	10
The decision about family Affairs	13 (9.42)	9 (9.78)	0	19 (12.02)	6 (6.52)	0	32 (10.81)	16 (8.69)	0	48	10
The decision about health at home	14 (10.14)	8 (8.70)	0	19 (12.02)	6 (6.52)	0	33 (11.14)	15 (8.15)	0	48	10
Total	138 (46.62)	92 (50)	0	158 (53.38)	92 (50)	0	296 (61.67)	184 (38.33)	0	480	100

The presented table 4.1.26 shows that the social empowerment status of the rural woman of Bhitarwar and Mohana. It was found that the overall social empowerment status is 296 (61.67) percentage of poor, while the minimum was 184 (38.33) was good.

Table 4.2 Sample Size of Shivpuri

Questionnaire Distributed in CHC	Questionnaire Distributed	Questionnaire Received	Questionnaire's Analyzed
Badarwas	30	27	27
Karera	30	20	20
Kolaras	30	22	22
Khaniadhana	30	28	28
Narwar	30	23	23
Pohari	30	24	24
Pichhore	30	18	18
Total	210	169	169

The above table no.4.2 shows that a total of 210 questionnaires were distributed among rural women and out of these received 169 back. It was observed that the highest response received from Depalpur and Mhow and the minimum is from Manpur and Sanwad CHC.

Table 4.2.1 Types of Category/ Population

Category	Badarwas	Karera	Kolaras	Khaniadhana	Narwar	Pichhore	Pohari	Total	Percentage
General	0	0	0	0	0	0	1 (5.55)	1	0.59
OBC	15 (50)	9 (45)	10 (41.66)	10 (35.71)	11 (47.82)	4 (15.38)	4 (22.22)	63	37.28
Scheduled Caste	10 (33.33)	8 (40)	6 (25)	11 (39.28)	6 (26.08)	10 (38.46)	8 (44.44)	59	34.91
Scheduled Tribal	5 (16.66)	3 (15)	8 (33.33)	7 (25)	6 (26.08)	12 (46.15)	5 (27.77)	46	27.22
Total	30 (17.75)	20 (11.83)	24 (14.20)	28 (16.57)	23 (13.61)	26 (15.38)	18 (10.65)	169	100

Above table 4.2.1 shows that the type of category among rural women which shows that 37.28% rural women belong to the OBC category, where 34.91% are SC, 27.22% are ST, 0.59 are General categories rural women live.

Table 4.2.2 Family's Monthly Income

Option	Badarwas	Karera	Kolaras	Khaniadhana	Narwar	Pichhore	Pohari	Total	Percentage
Up to 2000	0	0	0	0	2 (8.69)	3 (11.53)	4 (22.22)	9	5.33
2000-4000	25 (83.33)	18 (90)	14 (58.33)	24 (85.71)	18 (78.26)	22 (84.61)	11 (61.11)	132	78.11
5000-10000	5 (16.66)	2 (10)	10 (41.66)	4 (14.28)	3 (13.04)	1 (3.84)	3 (16.66)	28	16.57
10000 – more	0	0	0	0	0	1 (3.84)	0	0	0
Total	30 (17.75)	20 (11.83)	24 (14.20)	28 (16.57)	23 (13.61)	26 (15.38)	18 (10.65)	169	100.00

The data presented in table 4.2.2 shows that the family's income of rural women husband in which 78.11% rural women family income is up to 2000-4000 monthly, 16.57% rural women are between 5000-10000 monthly family income, and 5.33% rural women's family income is up to 2000 monthly income.

Table 4.2.3 Education Levels of Women

Option	Badarwas	Karera	Kolaras	Khaniadhana	Narwar	Pichhore	Pohari	Total	Percentage
Illiterate	8 (26.66)	12 (60)	7 (29.16)	10 (35.71)	13 (56.52)	16 (61.53)	7 (38.88)	73	43.20
Primary	11 (36.66)	6 (30)	5 (20.83)	9 (32.14)	5 (17.85)	3 (11.53)	9 (50)	48	28.40
Secondary	10 (33.33)	2 (10)	10 (41.66)	8 (28.57)	4 (17.39)	5 (19.23)	2 (11.11)	41	24.26
Higher Secondary	1 (3.33)	0	2 (8.33)	1 (3.57)	1 (4.34)	2 (7.69)	0	7	4.14
Graduate	0	0	0	0	0	0	0	0	0
Total	30 (17.75)	20 (11.83)	24 (14.20)	28 (16.57)	23 (13.61)	26 (15.38)	18 (10.65)	169	100

The data presented in Table 4.2.3 shows the education level of rural women in which 43.20% rural women are illiterate, 28.40% rural women have primary education, 24.26% rural women have secondary education level and 4.14% are higher educated rural women.

Table 4.2.4 Marital Status of Women

Option	Badarwas	Karera	Kolaras	Khaniadhana	Narwar	Pichhore	Pohari	Total	Percentage
Married	30 (100)	20 (100)	24 (100)	28 (100)	23 (100)	26 (100)	18 (100)	169	100
Unmarried	0	0	0	0	0	0	0	0	0
Total	30 (17.75)	20 (11.83)	24 (14.20)	28 (16.57)	23 (13.61)	26 (15.38)	18 (10.65)	169	100

Table 4.2.4 clearly shows the marital status of women. It was found that 100 percent of women are married in CHC.

Table 4.2.5 Occupation of the Rural Women's Husband

Occupation	Badarwas	Karera	Kolaras	Khaniadhana	Narwar	Pichhore	Pohari	Total	Percentage
Agriculture	25 (55.55)	20 (57.14)	15 (50)	25 (60.97)	21 (65.62)	23 (62.16)	12 (40)	141	56.4
Govt. Employee	0	0	0	0	0	0	0	0	0
No Employment	11 (24.44)	1 (2.85)	7 (23.33)	4 (9.75)	0	4 (10.81)	6 (20)	33	13.2
Farm Worker	0	0	0	0	0	0	0	0	0
Private	9 (20)	14 (40)	8 (26.66)	12 (29.26)	11 (34.37)	10 (27.02)	12 (40)	76	30.4
Driver	0	0	0	0	0	0	0	0	0
Business	0	0	0	0	0	0	0	0	0

Others	0	0	0	0	0	0	0	0	0
Total	45 (18)	35 (14)	30 (12)	41 (16.4)	32 (12.8)	37 (14.8)	30 (12)	250	100

Table 4.2.5 shows the occupations of rural woman's husbands in which 56.4% rural women husbands are farmers, 30.4% rural women 's husbands are private jobs and 13.2% of rural women's husbands are unemployed.

Table 4.2.6 Housing and Living Status of Women

Option	Categories	Badarwas	Karera	Kolaras	Khaniadhana	Narwar	Pichhore	Pohari	Total	Percentage
Type of House	Hut	24 (13.95)	20 (16.66)	22 (14.76)	26 (15.56)	18 (11.39)	18 (12.41)	13 (10.65)	141	13.65
	Tiled	3 (1.74)	0	0	0	0	0	0	3	0.29
	Concrete	0	0	1 (0.67)	2 (1.19)	4 (2.53)	6 (4.13)	5 (4.09)	18	1.74
Ownership of House	Rented	0	0	0	0	0	2 (1.37)	0	2	0.19
	Own	27 (15.69)	20 (16.66)	22	28 (16.76)	23 (14.55)	22 (15.17)	18 (14.75)	160	15.49
	Others	0	0	0	0	0	0	0	0	0
Number of Rooms	One	16 (9.30)	15 (12.5)	15 (10.06)	18 (10.77)	12 (7.59)	12 (8.27)	12 (9.83)	100	9.68
	Two	10 (5.81)	5 (4.16)	7 (4.69)	10 (5.98)	9 (5.69)	9 (6.20)	5 (4.09)	55	5.32
	Three	1 (0.58)	0	0	0	2 (1.26)	1 (0.68)	0	4	0.39
	Four	0	0	0	0	0	2	0	2	0.19

	More than	0	0	0	0	1 (0.63)	0	0	1	0.10
Toilet	Not Available	14 (8.13)	8 (6.66)	9 (6.04)	13 (7.78)	4 (2.53)	16 (11.03)	8 (6.55)	72	6.97
	Available	13 (7.55)	12 (10)	13 (8.72)	15 (8.98)	19 (12.02)	8 (5.51)	10 (8.19)	90	8.71
Drinking water	Tap	11 (6.39)	4 (3.33)	3 (2.01)	1 (0.59)	4 (2.53)	4 (2.75)	6 (4.91)	33	3.19
	Hand Pump	16 (9.30)	16 (13.33)	19 (12.75)	16 (9.58)	19 (12.02)	10 (6.89)	12 (9.83)	108	10.45
Electricity	Not Available	10 (5.81)	2 (1.66)	0	16 (9.58)	4 (2.53)	10 (6.89)	3 (2.45)	45	4.36
	Available	17 (9.88)	18 (15)	22 (14.76)	12 (7.18)	19 (12.02)	12 (8.27)	15 (12.29)	115	11.13
Leisure time	Television	4 (2.32)	0	11 (7.38)	0	4 (2.53)	4 (2.75)	11 (9.01)	34	3.29
	Radio	0	0	0	0	3 (1.89)	6 (4.13)	0	9	0.87
	News paper	0	0	0	0	0	0	0	0	0
	No activity	6 (3.48)	0	5 (3.35)	10 (5.98)	13 (8.22)	3 (2.06)	4 (3.27)	41	3.97
Total		172 (16.65)	120 (11.62)	149 (14.62)	167 (16.17)	158 (15.30)	145 (14.04)	122 (11.81)	1033	100

Table 4.2.6 shows the housing status of rural women, which is 141(13.65%) of rural women were living in Huts house, 3 (0.29) having tiles and 18(1.74) concrete houses. 2 (0.19) rented houses, 160(15.49) of rural women have their own home. 100 (9.68) of rural women are living in a single room, whereas 55(5.32) found that rural women live in a double room, 4(0.39) rural women living in a three-room set room. Around 115 (11.13) said they have electricity and 45 (4.36) are not having electricity.

Table 4.2.7 Awareness about Health Literacy

Awareness Health Literacy	Badarwas	Karera	Kolaras	Khaniadhana	Narwar	Pichhore	Pohari	Total	Percentage
Yes	22 (73.33)	15 (68.18)	20 (90.90)	20 (71.42)	20 (86.95)	18 (69.23)	13 (72.22)	124	76
No	8 (26.66)	7 (31.81)	2 (9.09)	8 (28.57)	3 (13.04)	8 (30.76)	5 (27.77)	40	24
Total	30 (17.75)	22 (13.02)	22 (13.02)	28 (16.67)	23 (13.61)	26 (15.38)	18 (10.65)	169	100

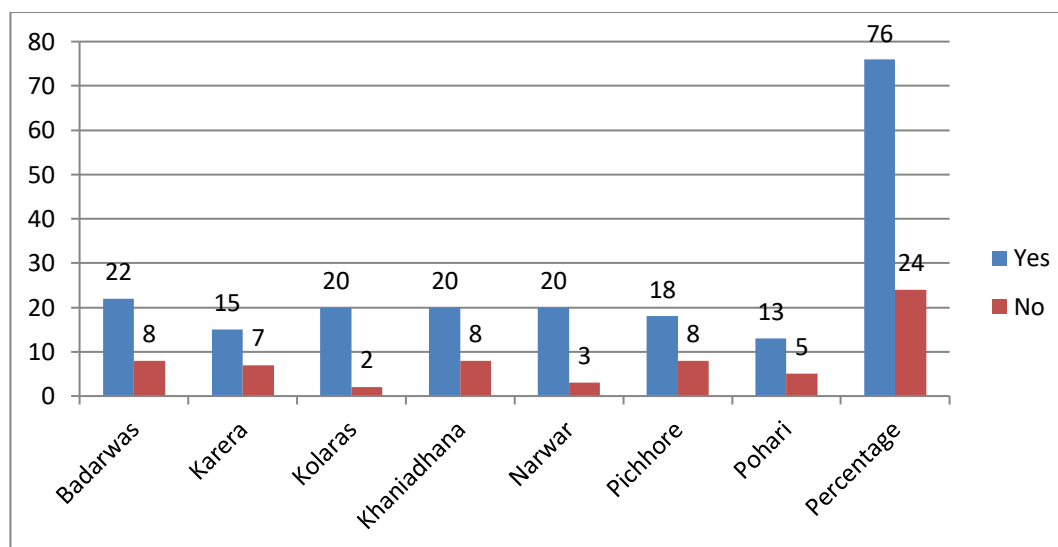


Fig.4.2.7 Awareness of Health Literacy

The table and fig. no4.2.7 shows that the awareness of health literacy among rural women was high, It was found that 124 (i.e. 76) women were aware of health literacy whereas 40 (i.e. 24) women were unaware of health literacy.

Table 4.2.8 Reasons for Non- Awareness about Health Literacy

Option	Badarwas	Karera	Kolaras	Khaniadhana	Narwar	Pichhore	Pohari	Total	Percentage
Lack of education	11 (35.48)	20 (30.76)	19 (48.71)	21 (50)	17 (47.22)	18 (47.36)	13 (50)	119	47.41

Lack of Health Information	15 (48.38)	14 (35.89)	18 (46.15)	21 (50)	19 (52.77)	18 (47.36)	13 (50)	118	47.01
Not interested	5 (16.12)	5 (12.82)	2 (5.12)	0	0	2 (5.26)	0	14	5.58
On opinion	0	0	0	0	0	0	0	0	0
Total	31 (12.35)	39 (15.54)	39 (15.54)	42 (16.73)	36 (14.34)	38 (15.14)	26 (10.36)	251	100

Table 4.2.8 shows that the majority of rural women 119(47.41) were not aware of health literacy because of lack of education, whereas 118(47.012) are not aware of health literacy because of lack of health information, and 14(5.58) are not interested.

Table 4.2.9 Provision of Health Information, Resources, and Services by CHC

Option	Badarwas	Karera	Kolaras	Khaniadhana	Narwar	Pichhore	Pohari	Total	Percentage
Yes	19 (63.33)	10 (45.45)	14 (63.63)	18 (64.28)	15 (53.57)	14 (53.84)	14 (77.77)	104	61.54

No	11 (36.66)	12 (54.54)	9 (40.90)	10 (35.71)	8 (34.78)	12 (46.15)	4 (22.22)	66	39.05
Total	30 (17.75)	22 (13.02)	22 (13.02)	28 (16.67)	23 (13.61)	26 (15.38)	18 (10.65)	169	100

Table 4.3.9 shows the provision for health information, resources, and service by CHC for rural women. It was found that the highest percentage of 104(61.54) of rural women access health information, resources, and services from the CHC, and 66(39.05) were not received the health information.

Table 4.2.10 Awareness, Source and Uses of immunization

Source	Category	Badarwas	Karera	Kolaras	Khaniadhana	Narwar	Pichhore	Pohari	Total	Percentage
Awareness about Immunization	No Awareness	17 (14.05)	8 (9.20)	6 (6.25)	7 (5.83)	21 (22.58)	16 (15.69)	8 (11.11)	83	12.01
	Had	10 (8.26)	12 (13.79)	14 (14.58)	21 (17.50)	2 (2.15)	9 (8.82)	10 (13.89)	78	11.29
Source of Information on Immunization	Doctors	15 (12.40)	5 (5.75)	10 (10.42)	10 (8.33)	5 (5.38)	6 (5.88)	11 (15.28)	62	8.97
	Health visitors	5 (4.13)	2 (1.65)	4 (4.17)	1 (0.33)	1 (1.08)	2 (1.96)	4 (5.56)	19	2.75
	AASHA	20 (16.53)	20 (22.99)	20 (20.83)	25 (20.83)	18 (19.35)	22 (21.57)	17 (23.61)	142	20.55
	Nurse	27	20	20	28	23	23	4	145	20.98

		(22.31)	(22.99)	(20.83)	(23.33)	(24.73)	(22.55)	(5.56)		
Awareness about Diseases prevented by Immunization	Fully aware	0	0	0	0	0	0	0	0	0
	Partially aware	24 (19.83)	19 (21.84)	20 (20.83)	20 (16.67)	21 (22.58)	23 (22.55)	14 (19.44)	141	20.41
	Not aware	3 (2.48)	1 (1.15)	2 (2.08)	8 (6.67)	2 (2.15)	1 (0.98)	4 (5.56)	21	3.04
Total		121 (17.51)	87 (12.88)	96 (13.89)	120 (71.01)	93 (13.46)	102 (14.76)	72 (10.42)	691	100

Table 4.2.10 show the awareness about Immunization, sources of immunization information, and awareness about diseases prevented by immunization among rural women. It was found that the highest percentage of Khaniadhana which is 71.01% of rural women were aware about Immunization, sources of immunization information, and awareness about diseases prevented, following it the second-highest 17.51% of Badarwas, followed by 14.76% in Pichhore, followed by 13.89% in Kolaras, followed by 13.46% Awareness about Immunization in Narwar. On moving forward it was found that Karera has the lowest 12.88% and 10.42% Pohari regarding of awareness respectively about immunization, sources of immunization information, and awareness about diseases prevented by immunization among rural women.

Table 4.2.11 Availability and Accessibility of Health Care Services by CHC

Variable	Categories	Badarwas	Karera	Kolaras	Khaniadhana	Narwar	Pichhore	Pohari	Total	Per.
Distance to Community Health	1.00-5.00	0	0	0	0	0	0	4 (5.88)	4	0.67

Center (in km)	6.00-10.0	5 (4.81)	14 (23.33)	2 (3.13)	21 (18.92)	0	20 (20.20)	12 (17.65)	74	12.31
	11.0-15.0	22 (21.15)	6 (10)	18 (28.13)	7 (6.31)	23 (24.21)	4 (4.04)	2 (2.94)	82	13.64
	16.0-20.0	0	0	3 (4.69)	0	0	0	0	3	0.50
	21.0-25.0	0	0	0	0	0	0	0	0	0
Reasons for visiting Community Health Centers	For free Medicine	27 (25.96)	20 (33.33)	20 931.25)	28 (25.23)	23 (24.21)	24 (24.24)	18 (26.47)	160	26.62
	Emergency	15 (14.42)	0	0	16 (14.41)	23 (24.21)	10 (10.10)	12 (17.65)	76	12.65
	Minor Illness	8 (7.96)	0	0	11 (9.91)	1 (1.05)	15 (15.15)	0	35	5.82
	Not visiting	0	0	0	0	0	0	0	0	0
Visiting Private Clinic	Minor Illness	0	0	0	0	0	2 (2.02)	0	2	0.33
	Partially	0	0	1 (1.56)	0	2 (2.11)	0	2 (2.94)	5	0.83
Distance to Medical Shop(in km)	00.-.50	27 (25.96)	20 (33.33)	20 (31.25)	28 (25.23)	23 (24.21)	24 (24.24)	18 (26.47)	160	26.62
	1.00-2.00	0	0	0	0	0	0	0	0	0
	3.00.-more than	0	0	0	0	0	0	0	0	0
Total		104 (17.30)	60 (9.98)	64 (10.65)	111 (18.87)	95 (15.81)	99 (16.47)	68 (11.31)	601	100

The table 4.2.11 shows the availability and accessibility of Health Care Services in CHC for rural women. It was found that the overall availability and accessibility in Khaniadhana is highest among rural women with 18.87%, which was followed by Badarwas where it was

17.30%, followed by Pichhore where it was 16.47% and followed by Narwar it was 15.81, followed by Pohari which is 11.31%, followed by Kolaras where it 10.65 and Karera which is 9.98 % shows the Availability and Accessibility of Health Care Services in CHC for rural women.

Table 4.2.12 Access to the Satisfactory Road Network in Rural Areas

Option	Badarwas	Karera	Kolaras	Khaniadhana	Narwar	Pichhore	Pohari	Total	Percentage
Yes	21 (70)	15 (75)	15 (65.21)	20 (71.42)	13 (56.52)	17 (62.96)	12 (66.66)	113	66.86
No	9 (30)	5 (25)	8 (34.78)	8 (28.57)	10 (23)	9 (34.61))	6 (33.33)	56	33.14
Total	30 (17.75)	20 (11.83)	23 (13.61)	28 (16.67)	23 (16.57)	27 (13.61)	18 (15.98)	169	100

The data presented in table 4.2.12 shows that the satisfactory road network in Badarwas, Karera, Khaniadhana, Narwar, Pichhore, and Pohari CHC. The satisfaction of road network highest was 113(66.86) and the lowest is 56(33.14) among rural women.

Table 4.2.13 Barriers to Health Treatment

Option	Badarwas			Karera			Kolaras			Khaniadhana			Narwar			Pichhore			Pohari			Total			Total &Per.
	Poor	Average	Good	Poor	Average	Good	Poor	Average	Good	Poor	Average	Good	Poor	Average	Good	Poor	Average	Good	Poor	Average	Good	Poor	Average	Good	
Social status	9 (8.65)	16 (2.3.88)	2 (9.52)	5 (1.063)	3 (3.0)	12 (1.518)	17 (2.151)	3 (5.0)	2 (4.08)	18 (1.258)	8 (10.52)	2 (2.16)	1 (1.66)	0	19 (1.727)	4 (2.0)	1 (2.5)	12 (16.66)	4 (19.04)	2 (6.06)	10 (15.06%)	39 (2.154)	21 (7.29)	324 (14.14)	
Self-perceived health	7 (6.73)	15 (2.238)	3 (1.428)	4 (3.404)	0	17 (2.151)	21 (2.658)	0	1 (2.04)	18 (1.258)	12 (21.05)	4 (2.05)	2 (3.03)	0	19 (1.727)	4 (2.0)	1 (2.5)	12 (16.66)	3 (14.28)	3 (9.09)	10 (15.06%)	36 (1.888)	29 (10.06)	334 (14.75)	
Not Able to pay for Medication	10 (9.61)	15 (2.238)	1 (4.76)	2 (4.25)	1 (1.0)	17 (2.151)	17 (2.151)	0	4 (8.16)	24 (1.678)	12 (10.52)	2 (10.52)	1 (1.66)	10 (21.27)	16 (1.454)	2 (1.0)	7 (17.5)	9 (12.5)	1 (4.76)	8 (24.24)	90 (13.29)	32 (1.67)	49 (17.01)	342 (14.29)	
Not Able to afford doctor	12 (11.53)	10 (1.492)	5 (2.380)	8 (1.702)	1 (1.0)	11 (1.392)	21 (2.658)	0	1 (2.04)	22 (1.38)	3 (10.52)	2 (10.52)	8 (7.76)	1 (1.66)	12 (25.53)	12 (1.90)	4 (2.0)	8 (13.88)	4 (19.04)	4 (12.12)	93 (13.73)	23 (1.70)	43 (14.93)	318 (13.78)	
Limited activities because of health problems	20 (9.23)	1 (1.49)	4 (1.904)	10 (2.127)	1 (1.0)	8 (1.12)	14 (1.72)	0	8 (16.32)	13 (9.09)	12 (2.52)	3 (19.78)	19 (1.44)	1 (1.66)	0	18 (1.36)	2 (1.0)	4 (10)	11 (15.27)	3 (14.28)	4 (12.12)	10 (15.50)	20 (1.04)	31 (10.76)	312 (13.16)
Monthly household income	22 (21.15)	3 (4.47)	1 (4.76)	10 (2.127)	2 (2.0)	6 (7.9)	6 (7.9)	1 (1.66)	15 (30.61)	24 (1.78)	2 (3.92)	3 (19.78)	11 (1.67)	0	12 (25.53)	16 (1.54)	0	9 (22.5)	8 (11.11)	4 (19.04)	6 (18.18)	97 (14.32)	12 (6.2)	52 (18.05)	322 (14.05)

Unable to reach out to CHC	24 (23.07)	7 (10.44)	5 (23.80)	8 (17.02)	2 (2.00)	8 (17.12)	2 (2.00)	2 (3.33)	18 (36.73)	24 (16.78)	2 (3.92)	3 (19.78)	10 (9.70)	0	13 (27.65)	10 (9.90)	4 (2.00)	10 (25)	10 (13.88)	2 (9.52)	6 (18.18)	88 (113)	19 (10.49)	63 (21.87)	340 (14.38)
Total	104 (15.63)	67 (37.02)	21 (72.9)	47 (65.94)	10 (5.2)	79 (27.43)	98 (14.48)	6 (3.1)	49 (17.01)	14 (32.1)	51 (28.17)	19 (6.60)	10 (1.52)	6 (3.31)	47 (16.31)	11 (1.6)	20 (1.1)	40 (13.89)	72 (10.6)	21 (11.6)	33 (11.46)	67 (59.1)	18 (1.5)	288 (25.13)	1146 (100)

Table 4.2.13 shows that the barriers to health treatment faced by rural women. The poor social status, Self-perceived health, not able to pay for Medication, not able to afford doctor, limited activities because of health problems, monthly household income, unable to reach out to CHC, were found to be main barriers 21.1 percentage in Khaniadhana, followed by 16.2 in Pichhore, followed by 15.4 in Badarwas. Moving forward Narwar has the second-lowest poor percentage of 15 and Kolaras has the lowest 27.43 percentage of rural women who have faced the Barriers to Health Treatment.

Table 4.2.14 Awareness about Nutritious Diet taken by Rural Women

Option	Badarwas	Karera	Kolaras	Khaniadhana	Narwar	Pichhore	Pohari	Total	Percentage
Yes	20 (66.66)	14 (70)	14 (70)	18 (64.28)	11 (47.82)	19 (73.07)	12 (66.66)	112	66.27
No	10 (33.33)	6 (30)	10 (30)	10 (35.71)	12 (52.17)	7 (26.92)	6 (33.33)	57	33.73
Total	30 (17.75)	20 (11.83)	24 (14.20)	28 (16.57)	23 (13.61)	26 (15.38)	18 (10.65)	169	100

The table no.4.2.14 show that the awareness about awareness about the nutritious diet taken by rural women. It was found that the highest 112(66.27) rural women were aware of a nutritious diet, whereas 57(33.73) percentage of rural were not aware about nutritious diet.

Table 4.2.15 Reasons for Non-Awareness of Nutritious Diet by Rural Women

Option	Badarwas	Karera	Kolaras	Khaniadhana	Narwar	Pichhore	Pohari	Total	Percentage
Monthly Income	25 (83.33)	19 (95)	22 (91.66)	25 (89.28)	18 (78.26)	22 (84.61)	15 (83.33)	149	88.17
Not Aware	5 (16.66)	1 (5)	2 (8.33)	3 (10.71)	5 (21.73)	4 (15.38)	3 (16.66)	20	11.83
Total	30 (17.75)	20 (11.83)	24 (14.20)	28 (16.56)	23 (13.60)	26 (15.38)	18 (10.65)	169	100

The data presented in table 4.2.15 shows the reasons for non-awareness about nutritious diet and foods by rural women. It found that the 88.17 percentage of rural women were not taking nutritious diet due to lack of monthly income and the lowest 11.83 percentage of rural women were not aware of the nutritious diet.

Table 4.2.16 Chosen Places for Delivery of their Child by Rural Women

Option	Badarwas	Karera	Kolaras	Khaniadhana	Narwar	Pichhore	Pohari	Total	Percentage
Home	0	0	0	0	1 (4.34)	0	3 (16.66)	4	2
Government facility	27 (100)	20 (100)	22 (100)	28 (100)	22 (95.65)	24 (100)	15 (83.33)	158	98
Accredited private facilities	0	0	0	0	0	0	0	0	0
Other private facilities	0	0	0	0	0	0	0	0	0
Total	27 (16.66)	20 (12.34)	22 (13.58)	28 (17.28)	23 (14.19)	24 (14.81)	18 (11.11)	162	100

The above table 4.2.16 shows the chosen places for delivery of their child by Rural Women. It was found that the 158(98) percentage of rural women in Badarwas, Karera, Karera, Karera, Karera, Pichhore, and Pohari has chosen government facility for delivery. While 4 (2) rural women have chosen to home for delivery of their child.

Table 4.2.17 Awareness about Contraception

Option	Badarwas	Karera	Kolaras	Khaniadhana	Narwar	Pichhore	Pohari	Total	Percentage
Yes	25 (83.33)	10 (50)	15 (62.5)	18 (64.28)	11 (47.82)	20 (76.92)	12 (66.66)	110	65
No	5 (16.66)	10 (50)	9 (37.5)	10 (35.71)	12 (52.17)	6 (23.07)	6 (33.33)	59	35
Total	30 (17.75)	20 (11.83)	24 (14.20)	28 (16.57)	23 (13.61)	26 (15.38)	18 (10.65)	169	100

The table 4.3.17 shows that awareness about contraception among rural women. It was found that the percentage of awareness about contraception was 110(65) in total rural women of all CHC. Whereas 59(35) percentage of rural women were not aware of contraception.

Table 4.2.18 Use of Contraception by Rural Women

Use of Contraception	Badarwas	Karera	Kolaras	Khaniadhana	Narwar	Pichhore	Pohari	Total	Percentage
Yes	25 (83.33)	10 (50)	15 (62.5)	18 (64.28)	11 (47.82)	20 (76.92)	12 (66.66)	110	65.08
No	5 (16.66)	10 (50)	9 (37.5)	10 (35.71)	12 (52.17)	6 (23.07)	6 (33.33)	59	34.92
Total	30 (17.75)	20 (11.83)	24 (14.20)	28 (16.57)	23 (13.61)	26 (15.38)	18 (10.65)	169	100

The table 4.2.18 shows the Use of Contraception by Rural Women. It was found that the percentage of use of contraception was 110 (65.08) in CHC. Whereas 59(34.92) percentage of rural women never used contraception.

Table 4.2.19 Reasons for not using Contraception by Rural Women

Option	Badarwas	Karera	Kolaras	Khaniadhana	Narwar	Pichhore	Pohari	Total.	Percentage
Lack of information	21 (73.75)	12 (44.44)	18 (43.86)	21 (42)	21 (45.65)	20 (46.51)	15 (39.47)	128	43
Husband 'not agree	18 (37.5)	11 (40.74)	9 (20.93)	10 (20)	5 (10.86)	15 (34.88)	11 (28.94)	79	27
Side effect	9 (18.75)	4 (59.25)	16 (37.20)	19 (41.30)	20 (43.47)	8 (18.60)	12 (42.85)	88	30
Total	48(16.27)	27(9.15)	43(14.57)	50(16.94)	46(15.59)	43(14.57)	38(12.88)	295	100

Table no. 4.2.19 shows that the Reasons for not using concentration by rural women. It was found that 43% were not using it due to lack of information, while 30% rural women were not using contraception because they are not used to, this due to their side effect, and 27% rural women are not using it due to their husbands are not ready for the same.

Table 4.2.20 Health Information received by Rural Women

Option	Badarwas	Karera	Kolaras	Khaniadhana	Narwar	Pichhore	Pohari	Total	Per.
Community health center	26 (76.47)	20 (90.90)	19 (86.36)	26 (72.22)	23 (54.76)	24 (100)	18 (81.18)	156	77
Sub-center	1 (2.94)	0	1 (4.54)	1 (2.77)	4 (9.52)	0	2 (9.09)	9	4
Primary Health Center	2 (5.88)	2 (9.09)	2 (9.09)	5 (13.88)	5 (11.90)	0	2 (9.09)	18	9
Districts hospital	3 (8.82)	0	0	4 (11.11)	10 (23.80)	0	0	17	8
Television	1 (2.94)	0	0	0	0	0	0	1	0
Newspapers	1 (2.94)	0	0	0	0	0	0	1	0
Adult education officials	0	0	0	0	0	0	0	0	0
Total	34 (16.83)	22 (10.89)	22 (10.89)	36 (17.82)	42 (20.79)	24 (11.88)	22 (10.89)	202	100

The above table 4.2.20 shows that Health Information received by rural women. It was found that the 156(77) percentage of rural women has received health information from CHC, while 18(9) rural women received health information from the primary health center, and 17(8) health information received from districts hospitals, and 9(4) health information received from sub-center.

Table 4.2.21 Treatment taken during Pregnancy by Rural Women

Option	Badarwas	Karera	Kolaras	Khaniadhana	Narwar	Pichhore	Pohari	Total	Percentage
Yes	24 (80)	10 (50)	18 (75)	18 (64.28)	13 (56.52)	14 (53.84)	15 (83.33)	112	66.27
No	6 (20)	10 (50)	5 (25)	10 (35.71)	10 (43.47)	12 (46.15)	3 (16.66)	57	33.33
Total	30 (17.75)	20 (11.83)	24 (14.20)	28 (16.57)	23 (13.61)	26 (15.38)	18 (10.65)	169	100

The presented in table 4.2.21 shows that the chosen treatment taken during pregnancy. It was found that the 112(66.27) percentage of rural women in Badarwas, Karera, Kolaras, Khaniadhana, Narwar, Pichhore, and Pohari has taken treatment during their pregnancy time from the CHC. 57(33.33) rural women were not taken treatment during pregnancy in Badarwas, Karera, Kolaras, Khaniadhana, Narwar, Pichhore, and Pohari districts.

Table 4.2.22 Types of Hospitals Preferred by Rural Women

Option	Badarwas	Karera	Kolaras	Khaniadhana	Narwar	Pichhore	Pohari	Total	Percentage
Community health center	30 (100)	20 (90.90)	22 (100)	26 (92.85)	22 (95.65)	24 (88.88)	18 (75)	162	92.04
Sub-center	0	2 (9.09)	0	1 (3.57)	1 (4.34)	2 (3.70)	5 (20.83)	11	6.25
Private hospital	0	0	0	1	0	1	1	3	1.13

				(3.57)		(2.70)	(4.16)		
Ayurvedic hospital	0	0	0	0	0	0	0	0	0
Traditional local health person	0	0	0	0	0	0	0	0	0
Total	30 (17.04)	22 (12.5)	22 (12.5)	28 (15.90)	23 (13.06)	27 (15.34)	24 (13.63)	176	100

The table 4.2.22 shows the Types of Hospitals preferred by Rural Women in case of health issues. It was found that 92% of rural women preferred CHC, whereas 6% of rural women preferred sub-center, 2% preferred to the private hospital.

Table 4.2.23 Availability of Medical Staff in CHC

Option	Badarwas		Karera		Kolaras		Khaniadhana		Narwar		Pichhore		Pohari		Total		Total & Percent age
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
Doctor	27 (22.88)	3 (3.06)	19 (26.76)	1 (1.12)	22 (22.91)	1 (1.13)	27 (18.49)	1 (1.28)	23 (15.6 4)	0	23 (13.60)	3 (7.69)	18 (19.1 4)	1 (1.7 2)	159 (18.9 0)	9 (1.87)	168 (12.71)
Nurse	27 (22.88)	3 (3.06)	20 (28.16)	0	22 (22.91)	1 (1.13)	28 (19.17)	0	23 (15.6 4)	0	24 (14.20)	2 (5.12)	18 (19.1 4)	1 (1.7 2)	162 (19.2 6)	7 (1.45)	169 (12.78)
Compounder	20 (16.94)	10 (10.20)	5 (7.04)	15 (16.8 5)	10 (10.41)	13 (14.7 7)	20 (13.69)	8 (10.2 5)	23 (15.6 4)	0	20 (11.83)	6 (15.3 8)	12 (12.7 6)	7 (12. 06)	110 (13.0 7)	59 (12.2 6)	169 (12.78)
Health inspector	5 (0.28)	15 (15.30)	1 (1.40)	19 (21.3 4)	4 (1.16)	19 (21.5 9)	15 (10.27)	13 (16.6 6)	19 (12.9 2)	4 (12.5)	22 (13.01)	4 (10.2 5)	11 (11.7 0)	8 (13. 79)	77 (9.15)	82 (17.0 4)	159 (12.03)

Health assistant (Male)	0 (30.61)	30 (30.61)	0 (5.63)	20 (20.40)	6 (6.25)	17 (19.31)	4 (2.73)	24 (30.76)	2 (1.36)	21 (65.62)	22 (13.01)	4 (10.25)	12 (12.76)	7 (12.06)	46 (5.46)	123 (25.57)	169 (12.78)
Health assistant (Female)	4 (3.38)	26 (26.53)	4 (5.63)	16 (17.97)	8 (8.33)	15 (17.04)	12 (8.21)	16 (20.51)	20 (13.60)	3 (9.37)	24 (14.20)	2 (5.12)	5 (5.31)	14 (24.13)	77 (9.15)	92 (19.12)	169 (12.78)
Lab technician	27 (22.88)	3 (3.06)	20 (28.16)	0	22 (22.91)	1 (1.13)	28 (19.17)	0	23 (15.64)	0	24 (14.20)	2 (5.12)	18 (19.14)	1 (1.72)	162 (19.26)	7 (1.45)	169 (12.78)
Peon	8 (6.77)	8 (8.16)	2 (2.81)	18 (20.22)	2 (2.08)	21 (23.86)	12 (8.21)	16 (20.51)	14 (9.52)	4 (12.5)	10 (5.91)	16 (41.02)	0	19 (32.75)	48 (5.70)	102 (21.20)	150 (11.34)
Total	118 (14.03)	98 (19.91)	71 (8.44)	89 (18.08)	96 (11.41)	88 (17.88)	146 (17.36)	78 15.85)	147 (17.47)	32 (6.50)	169 (20.09)	39 (7.92)	94 (11.17)	58 (11.78)	841 (63.6)	481 (36.38)	1322

The presented table 4.2.23 shows that the availability of medical staff presents in CHC. It was found that the availability of nurse staff was 162(19.26), the same as followed by a lab technician with 162(19.26), followed by a doctor with 159(18.90), followed by compounder with 110(13.07) percentage were available in CHC. While health assistant male with 123 (25.57), followed by Peon with 102 (21.10), followed by health female with 92 (19.12), followed by health inspector with 82 (17.04) percentage of medical staff were availability in CHC.

It was also found that the availability of complete staff maximum in Pichhore CHC 169 (20.09) and least was in Pohari CHC with 94(11.17).

Table 4.2.24 Satisfaction Level with CHC Staff

Option	Badarwas			Karera			Kolaras			Khaniadhana			Narwar			Pichhore			Pohari			Total			Total & Per.
	Poor	Good	V.Good	Poor	Good	V. Good	Poor	Good	V.Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V.Good	Poor	Good	V.Good	Poor	Good	V. Good	
Doctors	7	20 (20)	3 (50)	5 (9.80)	15 (21.73)	0	6 (10.90)	16 (19.51)	0	2 (3.27)	26 (24.29)	0	2 (4.25)	21 (23.07)	0	1 (1.72)	23 (25)	4 (30.76)	4 (8.51)	12 (20.68)	2 (28.57)	27 (6.87)	13 (22.35)	9 (3.62)	169 (16.66)
Nurse and Compounder	8 (10.81)	19 (19)	3 (50)	4 (7.84)	16 (23.18)	0	3 (5.45)	20 (24.39)	0	2 (3.27)	26 (24.29)	0	2 (4.25)	21 (23.07)	0	1 (1.72)	24 (26)	2 (15.38)	4 (8.51)	12 (20.68)	2 (28.57)	24 (6.11)	13 (23.19)	7 (2.92)	169 (16.66)
Labor rooms	4 (5.40)	26 (26)	0	0	20 (28.98)	0	0	23 (28.04)	0	1 (1.63)	27 (25.23)	0	0	23 (25.27)	0	1 (1.72)	23 (25)	3 (23.07)	3 (6.88)	12 (20.68)	3 (42.85)	9 (2.9)	15 (25.88)	6 (3.08)	169 (16.66)
Radiographers & X-Ray Machines	20 (27.02)	10 (10)	0	20 (39.21)	0	0	23 (41.81)	0	0	28 (45.90)	0	0	23 (48.93)	0	0	27 (46.55)	0	0	18 (38.29)	0	0	15 (4.46)	10 (1.68)	0	169 (16.66)
Lab Technician & Pathology Labs	5 (6.75)	25 (25)	0	2 (3.92)	18 (26.08)	0	0	23 (28.04)	0	1 (1.63)	27 (25.23)	0	0	23 (25.27)	0	1 (1.72)	22 (23.91)	4 (30.76)	0	18 (31.03)	0	9 (2.9)	15 (26.22)	4 (1.38)	169 (16.66)

Generators	30 (40.54)	0	0	20 (39.21)	0	0	23 (41.81)	0	0	27 (44.26)	1 (0.93)	0	20 (42.55)	3 (3.29)	0	27 (46.55)	0	0	18 (38.29)	0	0	16 (54.98)	4 (0.67)	0	169 (16.66)
Total	74 (18.8)	10 (16.8)	6 (23)	51 (13)	69 (11.6)	0	55 (14)	82 (13.8)	0	61 (15.52)	107 (18)	0	47 (12)	91 (15.29)	0	58 (14.8)	92 (15.5)	13 (50)	47 (12)	54 (9.07)	7 (26.92)	39 (38.76)	59 (58.68)	26 (2.56)	1014 (100)

The above table 4.2.24 shows that the overall satisfaction level with medical staff was available in CHC. It is found that 107 (18) percentage found that the maximum rural women were satisfied with staff in Khaniadhana, followed by 100 (17) in Pichhore medical staff, followed by 91 (15.3) with Narwar medical, followed by 82 (13.08) with Kolaras, followed by 69 (12) with Karera medical staff, followed by Pohari 54 (9.07) percentage were satisfied with medical staff available in CHC.

The overall rural women were satisfied with the medical staff, maximum 595 (58.68) are good. Whereas 393 (38.76) percentage of rural women are not satisfied with CHC staff (poor services).

Table 4.2.25 Aspects of Visiting to CHC by Rural Women

Option	Badarwas	Karera	Kolaras	Khaniadhana	Narwar	Pichhore	Pohari	Total	Percentage
Family planning	25 (12.56)	18 (13.04)	22 (14.10)	28 (12.72)	22 (13.01)	23 (12.5)	18 (14.28)	156	13
Pre and post natal care	24 (12.06)	20 (14.49)	22 (14.10)	28 (12.72)	22 (13.01)	23 (12.5)	18 (14.28)	157	13
Immunization	27 (13.56)	20 (14.49)	22 (14.10)	28 (12.72)	23 (13.60)	24 (13.04)	18 (14.28)	162	14
Communicable diseases	0	0	0	0	0	0	0	0	0
Malarial fever	20 (10.05)	17 (12.31)	14 (8.97)	24 (10.90)	20 (11.83)	22 (11.95)	14 (11.11)	131	11
Eye infections	11 (5.52)	4 (2.89)	4 (2.56)	10 (4.54)	4 (2.36)	1 (0.54)	6 (4.76)	40	3
Cough	15 (7.53)	10 (7.24)	10 (6.41)	23 (10.45)	19 (11.24)	22 (11.95)	12 (9.52)	111	9
Body pains	24 (12.06)	20 (14.49)	22 (14.10)	24 (10.90)	22 (13.01)	24 (13.04)	12 (9.52)	148	12
Knee pains	18 (9.04)	18 (13.04)	19 (12.17)	23 (10.90)	18 (10.65)	22 (11.95)	12 (9.52)	130	11
Problems of menopause	14 (7.03)	5 (3.62)	3 (1.92)	9 (41.36)	1 (0.59)	2 (1.08)	2 (1.58)	36	3
Cancer	1 (0.50)	0	0	0	0	0	0	1	0
Blood pressure	20 (10.05)	6 (4.34)	18 (11.53)	23 (10.90)	18 (10.65)	21 (11.41)	14 (11.11)	120	10
Total	199 (16.69)	138 (11.58)	156 (13.09)	220 (18.46)	169 (14.18)	184 (15.44)	126 (10.82)	1192	100

The above table 4.2.25 shows that the overall visiting aspects of CHC by rural women. It was found that the aspects of visit to CHC maximum is 220 (18.46) in Khaniadhana, followed by 1184 (16.69) in Pichhore, followed by 169 (14.18) in Narwar, followed by 156 (13.09) in Kolaras. Whereas 138 (11.58) in Karera of aspect visit by rural women.

Table 4.2.26 Social Empowerment Status of Rural Women

Status of Social Empowerment	Badarwas			Karera			Kolaras			Khaniadhana			Narwar			Pichhore			Pohari			Total			Total & Percentage (P+G+VG)
	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	
Using Toilets	20	7	0	4	1	3	15	7	0	6	18	0	1	21	1	6	18	0	1	5	0	65	88	4	157
		(9.85)		(3.53)	(2.53)	(6.81)	(9.31)	(12.06)		(3.38)	(22.5)		(0.68)	(27.63)	(14.28)	(4.91)	(16.21)		(9.48)	(15.85)		(6.20)	(18.48)	(6.15)	(9.88)
To increase hygiene in their area	19	8	0	1	1	7	15	6	0	8	18	0	0	22	1	4	20	0	1	5	1	59	91	19	169
		(11.6)		(0.88)	(2.53)	(15.9)	(9.34)	(10.34)		(4.51)	(22.5)			(28.94)	(14.28)	(4.32)	(18.01)		(8.75)	(15.5)	(9.9)	(5.63)	(19.11)	(29.23)	(10.64)
Steps to take safe drinking water	15	1	0	2	1	11	17	5	0	1	10	0	0	21	2	4	22	1	1	3	5	64	85	11	160
		(16.6)		(1.76)	(2.5)	(25)	(10.55)	(8.62)		(6.9)	(11.5)			(27.63)	(28.57)	(4.33)	(19.81)	(3.33)	(7.29)	(9.45)	(4.5)	(6.11)	(17.85)	(16.92)	(10.07)

		9 0)		5 3)	)			0 3 )			)	2 7 )		)	9))								
Family planning methods	18	9 (1 2. 6 7)	0	7 (6. 19)	5 (1 0. 6 3)	8 (18. 81)	5 (3 .1 0)	17 (2 9. 31)	0	1 4 (7. 9)	11 (1 3. 75)	0	11 (7. 58)	10 (1 3. 15)	2 (28. 57)	9 (13. 51)	15 (3 3. 33)	1 (3 0 7 9)	1 (2 4. 2 4)	8 (2 4. 2 4)	0	74 (0. 06)	75 (15 .75)	11 (16. 92)	160 (10.07)
Supporting equal status for women	23	4 (5 .6 3)	0	11 (9. 73)	3 (6 .3 8)	6 (13. 63)	20 (1 2. 42)	2 (3. 44)	0	2 0 (1 1. 2 9)	6 (7. 5)	0	20 (1 3. 79)	0	1 (14. 28)	1 5 (6.3 0)	1 (3 3. 33)	1 1 (1 8. 18)	6 (1 8. 1 8)	2 (1 8.)	12 0 (1 1.4 6)	28 (5. 88)	10 (15. 38)	158 (9.94)	
Securing the rights for Women	25	2 (2 .8 1)	0	14 (1 2. 38)	1 (2 .1 2)	5 (11. 36)	20 (1 2. 42)	2 (3. 44)	0	2 0 (1 1. 2 9)	6 (7. 5)	0	23 (1 5. 86)	0	0	1 6 (5.4 0)	0	1 4 (6 .0 6)	2 (1 8. 18)	2 (1 8.)	13 2 (1 2.6 0)	19 (3. 99)	7 (10. 76)	158	

Voicing against social injustice	22 (1 1.4 5)	5 (7 .0 4)	0	16 (1 4. 15)	1 (2 .1 2)	3 (6.8 1)	21 (1 3. 04)	1 (1. 72)	0	2 3 (1 2. 9 9)	3 (3. 75)	0	21 (1 4. 48)	2 (2. 63)	0	1 6 (1 3 .1 1)	7 (6.3 0)	0	1 5 (6 .0 6)	2 (9 .0 9)	13 4 (1 2.7 9)	21 (4. 41)	4 (6.1 5)	159 (10.01)	
Supporting widow premarital	20 (1 0.4 1)	7 (9 .8 5)	0	18 (1 5. 92)	1 (2 .1 2)	1 (2.2 7)	19 (1 1. 80)	3 (5. 17)	0	2 4 (1 3. 5 5)	2 (2. 5)	0	23 (1 5. 86)	0	0	2 1 (1 7 .2 2 1)	4 (3.6 0)	0	1 6 (1 .0 6 7)	2 (6 .0 6)	0	14 1 (1 3.4 6)	19 (3. 99)	1 (1.5 3)	161 (10.13)
Decision with regard to family Affairs	15 (7. 81)	1 2 (1 6. 9 0)	0	20 (1 7. 69)	0	0	8 (4 .9 6)	14 (2 4. 13)	0	2 3 (1 2. 9 9)	3 (3. 75)	0	23 (1 5. 86)	0	0	1 5 (1 2 .2 2 9)	4 (3.6 0)	0	1 8 (1 3. 1 3)	0	0	12 2 (1 1.6 5)	33 (6. 93)	0	155 (9.76)
Decision with regard to health at home	15 (7. 81)	5 (7 .0 4)	0	20 (1 7. 69)	0	0	21 (1 3. 04)	1 (1. 72)	0	2 3 (1 2. 9	3 (3. 75)	0	23 (1 5. 86)	0	0	1 6 (1 3 .3)	8 (7.2 0)	0	1 8 (1 3. 1 3)	0	0	13 6 (1 2.9 8)	17 (3. 57)	0	153 (9.63)

Table 4.3 Sample of Indore (South Zone)

Questionnaire Distributed in CHC	Questionnaire Distributed	Questionnaire Received	Questionnaire's Analyzed
Depalpur	30	30	30
Manpur	30	28	28
Mhow	30	30	30
Sanwad	30	27	27
Total	120	115	115

The above table no.4.3 shows that a total of 130 questionnaires were distributed among rural women and out of these 115 received back. It was observed that the highest response received from Depalpur and Mhow and the minimum is from Manpur and Sanwad CHC.

Table 4.3.1 Types of Category/ Population

Category	Depalpur	Manpur	Mhow	Sanwad	Total	Percentage
General	0	0	3 (10)	1 (3.70)	4	3.47
OBC	16 (53.33)	9 (21.42)	8 (26.66)	2 (7.40)	35	30.43
SC	12 (6.66)	11 (39.28)	13 (43.33)	16 (59.25)	52	45.21
ST	2 (6.66)	8 (28.57)	6 (20)	8 (29.62)	24	20.87
Total	30 (26.08)	28 (24.34)	30 (26.08)	27 (23.47)	115	100

OBC= Other Backward Class, SC=Scheduled Caste, ST=Scheduled Tribal

Above table 4.3.1 shows that the type of category among rural women which shows that the 3.47 rural women belong to the general category, where 30.43 are OBC, 45.21 are SC, and 20.87 are ST.

Table 4.3.2 Family's Monthly Income

Option	Depalpur	Manpur	Mhow	Sanwad	Total	Percentage
Up to 2000	0	0	0	3	3	2.60
2000-4000	18 (60)	11 (39.28)	16 (53.33)	20	65	56.52
5000-10000	12 (40)	17 (60.71)	13 (43.33)	4	46	40
10000 – more	0	0	1	0	1	0.86
Total	30 (26.08)	28 (24.34)	30 (26.08)	27 (23.47)	115	100

The table 4.3.2 shows that the family's income of rural women husband in which 3 (2.60) rural women family income is upto 2000 monthly, 65 (56.52) rural women are between 2000-4000 monthly family income, while 46 (40) rural women's family income is upto 5000-10000 monthly and 1 (0.86) rural women's family income is 10000 and more than 10000 monthly.

Table 4.3.3 Education Levels of Women

Status	Depalpur	Manpur	Mhow	Sanwad	Total	Percentage
Illiterate	8 (26.66)	15 (53.57)	14 (46.66)	15 (70.37)	52	45.217
Primary	20 (66.66)	10 (35.71)	10 (33.33)	10 (37.03)	50	43.478
Secondary	2 (6.66)	3 (10.71)	6 (20)	2 (7.40)	13	11.304
Higher Secondary	0	0	0	0	0	0
Graduate	0	0	0	0	0	0
Total	30 (26.08)	28 (24.34)	30 (26.08)	27 (23.47)	115	100

Table 4.3.3 shows the education level of rural women in which 52 (45.21) rural women are illiterate, 50 (43.47) rural women have primary education, 13 (11.30) rural women have secondary education level.

Table 4.3.4 Marital Status of Women

Option	Depalpur	Manpur	Mhow	Sanwad	Total	Percentage
Married	30 (100)	28 (100)	30 (100)	27 (100)	115	100
Unmarried	0	0	0	0	0	0
Total	30 (26.08)	28 (24.34)	30 (26.08)	27 (23.47)	115	100

Table 4.3.4 shows the marital status of women. It was found that 100 percent of women are married in CHC.

Table 4.3.5 Occupation of the Rural Women's Husband

Occupation	Depalpur	Manpur	Mhow	Sanwad	Total	Percentage
Agriculture	28 (53.84)	7 (31.81)	17 (56.66)	22 (46.80)	74	48.36
Govt. Employee	0	0	1 (3.33)	0	1	0.65
No Employment	2 (3.84)	1 (4.54)	4 (13.33)	6 (12.76)	13	8.49
Farm Worker	0	0	0	0	0	0
Private	24 (46.15)	14 (63.63)	8 (26.66)	18 (38.29)	64	41.83
Driver	0	0	0	0	0	0
Business	0	0	0	1 (2.12)	1	0.65
Others	0	0	0	0	0	0
Total	54 (35.29)	22 (14.37)	30 (19.60)	47 (30.71)	153	100

This table 4.3.5 shows the occupations of rural woman's husband in which 74 (48.36) rural women husband farmer, 1(0.65) rural women's husband are government employee, 13(8.49) rural women husband are unemployed, 64 (41.83) rural women husband are doing the private job, and 1 (0.65) women husband is doing business.

Table 4.3.6 Housing and Living Status of Women

Option	Categories	Depalpur	Manpur	Mhow	Sanwad	Total	Percentage
Type of House	Hut	28 (13.15)	20 (16.67)	28 (13.46)	25 (13.23)	101	13.7
	Tiled	3 (1.41)	0	1 (0.48)	1 (0.53)	5	0.68
	Concrete	2 (0.94)	0	1 (0.48)	1 (0.53)	6	0.82
Ownership of House	Rented	0	0	1 (0.48)	0	1	0.14
	Own	30 (14.08)	20 (16.67)	29 (13.94)	28 (14.29)	106	14.5
	Others	0	0	0	0	0	0
Number of Rooms	One	13 (6.10)	15 (12.50)	12 (5.77)	11 (5.82)	51	6.99
	Two	17 (7.98)	5 (4.17)	13 (6.25)	16 (8.47)	51	6.99
	Three	0	0	5 (2.40)	1 (0.53)	6	0.82
	Four	0	0	0	0	0	0
	More than	0	0	0	0	0	0
Toilet	Not Available	8 (3.76)	8 (6.67)	11 (5.29)	8 (4.23)	35	4.79
	Available	22 (10.33)	12 (10)	19 (9.13)	20 (10.58)	73	10
Drinking water	Tap	3 (1.41)	4 (3.33)	5 (2.40)	4 (2.12)	16	2.19
	Hand Pump	27 (12.68)	16 (13.33)	25 (12.02)	24 (12.70)	92	12.6
Electricity	Not Available	0	2 (1.67)	0	0	2	0.27
	Available	30 (14.08)	18 (15)	30 (14.42)	28 (14.81)	107	14.5
Leisure time	Television	25 (11.74)	0	9 (4.33)	4 (2.12)	38	5.21
	Radio	1 (0.47)	0	2 (0.96)	0	3	0.41
	News paper	0	0	5 (2.40)	0	5	0.68
	No activity	4 (1.88)	0	12 (5.77)	19 (10.05)	35	4.66
Total		213 (29.17)	120 (16.43)	208 (28.49)	189 (25.89)	730	100

Table 4.3.6 shows the housing status of rural women, which is 13.7 percentages of rural women were living in Huts house, whereas 13.60 are percentages of rural women have their own home. 14.5% of rural women are living in a single room, whereas 6.99 rural women live in a double room, followed by 0.82 rural women living in a three-room set room. Overall 10% of women have Toilet facility and 4.79 are not having. The drinking water facility for rural women shows that there is 2.19% having tap and 12.6 is a Hand pump for taken water facility. Around 14.5% said they have electricity and 0.27 are not having electricity. Television, News Papers, and leisure activities are not done by them.

Table 4.3.7 Awareness about Health Literacy

Awareness Health Literacy	Depalpur	Manpur	Mhow	Sanwad	Total	Percentage
Yes	13 (43.33)	19 (67.85)	17 (56.66)	9 (33.33)	60	52.17
No	17 (56.66)	9 (32.14)	13 (43.33)	18 (66.66)	55	47.82
Total	30 (26.08)	28 (24.34)	30 (26.08)	27 (23.47)	115	100

Table 4.3.7 shows the awareness of health literacy among rural women was very low, It was found that 60 (i.e. 52.17) women were aware of health literacy whereas 55 (i.e. 47.82) women were unaware of health literacy.

Table 4.3.8 Reasons for Non- Awareness about Health Literacy

Option	Depalpur	Manpur	Mhow	Sanwad	Total	Percentage
Lack of education	15 (50)	8 (28.57)	17 (56.66)	9 (33.33)	52	45.22
Lack of Health Information	15 (50)	19 (67.85)	13 (43.33)	18 (66.66)	63	54.78
Not interested	0	0	0	0	0	0
On opinion	0	0	0	0	0	0
Total	30 (26.08)	28 (24.34)	30 (26.08)	27 (23.47)	115	100

Table 4.3.8 shows that the majority of rural women i.e. 54.78 were not aware of health literacy, because of a lack of health information, whereas 45.22 of rural women were unaware of health literacy because of lack of health information.

Table 4.3.9 Provision of Health Information, Resources, and Services by CHC

Option	Depalpur	Manpur	Mhow	Sanwad	Total	Percentage
Yes	18 (60)	20 (71.42)	22 (73.33)	18 (66.66)	78	67.83
No	12 (40)	8 (28.57)	8 (26.66)	9 (33.33)	37	32.17
Total	30 (26.08)	28 (24.34)	30 (26.08)	27 (23.47)	115	100

The above table 4.3.9 shows the provision of health information, resources, and service by CHC for rural women. It was found that the highest percentage of 67.83 of rural women access health information, resources, and service from the CHC, and 32.17 were not received.

Table 4.3.10 Awareness, Source and Uses of immunization

Source	Category	Depalpur	Manpur	Mhow	Sanwad	Total	Percentage
Awareness about Immunization	No Awareness	12 (8.76)	8 (6.15)	14 (10.61)	19 (15.08)	53	10.09
	Yes	18 (13.14)	22 (16.92)	16 (12.12)	9 (7.14)	65	12.38
Source of Information on Immunization	Doctors	20 (14.60)	10 (7.69)	14 (10.61)	8 (6.35)	47	8.95
	Health visitors	10 (7.30)	4 (3.08)	8 (6.06)	8 (6.35)	25	4.76
	AASHA	20 (14.60)	28 (21.54)	28 (21.21)	27 (21.43)	113	21.52
	Nurse	27 (19.71)	28 (21.54)	30 (22.73)	27 (21.43)	112	21.33
Awareness about Diseases prevented by	Fully aware	0	0	0	0	0	0
	Partially aware	28 (20.44)	26 (20)	20 (1.52))	21 (21.67)	95	18.09

Immunization	Not aware	2 (1.46)	4 (3.08)	2	7 (5.56)	15	2.85
Total		137 (26.09)	130 (24.76)	132 (25.14)	126 (24)	525	100

Table 4.3.10 shows Awareness about Immunization, sources of immunization information, and awareness about diseases prevented by immunization among rural women. It was found that the highest percentage of Depalpur about awareness about Immunization, sources of immunization information, and awareness about diseases prevented is 26.09% follow by the second-highest percentage for the same belongs to Mhow which is 25.14%. On moving forward it was found that Manpur and Sanwad have the second-lowest 24.76 and lowest 24 percentage of awareness respectively about immunization, sources of immunization information, and awareness about diseases prevented by immunization among rural women.

Table 4.3.11 Availability and Accessibility of Health Care Services by CHC

Variable	Categories	Depalpur	Manpur	Mhow	Sanwad	Total	Percentage
Distance to Community Health Center (in km.)	1.00-5.00	0	0	0	0	0	0
	6.00-10.0	21 (18.42)	22 (20.75)	2 (2.70)	24 (22.22)	69	17.16
	11.0-15.0	9 (7.89)	8 (7.55)	18 (24.32)	4 (3.70)	39	9.7015
	16.0-20.0	0	0	3 (4.05)	0	3	0.7463
	21.0-25.0	0	0	0	0	0	0
Reasons for visiting Community Health Centers	For free Medicine	30 (26.32)	28 (26.42)	20 (27.03)	27 (25)	105	26.11
	Emergency	14 (12.28)	16 (15.09)	0	13 (12.04)	43	10.69
	Minor Illness	8 (7.02)	4 (3.77)	0	12 (11.11)	24	5.9701
	Not visiting	0	0	0	0	0	0
Visiting Private Clinic	Minor Illness	0	0	0	0	0	0
	Occasionally	2 (1.75)	0	1 (1.35)	1 (0.93)	4	0.99

Distance to Medical Shop (in km.)	00.-.50	30 (26.32)	28 (26.42)	30 (40.54)	27 (25)	115	28.60
	1.00-2.00	0	0	0	0	0	0
	3.00.-more than	0	0	0	0	0	0
Total		114 (28.36)	106 (26.37)	74 (18.41)	108 (26.87)	402 (100)	100

The table 4.3.11 show the availability and accessibility to Health Care Services CHC for rural women. It was found that the overall availability and accessibility are highest in Depalpur rural women are with 28.35%, which was followed in Sanwad where it was 26.86%, followed by Manpur where it was 26.36% and followed by Mhow it was 18.40%.

Table 4.3.12 Access to the Satisfactory Road Network in Rural Areas

Option	Depalpur	Manpur	Mhow	Sanwad	Total	Percentage
Yes	19 (63.33)	15 (53.57)	17 (56.66)	16 (59.25)	67	58.26
No	11 (36.66)	13 (46.42)	13 (43.33)	11	48	41.74
Total	30 (26.08)	28 (24.34)	30 (26.08)	27 (23.47)	115	100

The data presented in table 4.3.12% shows that the satisfactory road network in Depalpur, Manpur, Mhow, Sanwad CHC. It shows satisfaction about road network highest 58.26% and the lowest is 41.74% among rural women.

Table 4.3.13 Barriers to Health Treatment

Option	Depalpur			Manpur			Mhow			Sanwad			Total (P+E+D)			Total	Percentage
	Poor	good	V. good	Poor	good	V. good	Poor	good	V. good	Poor	good	V. good					
Social status	13 (9.21)	14 (38.88)	3 (9.09)	20 (16.26)	2	6 (15.38)	16 (11.51)	2 (8)	12 (26.08)	21 (18.58)	2 (9.09)	4 (7.27)	70 (13.56)	20 (17.09)	25 (14.79)	115	14.33
Self-perceived health	19 (13.47)	6 (16.66)	5 (15.15)	15 (12.19)	7	6 (15.38)	19 (13.66)	3 (12)	8 (17.39)	24 (21.23)	0	3 (5.45)	77 (14.92)	16 (13.67)	22 (13.01)	115	14.33
Able to pay for Medication	25 (17.73)	2 (5.55)	3 (9.09)	22 (17.88)	4 (12.12)	2 (5.12)	20 (14.38)	4 (16)	6 (13.04)	14 (12.38)	2 (9.09)	11 (20)	81 (15.69)	12 (10.25)	22 (13.01)	115	14.33
Not Able to afford doctor	23 (16.31)	3 (8.33)	4 (12.12)	12 (9.75)	7 (21.21)	9 (23.07)	22 (15.82)	4 (16)	4 (8.69)	16 (14.15)	2 (9.09)	10 (18.18)	73 (14.14)	16 (13.67)	27 (15.67)	116	14.46
Limited activities because of health	28 (19.)	0	2 (5.55)	12 (9.7)	9 (27.)	7 (21.21)	16 (11.)	5 (20)	9 (19.56)	13 (11.)	11 (50)	3 (5.45)	69 (13.3)	29 (24.7)	17 (10.05)	115	14.33

problems	85)		)	5)	27)		51)			50)			7)	8)			
Unable to reach out to CHC	17 (12.05)	6 (16.66)	7 (21.21)	21 (17.07)	2 (7.14)	5 (12.82)	23 (16.54)	18 (3.33)	4 (8.69)	12 (10.61)	2 (7.4)	13 (48.15)	73 (14.14)	11 (9.40)	29 (17.15)	113	14.09
Total	141 (27.32)	36 (30.76)	33 (19.52)	123 (23.83)	34 (29.05)	39 (23.07)	139 (26.93)	25 (21.36)	46 (24.85)	113 (21.89)	22 (18.80)	55 (32.54)	516 (64.33)	117 (14.58)	169 (21.07)	802	100

Table 4.3.13 shows that the barriers to health treatment faced by rural women. The poor social status, self-perceived health not, able to pay for Medication, not able to afford doctor, limited activities because of health problems, monthly household income were found to be main barriers 27.32, percentage in Depalpur, followed by 26.36 in Mhow. Moving forward Sanwad has the second-lowest poor percentage of 26.93 and Manpur has the lowest poor percentage of 23.05.

Table 4.3.14 Awareness about Nutritious Diet by Rural Women

Option	Depalpur	Manpur	Manpur	Sanwad	Total	Percentage
Yes	16 (53.33)	13 (46.42)	17 (60)	15 (55.55)	61	53.04
No	14 (46.66)	15 (53.57)	13 (40)	12 (44.44)	54	46.96
Total	30 (26.08)	28 (24.34)	30 (26.08)	27 (23.47)	115	100

Table no.4.3.14 shows that the Awareness about the nutritious diet taken by rural women. It was found that the highest 53.04% rural women were aware of a nutritious diet, whereas 46.96 percent of rural women were not aware of nutritious diet.

Table 4.3.15 Reasons for Non-awareness of Nutritious Diet by Rural Women

Option	Depalpur	Manpur	Manpur	Sanwad	Total	Percentage
Monthly Income	25 (83.33)	22 (78.57)	24 (80)	20 (74.07)	91	79.13
Not Aware	5 (16.66)	6 (21.42)	6 (20)	7 (25.92)	24	20.87
Total	30 (26.08)	28 (24.34)	30 (26.08)	27 (23.47)	115	100

Table 4.3.15 shows that the reasons for non- awareness about nutritious diet and foods by rural women. It found that the 79.13 percent of rural women were not taking nutritious diet due to lack of monthly income and the lowest 20.87 percent of rural women were not aware of the nutritious diet.

Table 4.3.16 Chosen Places for Delivery of their Child by Rural Women

Option	Depalpur	Manpur	Mhow	Sanwad	Total	Percentage
Home	0	0	0	1 (3.70)	1	0.87
Government facility	30 (100)	28 (100)	30 (100)	26 (96.29)	114	99.13
Accredited private facilities	0	0	0	0	0	0
Other private facilities	0	0	0	0	0	0
Total	30 (26.08)	28 (24.34)	30 (26.08)	27 (23.47)	115	100

The above table 4.3.16 shows that the chosen places for Delivery of their Child by Rural Women. It was found that 100 percent of rural women in Depalpur, Manpur, and Mhow have chosen a government facility for delivery. While in Sanwad 3.70 rural women have chosen to home for delivery of their child.

Table 4.3.17 Awareness about Contraception

Option	Depalpur	Manpur	Mhow	Sanwad	Total	Percentage
Yes	22 (73.33)	21 (75)	24 (80)	23 (85.18)	90	78.26
No	8 (26.66)	7 (25)	6 (20)	4 (14.81)	25	21.73
Total	30 (26.08)	28 (24.34)	30 (26.08)	27 (23.47)	115	100

The table 4.3.17 shows that awareness about contraception among rural women. It was found that the percentage of awareness about contraception was 78.26 in total rural women of all CHC, whereas 21.73 percent of rural women were not aware of contraception.

Table 4.3.18 Use of Contraception by Rural Women

Use of Contraception	Depalpur	Manpur	Mhow	Sanwad	Total	Percentage
Yes	8 (26.66)	15 (53.57)	6 (40)	6 (22.22)	90	78.26
No	22 (73.33)	13 (46.42)	24 (80)	21 (77.77)	25	21.73
Total	30 (26.08)	28 (24.34)	30 (26.08)	27 (23.47)	115	100

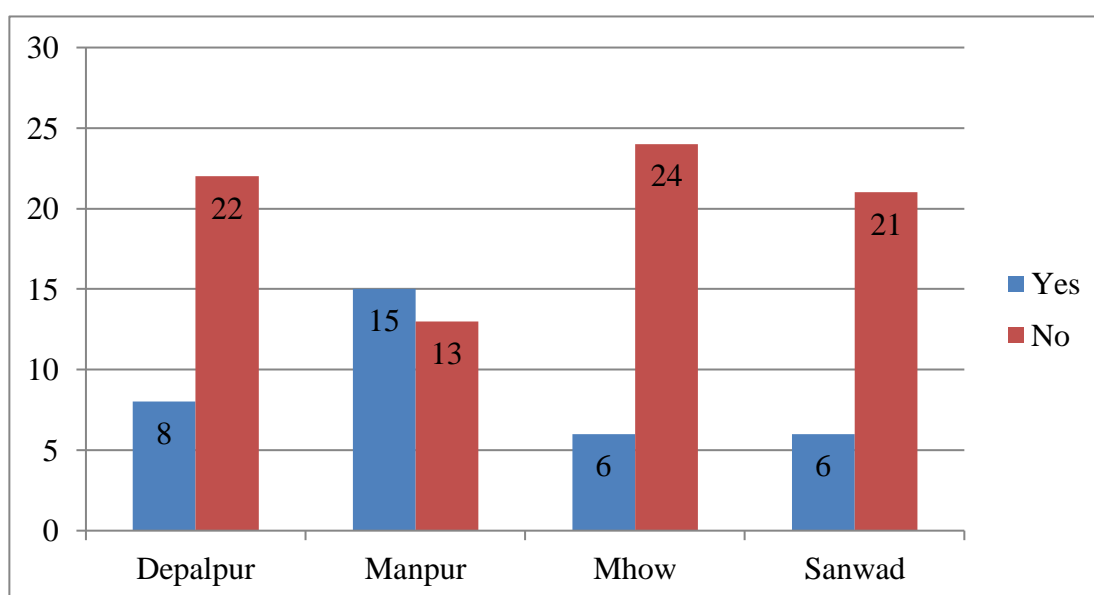


Fig. 4.3.18 Use of Contraception by Rural Women

The table 4.3.18 shows the Use of contraception by rural women. It was found that the percentage of use of contraception was 78.26 in CHC, whereas, 21.73 percentage of rural women never used contraception.

Table 4.3.19 Reasons for not using Contraception by Rural Women

Option	Depalpur	Manpur	Mhow	Sanwad	Total	Percentage
Lack of information	22 (36.66)	13 (46.42)	24 (47.05)	19 (45.23)	78	43.094
Not agree Husband	18 (30)	5 (17.85)	5 (9.80)	10 (23.80)	30	16.575
Side effect	20 (33.33)	10 (35.71)	22 (43.13)	13 (30.95)	73	40.331
Total	60 (33.14)	28 (15.46)	51 (28.17)	42 (23.20)	181	100

Table 4.3.19 shows that the reasons for not using concentration by rural women. It was found the highest percentage of Depalpur in which their rural women did not use contraception due to lack of information, husband not agree, 33.14 are due to side effect, followed by 28.17% the second-was Mhow where, followed by the second-lowest 23.20 and lowest 15.46 percentages of reasons for not using contraception by rural women in CHC.

Table 4.3.20 Health Information received by Rural Women

Option	Depalpur	Manpur	Mhow	Sanwad	Total	Percentage
Community health center	30 (100)	28 (100)	30 (100)	27 (100)	115	100
Sub-center	0	0	0	0	0	0
Primary Health Center	0	0	0	0	0	0
Districts hospital	0	0	0	0	0	0
Television	0	0	0	0	0	0
Newspapers	0	0	0	0	0	0
Adult education officials	0	0	0	0	0	0
Total	30 (26.08)	28 (24.34)	30 (26.08)	27 (23.47)	115	100

The above table 4.3.20 shows that Health Information received by rural women. It was found that 100 percent of rural women in Depalpur, Manpur, and Mhow and Sanwad have received health information from CHC.

Table 4.3.21 Treatment taken during Pregnancy by Rural Women

Option	Depalpur	Manpur	Mhow	Sanwad	Total	Percentage
Yes	30 (100)	28 (100)	30 (100)	27 (100)	115	100
No	0	0	0	0	0	100
Total	30 (26.08)	28 (24.34)	30 (26.08)	27 (23.47)	115	100

The above table 4.3.21 shows that the chosen treatment taken during pregnancy. It was found that 100 percent in Depalpur, Manpur, and Mhow has taken treatment during their pregnancy time from the CHC.

Table 4.3.22 Types of Hospitals Preferred by Rural Women

Option	Depalpur	Manpur	Mhow	Sanwad	Total	Percentage
Community health center	30 (100)	28 (93.33)	30 (100)	27 (90)	115	100
Sub-center	0	0	0	0	0	0
Private hospital	0	0	0	0	0	0
Ayurvedic hospital	0	0	0	0	0	0
Traditional local health person	0	0	0	0	0	0
Total	30 (26.08)	28 (24.34)	30 (26.08)	27 (23.47)	115	100

The above table 4.3.22 shows the types of hospitals preferred by rural women in case of health issues. It was found that the 100% rural woman in Depalpur, Manpur, and Mhow and Sanwad has preferred CHC in case of health issues.

Table 4.3.23 Availability of Medical Staff in CHC

Option	Depalpur		Manpur		Mhow		Sanwad		Total		Total Percentage (Y+N)
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
Doctor	30 (19.86)	0	24 (24.24)	4 (10)	30 (16.66)	0	23 (17.03)	4 (4.87)	107 (18.93)	8 (2.95)	115 (13.75)
Nurse	30 (19.86)	0	27 (27.27)	1 (2.5)	30 (16.66)	0	27 (20)	0	114 (20.17)	2 (0.73)	116 (13.87)
Compounder	16 (10.59)	14 (15.73)	11 (11.11)	16 (40)	18 (10)	12 (20)	20 (14.81)	7 (8.53)	54 (9.55)	19 (7.01)	73 (8.73)
Health inspector	30 (19.86)	0	0	28	25 (13.88)	5 (8.33)	10 (7.40)	17 (20.73)	65 (11.50)	36 (13.28)	101 (12.08)
Health assistant (Male)	3 (1.98)	27 (30.33)	12 (12.12)	16 (40)	0	0	4 (2.96)	23 (20.04)	7 (1.23)	80 (29.52)	87 (10.40)
Health assistant (Female)	8 (5.29)	22 (24.71)	15 (15.15)	13 (32.5)	26 (14.44)	4 (6.66)	12 (8.88)	15 (18.29)	61 (10.79)	53 (19.55)	114 (13.63)
Lab technician	30 (19.86)	0	28 (28.11)	0	25 (13.88)	5 (8.33)	27 (20)	0	110 (19.46)	5 (1.84)	115 (13.75)
Peon	4 (2.64)	26 (29.21)	5 (5.05)	23 (57.5)	26 (14.44)	4 (6.66)	12 (8.88)	15 (18.29)	47 (8.31)	68 (25.09)	115 (13.75)
Total	151 (26.72)	89 (32.84)	99 (17.52)	40 (14.76)	180 (31.85)	60 (22.14)	135 (23.89)	82 (30.25)	565 (67.58)	271 (32.41)	836 (100)

Above table 4.3.23 shows that the availability of medical staff was in CHC. It was found that the availability of nurse staff was maximum i.e 13.63, followed by a lab technician with 13.23, followed by a doctor with 12.79, followed by health inspector with 7.77, followed by health

assistant female staff with 7.29 and least were compounder with 6.45 availability were in CHC. It was also found that the availability of complete staff maximum in Mhow CHC 21.66 and least was in Manpur CHC with 11.91.

Table 4.3.24 Satisfaction Level with CHC Staff

Option	Depalpur			Manpur			Mhow			Sanwad			Total			Total & Per. (P+G+V)
	Poor	Good	V.G	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	VG	
Doctors	1 (1.42)	29 (26.36)	0	6 (15)	22 (22)	0	0	30 (23.07)	0	7 (9.45)	20 (22.72)	0	14 (5.98)	101 (23.59)	00	115 (17.37)
Nurse and Compounder	10 (14.28)	20	0	5 (12.5)	23 (23)	0	4 (8)	26 (20)	0	6 (8.10)	21 (23.86)	0	25 (10.68)	90 (21.02)	0	115 (15.37)
Labor rooms	0	30 (27.27)	0	0	28 (28)	0	0	30 (23.07)	0	5 (6.75)	22 (25)	0	5 (2.13)	110 (25.70)	0	115 (17.37)
Radiographers & X-Ray Machines	30 (42.85)	0	0	28 (70)	0	0	20 (40)	10 (7.69)	0	27 (36.48)	0	0	105 (44.87)	10 (2.33)	0	115 (17.37)
Lab Technician & Pathology Labs	2 (2.85)	28 (25.45)	0	1 (2.5)	27 (27)	0	6 (12)	24 (3.07)	0	2 (2.70)	25 (28.40)	0	11 (4.70)	104 (24.29)	0	115 (17.37)
Generators	27 (38.57)	3 (2.72)	0	0	0	0	20 (40)	10 (7.69)	0	27 (36.48)	0	0	74 (31.62)	13 (3.03)	0	87 (13.14)
Total	70 (29.91)	110 (25.70)	0	40 (17.09)	100 (23.36)	0	50 (21.37)	130 (30.37)	0	74 (31.62)	88 (20.56)	0	234 (35.34)	428 (64.65)	0	662 (100)

The above table 4.3.24 shows overall satisfaction level with medical staff available in CHC. 130 (30.37) percentage found that the maximum rural women were satisfied in Mhow, followed by 110 (25.70) percentage of rural women in Depalpur, followed by 100 (23.26) in Manpur are good. Whereas 88 (20.56) percentage of rural women satisfied with CHC staff in Sanwad.

Table 4.3.25 Aspects of visiting to CHC by Rural Women

Option	Depalpur	Manpur	Mhow	Sanwad	Total	Percentage
Family planning	29 (13.00)	25 (11.46)	29 (13.30)	22 (12.42)	110	13.15
Natal care (Pre and Post natal)	30 (13.45)	28 (12.84)	30 (13.76)	27 (15.25)	118	14.11
Immunization	30 (13.45)	28 (12.84)	30 (13.76)	27 (15.25)	118	14.11
Communicable diseases	0	0	0	0	0	0
a) Malarial fever	20 (8.96)	20 (9.17)	20 (9.17)	20 (11.29)	86	10.28
b) Eye infections	12 (5.38)	8 (3.66)	7 (3.21)	0	24	2.87
c) Cough	20 (8.96)	20 (9.17)	20 (9.17)	16 (9.03)	74	8.85
d) Body pains	28 (12.55)	22 (10.09)	28 (12.84)	22 (12.42)	107	12.79
e) Knee pains	18 (8.07)	17 (7.79)	24 (11.00)	20 (11.29)	71	8.49
f) Problems of menopause	10 (4.48)	15 (6.88)	6 (2.75)	0	28	3.34
g) Cancer	0	0	0	0	0	0
h) Blood pressure	28 (12.55)	27 (12.38)	25 (11.46)	20 (11.29)	100	11.96
Total	223	218	218	177	836	100

	(26.67)	(26.07)	(26.07)	(21.09)		
--	---------	---------	---------	---------	--	--

The above table 4.3.25 shows that the overall aspect of visiting CHC by rural women. It was found that the aspect of Natal care (Pre and Postnatal were maximum i.e 14.11, same as followed by Immunization with 14.11, followed by 13.15 family planning, followed by 13.79 body pain, followed by 11.96 blood pressure, followed by 10.28 malaria fever, followed by 8.85 cough, followed by 8.49 knee pain, followed by 3.34 menopause, followed by 2.87 eye infections were aspect for visiting CHC by rural women. It was also found that the availability of aspect of visit to CHC is maximum 26.67 in Depalpur CHC, followed by Manpur 26.07, same as 26.07 in Mhow CHC and least was 21.09 in Sanwad CHC.

Table 4.3.26 Social Empowerment Status of Rural Women

Option	Depalpur			Manpur			Mhow			Sanwad			Total			Total	Percentage
	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good			(P+G+VG)
Using Toilets	24 (11.26)	6 (8.10)	0	20 (10.20)	8 (8.08)	0	12 (6.18)	14 (20)	4 (12.90)	4 (2.22)	23 (26.43)	0	61 (7.79)	52 (15.75)	4 (122.90)	117	10.22
To increase hygiene in their area	18 (8.45)	12 (16.21)	0	14 (7.14)	12 (12.12)	0	10 (5.15)	18 (25.71)	2 (6.45)	6 (3.33)	22 (25.28)	0	46 (5.87)	66 (20)	2 (6.45)	114	9.96
Steps to take safe drinking water	20 (9.38)	10 (13.51)	0	20 (10.20)	8 (8.08)	0	15 (7.73)	10 (14.28)	5 (16.12)	8 (4.44)	19 (21.83)	0	63 (8.04)	40 (12.12)	5 (16.12)	108	9.44

Family planning methods	19 (8.92)	11 (14.86)	0	10 (5.10)	11 (11.11)	0	20 (10.37)	5 (7.14)	5 (16.12)	14 (14.44)	13 (14.94)	0	63 (8.04)	49 (14.84)	5 (16.12)	117	10.22
Supporting equal status for women	25 (11.73)	5 (6.75)	0	25 (12.75)	2 (2.02)	0	20 (10.30)	5 (7.14)	5 (16.12)	26 (14.44)	1 (1.14)	0	93 (11.87)	20 (6.06)	5 (16.12)	118	10.31
Securing the rights for Women	24 (11.26)	6 (8.10)	0	26 (13.26)	1 (1.01)	0	24 (12.37)	3 (4.28)	3 (9.67)	27 (15)	0	0	102 (13.02)	13 (3.93)	3 (9.67)	118	10.31
Voicing against social injustice	28 (13.14)	2 (2.70)	0	25 (12.75)	2 (2.02)	0	25 (12.88)	3 (4.28)	2 (6.45)	25 (13.88)	2 (2.29)	0	103 (13.15)	13 (3.93)	2 (6.45)	118	10.31
Supporting widow remarriage	24 (11.26)	6 (8.10)	0	22 (11.22)	4 (4.04)	0	24 (12.37)	3 (4.28)	0	22 (12.22)	5 (5.74)	0	93 (11.87)	22 (6.66)	0	115	10.05
Decision with regard to family Affairs	15 (7.04)	12 (16.21)	0	20 (10.20)	7 (7.07)	0	22 (11.34)	6 (8.75)	2 (6.45)	21 (11.66)	7 (8.04)	0	81 (10.34)	32 (9.96)	2 (6.45)	115	10.05
Decision about health at home	16 (7.51)	4 (5.40)	0	23 (11.73)	5 (5.05)	0	24 (12.37)	3 (4.28)	3 (9.67)	21 (11.66)	6 (6.89)	0	78 (9.96)	2 (0.60)	3 (9.67)	104	9.09
Total	213 (27.20)	74 (22.42)	0	196 (25.03)	99 (30)	0	194 (24.77)	70 (21.21)	31 (10)	180 (22.98)	87 (26.36)	0	783 (68.44)	330 (28.84)	31 (2.70)	1144	100

The above table no. 4.3.26 shows the overall social status of rural women. It is clear that the activities like using toilets 61, (i.g.7.79), Decision about health at home 78 (9.96), followed by 66 (8.42) status of hygiene in their area, followed by 102 (13.02), Supporting equal status for women, Securing the rights for Women, Voicing against social injustice 103 (13.15), Decision about family Affairs 81(10.34),Supporting widow remarriage 93 (11.87), family planning methods 63 (8.04), steps to take safe drinking water 63(8.04). The activity of social issues like to increase hygiene in their area 66 (8.42), using toilets 52 (6.51), family planning methods 49 (6.25), Steps to take safe drinking water 40 (5.10).The decision about family Affairs 32 (4.08), supporting widow remarriage 22 (2.80), supporting equal status for women 20 (2.55), Securing the rights for Women 13 (1.66), Voicing against social injustice 13 (1.66), decision about health at home is 3 (0.38), Decision about family Affairs 2 (0.25) are in good condition.

Table 4.4. Sample of Dewas

Questionnaire Distributed in CHC	Questionnaire Distributed	Questionnaire Received	Questionnaire's Analyzed
Bagli	30	27	27
Kannod	30	24	24
Khategoan	30	30	29
Sonkachh	30	26	26
Tondkhurd	30	23	23
Total	150	130	130

The above table 4.4 shows that the totals of 130 questionnaires were distributed among rural women and out of these 130 received back. It was observed that the highest response received from Khategoan, followed by Bagli is 27, followed by Sonkachh is 26 and the minimum is from kannod are 24, followed by Tondkhurd are 23 CHC.

Table 4.4.1 Types of Category/ Population

Category	Depalpur	Manpur	Mhow	Sanwad	Total	Percentage
General	0	0	3	1	4	3.47
OBC	16	9	8	2	35	30.43
SC	12	11	13	16	52	45.21
ST	2	8	6	8	24	20.87
Total	30	28	30	27	115	100
	(26.08)	(24.34)	(26.08)	(23.47)		

(Note-OBC= Other Backward Class, SC=Scheduled Caste, ST=Scheduled Tribal)

Table no. 4.4.1 shows that the type of category among rural women which shows that the highest category of rural women is that 45.21 rural women belonged to SC, followed by 30.43 belongs to OBC and 20.87 are ST and 3.47 percentages of rural women are General.

Table 4.4.2 Family's Monthly Income

Option	Bagli	Kannod	Khategoan	Sonkachh	Tondkhurd	Total	Percentage
Up to 2000	0	0	0	0	1 (4.34)	1	0.76
2000-4000	9 (33.33)	13 (54.16)	26 (86.66)	26 (100)	21 (91.30)	95	73.07
5000-10000	18 (78.26)	11 (45.83)	4 (13.33)	0	1 (4.34)	34	26.15
10000 - more	0	0	0	0	0	0	0
Total	27 (20.76)	24 (18.46)	30 (23.07)	26 (20)	23 (17.69)	130	100

Table 4.4.2 shows that the family's income of rural women husband in which 73.07 percentage of rural women's family income is up to 4000 monthly, followed by 26.15 rural women are between 5000-10000 monthly family incomes and 0.76 percentage of rural women family income is up to 2000.

Table 4.4.3 Education Levels of Women

Option	Bagli	Kannod	Khategoan	Sonkachh	Tondkhurd	Total	Percentage
Illiterate	16 (59.25)	13 (54.16)	16 (53.33)	4 (15.38)	2 (8.69)	51	39.23
Primary	9 (33.33)	10 (41.66)	12 (40)	9 (34.61)	15 (65.21)	55	42.31
Secondary	2 (7.40)	1 (4.16)	1 (3.33)	8 (30.76)	5 (21.73)	17	13.08
Higher Secondary	0	0	1 (3.33)	5 (19.23)	1 (4.34)	7	5.38
Graduate	0	0	0	0	0	0	0
Total	27 (20.76)	24 (18.46)	30 (23.07)	26 (20)	23 (17.69)	130	100

Table 4.4.3 shows the education level of rural women in which 41.53 percentage of rural women are illiterate, 40.76 rural women have primary education, and 12.30 of rural women have secondary education level and 5.38 percentage of rural women having higher secondary level education.

Table 4.4.4 Marital Status of Women

Option	Bagli	Kannod	Khategoan	Sonkachh	Tondkhurd	Total	Percentage
Married	27 (100)	24 (100)	30 (100)	26 (100)	23 (100)	130	100
Unmarried	0	0	0	0	0	0	0
Total	27 (20.76)	24 (18.46)	30 (23.07)	26 (20)	23 (17.69)	130	100

The table above 4.4.4 shows the marital status of rural women. It was found that 100 percent of women are married in CHC.

Table 4.4.5 Occupation of the Rural Women's Husband

Option	Bagli	Kannod	Khategoan	Sonkachh	Tondk hurd	Total	Perce ntage
Agriculture	5 (13.51)	7 (30.43)	15 (50)	11 (29.28)	20 (51.28)	68	43.31
Govt. Employee	0	0	0	0	0	0	0
No Employme nt	11 (29.72)	1 (4.34)	1 (3.33)	1 (3.57)	5 (12.82)	16	10.19
Farm Worker	1 (2.70)	1 (4.34)	0	0	0	2	1.27
Private	9 (24.32)	14 (60.86)	14 (46.66)	12 (42.85)	14 (35.89)	66	42.03
Driver	0	0	0	4 (14.28)	0	4	2.54
Business	1 (2.70)	0	0	0	0	1	0.63
Others	0	0	0	0	0	0	0
Total	37 (23.56)	23 (14.64)	30 (19.10)	28 (17.83)	39 (24.84)	157	100

This table 4.4.5 shows the occupations of rural woman's husband in which 43.31% rural women husband are doing agriculture work, while 42.03 rural women's husband is doing private work, followed by 10.19% are unemployed and 2.54 rural women husband are doing the driving, whereas 0.63 percentage of rural women husband is doing business.

Table 4.4.6 Housing and Living Status of Women

Variable	Categories	Bagli	Kannod	Khategoan	Sonkachh	Toankhurd	Total	Percentage
Type of House	Hut	25 (13.23)	21 (13.55)	29 (15.03)	26 (14.53)	22 (14.47)	123	14.17
	Tiled	2 (1.06)	2 (1.29)	0	0	0	4	0.46
	Concrete	0	0	1 (0.52)	0	1 (0.66)	2	0.23
Ownership of House	Rented	0	0	0	0	0	0	0
	Own	27 (14.29)	24 (15.48)	30 (15.54)	26 (14.53)	23 (15.13)	130	14.98
	Others	0	0	0	0	0	0	0
Number of Rooms	One	17 (8.99)	15 (9.68)	2 (1.04)	18 (10.06)	15 (9.87)	67	7.71
	Two	9 (4.76)	9 (5.81)	27 (13.99)	6 (3.35)	8 (5.26)	59	6.79
	Three	1 (0.53)	0	1 (0.52)	0	0	2	0.23
	Four	0	0	0	0	0	0	0
	More than	0	0	0	0	0	0	0
Toilet	Not Available	18 (9.52)	6 (3.87)	28 (14.51)	11 (6.15)	9 (5.92)	72	8.29
	Available	9 (4.76)	18 (11.61)	2 (1.04)	15 (8.38)	14 (9.21)	58	6.68
Drinking water	Tap	12 (6.35)	10 (6.45)	0	0	0	22	2.53
	Hand Pump	15 (7.94)	14 (9.03)	30 (15.54)	26 (14.53)	23 (15.13)	108	12.44
Electricity	Not Available	10 (5.29)	6 (3.87)	0	0	0	16	1.84
	Available	17 (8.99)	18 (11.61)	30 (15.54)	26 (14.53)	23 (15.13)	114	13.13
Leisure time	Television	1 (0.53)	0	11 (5.70)	11 (6.15)	14 (9.21)	37	4.26
	Radio	0	0	0	0	0	0	0
	News paper	0	0	0	0	0	0	0
	No activity	26 (13.76)	12 (7.74)	2 (1.04)	14 (9.21)	0	54	6.22
Total		189 (21.77)	155 (17.86)	193 (22.24)	179 (20.62)	152 (17.51)	868	100

Table 4.4.6 shows the housing and living status of rural women, which is 14.14 percentages of rural women, was living in Huts house, whereas 14.14 are percentages of rural women have their own home. 7.71% of rural women are living in a single room, whereas 6.79 found that rural women live in a double room, followed by 0.23 rural women living in a three-room set room. Overall 8.29% of women have toilet facility and 6.68 are not having. The drinking water facility for rural women shows that there is 12.44 tap and 6.23 is a Hand pump for taken water facility. Around 13.13% said that they have electricity and 1.84 are not having electricity. Television, News Papers, and leisure activities are not done by them.

Table 4.4.7 Awareness about Health Literacy

Awareness Health Literacy	Bagli	Kannod	Khategoan	Sonkachh	Tondkhurd	Total	Percentage
Yes	9 (33.33)	7 (29.73)	14 (46.67)	4 (15.38)	4 (19.39)	38	29.23
No	18 (66.67)	17 (70.83)	16 (53.33)	22 (84.62)	19 (82.61)	92	70.76
Total	27 (20.76)	24 (18.46)	30 (23.07)	26 (20)	23 (17.69)	130	100

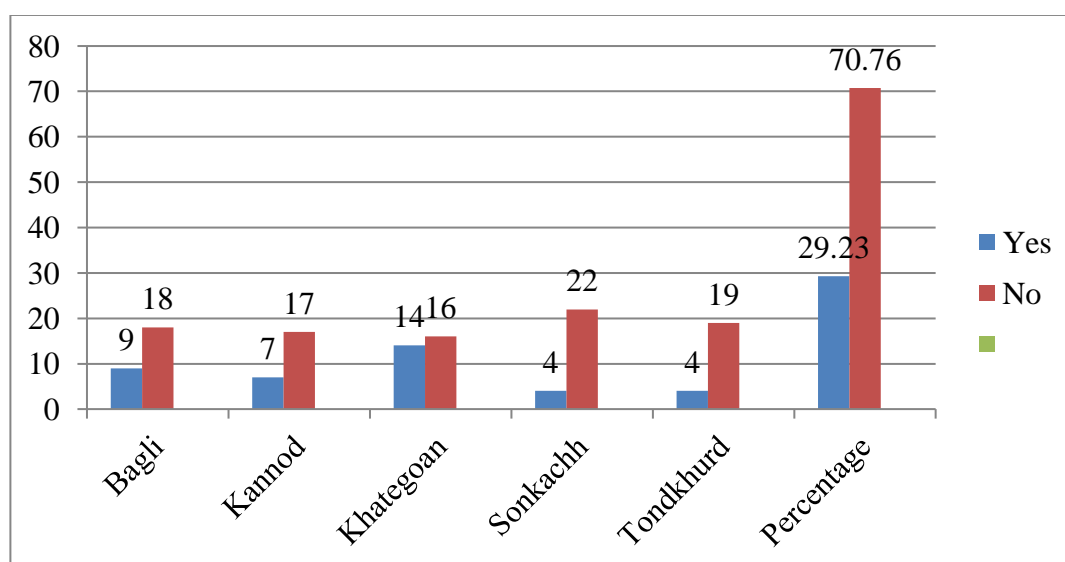


Fig. 4.4.7 Awareness about Health Literacy

The table and fig.4.4.7 show that the awareness of health literacy among rural women was very low. It was found that 70.76 women were unaware of health literacy, whereas 29.23 of women were aware of health literacy.

Table 4.4.8 Reasons for Non-awareness about Health Literacy

Option	Bagli	Kannod	Khategoan	Sonkachh	Tondkhurd	Total	Percentage
Lack of education	15 (34.88)	17 (37.78)	15 (32.61)	19 (32.20)	18 (41.86)	84	35.59
Lack of Health Information	18 (41.85)	14 (31.11)	16 (34.78)	22 (37.29)	19 (44.19)	89	37.71
Not interested	9 (20.93)	13 (28.89)	13 (28.26)	10 (16.95)	2 (4.65)	47	19.91
On opinion	1 (2.33)	1 (2.22)	2 (4.35)	8 (13.56)	4 (9.30)	16	6.77
Total	43 (18.22)	45 (19.06)	46 (19.49)	59 (25)	43 (18.22)	236	100

The table 4.4.8 shows that the majority of rural women i.e. 37.71 were not aware about health literacy because of lack of health information, whereas 35.59% of rural women were unaware of health literacy because of lack of education, followed by 6.77 percentage rural women were not interested in health literacy because of their some personal Reasons.

Table 4.4.9 Provision of Health Information, Resources, and Services by CHC

Option	Bagli	Kannod	Khategoan	Sonkachh	Tondkhurd	Total	Percentage
Yes	15 (55.66)	10 (41.67)	13 (43.33)	11 (42.31)	13 (56.52)	62	47.69
No	12 (44.44)	14 (58.33)	17 (56.67)	15 (57.69)	10 (43.48)	68	52.31
Total	27 (20.76)	24 (18.46)	30 (23.07)	26 (20)	23 (17.69)	130	100

The above table 4.1.9 shows that provision of health information, resources, and services provided by CHC for rural women. It was found that the highest 52.31 rural women did not have access to health information, resources, and service from the CHC and 47.96 was receiving it.

Table 4.4.10 Awareness, Source and Uses of Immunization

Option	Category	Bagli	Kannod	Khategoan	Sonkachh	Tondkhurd	Total	Percentage
Awareness about Immunization	No Awareness	22 (27.16)	17 (22.37)	3 (2.44)	7 (5.60)	12 (11.43)	61	11.96
	Had	5 (6.17)	8 (10.53)	27 (21.95)	19 (15.20)	11 (10.48)	70	13.73
Source of Information on Immunization	Doctors	5 (6.17)	2 (2.63)	9 (7.32)	10 (8)	10 (9.52)	36	7.059
	Health visitors	0	0	10 (8.13)	9 (7.20)	5 (4.76)	24	4.706
	AASHA	22 (27.16)	19 (25)	22 (17.89)	24 (19.20)	22 (20.95)	110	21.57
	Nurse	0	2 (2.63)	22 (17.89)	25 (20)	22 (20.95)	71	13.92
Awareness about Diseases prevented by Immunization	Fully aware	0	0	0	0	0	0	0
	Partially aware	23 (28.40)	20 (26.32)	23 (18.70)	25 (20)	21 (20)	111	21.76
	Not aware	4 (4.40)	8 (10.53)	7 (5.69)	6 (4.80)	2 (1.90)	27	5.294

Total	81 (15.88)	76 (14.90)	123 (24.12)	125 (24.51)	105 (20.29)	510	100
--------------	-----------------------------	-----------------------------	------------------------------	------------------------------	------------------------------	------------	------------

Table 4.4.10 shows Awareness about Immunization, sources of immunization information, and awareness about diseases prevented by immunization among rural women. It was found that the highest percentage of Sonkachh which is 24.5% were aware about Immunization, sources of immunization information, and awareness about diseases prevented, followed by Khategoan is 24.12, and followed by Toandkhurd is 20.29. While the lowest percentage of the Awareness about Immunization, sources of immunization information, and awareness about diseases prevented by immunization among rural women were 15.88 in Bagli and followed by 14.90 in Kannod.

Table 4.4.11 Availability and Accessibility of Health Care Services by CHC

Option	Categories	Bagli	Kannod	Khategoan	Sonkachh	Toandkhurd	Total	Percentage
Distance to Community Health Center (in km)	1.00-5.00	0	0	0	0	0	0	0
	6.00-10.0	7 (7.61)	16 (21.05)	2 (2.13)	5 (5.15)	2 (2.17)	32	6.275
	11.0-15.0	20 (21.74)	7 (9.21)	25 (26.60)	21 (21.65)	17 (18.48)	90	17.65
	16.0-20.0	0	0	3 (3.19)	4 (4.12)	4 (4.35)	11	2.157
	21.0-25.0	0	0	0	0	0	0	0
Reasons for visiting Community Health Centers	For free Medicine	22 (23.91)	24 (31.58)	28 (29.79)	26 (26.80)	23 (25)	123	25.1
	Emergency	12 (13.04)	1 (1.32)	2 (2.13)	15 (15.46)	5 (5.43)	35	17.45
	Minor Illness	4 (4.35)	8 (10.53)	3 (3.19)	0	0	11	2.157
	Not visiting	0	0	0	0	0	0	0
Visiting Private Clinic	Minor Illness	0	0	0	0	0	0	0
	Partially	0	0	1 (1.06)	0	18 (19.97)	19	3.725
Distance to Medical Shop(in km)	00.-.50	26 (28.26)	20 (26.32)	30 (31.91)	26	23 (25)	129	25.29
	1.00-2.00	1 (1.09)	0	0	0	0	1	0.196
	3.00.-more than	0	0	0	0	0	0	0
Total		92 (20.40)	76 (16.85)	94 (20.84)	97 (21.51)	92 (21.51)	451	100

The presented data in table 4.4.11 Availability and Accessibility of Health Care Services in CHC for rural women. It was found that the overall availability and accessibility are highest is Khategoan among rural women with 24.83, which was followed by Bagli where it was 24.61, followed by Toandkhurd is 24.17, followed by Sonkachh is 22.62. While the lowest percentage of that the Availability and Accessibility of Health Care Services in CHC for rural women in Kannod is 16.85.

Table 4.4.12 Access to the Satisfactory Road Network

Option	Bagli	Kannod	Khategoan	Sonkachh	Toandkhurd	Total	Percentage
Yes	19 (55.56)	8 (41.67)	14 (43.33)	17 (42.31)	13 (56.52)	71	54.62
No	8 (44.44)	16 (58.33)	16 (56.67)	9 (56.67)	10 (57.69)	59	45.38
Total	27 (20.76)	24 (18.46)	30 (23.07)	26 (20)	23 (17.69)	130	100

The table 4.4.12 shows satisfactory road network in Bhitwar and Mohan CHC. It shows satisfaction about road network is the highest 54.62 and the lowest is 45.38 with satisfied rural women to the road network.

Table 4.4.13 Barriers to Health Treatment Faced by Rural Women

Indicator	Bagli			kannod			Khategoan			Sonkachh			Tondkhurd			Total			Total	Peren tage
	Poor	Good	V. good	Poor	Good	V. good	Poor	Good	V. good	Poor	Good	V. good	Poor	Good	V. good	Poor	Good	V. good	(P+G+V.G.)	(P+G+V.G.)
Social status	7 (7)	18 (25)	2 (9.52)	2 (5.1)	3 (27.3)	17 (20.48)	17 (16)	5 (5.0)	8 (11.27)	16 (14)	0	9 (13.43)	5 (5.2)	18 (30)	0	47 (10)	45	35 (14.29)	127	14.80
Self-perceived health	5 (5)	17 (23.6)	3 (14.29)	2 (5.1)	1 (9.09)	17 (20.48)	21 (20)	0	1 (1.40)	16 (14)	0	10 (14.93)	6 (6.3)	17 (27)	0	50 (11)	35 (28.84)	31 (12.65)	116	13.52
Not Able to pay for Medication	9 (9)	16 (22.2)	1 (4.76)	2 (5.1)	1 (9.09)	16 (19.28)	22 (21)	0	6 (8.45)	17 (15)	0	10 (14.93)	7 (7.3)	16 (25.39)	1 (25)	57 (12)	33 (22.43)	34 (13.88)	124	14.45
Not Able to afford doctor	15 (15)	8 (11.1)	5 (23.81)	5 (13)	1 (9.09)	11 (13.25)	21 (20)	0	6 (8.45)	18 (16)	0	8 (11.94)	14 (15)	8 (12.69)	1 (25)	73 (16)	17 (10.89)	31 (12.65)	121	14.10
Limited activities because of health problems	19 (19)	2 (2.78)	4 (19.05)	10 (26)	1 (9.09)	8 (9.63)	14 (13)	0	9 (12.68)	10 (8.7)	0	16 (23.88)	22 (23)	1 (1.58)	0	75 (16.97)	4 (2.56)	37 (15.10)	116	13.52
Monthly household income	22 (22)	3 (4.17)	1 (4.76)	10 (26)	2 (18.2)	6 (7.22)	6 (6)	3 (3.0)	19 (26.76)	18 (16)	0	8 (11.94)	21 (22)	1 (1.58)	1 (25)	77 (16.85)	9 (5.76)	35 (14.28)	121	14.10

Unable to reach out to CHC	23 (23)	8 (11.1)	5 (23.8 1)	8 (2 1)	2 (18. 2)	8 (9. 63)	6 (6)	2 (2 0)	22 (3 0. 99)	20 (1 7)	0	6 (8.9 5)	21 (22)	1 (1.58)	1 (25)	78 (17.0 7)	13 (8.33)	42 (17.1 4)	133	15.50
Total	100 (21.9)	72 (46.2)	21 (8.57)	39 (8. 5)	11 (7.0 5)	83 (3 3. 74)	10 (2 7 3)	10 (6. 41)	71 (2 8. 98)	11 5 (2 5. 2)	0	67 (27. 34)	96 (21)	63 (40.4)	4 (1. 63)	457 (53.3)	156 (18.2)	245 (28.5 5)	858 (100)	

Table 4.4.13 shows that the barriers to health treatment faced by rural women. The poor social status, self-perceived health, not able to pay for Medication, not able to afford doctor, limited activities because of health problems, monthly household income condition were found to be the main barriers 25.16% in Sonkachh, followed by 23.41% in Khategoan, followed by 21.88% in Bagli. Moving forward Toandkhurd has the second-lowest poor percentage of 21.01% and 8.53% in Kannod has the lowest poor. The rural women who were good with all the above mention barriers were found to be the highest 46.15 percentage in Bagli, followed by 39.74 in Toandkhurd, same as followed by 7.05 in Kannod. Moving forward Khategoan has the second-lowest easy percentage of 23.11 and Sonkachh has the lowest good percentage of 0.64.

The percentage of rural women V.Good social status and other mention barriers was found to be the highest percentage 33.74 in Kannod, as same followed by 28.86 in Khategoan. Moving forward Sonkachh has second-lowest 27.24, same as followed by 8.24 in Kannod and Toandkhurd has the lowest percentage of 1.63 faced by rural women for health treatment. It was also found that shows that the barriers to health treatment faced by rural women highest are 53.20 poor.

Table 4.4.14 Awareness of Nutritious Diet by Rural Women

Option	Bagli	Kannod	Khategoan	Sonkachh	Toandkhurd	Total	Percentage
Yes	17 (62.96)	15 (62.5)	12 (40)	11 (42.31)	4 (17.39)	59	45.38
No	10 (37.04)	9 (37.5)	18 (60)	15 (57.69)	19 (82.61)	71	54.62
Total	27 (20.76)	24 (18.46)	30 (23.07)	26 (20)	23 (17.69)	130	100

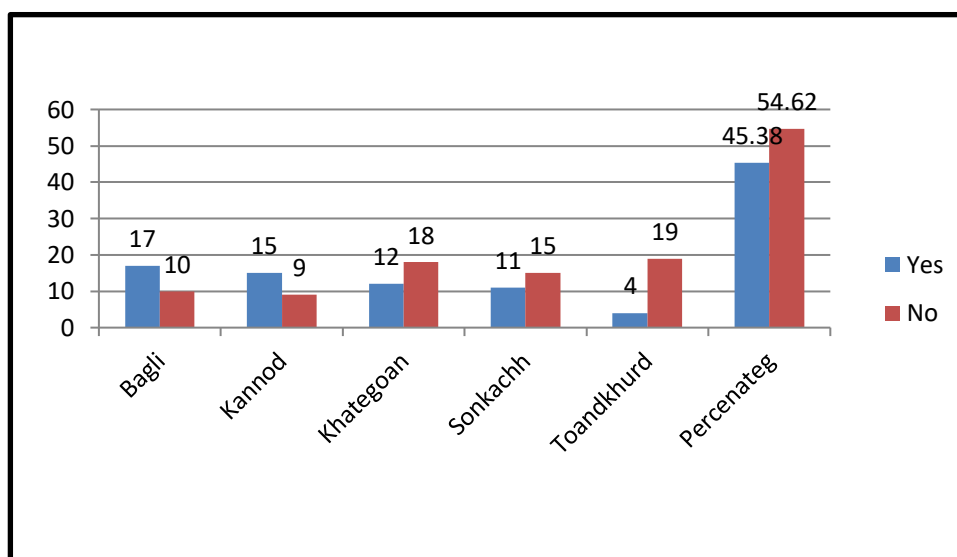


Fig.4.4.14 Awareness of Nutritious Diet by Rural Women

The table and fig.no.4.4.14 show that the awareness about the nutritious diet taken by rural women. It was found that the highest 54.62 rural women were not aware of a nutritious diet and 45.38 percentage of rural women were aware.

Table 4.4.15 Reasons for Non-awareness of Nutritious Diet by Rural Women

Option	Bagli	Kannod	Khategoan	Sonkachh	Toandkhurd	Total	Percentage
Monthly Income	20 (74.07)	19 (79.17)	23 (76.67)	23 (88.46)	20 (86.96)	105	80.77
Not Aware	7 (25.93)	5 (20.83)	7 (23.33)	3 (11.54)	3 (13.04)	25	19.23
Total	27 (20.76)	24 (18.46)	30 (23.07)	26 (20)	23 (17.69)	130	100

The table 4.4.15 show the reasons for non-awareness about nutritious diet and foods by rural women. It was found that the highest 80.77 percentage of rural women were not taking nutritious diet due to their lack of monthly income and the lowest 19.23 percentage of rural women were not aware of the nutritious diet.

Table 4.4.16 Chosen Places for Delivery of their Child by Rural Women

Option	Bagli	Kannod	Khategoan	Sonkachh	Tondkhurd	Total	Percentage
Home	2 (7.41)	7 (29.17)	1 (3.33)	4 (15.38)	4 (17.39)	18	13.85
Government facility	25 (92.59)	17 (70.83)	29 (96.67)	22 (92.31)	19 (82.61)	112	86.15
Accredited private facilities	0	0	0	0	0	0	0
Other private facilities	0	0	0	0	0	0	0
Total	27 (20.76)	24 (18.46)	30 (23.07)	26 (20)	23 (17.69)	130	100

The above table 4.4.16 shows that the Chosen Places for Delivery of their Child by Rural Women. It was found that the 89.23 percentage of rural women have chosen government facility for delivery, whereas 10.76 of rural women have chosen home for delivery of their child.

Table 4.4.17 Awareness about Contraception

Option	Bagli	Kannod	Khategoan	Sonkachh	Tondkhurd	Total	Percentage
Yes	22 (81.48)	17 (70.83)	26 (86.67)	19 (73.08)	20 (86.96)	104	80
No	5 (18.52)	7 (29.17)	4 (13.33)	7 (26.92)	3 (13.04)	26	20
Total	27 (20.76)	24 (18.46)	30 (23.07)	26 (20)	23 (17.69)	130	100

The table 4.4.17 shows that awareness about contraception among rural women. It was found that the percentage of awareness about contraception was 80 in total of rural women of all CHC, While 20 rural women were not aware of contraception.

Table 4.4.18 Use of Contraception by Rural Women

Use of Contraception	Bagli	Kannod	Khategoan	Sonkachh	Tondkhurd	Total	Percentage
Yes	5 (18.52)	4 (16.67)	2 (6.67)	4 (15.38)	1 (4.35)	16	12.30
No	22 (81.48)	20 (83.33)	28 (93.33)	22 (84.62)	22 (95.65)	114	87.69
Total	27 (20.76)	24 (18.46)	30 (23.07)	26 (20)	23 (17.69)	130	100

The table 4.4.18 shows the Use of contraception by rural women. It was found that the percentage of rural women never used contraception use was 87.69% in CHC while 12.30% of rural women never used contraception.

Table 4.4.19 Reasons for not using Contraception by Rural Women

Option	Bagli	Kannod	Khategoan	Sonkachh	Tondkhurd	Total	Percentage
Lack of information	10 (37.04)	20 (41.67)	13 (46.43)	18 (41.86)	22 (52.38)	83	44.14
Husband's not agree	4 (14.81)	10 (20.83)	4 (14.29)	6 (13.95)	18 (42.86)	43	22.87
Side effect	12 (44.44)	18 (37.5)	11 (39.29)	19 (44.19)	2 (4.76)	62	32.97
Total	27 (14.36)	48 (25.53)	28 (14.89)	43 (22.87)	42 (22.34)	188	100

The table 4.4.19 shows the Reasons for not using concentration by rural women. It was found in Kannod in which their rural women were not using contraception due to the lack of information, to husband is not agree, the side effect 25.53, followed by 22.87 in Sonkachh, followed by 42.34 in Toandkhurd. It was the lowest percentage for the same belong to Khategoan which is 14.89, followed by 14.36 in Bagli.

Table 4.4.20 Health Information received by Rural Women

Option	Bagli	Kannod	Khategoan	Sonkachha	Tondkhurd	Total	Percentage
Community health center	24 (88.9)	22 (91.67)	22 (73.33)	22 (84.62)	20 (86.96)	116	89.23
Sub-center	0	0	2 (6.67)	0	0	0	0
Primary Health Center	2 (7.41)	2 (8.33)	0	4 (15.38)	0	4	3.07
Districts hospital	0	0	6 (20)	0	2 (8.70)	8	6.15
Television	1 (3.7)	0	0	0	1 (4.35)	2	1.53
Newspapers	0	0	0	0	0	0	0
Adult education officials	0	0	0	0	0	0	0
Total	27 (20.76)	24 (18.46)	30 (23.07)	26 (20)	23 (17.69)	130	100

The above table 4.4.20 shows receiving health information from rural women. It was found that the 89.23% of rural women received health information from CHC, followed by 6.15 received from district hospitals, followed by 3.07 received from Primary Health Center. Some Rural Women have received health information (1.53) from the television.

Table 4.4.21 Treatment during Pregnancy by Rural Women

Option	Bagli	Kannod	Khategoan	Sonkachh	Tondkhurd	Total	Percentage
Yes	27 (100)	24 (100)	30 (100)	26 (100)	23 (100)	130	100
No	0	0	0	0	0	0	0
Total	27 (20.76)	24 (18.46)	30 (23.07)	26 (20)	23 (17.69)	130	100

The above table 4.4.21 shows that the chosen treatment taken during pregnancy. It was found 100 percent of rural women have taken treatment during their pregnancy time from the CHC.

Table 4.4.22 Types of Hospitals Preferred by Rural Women

Option	Bagli	Kannod	Khategoan	Sonkachh	Tondkhurd	Total
Community health center	26 (96.30)	20 (83.33)	29 (96.67)	24 (92.31)	22 (95.65)	121 (93.08)
Sub-center	1 (3.70)	4 (16.67)	1 (3.33)	2 (7.69)	1 (4.35)	9 (6.92)
Private hospital	0	0	0	0	0	0
Ayurvedic hospital	0	0	0	0	0	0
Traditional local health person	0	0	0	0	0	0
Total	27 (20.76)	24 (18.46)	30 (23.07)	26 (20)	23 (17.69)	130 (100)

The above table 4.4.22 shows the types of hospitals preferred by rural women in case of health issues. It was found that the 97.69 of rural women preferred to CHC, followed by 1.53 private hospitals, and 0.76 of rural women preferred sub-center in case of health needs.

Table 4.4.23 Availability of Medical Staff in CHC

Option	Bagli		Kannod		Khategoan		Sonkachha		Tondkhurd		Total & Percentage	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Doctor	24 (22.6)	3 (2.7)	21 (21.4)	6 (6)	27 (20.3)	3 (2.8)	25 (21)	1 (1.1)	20 (18.18)	3 (4.05)	117 (20.67)	16 (3.33)
Nurse	22 (20.8)	5 (4.5)	24 (24.5)	3 (3)	29 (21.8)	1 (0.9)	26 (21.8)	0	23 (20.91)	0	124 (21.91)	9 (1.88)
Compounder	10 (9.4)	17 (15.5)	9 (9.2)	15 (15)	25 (18.8)	5 (4.7)	20 (16.8)	6 (6.7)	19 (17.27)	4 (5.41)	83 (14.66)	47 (9.79)
Health inspector	10 (9.4)	17 (15.5)	5 (5.1)	19 (19)	22 (16.5)	8 (7.5)	7 (5.9)	19 (21.3)	8 (7.27)	15 (20.27)	52 (9.91)	78 (16.25)
Health assistant (Male)	0	27 (24.5)	6 (6.1)	18 (18)	2 (1.5)	28 (26.2)	7 (5.9)	19 (21.3)	8 (7.27)	15 (20.27)	23 (4.06)	107 (22.29)
Health assistant (Female)	5 (4.7)	22 (20)	4 (4.1)	20 (20)	8 (6)	22 (20.6)	8 (6.7)	18 (20.2)	9 (8.18)	14 (18.92)	34 (6.01)	96 (20)
Lab technician	25 (23.6)	2 (1.8)	23 (23.5)	1 (1)	20 (15)	10 (9.3)	26 (21.8)	0	23 (20.91)	0	117 (20.67)	13 (2.71)
Peon	10 (9.4)	17 (15.5)	6 (6.1)	18 (18)	0	30 (28)	0	26 (29.2)	0	23 (31.08)	16 (2.83)	114 (23.75)
Total	106 (18.73)	110 (22.92)	98 (17.31)	100 (20.83)	133 (23.50)	107 (22.29)	119 (21.02)	89 (18.54)	110 (19.43)	74 (15.42)	566 (54.11)	480 (45.89)

The data in table 4.4.23 shows the overall availability of medical staff in CHC. It was found that the availability of nurse staff was maximum i.e. 21.91, followed by a doctor with 20.67, same as followed by a lab technician with 20.67, followed by compounder with 14.66, followed by

health inspector with 9.18, followed by health assistant with 4.06 followed by health assistant female staff with 6.00 and least were Peon with 2.82% availability in CHC.

It was also found that the availability of complete staff in Khategoan CHC with 23.50, followed by Sonkachha with 21.02, followed by Toandkhurd with 19.43, and least was in Bagli CHC with 18.73 and Kannod CHC with 17.31.

Table 4.4.24 Satisfaction Level about CHC Staff

Option	Bagli			Kannod			Khategoan			Sonkachh			Tondkhurd			Total			Total
	Poor	Go od	V.G ood	Poo r	Go od	V.Go od	Poo r	Go od	V.Go od	Poo r	Go od	V.Go od	Poo r	Go od	V. Go od	P	G	VG	(P+G +VG)
Doctors	8 (17.7 8)	19 (21. 11)	0	10 (23. 3)	14 (18. 18)	0	0	4 (5. 40)	0	8 (14. 8)	18 (17. 64)	0	5 (8.6 2)	17 (24. 64)	0	31 (12. 1)	72 (17. 48)	0	103 (15.42)
Nurse and Compounder	9 (20)	19 (21. 11)	0	10 (23. 3)	14 (18. 18)	0	0	26 (35 .14)	0	1 (1.8 5)	25 (24. 51)	0	5 (8.6 2)	18 (26. 09)	0	25 (9.7 7)	102 (24. 76)	0	127 (19.01)
Labor rooms	5 (11.1 1)	23 (25. 56)	0	0	24 (31. 17)	0	0	22 (29 .73)	0	0	26 (25. 49)	0	8 (13. 8)	12 (17. 39)	0	13 (5.0 8)	107 (25. 97)	0	120 (17.96)
Radiographers & X-Ray Machines	19 (42.2)	8 (8.8)	0	20 (46.	4 (5.1	0	26 (46.	0	0	26 (48.	0	0	22 (37.	0	0	113	12 (2.9	0	125 (18.71

	2)	9)		5)	9)		4)			1)			9)			(44)	1))
Lab Technician & Pathology Labs	4 (8.89)	21 (23.33)	0	3 (6.98)	21 (27.27)	0	4 (7.14)	22 (29.73)	0	4 (7.41)	22 (21.56)	0	0	22 (28.99)	0	15 (5.86)	108 (26.21)	0	123 (18.41)
Generators	0	0	0	0	0	0	26 (46.4)	0	0	15 (27.8)	11 (10.78)	0	18 (31)	0	0	59 (23)	11 (2.67)		70 (10.48)
Total	45 (17.58)	90 (21.84)	0	43 (16.88)	77 (18.69)	0	56 (22.7)	74 (17.96)	0	54 (21.1)	102 (24.75)	0	58 (22.7)	69 (16.75)	0	256 (38.3)	412 (61.68)	0	658

The above table 4.4.24 shows that the overall satisfaction level with medical staff available in CHC.102 (24.76) percentage found that the maximum rural women were satisfied in Sonkachh, followed by 90 (21.84) percentage of rural women in Bagli, followed by 77 (18.69) in Kannod, followed by 74 (17.96) in Khategoan, followed by 69 (16.75) in Toandkhurd CHC about medical staff and were good. Overall it was found that the 412 (67.21) percentage of rural women are not satisfied with CHC staff, followed by 199 (32.57) percentage rural women are not satisfied with CHC staff (poor services).

Table 4.4.25 Aspects of visiting to CHC by Rural Women

Option	Bagli	Kannod	Khategoan	Sonkachh	Tondkhurd	Total
Family planning	25 (12.56)	24 (14.91)	28 (13.79)	22 (12.29)	21 (13.91)	120 (12.77)
Natal care (Pre-natal, and post natal)	25 (12.56)	24 (14.91)	30 (14.78)	25 (13.97)	23 (15.23)	127 (13.51)
Immunization	27 (13.57)	21 (13.04)	28 (13.79)	26 (14.53)	23 (15.23)	125 (13.30)
Communicable diseases	0	0	0	0	0	0
a) Malarial fever	27 (13.57)	22 (13.66)	24 (11.84)	20 (11.17)	20 (13.25)	113 (12.02)
b) Eye infections	11 (5.53)	8 (4.97)	5 (2.46)	10 (5.59)	4 (2.65)	38 (4.04)
c) Cough	13 (6.53)	12 (7.45)	26 (12.81)	20 (11.17)	18 (11.92)	89 (9.47)
d) Body pains	22 (11.06)	20 (12.42)	30 (14.78)	22 (12.29)	19 (12.58)	113 (12.02)
e) Knee pains	17 (8.54)	19 (11.80)	28 (13.79)	21 (11.73)	16 (10.60)	101 (10.74)
f) Problems of menopause	16 (8.04)	8 (4.97)	2 (0.99)	8 (4.47)	1 (0.66)	35 (3.72)
g) Cancer	2 (1.01)	3 (1.86)	0	0	0	5 (0.53)
h) Blood pressure	14 (7.04)	0	2 (0.99)	5 (2.79)	6 (3.97)	74 (7.87)
Total	199 (21.17)	161 (17.13)	230 (24.47)	186 (19.29)	164 (17.45)	940 (100)

The above table 4.4.25 shows the overall aspect of visiting to CHC by rural women. It was found that aspect of visit to CHC is maximum i.e 13.51 natal care, followed by 13.30 immunization, same as followed by 12.77 family planning, followed by 12.02 malaria, followed by 10.74 knee pain, followed by 9.47 cough, followed by 3.72 problems of menopause, followed by 4.04 Eye infections and Blood pressure and least was 0.53 cancer aspect for visiting CHC by rural women.

It was also found that aspect of visit to CHC is maximum 24.47 in Khategoan, and least was 17.45 in Toandkhurd CHC.

Table 4.4.26 Social Empowerment status of rural women

Option	Bagli			Kannod			Khategoan			Sonkachh			Tondkhurd			Total Res.			
	Poor	Good	V.Go od	Poor	Good	V.Go od	Poor	Good	V.Go od	Poor	Go od	V.G ood	Poor	Go od	V.G ood	Poo r	Go od	V.G ood	(P+ G+ VG)
Using Toilets	8 (5.5 6)	19 (16.8 1)	24.5	0	12 (24.5)	11 (16.4 2)	18	0	0	6 (3.3 9)	18 (22. 5)	0	8 (4.68)	15 (30)	0	41 (4.8 9)	64 (20. 85)	11 (14. 67	116 (9.4 8)
0	8 (5.5 6)	19 (16.8 1)	24.5	0	12 (24.5)	11 (16.4 2)	23 (9.91)	0	0	8 (4.5 2)	18 (22. 5)	0	8 (4.68)	16 (32)	0	48 (5.7 2)	65 (21. 17)	11 (14. 67)	124 (10. 13)
0	9 (6.2 5)	18 (15.9 3)	24.5	0	12 (24.5)	11 (16.4 2)	25 (10.8)	0	0	16 (9.0 4)	10 (12. 5)	0	19 (11.1)	4 (8)	0	71 (8.4 6)	44 (14. 33)	11 (12)	130 (10. 62)
Family planning methods	5 (3.4 7)	22 (19.4 7)	10.2	0	5 (10.2)	9 (13.4 3)	19 (8.19)	0	0	14 (7.9 1)	11 (13. 8)	0	18 (10.5)	5 (10)	0	63 (7.5 1)	43 (14. 01)	9 (12)	115 (9.4 0)
Supporting equal status for women	22 (15. 3)	5 (4.42)	6.12	0	3 (6.12)	7 (10.4 2)	28 (12.1)	0	0	20 (11. 30)	6 (7.5)	0	18 (10.5)	1 (2)	2 (25)	99 (11. 80)	15 (4.8 9)	9 (12)	123 (10. 05)

Securing the rights for Women	25 (17.4)	2 (1.77)	2.04	14 (12.17)	1 (2.04)	6 (8.95)	28 (12.1)	0	0	20 (11.30)	6 (7.5)	0	20 (11.7)	1 (2)	2 (25)	107 (12.75)	10 (3.26)	8 (10.67)	121 (9.89)
Voicing against social injustice	21 (14.6)	6 (5.31)	2.04	17 (14.78)	1 (2.04)	3 (4.47)	28 (12.1)	0	0	23 (12.99)	3 (3.75)	0	20 (11.7)	2 (4)	1 (12.5)	109 (12.99)	12 (3.26)	4 (5.33)	125 (10.21)
Supporting widow remarriage	19 (13.2)	8 (7.08)	2.04	22 (19.13)	1 (2.04)	3 (4.47)	29 (12.5)	0	0	24 (13.56)	2 (2.5)	0	20 (11.7)	2 (4)	1 (12.5)	114 (13.59)	13 (3.26)	4 (5.33)	130 (10.62)
Decision with regard to family Affairs	13 (9.03)	9 (7.96)	0	20 (17.39)	1 (2.04)	3 (4.47)	8 (3.45)	11 (73.33)	0	23 (12.99)	3 (3.75)	0	20 (11.7)	2 (4)	1 (12.5)	84 (10.01)	26 (8.47)	4 (5.33)	114 (9.31)
Decision with regard to health at home	14 (9.72)	5 (4.42)	0	20 (17.39)	1 (2.04)	3 (4.47)	26 (11.2)	4 (26.67)	0	23 (12.99)	3 (3.75)	0	20 (11.7)	2 (4)	1 (12.5)	103 (12.28)	15 (4.89)	4 (5.33)	126 (12.29)
Total	144 (17.2)	113 (36.81)	0	115 (13.71)	49 (15.96)	67 (89.33)	232 (27.65)	15 (4.89)	0	177 (21.10)	80 (26.06)	0	171 (20.38)	50 (16.29)	8 (10.67)	839 (68.71)	307 (25.14)	75 (.14)	122 (10.01)

The above table no. 4.4.26 shows the overall social status of rural women. It is clear that the activities like Steps to supporting widow remarriage 114 (13.59), Voicing against social injustice 109 (12.99), Securing the rights for Women 107 (12.75), Decision about health at home 103 (12.28), safe drinking water 71 (8.46), Family planning methods 63 (7.51), Supporting equal status for women 99 (11.80), Decision about family Affairs 84 (10.01), are in poor condition.

It was found that the overall social empowerment status 232 (27.65) percentage of rural women were poor in Khategoan, while it is least social empowerment is 115 (13.71) only.

Table 4.5: Sample Size of Ujjain (East Zone)

Questionnaire Distributed in CHC	Questionnaire Distributed	Questionnaire Received	Questionnaire's Analyzed
Ghatia	30	30	30
Tarana	30	23	23
Total	60	53	53

The above table no. 4.5 shows that the totals of 60 questionnaires were distributed among rural women and out of these 53 received back. It was observed that the highest response received 30 from Ghatia and the minimum is 23 from Tarana CHC.

Table 4.5.1 Types of Category/ Population

Category	Ghatia	Tarana	Total & Percent
General	0	0	0
OBC	8 (26.66)	13 (56.32)	21 (39.32)
SC	12 (40)	6 (26.09)	18 (33.96)
ST	10 (33.33)	4 (17.39)	14 (26.42)
Total	30 (56.60)	23 (43.39)	53

OBC= Other Backward Class, SC=Scheduled Caste, ST=Scheduled Tribal

Table 4.5.1 show type of category among rural women which shows that the highest category of rural women is that 39.62 % rural women belong to OBC, followed by 33.96 belongs to SC, and 26.42 are ST.

Table 4.5.2 Family's Monthly Income

Income (in Rs.)	Ghatia	Tarana	Total & Percentage
Up to 2000	2 (6.67)	1 (4.35)	3 (5.66)
2000-4000	22 (73.33)	22 (95.65)	44 (83.02)
5000-10000	6 (20)	0	6 (11.32)
10000 - more	0	0	0
Total	30 (56.60)	23 (43.39)	53

Table 4.5.2 shows that the family's income of rural women's husband in which 83.02% rural women's family income is up to 2000 monthly, followed by 11.32% rural women are between Rs. 5000-10000 monthly family income, followed by 5.66 are having Rs. 2000 as family income.

Table 4.5.3 Education Levels of Women

Option	Ghatia	Tarana	Total	Percentage
Illiterate	10 (33.33)	6 (26.09)	16	30.19
Primary	16 (53.33)	11 (47.83)	27	50.94
Secondary	4 (13.33)	5 (21.74)	9	16.98
Higher Secondary	0	1 (4.35)	1	1.89
Graduate	0	0	0	0
Total	30 (56.60)	23 (43.39)	53	100

Table 4.5.3 shows that the education level of rural women in which 50.94% rural women are having primary education, 30.19% rural women are illiterate, 16.98% rural women are secondary education level and 1.89% are higher secondary education level.

Table 4.5.4 Marital Status of Women

Option	Ghatia	Tarana	Total	Percentage
Married	30 (100)	23 (100)	53	100
Unmarried	0	0	0	0
Total	30 (56.60)	23 (43.39)	53	100

The table above 4.5.4 shows the marriage status of rural women. It was found that 100 percent of women are married in CHC.

Table 4.5.5 Occupation of the Rural Women's Husband

Option	Ghatia	Tarana	Total	Percentage
Agriculture	15 (50)	20 (51.28)	35	50.72
Govt. Employee	0	0	0	0
No Employment	1 (3.33)	5 (12.82)	6	8.70
Farm Worker	0	0	0	0
Private	14 (46.66)	14 (35.89)	28	40.58
Driver	0	0	0	0
Business	0	0	0	0
Others	0	0	0	0
Total	30 (43.47)	39 (56.52)	69	100

Table 4.5.5 shows the occupations of rural woman's husbands in which 50.72% rural women's husbands are doing agriculture work, while 40.58% rural women 's husbands

are doing private work, followed by 8.70% are farm workers and 4.35 rural women husband are unemployed.

Table 4.5.6 Housing and Living Status of Rural Women

Option	Categories	Ghatia	Tarana	Total	Percentage
Type of House	Hut	29 (15.03)	23 (15.13)	52	15.1
	Tiled	0	0	0	0
	Concrete	1 (0.52)		1	0.29
Ownership of House	Rented	0	0	0	0
	Own	30 (15.54)	23 (15.13)	53	15.4
	Others	0	0	0	0
Number of Rooms	One	2 (1.04)	15 (9.87)	17	4.93
	Two	27 (13.99)	8 (5.26)	35	10.1
	Three	1 (0.52)	0	1	0.29
	Four	0	0	0	0
	More than	0	0	0	0
Toilet	Not Available	28 (14.51)	9 (5.92)	37	10.7
	Available	2 (1.04)	14 (9.21)	16	4.64
Drinking water	Tap	0	0	0	0
	Hand Pump	30 (15.54)	23 (15.13)	53	15.4

Electricity	Not Available	0	0	0	0
	Available	30 (15.54)	23 (15.13)	53	15.4
Leisure time	Television	11 (5.70)	14 (9.21)	25	7.25
	Radio	0	0	0	0
	News paper	0	0	0	0
	No activity	2	0	2	0.58
Total		193 (55.94)	152 (44.05)	345	100

Table 4.5.6 shows the housing status of rural women, which is 15.1 percent of rural women, were living in Huts house, whereas 15.4 percent of rural women have their own home. 10.1% of rural women are living in a double room, whereas 4.91 found that rural women live in a one-room, followed by 0.23 rural women living in a three-room set room. Overall 4.64% of women have toilet facility and 10.7 are not having. The drinking water facility for rural women shows that there are 15.4 hand pumps for taken water facilities. Around 15.4% said that they have electricity, television, News Papers, and leisure activities are not done by them.

Table 4.5.7 Awareness about Health Literacy

Awareness Health Literacy	Ghatia	Tarana	Total	Percentage
Yes	16 (53.33)	4 (17.39)	20	37.74
No	14 (469.67)	19 (82.61)	33	62.26
Total	30 (56.60)	23 (43.39)	53	100

The table 4.5.7 shows the awareness of health literacy among rural women was low, It was found that 33 (i.e. 62.26%) women were unaware of health literacy whereas 20 (i.e. 37.74%) women were aware of health literacy.

Table 4.5.8 Reasons for Non-awareness about Health Literacy

Option	Ghatia	Tarana	Total	Percentage
Lack of education	15 (31.8)	18 (52.9)	33	40.24
Lack of Health Information	18 (37.8)	14 (43.8)	32	39.02
Not interested	13 (27.1)	2 (6.3)	15	18.29
On opinion	2 (4.2)	0	2	2.44
Total	48 (58.54)	34 (41.46)	82	100

Table 4.5.8 shows the majority of rural women i.e. 50.24% were not aware of health literacy because of a lack of health information, whereas 48.24% of rural women were unaware of health literacy due to health education.

Table 4.5.9 Provision of Health Information, Resources, and Services by CHC

Option	Ghatia	Tarana	Total	Percentage
Yes	10 (33.33)	6 (26.09)	16	30.19
No	20 (66.67)	17 (73.91)	37	69.81
Total	30 (56.60)	23 (43.40)	53	100

The above table 4.5.9 shows that provision of Health Information, Resources, and Service by CHC for rural women. It was found that the highest 69.81 of rural women did not access health information, resources, and service from the CHC, and 30.19 were receiving it form CHC.

Table 4.5.10 Awareness, Source and Uses of Immunization

Option	Category	Ghatia	Tarana	Total	Percentage
Awareness about Immunization	No Awareness	7 (5.43)	11 (11.22)	18	7.93
	Is	23 (17.83)	12 (12.24)	35	15.4
Source of Information on Immunization	Doctors	9 (6.98)	10 (10.20)	19	8.37
	Health visitors	10 (7.75)	5 (5.10)	15	6.61
	AASHA	24 (18.60)	21 (21.43)	45	19.8
	Nurse	26 (20.16)	17 (17.35)	43	18.9
Awareness about Diseases prevented by Immunization	Fully aware	0	0	0	0
	Partially aware	23 (17.83)	18 (18.37)	41	18.1
	Not aware	7 (5.43)	4 (4.08)	11	4.85
Total		129 (56.83)	98 (43.17)	227	100

The table 4.5.10 shows that most of the rural women get health information about sources of information on Immunization, 19.8 from ASHA worker, followed by Nurse with 18.9, followed by health visitor with 6.61. 15.4 are aware about Immunization

and 7.93 of rural women do not know about immunization. Whereas awareness about diseases prevented by immunization is 18.1 partially aware and 4.85 are not aware.

Table 4.5.11 Availability and Accessibility of Health Care Services by CHC

Variable	Categories	Ghatia	Tarana	Total	Percentage
Distance to Community Health Center (in km)	1.00-5.00	0	0	0	0
	6.00-10.0	2 (1.33)	0	2	0.70
	11.0-15.0	25 (16.67)	21 (16.15)	46	16.08
	16.0-20.0	3 (2)	3 (2.31)	6	2.10
	21.0-25.0	0	0	0	0
Reasons for visiting Community Health Centers	For free Medicine	30 (20)	23 (17.69)	53	18.53
	Emergency	30 (20)	23 (17.69)	53	18.53
	Minor Illness	0	20 (15.38)	20	6.99
	Not visiting	0	0	0	0
Visiting Private Clinic	Minor Illness	5 (3.33)	3 (2.31)	8	2.79
	Partially	25	20	45	15.73

		(16.67)	(15.38)		
Distance to Medical Shop(in km)	00.-.50	30 (20)	23 (17.69)	53	18.53
	1.00-2.00	0	0	0	0
	3.00.-more than	0	0	0	0
Total		150 (52.44)	136 (47.55)	286	100

Table 4.5.11 shows the availability and accessibility of Health Care Services in CHC for rural women. It was found that the overall availability and accessibility are highest in Ghatia among rural women with 52.44 and lowest by Tarana where it was 47.55.

Table 4.5.12 Access to the Satisfactory Road Network in Rural Areas

Option	Ghatia	Tarana	Total	Percentage
Yes	19 (63.33)	13 (56.52)	32	60.38
No	11 (36.67)	10 (43.48)	21	39.62
Total	30 (56.60)	23 (43.40)	53	100

The presented data in table 4.5.12 shows the satisfactory road networks in Ghatia and Tarana CHC. It shows the satisfaction about road network is the highest 60.38 and the lowest is 39.62 with satisfied rural women regarding road network.

Table 4.5.13 Barriers to Health Treatment

Barriers	Ghatia			Tarana			Total			Total & Per.
	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	
Social status	17 (14.53)	0	13 (26)	14 (18.67)	8 (12.12)	1 (5.56)	31 (16.15)	8 (7.34)	14 (20.59)	53 (14.39)
Self-perceived health	18 (15.38)	6 (13.95)	6 (6)	2 (2.67)	17 (25.76)	3 (16.67)	20 (10.42)	23 (11.58)	9 (13.24)	52 (14.09)
Able to pay for Medication	16 (13.68)	4 (9.30)	10 (20)	6 (8)	16 (24.24)	1 (5.56)	22 (11.46)	20 (18.35)	11 (16.18)	53 (14.36)
Able to afford doctor	18 (15.38)	5 (11.63)	7 (14)	10 (13.33)	8 (12.12)	5 (27.78)	28 (14.58)	13 (11.93)	12 (17.64)	53 (14.36)
Limited activities because of health problems	10 (8.55)	14 (32.56)	6 (12)	12 (16)	7 (10.61)	4 (22.22)	22 (11.46)	21 (19.27)	10 (14.71)	53 (14.36)
Monthly household income	18 (15.38)	8 (18.60)	4 (8)	18 (24)	3 (4.55)	1 (5.56)	36 (18.75)	11 (8.26)	5 (7.35)	52 (14.09)
Unable to reach out to CHC	20 (17.09)	6 (13.95)	4 (8)	13 (17.33)	7 (10.61)	3 (16.67)	33 (17.19)	13 (11.93)	7 (10.29)	53 (14.36)
Total	117 (60.94)	43 (39.45)	50 (73.53)	75 (39.06)	66 (60.55)	18 (26.47)	192 (52.03)	109 (29.54)	68 (18.43)	369

Table 4.5.13 shows that the barriers to health treatment faced by rural women. The poor social status, self-perceived health, not able to pay for Medication, not able to afford doctor, limited activities because of health problems, monthly household income were found to be the main barriers 117 (60.94), the percentage in Ghatia, followed by 75 (39.06) in Tarana. Moving forward Tarana has the second lowest poor percentage of 66 (60.55). Overall it is found that the barrier for the health treatment faced by rural women 192 (52.03) percentage are poor, followed by 109 (29.54) percentages are good and 68 (18.43) percentages are v. good.

Table 4.5.14 Awareness about Nutritious Diet by Rural Women

Option	Ghatia	Tarana	Total	Percentage
Yes	16 (53.33)	13 (56.52)	29	54.72
No	14 (46.67)	10 (43.48)	24	45.28
Total	30 (56.60)	23 (43.40)	53	100

The table.4.5.14 show that the awareness about the nutritious diet taken by rural women. It was found that the highest 54.72 rural women were aware of a nutritious diet, whereas 45.28 percentage of rural women were not aware of nutritious diet.

Table 4.5.15 Reasons for Non-awareness of Nutritious Diet by Rural Women

Option	Ghatia	Tarana	Total	Percentage
Monthly Income	25 (83.33)	22 (95.65)	47	88.68
Not Aware	5 (16.67)	1 (4.35)	6	11.32
Total	30 (56.60)	23 (43.39)	53	100

The table 4.5.15 show that the reasons for not awareness of nutritious diet and foods by rural women. It found that the 88.68 percentage of rural women were not taking nutritious diet due to lack of monthly income and the lowest 11.32 percentage of rural women were not aware of the nutritious diet.

Table 4.5.16 Chosen Places for Delivery of their Child by Rural Women

Option	Ghatia	Tarana	Total	Percentage
Home	0	0	0	0
Government facility	30 (100)	23 (100)	53	53
Accredited private facilities	0	0	0	0
Other private facilities	0	0	0	0
Total	30 (56.60)	23 (43.39)	53	53

Table 4.5.16 shows that the place for child delivery by rural women. It was found that the maximum women were chosen government facilities for delivery of their child.

Table 4.5.17 Awareness about Contraception

Option	Ghatia	Tarana	Total	Percentage
Yes	19 (63.33)	16 (69.57)	35	66.04
No	11 (36.67)	7 (30.43)	18	33.96
Total	30 (26.60)	23 (53.39)	53	100

The table and fig. 4.5.17 shows the awareness about contraception among rural women. It was found that the percentage of awareness about contraception was 78.26 in total rural women of all CHC, whereas, 21.73 percent of rural women were not aware of contraception.

Table 4.5.18 Use of Contraception by Rural Women

Use of Contraception	Ghatia	Tarana	Total	Percentage
Yes	8 (26.67)	6 (26.09)	14	26.42
No	22 (73.33)	17 (73.91)	39	73.58
Total	30 (56.60)	23 (43.39)	53	100

The table 4.5.18 shows the Use of contraception by rural women. It was found that the percentage of women never use contraception were 73.58 in CHC. Where 26.42% of rural women were never used contraception in CHC.

Table 4.5.19 Reasons for not using Contraception by Rural Women

Option	Ghatia	Tarana	Total	Percentage
Lack of information	22 (36.07)	17 (40.48)	39	37.86
Husband's	19 (31.15)	8 (19.05)	27	26.21
Side effect	20 (32.79)	17 (40.48)	37	35.92
Total	61 (59.22)	42 (40.78)	103	100

The table 4.5.19 shows that the Reasons for not using concentration by rural women. It was found in Ghatia in which their rural women were not using contraception because of lack of information, husband not agree, side effect and the total percentage is 59.22, followed by 40.78in Tarana.

Table 4.5.20 Health Information received by Rural Women

Option	Ghatia	Tarana	Total	Percentage
Community health center	30 (37.04)	23 (35.94)	53	36.55
Sub-center	7 (8.64)	10 (15.63)	17	11.72
Primary Health Center	14 (17.28)	8 (12.50)	22	15.17
Districts hospital	30 (37.04)	23 (35.94)	53	36.55
Television	0	0	0	0
Newspapers	0	0	0	0
Adult education officials	0	0	0	0
Total	81 (56.86)	64 (44.14)	145	100

The above table 4.5.20 shows that Health Information received by rural women. It was found that the 36.55 percentage of rural women received health information from CHC, followed by 36.55 received from the district hospital, followed by 15.17 received from PHP, Depalpur, Manpur, and Mhow, and Sanwad have received health information from CHC and 11.72 health information received from sub-center.

It is clear that overall the rural women have received health information in Ghatia CHC, whereas 44.14 in Tarana.

Table 4.5.21 Treatment taken During Pregnancy by Rural Women

Option	Ghatia	Tarana	Total	Percentage
Yes	25 (83.33)	19 (82.61)	44	83.02
No	5 (16.67)	4 (17.39)	9	16.98

Total	30 (56.60)	23 (43.39)	53	100
--------------	-----------------------------	-----------------------------	-----------	------------

The above table 4.5.21 shows that the chosen treatment taken during pregnancy. It was found that the 83.02 percentage of rural women have chosen to CHC, followed by 16.98 rural women who have not taken treatment during their pregnancy time from the CHC.

Table 4.5.22 Types of Hospitals Preferred by Rural Women

Option	Ghatia	Tarana	Total	Percentage
Community health Center	28 (70)	23 (69.70)	51	69.86
Sub-Center	12 (30)	10 (30.30)	22	30.14
Private hospital	0	0	0	0
Ayurvedic hospital	0	0	0	0
Traditional local health person	0	0	0	0
Total	40 (54.79)	33 (45.21)	73	100

The above Table 4.5.22 shows the types of hospitals preferred by rural women in case of health issues. It was found that 69.86 % of rural women in Ghatia and has 45.21 in Tarana have preferred CHC in case of health issue.

Table 4.5.23 Availability of Medical Staff in CHC

Option	Ghatia		Tarana		Total		Total & Per. (Y+N)
	Yes	No	Yes	No	Yes	No	
Doctor	28 (27.45)	2 (1.45)	20 (2174)	3 (3.26)	48 (24.74))	5 (2.17)	53 (12.5)
Nurse	30 (29.41)	0	23 (25)	0	53 (27.32))	0 (0)	53 (12.5)

Compounder	15 (14.71)	15 (10.87)	21 (22.83)	2 (2.17)	36 (18.56)	17 (7.39))	53 (12.5))
Health inspector	0	30 (21.74)	6 (6.52)	17 (18.48)	6 (3.09)	47 (20.43)	53 (12.5))
Health assistant (Male)	0	30 (21.74)	0	23 (25)	0 (0)	53 (23.04)	53 (12.5))
Health assistant (Female)	0	30 (21.74)	0	23 (25)	0 (0)	53 (23.04)	53 (12.5))
Lab technician	29 (28.43)	1 (0.72)	22 (23.91)	1 (1.09)	51 (26.29)	2 (0.87)	53 (12.5))
Peon	0	30 (21.74)	0	23 (25)	0 (0)	53 (23.04)	53 (12.5))
Total	102 (52.58)	138 (60)	92 (40)	92 (21.70)	194 (45.75)	230 (54.25)	424 (100))

Table 4.5.23 shows that the medical staff were available in CHC. It was found that the availability of nurse staff was maximum i.e 21.14; same as followed by a lab technician with 21.14, followed by a doctor with 20.73, followed by a compounder with 18.56 were availability in CHC. While Peon were available with 23.04%, followed by health assistant inspector 12.5%, followed by health assistant male 12.5%, same as followed by female 12.5%.

It was also found that the availability of complete staff maximum in Ghatia CHC was 52.85 and least was in Tarana CHC with 47.15.

Table 4.5.24 Satisfaction level with CHC Staff

Option	Ghatia			Tarana			Total			Total	Percentage
	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good		
Doctors	10 (11.36)	20 (21.74)	0	14 (19.18)	9 (13.85)	0	24 (14.91)	29 (18.47)	0	53	16.67
Nurse and Compounder	8 (9.09)	22 (23.91)	0	5 (6.85)	18 (27.69)	0	13 (8.07)	40 (25.48)	0	53	16.67
Labor rooms	10 (11.36)	20 (21.74)	0	5 (6.85)	18 (27.69)	0	15 (9.32)	38 (24.20)	0	53	16.67
Radiographers & X-Ray Machines	30 (34.09)	0	0	23 (31.51)	0	0	53 (32.92)	0	0	53	16.67
Lab Technician & Pathology Labs	1 (1.14)	29 (31.52)	0	3 (4.11)	20 (30.77)	0	4 (2.48)	49 (31.21)	0	53	16.67
Generators	29 (32.95)	1 (1.09)	0	23 (31.51)	0	0	52 (32.30)	1 (0.64)	0	53	16.67
Total	88 (54.66)	92 (58.60)	0	73 (45.34)	65 (41.40)	0	161 (50.63)	157 (49.37)	0	318	100

The table 4.5.24 shows overall satisfaction level of medical staff available in CHC. 92 (58.60) percentage found that the maximum rural women satisfied in Ghatia and 73 (45.34) percentage of rural women are not satisfied with CHC staff in Tarana.

Table 4.5.25 Aspects of visiting to CHC by Rural Women

Option	Ghatia	Tarana	Total	Percentage
Family planning	22 (10.78)	21 (12.43)	43	11.53
Natal care	25 (12.25)	23 (13.61)	48	12.87
Immunization	30 (14.71)	23 (13.61)	53	14.21
Communicable diseases	0	0	0	0
a) Malarial fever	24 (11.76)	20 (11.83)	44	11.80
b) Eye infections	10 (4.90)	4 (2.37)	14	3.75
c) Cough	20 (9.80)	18 (10.65)	38	10.19
d) Body pains	22 (10.78)	20 (11.83)	42	11.26
e) Knee pains	21 (10.29)	20 (11.83)	41	10.99
f) Problems of menopause	8 (3.92)	1 (0.59)	9	2.41
g) Cancer	0	0	0	0
h) Blood pressure	22 (10.78)	19 (11.24)	41	10.99
Total	204 (54.69)	169 (45.31)	373	100

The above table 4.5.25 shows that the overall Aspects of visiting to CHC by Rural Women. It was found that the aspect of visit to CHC is maximum i.e 14.11 Natal care (Pre and Postnatal), same as followed by 14.11 Immunization, family planning with 13.15, body pain with 13.79, followed by 11.96 blood pressure, followed by 10.28 malaria fever, followed by 8.85 cough, followed by 8.49 knee pain, menopause with 3.34, followed by 2.87 eye infections main aspects for visiting CHC by rural women.

Table 4.5.26 Social Empowerment status of Rural Women

Option	Ghatia			Tarana			Total			Total	Percentage
	Poor	Good	V.Good	Poor	Good	V. good	Poor	Good	V. good		
Using Toilets	17 (9.83)	13 (10.66)	0	15 (9.49)	8 (9.09)	0	32 (9.67)	21 (10)	0	9.67	10
To increase hygiene in their area	12 (6.94)	11 (9.02)	0	9 (5.70)	14 (15.91)	0	21 (6.34)	25 (11.90)	0	6.34	11.90
Steps to take safe drinking water	12 (6.94)	18 (14.75)	0	14 (8.86)	11 (12.50)	0	26 (7.85)	29 (13.81)	0	7.85	13.81
Family planning methods	11 (6.36)	19 (15.57)	0	14 (8.86)	11 (12.50)	0	25 (7.55)	30 (14.29)	0	7.55	14.29
Supporting equal status for women	22 (12.72)	8 (6.56)	0	15 (9.49)	10 (11.36)	0	37 (11.18)	18 (8.57)	0	11.18	8.57
Securing the rights for	21 (12.1)	11 (9.02)	0	14 (8.86)	11 (12.50)	0	35 (10.57)	22 (10.48)	0	10.57	10.48

Women	4)										
Voicing against social injustice	20 (11.56)	10 (8.20)	0	17 (10.76)	8 (9.09)	0	37 (11.18)	18 (8.57)	0	11.18	8.57
Supporting widow remarriage	17 (9.83)	13 (10.66)	0	22 (13.92)	3 (3.41)	0	39 (11.78)	16 (7.62)	0	11.78	7.62
Decision with regard to family Affairs	21 (12.14)	9 (7.38)	0	19 (12.03)	6 (6.82)	0	40 (12.08)	15 (7.14)	0	12.08	7.14
Decision with regard to health at home	20 (11.56)	10 (8.20)	0	19 (12.03)	6 (6.82)	0	39 (11.78)	16 (7.62)	0	11.78	7.62
Total	173 (52.27)	122 (58.10)	0	158 (47.73)	88 (41.90)	0	331 (61.18)	210 (38.82)	0	541	100

Table 4.5.26 shows that the aspect of rural women regarding social status. The factors like securing rights of women voicing against social justice, decision with regard to family are taken into consideration.

Table 4.6 Sample of Mandsour

Questionnaire Distributed in CHC	Questionnaire Distributed	Questionnaire Received	Questionnaire's Analyzed
Malhargarh	30	29	29
Sitamau	30	30	30
Shamgarh	30	30	30
Total	90	89	89

Table 4.6 shows that the totals of 90 questionnaires were distributed among rural women and out of these 89 received back. It was observed that the highest response received from Sitamau, the same followed by 30 in Shamgarh and the minimum is 29 from Malhargarh CHC.

Table 4.6.1 Types of Category/ Population

Category	Malhargarh	Sitamau	Shamgarh	Total
General	0	3 (10)	1 (3.33)	4 (4.49)
OBC	13 (44.83)	8 (26.67)	5 (16.67)	26 (29.21)
Scheduled Caste	11 (37.93)	13 (43.33)	16 (53.33)	40 (44.94)
Scheduled Tribal	5 (17.24)	6 (20)	8 (26.67)	19 (21.35)
Total	29 (32.58)	30 (33.70)	30 (33.70)	89 (100)

OBC= Other Backward Class, SC=Scheduled Caste, ST=Scheduled Tribal

Table 4.6.1 shows that the type of category among rural women which shows that the highest category of rural women is that 44.94 rural women belong to SC, followed by 29.21 belongs to OBC and 21.35% are ST.

Table 4.6.2 Family's Monthly Income

Option	Malhargarh	Sitamau	Shamgarh	Total
Up to 2000	0	0	0	0
2000-4000	18 (62.06)	25 (62.06)	16 (53.33)	59 (66.29)
5000-10000	11 (37.93)	5 (16.66)	13 (43.33)	29 (32.58)
10000 - more	0	0	1 (3.33)	1 (1.12)
Total	29 (32.58)	30 (33.70)	30 (33.70)	89 (100)

The table 4.6.2 shows that the family's income of rural women's husbands in which 66.29 percentage of rural women's family income is up to 2000-4000 monthly, followed by 32.58 rural women are between 5000-10000 monthly family incomes, followed by 1.12 percentages of rural women family incomes are more than 10000.

Table 4.6.3 Education Levels of Women

Option	Malhargarh	Sitamau	Shamgarh	Total
Illiterate	5 (17.24)	5 (16.66)	14 (46.67)	27 (30.33)
Primary	10 (34.48)	16 (53.33)	10 (33.33)	36 (40.45)
Secondary	11 (37.93)	6 (20)	6 (20)	23 (25.84)
Higher Secondary	3 (10.34)	0	0	3 (3.37)
Graduate	0	0	0	0
Total	29 (32.58)	30 (33.70)	30 (33.70)	89 (100)

The table 4.6.3 shows the education level of rural women in which 40.44 rural women have primary level education, 30.33 rural women are illiterate, and 25.84 of rural women have secondary level education level, and 3.37 are having higher secondary education level.

Table 4.6.4 Marital Status of Women

Option	Malhargarh	Sitamau	Shamgarh	Total
Married	29 (100)	30 (100)	30 (100)	89
Unmarried	0	0	0	0
Total	29 (32.58)	30 (33.70)	30 (33.70)	89 (100)

The table above 4.6.4 shows the marital status of rural women. It was found that 100 percent of women are married in CHC.

Table 4.6.5 Occupation of the Rural Women's Husband

Option	Malhargarh	Sitamau	Shamgarh	Total
Agriculture	16 (55.17)	17 (56.67)	17 (56.67)	50 (56.17)
Govt. Employee	0	0	1 (3.33)	1 (1.12)
No Employment	0	2 (6.67)	4 (13.33)	6 (6.74)
Farm Worker	0	0	0	0
Private	14 (48.27)	11 (36.67)	8 (26.67)	32 (35.95)
Driver	0	0	0	0
Business	0	0	0	0
Others	0	0	0	0
Total	29 (32.58)	30 (33.70)	30 (33.70)	89 (100)

This Table 4.6.5 shows the occupations of rural woman's husband in which 56.18 rural women's husbands are doing agriculture work, while 35.96 rural women husbands are doing private work, followed by 1.12 are Govt. employee and 6.74 of rural women's husbands are unemployed.

Table 4.6.6 Housing and Living Status of Rural Women

Option	Categories	Malhargarh	Sitamau	Shamgarh	Total
Type of House	Hut	20 (9.85)	22 (12.22)	25 (11.57)	67 (11.18)
	Tiled	0	0	0	0
	Concrete	9 (4.43)	8 (4.44)	5 (2.31)	22 (3.67)
Ownership of House	Rented	0	0	0	0
	Own	29 (14.28)	30 (16.67)	30 (13.88)	89 (14.85)
	Others	0	0	0	0
Number of Rooms	One	13 (6.40)	17 (9.44)	14 (6.48)	44 (7.34)
	Two	15 (7.38)	13 (7.22)	14 (6.48)	42 (7.01)
	Three	1 (.49)	0	1 (0.46)	2 (0.33)
	Four	0	0	2 (0.92)	2 (0.33)
	More than	0	0	0	0
Toilet	Not Available	10 (4.92)	8 (4.44)	18 (8.33)	36 (6.01)
	Available	19 (9.35)	22 (12.22)	12 (5.55)	53 (8.84)
Drinking water	Tap	9 (4.43)	8 (4.44)	4 (1.85)	21 (3.50)

	Hand Pump	20 (9.85)	22 (12.22)	26 (12.03)	68 (11.35)
Electricity	Not Available	3 (1.47)	2 (11.11)	2 (0.92)	7 (1.16)
	Available	26 (12.80)	28 (15.55)	28 (12.96)	82 (13.68)
Leisure time	Television	17 (8.37)	0	12 (5.55)	29 (4.84)
	Radio	1 (49)	0	3 (1.38)	10 (1.66)
	News paper	2 (98)	0	6 (2.77)	8 (1.33)
	No activity	9 (4.43)	0	8 (3.70)	17 (2.83)
Total		203 (33.88)	180 (30.05)	216 (36.06)	599 (100)

Table 4.6.6 shows the housing and living status of rural women, which is 11.2 percentages of rural women, was living in Huts house, whereas 14.9 are percentages of rural women have their own home. 7.35% of rural women are living in a single room, whereas 6.79 rural women live in a double room, followed by 0.23 rural women living in a three-room set room. Overall 8.85% of women have Toilet facility and 6.01 are not having. The drinking water facility for rural women shows that there is 11.4 are having tap and 6.23 are having Hand pump for water facility. Around 13.7% said they have electricity and 10.61 are not having electricity. followed by 1.67 are having the radio and 1.34 are using the newspaper, and 2.84 percent of rural women are not doing such activities done by rural women in leisure tim, and leisure activities are not done by them.

Table 4.6.7 Awareness about Health Literacy

Awareness Health Literacy	Malhargarh	Sitamau	Shamgarh	Total
Yes	17 (58.62)	20 (66.67)	10 (33.33)	47 (52.81)
No	12 (41.38)	10 (33.33)	20 (66.67)	42 (47.19)
Total	29 (32.58)	30 (33.71)	30 (33.71)	89 (100)

The table 4.6.7 shows the awareness of Health Literacy among Rural Women. It was found that the highest 52.80 of women were aware of health literacy, whereas 47.19 of women were unaware of health literacy.

Table 4.6.8 Reasons for Non-Awareness about Health Literacy

Option	Malhargarh	Sitamau	Shamgarh	Total
Lack of education	12 (41.37)	10 (33.33)	10 (33.33)	32 (35.95)
Lack of Health Information	17 (58.62)	20 (66.66)	20 (66.66)	57 (64.04)
Not interested	0	0	0	0
On opinion	0	0	0	0
Total	29 (32.58)	30 (33.71)	30 (33.71)	89 (100)

Table 4.6.8 shows the majority of rural women i.e. 64.04 were not aware of health literacy because of lack of health information, whereas 35.95 of rural women were unaware of health literacy due to lack of education.

Table 4.6.9 Provision of Health Information, Resources, and Services provided by CHC

Option	Malhargarh	Sitamau	Shamgarh	Total
Yes	20 (68.96)	24 (80)	20 (66.66)	64 (71.91)
No	9 (31.03)	6 (20)	10 (33.33)	25 (28.08)
Total	29 (32.58)	30 (33.71)	30 (33.71)	89 (100)

The above table 4.6.9 shows that provision of health information, resources, and services provided by CHC for rural women. It was found that 71.91 of rural women access health information, resources, and service from the CHC and 28.08 were not receiving the same.

Table 4.6.10 Awareness, Source and Uses of Immunization

Option	Category	Malhargarh	Sitamau	Shamgarh	Total
Awareness about Immunization	No	12 (8.95)	9 (6)	9 (6.81)	30 (7.21)
	Had	17 (12.68)	21 (14)	21 (15.90)	59 (14.18)
Source of Information on Immunization	Doctors	22 (16.41)	28 (18.66)	12 (9.09)	62 (14.90)
	Health visitors	0	2 (1.33)	0	2 (0.48)
	AASHA	29 (21.64)	30 (22.38)	30 (22.72)	89 (21.39)
	Nurse	25 (18.65)	30 (22.38)	30 (22.72)	85 (20.43)

Awareness about Diseases prevented by Immunization	Fully aware	0	0	0	0
	Partially aware	20 (8.95)	27 (18)	23 (17.42)	70 (16.82)
	Not aware	9 (6.71)	3 (2)	7 (5.30)	19 (4.56)
Total		134 (32.21)	150 (36.06)	132 (31.73)	416 (100)

Table 4.6.10 shows that the Awareness about Immunization, Sources of information on immunization, and awareness about diseases prevented by immunization among rural women. It was found that the highest percentage of Mohana which is 52.33 were aware about Immunization, sources of information on immunization, and awareness about diseases prevented, while in Bhitwar was 48.66.

Table 4.6.11 Availability and Accessibility of Health Care Services by CHC

Option	Categories	Malhargarh	Sitamau	Shamgarh	Total
Distance to Community Health Center (in km)	1.00-5.00	0	0	0	0
	6.00-10.0	17 (13.18)	24 (17.52)	19 (12.67)	60 (14.42)
	11.0-15.0	12 (9.30)	6 (4.38)	11 (7.33)	29 (6.67)
	16.0-20.0	0	0	0	0
	21.0-25.0	0	0	0	0
Reasons for visiting Community Health Centers	For free Medicine	29 (22.8)	30 (21.90)	30 (20)	89 (21.39)
	Emergency	29 (22.48)	30 (21.90)	30 (20)	89 (21.39)
	Minor Illness	8 (6.20)	7 (5.11)	15 (10)	30 (7.21)
	Not visiting	0	0	0	0
Visiting Private	Minor Illness	0	0	0	0

Clinic	Partially	5	10	15	30
		(3.88)	(7.30)	(10)	(7.21)
Distance to Medical Shop(in km)	00.-.50	29	30	30	89
		(22.48)	(21.90)	(20)	(21.39)
	1.00-2.00	0	0	0	0
	3.00.-more than	0	0	0	0
Total		129	137	150	416
		(31.01)	(32.93)	(36.06)	(100)

Table 4.6.11 shows the Availability and Accessibility of Health Care Services in CHC for rural women. It was found that the overall availability and accessibility are highest in Shamgarh rural women with 36.06, which was followed by Sitamau where it was 32.93 and lowest in Malhargarh which is 31.01.

Table 4.6.12 Access to the Satisfactory Road Network

Road Network	Malhargarh	Sitamau	Shamgarh	Total	Percentage
Yes	17	19	14	50	56.18
	(58.62)	(63.33)	(46.67)		
No	12	11	16	39	43.82
	(41.38)	(36.67)	(53.33)		
Total	29	30	30	89	100
	(32.58)	(33.70)	(33.70)		

The presented table and fig 4.6.12 show that satisfactory road networks in Malhargarh, Sitamau, and Shamgarh CHC. It shows satisfaction about road network is highest 56.18 and the lowest is 43.82 among rural women.

Table 4.6.13 Barriers to Health Treatment Faced by Rural Women

Indicator	Malhargarh			Sitamau			Shamgarh			Total			Total
	Poor	good	v. good	Poor	good	v. good	Poor	good	v. good	Poor	good	v. good	(P+G+VG)
Social status	16 (12.30)	8 (21.62)	5 (13.89)	19 (13.47)	6 (19.35)	5 (13.15)	29 (17.15)	1 (5.26)	0	64 (14.54)	15 (17.24)	10 (10.30)	89 (14.26)
Self-perceived health	18 (13.85)	8 (21.62)	3 (8.33)	17 (12.05)	5 (16.12)	8 (21.05)	29 (17.15)	1 (5.26)	0	64 (14.54)	14 (16.09)	11 (11.34)	89 (14.26)
Not Able to pay for Medication	17 (13.07)	3 (8.10)	9 (25)	25 (17.73)	2 (6.45)	3 (7.89)	20 (11.83)	4 (21.05)	6 (26.08)	0	9 (10.34)	18 (18.55)	89 (14.26)
not Able to afford doctor	20 (15.38)	5 (13.51)	4 (11.11)	18 (12.76)	4 (12.90)	8 (21.05)	23 (13.60)	2 (10.52)	6 (26.08)	61 (13.86)	11 (12.64)	18 (18.55)	90 (14.42)
Limited activities because of health problems	16 (12.30)	5 (13.51)	8 (22.22)	12 (8.52)	10 (32.25)	8 (21.05)	14 (8.28)	10 (52.63)	6 (26.08)	42 (9.54)	25 (28.73)	22 (22.68)	89 (14.26)
Monthly household income	20 (15.38)	5 (13.51)	4 (11.11)	24 (17.02)	2 (6.45)	4 (10.52)	27 (15.97)	1 (5.26)	2 (8.69)	71 (16.13)	8 (9.19)	10 (10.30)	89 (14.26)
Unable to reach out to CHC	23 (17.69)	3 (8.10)	3 (8.33)	26 (18.43)	2 (6.45)	2 (5.26)	27 (15.97)	0	3 (13.04)	76 (17.27)	5 (5.74)	8 (8.24)	89 (14.26)
Total	130 (29.54)	37 (42.53)	36 (37.11)	141 (32.05)	31 (35.63)	38 (39.18)	169 (38.41)	19 (21.84)	23 (23.71)	440 (70.51)	87 (13.94)	97 (15.54)	624 (100)

)			
--	--	--	--	--	--	--	--	--	--	---	--	--	--

Table 4.6.13 shows the barriers to health treatment faced by rural women. The social status, self-perceived health, not able to pay for Medication, not able to afford doctor, limited activities because of health problems, monthly household income were found to be the main barriers 30.89 percentage in Bhitwar and Mohana has the lowest poor percentage of 29.32. Moving forward Mohana has the second-lowest poor percentage of 29.32, followed by Bhitwar has 16.75. The percentage of rural women who have difficult social status and other mention barriers were found to be the highest percentage 17.28 in Mohana, as followed by 1.05 in Bhitwar.

Table 4.6.14 Awareness about nutritious diet by Rural Women

Option	Malhargarh	Sitamau	Shamgarh	Total	Percentage
Yes	13 (44.83)	12 (40)	16 (53.33)	41	46.06
No	16 (55.17)	18 (60)	14 (46.67)	48	53.93
Total	29 (32.58)	30 (33.71)	30 (33.71)	89	100

Table 4.6.14 shows that the awareness about the nutritious diet taken by rural women. It was found that the highest 53.93% rural women were not aware of a nutritious diet.

Table 4.6.15 Reasons for Non-awareness of nutritious diet by Rural Women

Option	Malhargarh	Sitamau	Shamgarh	Total	Percentage
Monthly Income	22 (75.86)	24 (80)	26 (86.67)	72	80.89
Not Aware	7 (24.14)	6 (20)	4 (13.33)	17	19.10
Total	29 (32.58)	30 (33.71)	30 (33.71)	89	100

The table 4.6.15 show that the reasons for non awareness about nutritious diet and foods by rural women. It found that the 80.89% of rural women were not taking nutritious diet due to lack of monthly income and the lowest 19.10 percentage of rural women were not aware of the nutritious diet.

Table 4.6.16 Chosen Places for Delivery of their Child by Rural Women

Option	Malhargarh	Sitamau	Shamgarh	Total
Home	0	0	0	0
Government facility	29 (100)	30 (100)	30 (100)	89 (100)
Accredited private facilities	0	0	0	0
Other private facilities	0	0	0	0
Total	29 (32.58)	30 (33.71)	30 (33.71)	89 (100)

Table 4.6.16 shows that the Chosen Places for Delivery of their Child by Rural Women. It was found that 100 percent of rural women in Malhargarh, followed by 100 percentages in Sitamau and the same as Shamgarh has chosen government facilities for delivery of their child.

Table 4.6.17 Awareness about Contraception

Option	Malhargarh	Sitamau	Shamgarh	Total
Yes	20 (68.95)	24 (80)	23 (76.67)	66 (74.15)
No	10 (34.48)	6 (20)	7 (23.33)	23 (25.85)
Total	29 (32.58)	30 (33.71)	30 (33.71)	89 (100)

The table and fig. 4.6.17 shows that awareness about contraception among rural women. It was found that the percentage of awareness about contraception was 77.08 in total rural women of all CHC, whereas 22.91 of rural women were not aware of contraception.

Table 4.6.18 Use of Contraception by Rural Women

Use of Contraception	Malhargarh	Sitamau	Shamgarh	Total
Yes	12 (41.37)	13 (43.33)	6 (20)	32 (35.95)
No	16 (55.17)	17 (56.67)	24 (80)	57 (64.04)
Total	29 (32.58)	30 (33.71)	30 (33.71)	89 (100)

The table 4.6.18 shows the Use of contraception by rural women. It was found that the percentage of rural women never used contraception were was 85.41 in CHC, whereas 14.58% of rural women never used contraception.

Table 4.6.19 Reasons for not using Contraception by Rural Women

Option	Malhargarh	Sitamau	Shamgarh	Total
Lack of information	16 (42.10)	17 (45.94)	24 (44.44)	57 (44.18)
Husband's not agree	6 (15.78)	10 (27.02)	10 (18.51)	26 (20.15)
Side effect	16 (42.110)	10 (27.02)	20 (37.03)	46 (35.65)
Total	38 (29.46)	37 (28.68)	54 (41.86)	129 (100)

Table no. 4.6.19 shows that the Reasons for not using concentration by rural women. It was found that 65.75% were not using due to lack of information, while 35.65% rural women were not using contraception because they are not used, this due to side effect, and 20.15% rural women are not using it due to their husbands are not ready for the same.

Table 4.6.20 Health Information received by Rural Women

Option	Malhargarh	Sitamau	Shamgarh	Total
Community health center	29 (100)	30 (100)	30 (100)	89 (100)
Sub-center	0	0	0	0
Primary Health Center	0	0	0	0
Districts hospital	0	0	0	0
Television	0	0	0	0
Newspapers	0	0	0	0
Adult education officials	0	0	0	0
Total	29 (32.58)	30 (33.70)	30 (33.70)	89 (100)

The above table 4.6.20 shows that health Information received by rural women. It was found 87.5 percentage of rural women received from CHC, followed by 8.33 received form district hospitals, 4.17 received form Primary health center, where as rural women have received health information from CHC.

Table 4.6.21 Taken treatment during Pregnancy by Rural Women

Option	Malhargarh	Sitamau	Shamgarh	Total
Yes	29 (100)	30 (100)	30 (100)	89 (100)
No	0	0	0	0
Total	29 (32.58)	30 (33.70)	30 (33.70)	89 (100)

Table 4.6.21 shows that the chosen treatment taken during pregnancy. It was found that the 33.70 percentage of rural women in Sitamau, the same as followed by 33.70 in

Shamgarh and 32.58 in Malhargarh taken treatment during their pregnancy time from the CHC.

Table 4.6.22 Types of Hospitals preferred by Rural Women

Option	Malhargarh	Sitamau	Shamgarh	Total
Community Health Center	29 (100)	30 (100)	30 (100)	89 (100)
Sub-center	0	0	0	0
Private hospital	0	0	0	0
Ayurvedic hospital	0	0	0	0
Traditional local health person	0	0	0	0
Total	29 (32.58)	30 (33.70)	30 (33.70)	89 (100)

The above Table 4.6.22 shows the types of hospitals preferred by rural women in case of health issues. It was found that the 100 of rural women were preferred to CHC in case of health needs.

Table 4.6.23 Availability of Medical Staff in CHC

Option	Malhargarh		Sitamau		Shamgarh		Total		Total & Per.
	Yes	No	Yes	No	Yes	No	Yes	No	
Doctor	25 (18.79)	4 (4.04)	28 (19.31)	2 (2.10)	29 (21.01)	1 (.98)	82 (19.71)	7 (2.36)	89 (12.5)
Nurse	29 (21.80)	0	30 (20.68)	0	29 (21.01)	1 (.98)	88 (21.15)	1 (0.34)	89 (12.5)
Compounder	15	14	20	10	20	10	55	34	89

	(11.27)	(14.14)	(13.79)	(10.52)	(14.9)	(9.80)	(13.22)	(11.49)	(12.5)
Health inspector	0 (9.77)	29 (16.16)	0 (9.65)	30 (16.84)	7 (14.9)	23 (9.80)	7 (11.30)	82 (14.19)	89 (12.5)
Health assistant (Male)	13 (9.77)	16 (16.16)	14 (9.65)	16 (16.84)	20 (14.9)	10 (9.80)	47 (11.30)	42 (14.19)	89 (12.5)
Health assistant (Female)	10 (7.51)	19 (19.19)	15 (10.34)	15 (15.78)	4 (2.89)	26 (25.49)	29 (6.97)	60 (20.27)	89 (12.5)
Lab technician	29 (21.80)	0	28 (19.31)	2 (2.10)	29 (21.01)	1 (.98)	86 (20.67)	3 (1.01)	89 (12.5)
Peon	12 (9.02)	17 (17.17)	10 (6.89)	20 (21.05)	0	30 (29.42)	22 (5.29)	67 (22.64)	89 (12.5)
Total	133 (31.97)	99 (33.45)	145 (34.86)	95 (32.09)	138 (33.17)	102 (34.46)	416 (58.43)	296 (41.57)	712 (100)

Above table 4.6.23 shows that the overall availability of medical staff in CHC. It was found that the availability of nurse staff was maximum i.e 21.15, same as followed by a lab technician with 20.67, followed by a doctor with 19.71, followed by a compounder with 13.25, followed by health inspector with 1.68, followed by health assistant male in CHC with 20.27%. While the availability of health assistant female staff with 20.27 and the least peon was with 22.64 were, not available in a regular way in CHC.

It was also found that the availability of complete staff was maximum in Sitamau CHC 35.85, followed by 33.17 in Shamgarh CHC and least was in Malhargarh CHC with 31.97.

Table 4.6.24 Satisfaction level with CHC Staff

Option	Malhargarh			Sitamau			Shamgarh			Total			Total
	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	(P+G+VG)
Doctors	9 (12)	20 (20.20)	0	3 (4.61)	27 (41.53)	0	1 (1.47)	29 (25.89)	0	13 (6.25)	76 (23.53)	0	89 (16.67)
Nurse and Compounder	10 (13.33)	19 (19.19)	0	2 (3.07)	28 (43.07)	0	5 (7.35)	25 (22.32)	0	17 (8.17)	72 (22.29)	0	89 (16.67)
Labor rooms	0	29 (29.29)	0	0	30 (46.15)	0	0	30 (26.78)	0	0	89 (27.55)	0	89 (16.67)
Radiographers & X-Ray Machines	29 (38.67)	0	0	30 (46.15)	0	0	30 (44.11)	0	0	89 (42.78)	0	0	89 (16.67)
Lab Technician & Pathology Labs	1 (1.33)	28 (28.28)	0	0	30 (46.15)	0	2 (2.94)	28 (25)	0	3 (1.44)	86 (26.63)	0	89 (16.67)
Generators	26 (34.67)	3 (3.03)	0	30 (46.15)	0	0	30 (44.11)	0	0	86 (41.35)	0	0	89 (16.67)
Total	75 (36.06)	99 (30.28)	0	65 (31.25)	115 (35.17)	0	68 (32.69)	112 (35.25)	0	208 (39.17)	323 (68.83)	0	534 (100)

The above Table 4.6.24 shows the overall satisfaction level with medical staff available in CHC. 115 (35.17) percentage found that the maximum rural women were satisfied in Sitamau, followed by 112 (35.25) percentage of rural women in Shamgarh, followed by 99 (30.28) in Malhargarh are good. Whereas 75 (36.06) percentage of rural women are not satisfied with CHC staff satisfied in Malhargarh, followed by 68 (32.69) percentage of rural women are not satisfied with CHC staff in Shamgarh, followed by 65 (31.25) percentage rural women are not satisfied with CHC staff in Sitamau (poor services).

Table 4.6.25 Aspects of visiting to CHC by Rural Women

Option	Malhargarh	Sitamau	Shamgarh	Total
Family planning	25 (13.96)	30 (16.48)	29 (13.80)	84 (14.71)
Natal care (Pre and Post natal)	29 (16.20)	30 (16.48)	25 (11.90)	84 (14.71)
Immunization	29 (16.20)	30 (16.48)	30 (4.28)	89 (15.58)
Communicable diseases	0	0	0	0
a) Malarial fever	20 (11.17)	18 (9.89)	20 (9.52)	58 (10.115)
b) Eye infections	10 (5.58)	2 (1.09)	10 (4.76)	22 (3.85)
c) Cough	17 (9.49)	22 (12.08)	20 (9.52)	59 (10.33)
d) Body pains	19 (10.61)	30 (16.48)	28 (13.33)	77 (13.48)
e) Knee pains	12 (6.70)	10 (5.49)	20 (9.52)	42 (7.33)
f) Problems of menopause	0	1 (.54)	6 (2.85)	7 (1.22)
g) Cancer	0	0	0	0
h) Blood pressure	18 (10.05)	11 (6.04)	20 (9.52)	49 (8.58)
Total	179 (31.35)	182 (31.87)	210 (36.78)	571 (100)

Table 4.6.25 shows that the overall aspect of visiting to CHC by rural women. It was found that the aspect of was maximum immunization with 15.59, followed with family planning 14.71, same as followed by natal care with 14.71, followed by body pain with 10.3, followed by cough with 10.33, followed by malaria with 10.16, followed by knee pains with 7.35, followed by problems of menopause with 6.61, followed by Blood pressure with 8.58, followed by Eye infections with 3.85 and least was menopause with 1.22 were aspect for visiting CHC by rural women.

It was also found that the aspect to visit is maximum in Shamgarh CHC 36.78, followed by 31.87 in Sitamau and least was in Malhargarh CHC with 31.35.

Table 4.6.26 Social Empowerment Status of Rural Women

Option	Malhargarh			Sitamau			Shamgarh			Total			Total
	Poor	Good	V.Good	Poor	Good	V.Good	Poor	Good	V.Good	P	G	VG	(P+G+VG)
Using Toilets	25 (12.37)	4 (4.54)	0	21 (9.25)	9 (12.32)	0	7 (3.55)	23 (22.33)	0	53 (8.47)	36 (13.64)	0	89 (10)
To increase hygiene in their area	20 (9.90)	9 (10.22)	0	22 (9.69)	8 (10.95)	0	7 (3.55)	23 (22.33)	0	49 (7.83)	40 (15.15)	0	89 (10)
Steps to take safe drinking water	18 (8.911)	11 (12.5)	0	25 (11.01)	5 (6.84)	0	10 (5.07)	20 (19.41)	0	53 (8.47)	36 (13.64)	0	89 (10)
Family planning methods	15 (7.42)	14 (15.90)	0	20 (8.81)	10 (13.69)	0	10 (5.07)	20 (19.41)	0	45 (7.19)	44 (6.67)	0	89 (10)
Supporting equal status for women	22 (10.89)	7 (7.95)	0	25 (11.01)	5 (6.84)	0	20 (10.15)	10 (9.70)	0	67 (10.70)	22 (3.14)	0	89 (10)
Securing the rights for Women	25 (12.37)	4 (4.54)	0	26 (11.45)	4 (5.47)	0	29 (14.71)	1 (0.97)	0	80 (12.78)	9 (3.41)	0	89 (10)
Voicing against social injustice	21 (10.40)	8 (9.09)	0	23 (10.13)	7 (9.58)	0	29 (14.71)	1 (0.97)	0	73 (11.66)	16 (6.06)	0	89 (10)
Supporting widow remarriage	22 (10.89)	7 (7.95)	0	24 (10.57)	6 (8.21)	0	29 (14.71)	1 (0.97)	0	75 (11.58)	14 (5.30)	0	89 (10)

Decision with regard to family Affairs	19 (9.40)	10 (11.36)	0	20 (8.81)	10 (13.69)	0	29 (14.72)	1 (0.97)	0	68 (10.86)	21 (7.95)	0	89 (10)
Decision with regard to health at home	15 (7.42)	14 (15.90)	0	21 (9.25)	9 (12.32)	0	27 (13.70)	3 (2.91)	0	63 (10.06)	26 (9.85)	0	89 (10)
Total	202 (32.27)	88 (33.33)	0	227 (36.26)	73 (27.65)	0	197 (31.47)	103 (39.02)	0	626 (70.34)	264 (29.66)	0	890 (100)

The above table no. 4.6.26 shows the overall social status of rural women. It is clear that the activities like Using Toilets 84.7, to increase hygiene in their area 78.3, Steps to take safe drinking water 84, Securing the rights for Women 12.78, Supporting widow remarriage 11.58, Voicing against social injustice 11.66, Supporting equal status for 10.70, Decision about family Affairs 10.68, Decision about health at home 10.06 Family planning methods 7.17 were in poor condition. It was found that the overall social empowerment status 227 (36.26) percentage of rural women were poor in Sitamau, followed by 202 (32.27) in Malhargarh, while 103 (9.02) in Shamgarh.

Table 4.7 Sample Size of Satna (West Zone)

Questionnaire Distributed in CHC	Questionnaire Distributed	Questionnaire Received	Questionnaire's Analyzed
Amarpatan	30	30	30
Devrajnagar	30	26	26
Mukundpur	30	20	20
Majhgawan	30	30	30
Nagod	30	30	30
Rampur Baghelan	30	20	20
Uchehra	30	30	30
Total	210	186	186

Table no.4.8 shows that a total of 210 questionnaires were distributed among rural women and out of these 186 received back. It was observed that the highest response received from Amarpatan is 30, followed by Majhgawan is 30, followed by Nagod is 30 and the minimum is from Devrajnagar is 26, followed by 20 and same as Rampur Baghelan is 20 at presented rural women in all CHC.

Table 4.7.1 Types of Category/ Population

Category	Amarpatan	Devrajnagar	Mukundpur	Majhgawan	Nagod	Rampur Baghelan	Uchehra	Percentage
General	0	1 (3.84)	0	0	0	0	3 (10)	4
OBC	10 (33.33)	1 (3.84)	9 (45)	10 (33.33)	11 (36.66)	9 (45)	8 (26.67)	58
Scheduled Caste	16 (53.33)	16 (61.53)	8 (40)	11 (36.67)	13 (43.33)	8 (40)	13 (43.33)	85
Scheduled Tribal	4 (13.33)	8 (30.76)	3 (15)	9 (30)	6 (20)	3 (15)	6 (20)	39
Total	30 (16.13)	26 (13.18)	20 (10.75)	30 (16.13)	30 (16.13)	20 (10.75)	30 (16.13)	186 (100)

OBC= Other Backward Class, SC=Scheduled Caste, ST=Scheduled Tribal

Table 4.7.1 shows the type of category among rural women which shows that the highest category of rural women 85 belong to SC, followed by 58 belongs to OBC, and 39 are ST and 4 percentages of rural women are General category.

Table 4.7.2 Family's Monthly Income

Option	Amarpa tan	Devrajna gar	Mukund pur	Majhga wan	Nagod	Rampur Baghelan	Uchehra	Percentage
Up to 2000	0	3 (11.54)	0	5 (16.67)	0	4 (20)	7 (23.33)	19 (10.22)
2000-4000	22 (73.33)	21 (80.77)	16 (80)	22 (73.33)	18 (60)	13 (65)	18 (60)	130 (69.89)
5000-10000	8 (26.67)	2 (7.70)	4 (20)	3 (10)	12 (40)	3 (15)	5 (16.67)	37 (19.89)
10000 - more	0	0	0	0	0		0	0
Total	30 (16.13)	26 (13.18)	20 (10.75)	30 (16.13)	30 (16.13)	20 (10.75)	30 (16.13)	186 (100)

Table 4.7.2 shows that the family's income of rural women's husband in which 69.89 rural women family income is up to 2000-4000 monthly, followed by 10.22 women family income is up to 2000, followed by 19.89 rural women are between 5000-10000 monthly family incomes.

Table 4.7.3 Education Levels of Women

Option	Amarpatan	Devrajnagar	Mukundpur	Majhgawan	Nagod	Rampur Baghelan	Uchehra	Total	Percentage
Illiterate	9 (30)	10 (38.46)	11 (55)	14 (46.67)	13 (43.13)	8 (40)	13 (43.33)	78	41.94
Primary	15 (50)	10 (38.46)	5 (25)	13 (43.33)	10 (33.33)	5 (25)	11 (36.67)	69	23.12
Secondary	3 (10)	5 (19.23)	4 (20)	2 (6.67)	4 (13.33)	4 (20)	6 (20)	28	15.05
Higher Secondary	3 (10)	1 (3.85)	0	1 (3.33)	3 (10)	3 (15)	0	11	5.91
Graduate	0	0	0	0	0	0	0	0	0
Total	30 (16.13)	26 (13.18)	20 (10.75)	30 (16.13)	30 (16.13)	20 (10.75)	30 (16.13)	186	100

The Table 4.7.3 shows the education level of rural women in which 41.94 rural women are illiterate, 23.12 rural women have primary education, and 15.05 of rural women have secondary level education and 5.91 rural women have higher secondary education.

Table 4.7.4 Marital Status of Women

Option	Amarpatan	Devraj nagar	Mukund pur	Majhg awan	Nagod	Rampur Baghela n	Uchehr a	Total	Percentage
Married	30 (100)	26 (100)	20 (100)	30 (100)	30 (100)	20 (100)	30 (100)	186	100
Unmarried	0	0	0	0	0	0	0	0	0
Total	30 (16.13)	26 (13.18)	20 (10.75)	30 (16.13)	30 (16.13)	20 (10.75)	30 (16.13)	186 (100)	100

Table 4.7.4 shows the marital status of rural women. It was found that 100 percent of women are married in CHC.

Option	Amarpatan	Devrajnagar	Mukundpur	Majhgawan	Nagod	Rampur Baghelan	Uchehra	Total	Percentage
Agriculture	28 (70)	17 (54.83)	19 (65.52)	26 (55.32)	12 (40)	11 (37.93)	23 (57.5)	136	55.28
Govt. Employee	0	0	0	0	0	0	0	0	0
No Employment	2 (5)	0	0	2 (4.26)	0	6 (20.68)	0	10	4.07
Farm Worker	0	0	0	0	0	0	0	0	0
Private	10 (25)	14 (45.16)	10 (34.48)	18 (38.30)	18 (60)	12 (41.37)	17 (42.5)	99	40.24
Driver	0	0	0	0	0	0	0	0	0
Business	0	0	0	1 (2.12)	0	0	0	1	0.41
Others	0	0	0	0	0	0	0	0	0
Total	40 (16.26)	31 (12.60)	29 (11.29)	47 (19.11)	30 (12.20)	29 (11.79)	40 (16.26)	246	100

Table 4.7.5 Occupation of the Rural Women's Husband

Table 4.7.5 shows the occupations of rural woman's husbands in which 55.2 rural women's husbands are doing agriculture, while 40.24 rural women's husbands are doing private work, followed by 0.415 are doing business and 4.07 rural women husband are unemployed.

Table 4.7.6 Housing and living Status of rural women

Housing Status (Variable)	Categories	Amarpatan	Devrajnagar	Mukundpur	Majhgawan	Nagod	Rampur Baghelan	Uchehra	Total	Percentage
Type of House	Hut	15 (7.14)	12 (7.70)	20 (15.15)	18 (9.68)	20 (11.11)	17 (11.73)	24 (11.60)	126	10.36
	Tiled	3 (1.42)	0	0	0	0	0	1 (0.48)	4	0.33
	Concrete	12 (5.72)	14 (8.98)	0	12 (6.45)	10 (5.56)	6 (4.13)	5 (2.41)	59	4.85
Ownership of House	Rented	0	0	0	0	0	0	0	0	0
	Own	30 (14.28)	28 (17.95)	20 (15.15)	30 (16.12)	30 (16.67)	20 (13.80)	30 (14.49)	186	15.30
	Others	0	0	0	0	0	0	0	0	0
Number of Rooms	One	12 (5.72)	11 (7.05)	4 (3.03)	12 (6.45)	12 (6.67)	10 (6.90)	12 (5.80)	73	6.00
	Two	18 (8.58)	15 (9.62)	10 (7.58)	18 (9.68)	13 (7.22)	12 (8.27)	18 (8.70)	104	8.55
	Three	0	0	6 (4.55)	0	5 (2.78)	0	0	11	0.90
	Four	0	0	0	0	0	0	0	0	0
	More than	0	0	0	0	0	0	0	0	0

Toilet	Not Available	6 (2.86)	4 (2.57)	16 (12.12)	11 (5.92)	13 (7.22)	9 (6.20)	8 (3.87)	67	5.51
	Available	24 (11.42)	22 (14.10)	4 (3.03)	7 (3.77)	17 (9.44)	11 (7.59)	22 (10.63)	107	8.80
Drinking water	Tap	7 (3.33)	6 (3.85)	2 (1.52)	12 (6.45)	11 (6.11)	4 (2.76)	8 (3.87)	50	4.11
	Hand Pump	23 (13.33)	20 (12.82)	18 (13.64)	18 (9.68)	19 (10.56)	16 (11.03)	22 (10.63)	136	11.18
Electricity	Not Available	0	2 (1.28)	10 (7.58)	6 (3.22)	2 (1.11)	7 (4.83)	3 (1.44)	30	2.47
	Available	30 (14.28)	24 (15.38)	10 (7.58)	24 (12.90)	24 (13.33)	13 (8.97)	27 (13.04)	156	12.83
Leisure time	Television	22 (10.47)	0	0	0	0	10 (6.90)	12 (5.80)	44	3.62
	Radio	4 (1.90)	0	0	0	0	3 (2.06)	0	7	0.58
	News paper	0	0	0	0	0	0	0	0	0
	No activity	4 (1.90)	0	12 (9.09)	18 (9.68)	0	7 (4.83)	15 (7.24)	56	4.61
Total		210 (17.27)	156 (12.83)	132 (10.86)	186 (15.30)	180 (14.80)	145 (11.92)	207 (17.02)	1216	100

The data presented in the table 4.7.6 shows the housing status of rural women, which is 10.36 percent of rural women, were living in Huts house, whereas 15.30 percent of rural women have their own home. 8.55% of rural women are living in a double room, whereas 6.00% rural women live in a single room, followed by 0.90 rural women living in a three-room set room. Overall 8.80% of women have Toilet facility and 5.51 are

not having. The drinking water facility for rural women shows that there is 11.18 using hand pump and 4.11 are having taps for taken water facility. Around 12.83% said they have electricity and 2.47 are not having electricity. Television, Newspapers and leisure activities are not done by them.

Table 4.7.7 Awareness about Health Literacy

Awareness Health Literacy	Amarpatan	Devrajnagar	Mukundpur	Majhgawan	Nagod	Rampur Baghelan	Uchehra	Total	Percentage
Yes	12 (40)	12 (46.15)	9 (45)	13 (43.33)	11 (36.67)	5 (25)	13 (43.33)	75	40.32
No	18 (60)	14 (53.85)	11 (55)	17 (56.67)	19 (63.33)	15 (75)	17 (56.67)	111	59.68
Total	30 (16.13)	26 (13.18)	20 (10.75)	30 (16.13)	30 (16.13)	20 (10.75)	30 (16.13)	186 (100)	100

The table no 4.8.7 shows the awareness of Health Literacy among rural women was very low. It was found that 59.68 of women were unaware of health literacy, whereas 40.32 of women were aware of health literacy.

Table 4.7.8 Reasons for Non-Awareness about Health Literacy

Option	Amarpatan	Devrajnag	Mukun	Majhgaw	Nagod	Rampur	Uchehra	Total	Percentag
---------------	------------------	------------------	--------------	----------------	--------------	---------------	----------------	--------------	------------------

		ar	dpur	an		Baghela n			e
Lack of education	14 (48.27)	14 (51.86)	10 (40)	16 (45.71)	17 (47.22)	14 (48.27)	15 (46.88)	100	46.95
Lack of Health Information	15 (51.73)	12 (44.44)	13 (52)	17 (48.58)	19 (52.78)	15 (51.73)	17 (53.12)	108	50.70
Not interested	0	0	2 (8)	0	0	0	0	2	0.94
On opinion	0	1 (3.70)	0	2 (5.71)	0	0	0	3	1.41
Total	29 (13.61)	27 (12.67)	25 (11.73)	35 (16.43)	36 (16.90)	29 (13.61)	32 (15.02)	213	100

The Table 4.7.8 shows that the majority of rural women i.e. 50.70 were not aware of health literacy due to lack of health information, whereas 46.95 of rural women were unaware of health literacy because of lack of education, followed by 0.94 were not interested in health literacy because of their some personal Reasons.

Table 4.7.9 Provision of Health Information, Resources, and Services

Option	Amarpatan	Devrajnagar	Mukundpur	Majhgawan	Nagod	Rampur Baghelan	Uchehera	Total	Percentage
Yes	12 (40)	12 (46.15)	9 (45)	13 (43.33)	11 (36.67)	5 (25)	13 (43.33)	75	40.32
No	18 (60)	14 (53.85)	11 (55)	17 (56.67)	19 (63.33)	15 (75)	17 (56.67)	111	59.68
Total	30 (16.12)	26 (13.97)	20 (10.75)	30 (16.12)	30 (16.12)	20 (10.75)	30 (16.12)	186	100

Table 4.7.9 shows the provision of health information, resources, and services provided by CHC for rural women. It was found that the maximum highest 40.32 rural women access health information, resources, and services from the CHC and a minimum 59.68 were not received if from CHC.

Table 4.7.10 Awareness, Source and Uses of Immunization

Option	Category	Amarpata n	Devrajnaga r	Mukundp ur	Majhgaw an	Nagod	Rampur Baghelan	Uchehra	Total	Percentage
Awareness about Immunization	No Awareness	8 (5.84)	4 (3.36)	5 (4.90)	17 (12.78)	9 (6.76)	11 (12.95)	14 (10.69)	68	8.10
	Had	22 (16.05)	22 (18.48)	15 (14.70)	13 (9.78)	21 (15.79)	9 (10.59)	16 (12.21)	118	14.05
Source of Information on Immunization	Doctors	15 (10.95)	11 (9.24)	14 (13.73)	15 (11.27)	20 (15.03)	5 5.89	11 (8.39)	91	10.83
	Health visitors	5 (3.65)	4 (3.36)	8 (7.85)	0	0	0	0	17	2.02
	AASHA	30 (21.90)	28 (23.53)	20 (19.60)	30 (22.56)	30 (22.56)	20 (23.53)	30 (22.90)	186	22.14
	Nurse	27 (19.70)	26 (21.85)	20 (19.60)	30 (22.56)	23 (17.29)	20 (23.53)	30 (22.90)	176	20.95

Awareness about Diseases prevented by Immunization	Fully aware	0	0	0	0	0	0	0	0	0
	Partially aware	17 (12.40)	26 (21.85)	17 (16.67)	21 (15.79)	28 (21.05)	14 (1.47)	24 (18.32)	147	17.5
	Not aware	13 (9.48)	0	3 (2.95)	7 (5.26)	2 (1.50)	6 (7.05)	6 (4.59)	37	4.40
Total		137 (16.31)	119 (14.17)	102 (12.14)	133 (15.83)	133 (15.83)	85 (15.60)	131 (16.31)	840	100

Table 4.7.10 shows that the Awareness about Immunization, Sources of Immunization Information, and Awareness about diseases prevented by Immunization among rural women. It was found that the highest percentage of Uchehra which is 19.06 were aware about Immunization, sources of information on immunization, and awareness about diseases prevented, while minimum in Rampur Baghelan, i.e. is 10.29.

Table 4.7.11 Availability and Accessibility of Health Care Services Provided by CHC

Variable	Categories	Amarpatan	Devrajnagar	Mukundpur	Majhgawan	Nagod	Rampur Baghela	Uchehera	Total	Percentage
Distance to Community Health Center (in km)	1.00-5.00	0	0	0	0	0	0	2 (1.33)	2	0.25
	6.00-10.0	21 (17.21)	22	7 (7.29)	9 (7.5)	13 (10.84)	18 (22.22)	22 (14.67)	112	14.23
	11.0-15.0	9 (7.37)	4 (4.08)	10 (10.41)	15 (12.5)	12 (10)	2 (2.46)	6 (4)	66	8.39

	16.0-20.0	0	0	3 (3.12)	6 (5)	5 (4.16)	0	0	14	1.78
	21.0-25.0	0	0	0	0	0	0	0	0	0
Reasons for visiting Community Health Centers	For free Medicine	30 (24.59)	28 (22.44)	20 (20.84)	30 (25)	30 (25)	20 (24.70)	30 (20)	186	23.63
	Emergency	20 (16.39)	16 (16.32)	8 (8.33)	22 (18.33)	25 (20.84)	11 (13.59)	24 (16)	126	16.01
	Minor Illness	10 (8.19)	4 (4.08)	0	8 (6.67)	5 (4.16)	9 (11.11)	6 (4)	42	5.34
	Not visiting	0	0	0	0	0	0	0	0	0
Visiting Private Clinic	Minor Illness	0	0	0	0	0	1 (1.23)	0	1	0.13
	Partially	2 (1.64)	0	20 (20.84)	0	0	0	30 (20)	52	6.61
Distance to Medical Shop(in km)	00.-.50	30 (24.59)	28 (22.44)	20 (20.84)	30 (25)	30 (25)	20 (24.70)	30 (20)	186	23.63
	1.00-2.00	0	0	0	0	0	0	0	0	0
	3.00.-more than	0	0	0	0	0	0	0	0	0
Total		122 (15.50)	98 (12.45)	96 (12.20)	120 (15.25)	120 (15.20)	81 (10.29)	150 (19.06)	787	100

Table 4.7.11 shows the availability and accessibility of Health Care Services in CHC for rural women. It was found that the overall availability and accessibility is poor in Uchehra 19.06, followed by Amarpatan, it was 15.50, followed by Nagod, it was 15.25, followed by Majhgawan, it was 15.20, followed by Devrajnagar, which was 12.45, followed by Mukundpur, where it was 12.20 and lowest poor in Rampur Baghelan, where it was 10.29.

Table 4.7.12 Access to the Satisfactory Road Network in Rural Areas

Option	Amarpatan	Devrajnagar	Mukundpur	Majhgawan	Nagod	Rampur Baghelan	Uchehra	Total	Percentage
Yes	18 (60)	16 (61.54)	12 (60)	18 (60)	19 (63.33)	15 (75)	18 (60)	116	62.36
No	12 (40)	10 (38.46)	8 (40)	12 (40)	11 (36.67)	5 (25)	12 (40)	70	37.64
Total	30 (16.13)	26 (13.18)	20 (10.75)	30 (16.13)	30 (16.13)	20 (10.75)	30 (16.13)	186 (100)	100

The presented data in table 4.7.12 shows that the satisfactory road network in Amarpatan, Devrajnagar, Mukundpur, Majhgawan, Nagod, Rampur Baghelan, and Uchehra CHC. It was satisfaction about road network the highest is 62.63 and the lowest is 37.36 among rural women.

Table 4.7.13 Barriers to Health Treatment

Option	Amarpatan			Devrajnagar			Mukundpur			Majhgawan			Nagod			Rampur Baghelan			Uchehra			Total			Total
	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	
Social status	15 (10.72)	1 (3.548)	4 (11.11)	1 (1.798)	3 (7.65)	6 (16.67)	1 (1.37)	2 (3.33)	4 (10.67)	2 (5.26)	4 (11.11)	6 (16.67)	2 (5.26)	4 (11.11)	3 (8.33)	1 (2.78)	0	1 (2.78)	18 (47.77)	4 (10.38)	8 (20.4)	126 (14.06)	28 (18.18)	32 (12.74)	186
Self-perceived health	19 (13.58)	7 (2.59)	4 (11.11)	1 (1.298)	4 (10.33)	5 (13.89)	1 (1.24)	1 (2.67)	8 (20.33)	2 (5.26)	4 (10.67)	4 (10.67)	2 (5.26)	6 (15.79)	4 (10.67)	1 (2.78)	0	1 (2.78)	22 (56.6)	3 (7.69)	5 (12.9)	130 (14.50)	25 (16.23)	31 (12.35)	186

Not Able to pay for Medication	24 (17.14)	2 (6.45)	4 (11.11)	2 (1.68)	1 (5.89)	5 (13.89)	2 (1.68)	0 (0.00)	0 (0.00)	1 (1.45)	5 (14.70)	10 (22.22)	1 (1.20)	8 (2.53)	7 (1.73)	1 (1.45)	2 (3.33)	2 (7.70)	18 (12.77)	4 (15.38)	8 (19.04)	130 (14.50)	22 (14.28)	36 (14.34)	190
Not Able to afford doctor	22 (15.72)	2 (6.45)	6 (16.67)	2 (1.52)	2 (1.77)	4 (11.11)	1 (1.56)	1 (1.67)	1 (6.67)	1 (1.29)	5 (14.70)	8 (17.78)	1 (1.45)	1 (2.59)	1 (1.90)	1 (1.00)	4 (6.67)	4 (15.38)	20 (14.18)	4 (15.38)	5 (11.90)	127 (14.17)	19 (12.33)	38 (15.93)	184
Limited activities because of health problems	28 (22.00)	0	2 (5.56)	1 (7.64)	6 (3.59)	10 (27.78)	1 (1.31)	2 (3.33)	2 (13.33)	1 (1.45)	1 (3.59)	3 (6.67)	1 (1.52)	6 (17.65)	5 (9.80)	1 (1.63)	0	2 (7.70)	21 (14.90)	5 (19.23)	4 (9.53)	127 (14.17)	31 (20.12)	28 (11.15)	186
Monthly household income	18 (12.86)	5 (1.61)	7 (19.44)	2 (1.68)	0	4 (11.11)	2 (1.68)	0 (0.00)	0 (0.00)	2 (1.68)	2 (5.89)	6 (13.33)	1 (.88)	7 (2.05)	1 (2.35)	1 (2.45)	0	4 (15.38)	20 (14.18)	4 (15.38)	6 (14.28)	129 (14.39)	18 (11.68)	39 (15.53)	186
Unable to reach out to CHC	14 (14.00)	4 (1.90)	9 (25.00)	2 (1.75)	1 (.89)	2 (5.56)	2 (1.68)	0 (0.00)	0 (0.00)	2 (1.59)	2 (5.90)	8 (17.78)	1 (1.45)	2 (5.90)	1 (1.90)	1 (1.00)	0	10 (38.46)	22 (15.60)	2 (7.70)	6 (14.28)	127 (14.17)	11 (7.14)	45 (17.92)	183

Total	140 (15.63)	3 (1.03)	36 (14.34)	1 (1.46)	1 (1.4)	36 (11.34)	1 (1.3)	6 (3.9)	15 (5.98)	1 (1.4)	3 (2.08)	45 (17.93)	1 (1.4)	3 (2.08)	5 (2.0)	1 (1.2)	6 (3.9)	26 (10.36)	141 (15.74)	26 (16.88)	42 (16.73)	896 (68.87)	15 (11.84)	251 (19.29)	1301
--------------	-----------------------	--------------------	----------------------	--------------------	-------------------	----------------------	-------------------	-------------------	---------------------	-------------------	--------------------	----------------------	-------------------	--------------------	-------------------	-------------------	-------------------	----------------------	-----------------------	----------------------	----------------------	-----------------------	----------------------	-----------------------	-------------

Note- P=Poor, E=Easy, V.G= Very Good.

Table 4.7.13 shows the barriers to health treatment faced by rural women. The poor social status, Self-perceived health, not able to pay for Medication, not able to afford doctor, limited activities because of health problems, monthly household income condition was found to be the main barriers 15.74 percentage in Uchehra, followed by Amarpatan it was 15.63, followed by Devrajnagar it were 14.62, followed by Majhgawan it was 14.62, Mukundpur, which was 13.28, followed by Nagod, where it was 13.84 and Rampur Baghelan has the lowest percentage of 12.28.

Table 4.7.14 Awareness about Nutritious diet taken by Rural Women

Option	Amarpatan	Devrajnagar	Mukundpur	Majhgawan	Nagod	Rampur Baghelan	Uchehra	Total	Percentage
Yes	12 (40)	9 (34.62)	8 (40)	11 (36.67)	10 (33.33)	6 (30)	9 (30)	65	34.95
No	18 (60)	17 (65.38)	12 (60)	19 (63.33)	20 (66.67)	14 (70)	21 (70)	121	65.05
Total	30	26	20	30	30	20	30	186	100

	(16.13)	(13.18)	(10.75)	(16.13)	(16.13)	(10.75)	(16.13)	(100)	
--	---------	---------	---------	---------	---------	---------	---------	-------	--

The table 4.7.14 shows the awareness about nutritious diet taken by rural women. It was found that the highest 65.05 rural women were not aware of nutritious diet.

Table 4.7.15 Reasons for Non awareness of Nutritious Diet by Rural Women

Option	Amarpatan	Devrajnagar	Mukundpur	Majhgawan	Nagod	Rampur Baghelan	Uchehra	Total
Monthly Income	12 (40)	9 (34.62)	8 (40)	11 (36.67)	10 (33.33)	14 (70)	21 (70)	65
Not Aware	18 (60)	17 (65.38)	12 (60)	19 (63.33)	20 (66.67)	6 (30)	9 (30)	121
Total	30 (16.13)	26 (13.18)	20 (10.75)	30 (16.13)	30 (16.13)	20 (10.75)	30 (16.13)	186 (100)

The table 4.7.15 show that the Reasons for Non awareness about nutritious diet and foods by rural women. It found that 70.83 percent of rural women were not taking nutritious diet due to their lack of monthly income and the lowest 29.17 percentage of rural women were not aware of the nutritious diet.

Table 4.7.16 Chosen Places for Delivery of their Child by Rural Women

Option	Amarpata n	Devrajnagar	Mukundpur	Majhgawa n	Nagod	Rampur Baghelan	Uchehra	Total % Percentage
Home	0	0	0	0	0	0	0	0
Government facility	30 (100)	28 (100)	20 (100)	30 (100)	30 (100)	20 (100)	30 (100)	186 (100)
Accredited private facilities	0	0	0	0	0	0	0	0
Other private facilities	0	0	0	0	0	0	0	0
Total	30 (16.13)	28 (13.18)	20 (10.75)	30 (16.13)	30 (16.13)	20 (10.75)	30 (16.13)	186 (100)

The above table 4.7.16 shows that the Chosen Places for Delivery of their Child by Rural Women. It was found that 100 percent of rural women in all CHC chosen government facilities for delivery of their child.

Table 4.7.17 Awareness about Contraception

Option	Amarpata n	Devrajna gar	Mukun dpur	Majhgawa n	Nagod	Rampur Baghelan	Uchehra	Total	Perce ntage
Yes	23 (76.67)	16 (57.14)	14 (70)	22 (73.33)	21 (70)	11 (55)	16 (53.33)	121	65.05
No	7 (23.33)	12 (42.86)	6 (30)	8 (26.67)	9 (30)	9 (45)	14 (46.67)	65	34.95
Total	30	28	20	30	30	20	30	186	100

	(16.12)	(15.05)	(10.75)	(16.12)	(16.12)	(10.75)	(16.12)		
--	---------	---------	---------	---------	---------	---------	---------	--	--

Table 4.7.17 shows that awareness about contraception among rural women. It was found that the percentage of awareness about contraception was 65.05% in CHC, whereas 34.95 percent of rural women were not aware of contraception.

Table 4.7.18 Use of Contraception by Rural Women

Use of Contraception	Amarpatan	Devrajnagar	Mukundpur	Majhgawan	Nagod	Rampur Baghelan	Uchhra	Total	Percentage
Yes	10 (33.33)	12 (46.15)	5 (25)	10 (33.33)	17 (56.67)	8 (40)	13 (43.33)	75	40.32
No	20 (66.67)	14 (53.85)	15 (75)	20 (66.67)	13 (43.33)	12 (60)	17 (56.67)	111	59.68
Total	30	26	20	30	30	20	30	186	100

	(16.13)	(13.18)	(10.75)	(16.13)	(16.13)	(10.75)	(16.13)		
--	---------	---------	---------	---------	---------	---------	---------	--	--

The table 4.7.18 shows the Use of contraception by Rural Women. It was found that the percentage of rural women never used contraception were 59.68 in total rural women of all CHC, whereas 40.32 percent of rural women used contraception.

Table 4.7.19 Reasons for not using Contraception by Rural Women

Option	Amarpatan	Devrajnagar	Mukundpur	Majhgawan	Nagod	Rampur Baghelan	Uchehra	Total	Percentage
Lack of information	19 (63.33)	14 (50)	14 (70)	20 (66.66)	13 (43.33)	12 (60)	15 (50)	107	37.68
Husband's	11 (36.67)	8 (28.57)	5 (25)	10 (33.33)	10 (33.33)	9 (45)	11 (36.67)	64	22.54
Side effect	20 (66.67)	16 (57.14)	15 (75)	20 (66.66)	13 (43.33)	12 (60)	17 (56.67)	113	39.79
Total	50 (17.61)	38 (13.38)	34 (11.97)	50 (17.61)	36 (12.68)	33 (11.62)	43 (15.14)	284	100

)				
--	--	--	--	--	---	--	--	--	--

The table 4.7.19 shows that the reasons for not using concentration by rural women. It was found the highest percentage of Amarpatan, where rural women did not use contraception due to lack of information because their husband are not agree, the side effect the total percentage is 17.61, followed by Majhgawan, it was the second-highest percentage for the same belong to Majhgawan which is 17.61, followed by Uchehra it was 15.14, moving on 13.38 is Devrajnagar, followed by Nagod where is 12.68. The lowest percentage of Mukundpur is 11.97 and Rampur Baghelan, which their rural women did not use contraception due to lack of information because of their husband are not agree, the side effect is 11.62.

Table 4.7.20 Health Information received by Rural Women

Option	Amarpatan	Devrajnagar	Mukundpur	Majhgawan	Nagod	Rampur Baghelan	Uchehra	Total
Health Community health Center	30 (27.27)	25 (29.76)	30 (28.57)	30 (31.25)	22 (24.72)	30 (26.79)	23 (26.14)	190 (27.78)
Sub-Center	15 (13.64)	5 (5.95)	10 (9.52)	6 (6.25)	10 (11.24)	13 (11.61)	9 (10.23)	68 (9.94)
Primary Health Center	10 (0.09)	12 (14.29)	15 (14.29)	12 (12.50)	18 (20.22)	10 (8.93)	11 (12.50)	88 (12.87)
Districts hospital	20 (18.18)	22 (26.19)	25 (23.81)	23 (23.96)	18 (20.22)	25 (22.32)	20 (22.73)	153 (22.37)
Television	20 (18.18)	13 (15.48)	20 (19.05)	21 (21.88)	19 (21.35)	24 (21.43)	19 (21.59)	136 (19.88)

Newspapers	15 (13.64)	7 (8.33)	5 (4.76)	4 (4.17)	2 (2.25)	10 (8.93)	6 (6.82)	49 (7.16)
Adult education officials	0	0	0	0	0	0	0	0
Total	110 (16.08)	84 (12.28)	105 (15.35)	96 (14.04)	89 (13.01)	112 (16.37)	88 (12.87)	684

Table 4.7.20 shows that health Information received by rural women. It was found that the highest 27.18% percentage of rural women received from CHC, followed by 22.37% received from the district hospital, followed by 19.88% television, followed by 12.87% received from the Primary Health Center, followed by 9.94% received from sub-center, followed by 7.16% received from Newspapers, whereas others received from CHC.

Table 4.7.21 Treatment taken during Pregnancy by Rural Women

Option	Amarpata n	Devrajnagar	Mukundpur	Majhgawa n	Nagod	Rampur Baghela n	Uchehra	Total	Percentage
Yes	30 (100)	26 (100)	20 (100)	30 (100)	30 (100)	20 (100)	30 (100)	186	100
No	0	0	0	0	0	0	0	0	0
Total	30	26	20	30	30	20	30	186	100

	(16.13)	(13.18)	(10.75)	(16.13)	(16.13)	(10.75)	(16.13)		
--	---------	---------	---------	---------	---------	---------	---------	--	--

The above table 4.7.21 shows that the chosen treatment taken during pregnancy. It was found that 100 percent of rural women in all CHC have taken treatment during their pregnancy time from the CHC.

Table 4.7.22 Types of Hospitals Preferred by Rural Women

Option	Amarpatan	Devrajnagar	Mukundpur	Majhgawan	Nagod	Rampur Baghelan	Uchehra	Total	Percentage
Community health Center	30 (100)	26 (100)	20 (100)	30 (100)	3 (100)	20 (100)	30 (100)	186	100
Sub-Center	0	0	0	0	0	0	0	0	0
Private hospital	0	0	0	0	0	1	0	0	0

Ayurveda hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Traditional local health person	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	30 (16.13)	26 (13.18)	20 (10.75)	30 (16.13)	30 (16.13)	20 (10.75)	30 (16.13)	186	100								

The above table 4.7.22 shows the types of hospitals preferred by rural women in case of health issues. It was found that 100 percent of rural women preferred to CHC in case of health needs.

Table 4.7.23 Availability of Medical Staff in CHC

Option	Amarpatan		Devrajnagar		Mukundpur		Majhgawan		Nagod		Rampur Baghelan		Uchehra		Total & Percentage		Total & Percentage (Y+N)
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
Doctor	30 (19.87)	0	15 (17.24)	11 (9.09)	20 (17.70)	10 (13.70)	30 (15.79)	0	30 (18.64)	0	20 (20)	0	30 (18.40)	0	175 (18.08)	21 (3.78)	196 (12.86)
Nurse	30 (19.8)	0	26 (29.1)	0	20 (17.70)	10 (13.70)	30 (15.79)	0	30 (18.64)	0	20 (20)	0	30 (18.40)	0	186 (19.21)	10 (1.80)	196 (12.86)

	7)		89)		70)	.70)	79)		64)				.40)				
Compounder	16 (10.6 0)	14 (15. 74)	0	26 (21. 48)	18 (15. 93)	8 (10 .96)	30 (15. 79)	0	23 (14. 28)	17 (19 .77)	20 (20)	0	20 (12 .26)	10 (1 2. 99)	127 (13.12)	75 (13.49)	202 (13.25)
Health inspector	30 (19.8 7)	0	0	26 (21. 48)	5 (4.4 2)	15 (20 .55)	8 (4.2 1)	22 (4 4)	19 (11. 80)	11 (12 .80)	0	20 (33.33)	11 (6. 75)	19 (2 4. 68)	73 (7.54)	113 (20.32)	186 (12.20)
Health assistant (Male)	3 (1.99)	27 (30. 33)	0	26 (21. 48)	0	0	22 (11. 58)	8 (1 6)	2 (1.2 4)	28 (32. 55)	0	20 (33.33)	12 (7. 36)	18 (2 3. 37)	39 (4.03)	127 (22.84)	166 (10.89)
Health assistant (Female)	8 (5.29)	22 (24. 72)	15 (17. 24)	11 (9.0 9)	20 (17. 70)	10 (13 .70)	10 (5.2 6)	20 (4 0)	0	30 (34 .89)	0	20 (33.33)	0	30 (3 8. 97)	53 (5.48)	143 (25.72)	196 (12.86)
Lab technician	30 (19.8 7)	0	26 (29. 89)	0	20 (17. 70)	10 (13 .70)	30 (15. 79)	0	30 (18. 64)	0	20 (20)	0	30 (18 .40)	0	186 (19.21)	10 (1.80)	196 (12.86)
Peon	4 (2.65)	26 (29. 21)	5 (5.7 5)	21 (17. 35)	10 (8.8 5)	10 (13 .70)	30 (15. 79)	0	30 (18. 64)	0	20 (20)	0	30 (18 .40)	0	129 (13.33)	57 (10.25)	186 (12.20)

Total	151 (16.01)	89 (9.19)	87 (9.19)	121 (21.76)	113 (11.67)	73 (13.13)	190 (19.63)	50 (16.94)	164 (16.94)	86 (15.5)	100 (10.33)	60 (10.79)	163 (16.8)	77 (13.8)	968 (63.52)	556 (36.5)	1524
--------------	------------------------------	--------------	--------------	------------------------------	----------------	---------------	------------------------------	---------------	------------------------------	--------------	------------------------------	---------------	-----------------------------	--------------	------------------------------	-----------------------------	-------------

Table 4.7.23 shows that the overall availability of medical staff in CHC. It was found that the availability of nurse staff was maximum i.e 19.21, same as followed by a lab technician with 19.21, followed by a doctor with 18.08, followed by peon with 13.33, followed by compounder with 13.72, whereas it was found that the availability of health females which is 25.72, followed by health male 22.84, and health inspector staff were with 20.23 were not available in CHC.

It was also found that the availability of complete staff maximum in Majhgawan CHC 19.63 and least was in Rampur Baghelan CHC with 10.33.

Table 4.7.24 Satisfaction level with CHC Staff

Option	Amarpatan			Devrajnagar			Mukundpur			Majhgawan			Nagod			Rampur Baghelan			Uchehra			Total			Percentage
	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	
Doctors	5 (7.35)	25 (22.52)	0	5 (10.64)	21 (24.70)	2 (10)	11 (15.95)	9 (12.65)	0	16 (18.39)	1 (1.5)	0	8 (10.12)	22 (21.79)	0	6 (13.04)	14 (18.92)	0	6 (13.64)	22 (21.57)	2 (50)	57 (12.95)	12 (20.58)	2 (1.33)	186

				)			)	)			0 5))			
Nurse and Compou nder	3 (4. 41)	27 (24 .32)	0	16 (3 4. 04)	12 (14. 11)	0	14 (2 0. 28)	6 (1 1. 77)	0	12 (13 .80)	1 8 (1 9. 3 5)	0	10 (12 .66)	20 (19 .80)	0	0	20 (27 .02)	0	3 (6.8 2)	25 (24. 50)	2 (50)	58 (13 .18)	12 8 (20 .75)	2 (1.3 3)	188
Labor rooms	0	30 (27 .02)	0	2 (4 .2 5)	26 (30. 59)	0	0	20 (3 9. 21)	0	0	3 0 (3 2. 2 5)	0	1 (1. 26)	29 (28 .72)	0	0	20 (27 .02)	0	0	30 (29. 41)	0	1 (0. 23)	18 5 (29 .98)	0	186
Radiogra phers & X-Ray Machines	30 (44 .11)	0	0	28 (5 9. 58)	0	0	20 (2 8. 99)	0	0	30 (34 .48)	0	0	30 (37 .98)	0	0	20 (43 .47)	0	0	30 (68. 18)	0	0	18 6 (42 .47)	0	0	186
Lab Technici an & Patholog y Labs	2 (2. 95)	28 (25 .22)	0	2 (4 .2 5)	26 (30. 59)	0	4 (5 .8 0)	16 (3 1. 37)	0	1 (1. 14)	2 9 (3 1. 1 8)	0	0	30 (29 .70)	0	0	20 (27 .02)	0	5 (11. 36)	25 (24. 50)	0	12 (2. 73)	17 4 (28 .20)	0	186
Generato rs	28 (41 .17)	1 (0. 90)	0	0	0	0	20 (2 8. 99)	0	0	28 (32 .18)	2 2 (2 .1 5)	0	30 (37 .98)	0	0	20 (43 .47)	0	0	0	0	0	12 6 (28 .64)	3 (0. 49)	0	129

)			
Total	68 (15 .45)	11 1 (17 .99)	0	47 (1 0. 68)	85 (13. 78)	2	69 (1 5. 7)	51 (8 .2 6)	0	87 (19 .77)	9 3 (1 5. 0 7)	0	79 (17 .95)	10 1 (16 .37)	0	46 (10 .45)	74 (11 .99)	0	44 (10)	102 (16. 53)	4 (100)	44 0 (41 .47)	61 7 (58 .2)	4 (0.3 7)	1061

Table 4.7.24 shows that overall satisfaction level with medical staff available in CHC. 617 (58.2) percentage found that the maximum rural women were satisfied with the staff. Whereas 440 (41.47) percentage of rural women are not satisfied with CHC staff, followed by 60 (45.11) percentage rural women are not satisfied with CHC staff (poor services).

Table 4.7.25 Aspects of visiting to CHC by Rural Women

Options	Amarpatan	Devrajnagar	Mukundpur	Majhgawan	Nagod	Rampur Baghelan	Uchehra	Total	Percentage
Family planning	30 (14.21)	28 (14.35)	20 (11.63)	30 (14.21)	30 (14.08)	20 (12.26)	28 (12.28)	186	13.35
Natal care (pre and post natal)	30 (14.21)	28 (14.35)	20 (11.63)	30 (14.21)	30 (14.08)	20 (12.26)	29 (12.72)	186	13.35

Immunization	30 (14.21)	28 (14.35)	20 (11.63)	30 (14.21)	30 (14.08)	20 (12.26)	30 (13.15)	186	13.35
Communicable diseases	0	0	0	0	0	0	0	0	0
a) Malarial fever	20 (9.47)	17 (8.72)	20 (11.63)	25 (11.85)	24 (11.26)	20 (12.26)	25 (10.97)	151	10.84
b) Eye infections	2 (0.95)	3 (1.54)	7 (4.06)	0	10 (4.70)	1 (0.62)	6 (2.64)	29	2.08
c) Cough	10 (4.74)	17 (8.72)	20 (11.63)	16 (7.59)	19 (8.93)	20 (12.26)	20 (9.65)	122	8.76
d) Body pains	30 (14.21)	28 (14.35)	19 (11.04)	30 (14.21)	28 (13.14)	20 (12.26)	30 (13.15)	185	13.28
e) Knee pains	20 (9.47)	17 (8.72)	20 (11.63)	21 (9.96)	20 (9.38)	20 (12.26)	25 (10.97)	143	10.27
f) Problems of menopause	11 (5.21)	8 (4.10)	6 (3.48)	0	1 (0.46)	2 (1.22)	2 (0.88)	30	2.15
g) Cancer	0	0	0	0	0	0	0	0	0
h) Blood pressure	28 (13.27)	27 (13.85)	20 (11.63)	30 (14.21)	20 (9.38)	20 (12.26)	30 (13.15)	175	12.56
Total	211 (15.15)	195 (14)	172 (12.35)	211 (15.15)	213 (15.29)	163 (11.7)	228 (16.8)	1393	100

The above table 4.7.25 shows that the overall aspect of visiting CHC by rural women. It was found that the aspect of visit to CHC is were maximum i.e 13.35family planning, followed by natal care with 13.25, followed by immunization with 13.35, followed by body pain with 13.28, followed by blood pressure with 12.56, followed by malarial fever with 1084, followed by problems of knee pain with 10.27, followed by cough with 8.76, followed by menopause problems with 2.15 and least was eye infection with 2.08 were aspect for visiting CHC by rural women.

It was also found that the availability of complete aspect maximum in Uchehra CHC 16.08 and least was in Rampur Baghelan CHC with 11.7.

Table 4.7.26 Social Empowerment Status of Rural Women

Option	Amarpatan			Devrajnagar			Mukundpur			Majhgawan			Nagod			Rampur Baghelan			Uchehra			Total			Total	Percentage
	poor	good	V. Good	poor	good	V. Good	poor	good	V. Good	poor	good	V. Good	poor	good	V. Good	poor	good	V. Good	poor	good	V. Good	poor	good	V. Good		
Using Toilets	16 (8.60)	14 (12.28)	0	21 (1.235)	6 (.80)	1 (.67)	14 (8.04)	6 (24)	0	10 (5.20)	20 (18.52)	0	2 (1.08)	21 (21.665)	0	8 (5.72)	1 (2.67)	0	23 (9.88)	5 (10.87)	2 (9.53)	101 (7.89)	62 (11.76)	3 (6.38)	166	8.95
To increase hygiene in their area	18 (9.68)	12 (10.53)	0	14 (8.239)	1 (.25)	2 (1.33)	19 (10.92)	1 (4)	0	13 (6.78)	17 (15.75)	0	17 (9.18)	13 (13.40)	0	1 (7.86)	9 (11.5)	0	22 (9.44)	6 (13.04)	3 (14.28)	114 (8.90)	68 (12.90)	4 (8.51)	186	10.03
Steps to take safe drinking water	20 (10.76)	10 (8.78)	0	10 (5.89)	1 (.27)	2 (1.33)	15 (8.63)	5 (20)	0	8 (4.16)	22 (20.37)	0	8 (4.32)	21 (21.65)	2 (18.18)	1 (6.14)	4 (6.67)	0	20 (8.59)	5 (10.87)	5 (23.81)	97 (7.57)	82 (13.47)	7 (14.89)	186	10.03

Family planning methods	11 (5.92)	19 (16.67)	0	1 (6.7)	9 (1.69)	8 (5.33)	17 (9.78)	2 (8)	0	17 (8.86)	13 (12.03)	0	12 (6.48)	11 (11.34)	0	1 (7.86)	9 (1.5)	0	20 (8.59)	8 (17.39)	2 (9.53)	99 (7.73)	71 (13.47)	10 (21.28)	180	9.71
Supporting equal status for women	23 (12.36)	7 (6.14)	0	2 (12.95)	6 (7.80)	0	20 (11.49)	0	0	27 (14.06)	3 (2.78)	0	20 (10.82)	9 (9.27)	1 (9.09)	1 (12.14)	3 (5)	0	22 (9.44)	6 (13.04)	2 (9.53)	15 (11.79)	32 (6.07)	3 (6.38)	186	10.03
Securing the rights for Women	20 (10.76)	10 (8.78)	0	2 (12.95)	6 (7.80)	0	17 (9.78)	3 (12)	0	28 (14.59)	2 (1.86)	0	21 (11.35)	8 (8.24)	1 (9.09)	1 (11.42)	4 (6.7)	0	24 (10.30)	4 (8.70)	2 (9.53)	14 (11.40)	37 (7.02)	3 (6.38)	186	10.03
Voicing against social injustice	10 (10.21)	11 (9.65)	0	2 (12.95)	4 (5.19)	2 (13.33)	19 (10.92)	1 (4)	0	28 (14.59)	1.8 (6)	0	25 (13.52)	5 (5.15)	0	1 (12.14)	3 (5)	0	23 (9.88)	5 (10.87)	3 (14.28)	15 (11.71)	31 (5.88)	5 (10.64)	186	10.03
Supporting widow remarriage	23 (13.44)	5 (4.38)	0	2 (12.95)	5 (6.49)	2 (13.33)	16 (9.19)	4 (16)	0	18 (9.37)	12 (11.11)	0	26 (14.05)	3 (3.09)	1 (9.09)	1 (12.14)	4 (6.7)	0	24 (10.30)	3 (6.53)	3 (14.28)	14 (11.25)	36 (6.83)	6 (12.77)	186	10.03
Decision with regard to family	18 (9.6)	12 (10.53)	0	1 (12.95)	1 (12.95)	0	19 (10.92)	1 (4)	0	23 (11.98)	7 (6.48)	0	24 (12.98)	4 (4.12)	2 (18.18)	1 (12.14)	5 (8.3)	0	28 (12.01)	2 (4.34)	0	14 (11.01)	43 (8.16)	2 (4.26)	186	10.03

Affairs	8)			5 9)	9 9)										7 2))						
Decision with regard to health at home	1 6 (8 .6 0)	14 (12. 28)	0	2 0 (1 1. 7 7)	6 (7 .8 0) 3 3)	2 (1 3)	18 (10 .34)	2 (8)	0	20 (10.4 1)	10 (9. 25)	0	23 (12 .43)	3 (3. 09)	4 (36 .36)	1 3 (9 .2 8)	7 3 (1 1. 6 7)	0	28 (12.01)	2 (4. 34)	0	13 7 (10 .70)	45 (8. 54)	4 (8.5 1)	186	10.0 3
Total	1 8 6 (1 4. 5 3)	114 (21. 63)	0	1 7 0 (1 3. 2 8)	7 7 (1 4. 1) 6 1)	1 5 (3 1. .59)	17 4 (13 .59)	25 (4. 74)	0	192 (15)	10 8 (20 .49)	0	18 5 (14 .45)	97 (18 .41)	11 (23 .04)	1 4 0 (1 1. 0. 9)	6 0 (1 1. 3 8)	0	233 (18.2)	46 (8. 72)	21 (44 .68)	12 8 0 (69 .03)	52 7 (28 .42)	47 (2.5 3)	185 4	99.9 2

Table no. 4.8.26 shows the overall social status of rural women. It is clear that activities like Using Toilets 101 (7.89), followed by to increase hygiene in their area 114 (8.90), followed by steps to take safe drinking water 97 (7.57), followed by Family planning methods 99 (7.73), followed by supporting equal status for women 151 (11.79), followed by securing the rights for women 146 (11.40), followed by voicing against social injustice 150 (11.71), followed by supporting widow remarriage 144 (11.25), followed by decision about family Affairs 141 (11.01), followed by Decision about health at home 137 (10.70) are in poor condition. It was found that the overall social empowerment status 233 (18.2) percentage of poor in Uchehra, while the minimum in Devrajnagar is 170 (13.28).

Table 4.8 Sample of Sagar

CHC	Questionnaire Distributed	Questionnaire Received	Questionnaire's Analyzed
Banda	30	30	30
Gadakota	30	25	25
Devori	30	30	30
Jaisinagar	30	30	30
Kesli	30	22	22
Khurai	30	30	30
Malthone	30	22	22
Rahatgarh	30	22	22
Shahgarh	30	26	26
Surkhi	30	24	24
Total	300	261	261

The above table no. 4.8 shows that the totals of 300 questionnaires were distributed among rural women and out of these 261 received back. It was observed that the highest response received from all over CHC which is included Banda is 30, followed by Devori is 30, followed by Jaisinagar is 30, same as followed by Khurai and the minimum is from Shahgarh is 26, followed by Gadakota is 25, followed by Surkhi is 24 and Malthone and Rahatgarh is both 22 followed by Kesli is 22 questionnaires were received from rural women.

Table 4.8.1 Types of Category/ Population

Category	Banda	Gadakota	Devori	Jaisinagar	Kesli	Khurai	Malthone	Rahatgarh	Shahgarh	Surkhi	Total	Percentage
Gen	6	1	5	5	6	6	0	4	0	0	33	12.5
OBC	20	14	13	15	10	23	8	10	19	20	152	57.58
Scheduled Caste	2	10	12	10	13	1	14	8	7	4	77	29.17
Scheduled Tribal	2	0	0	0	0	0	0	0	0	0	2	0.76
Total	30 (11.36))	25 (9.47)	30 (11.36)	30 (11.36)	22 (9.47)	30 (11.36)	22 (8.33)	22 (8.33)	26 (9.85)	24 (9.09)	261 (100)	100

Gen. = General, OBC= Other Backward Class, SC=Scheduled Caste, ST=Scheduled Tribal The above table 4.7..2 shows that the type of category among rural women which shows that the highest category of rural women is that 57.47 rural women belong to OBC, followed by 29.11 belongs to SC, followed by 12.64 rural women were belong to Gen. and 0.76 are ST.

Table 4.8.2 Family's Monthly Income

Option	Banda	Gadakota	Devori	Jaisinagar	Kesli	Khurai	Malthone	Rahatgarh	Shahgarh	Surkhi	Total
Up to 2000	6 (20)	1 (4)	5 (16.67)	5 (16.67)	4 (18.18)	6 (20)	2 (9.52)	4 (18.18)	0	0	33 (12.64)
2000-4000	20 (66.67)	14 (56)	13 (43.33)	15 (50)	10 (45.45)	23 (76.67)	6 (28.57)	10 (45.45)	19 (73.08)	20 (83.33)	150 (57.47)
5000-10000	2 (6.67)	10 (40)	12 (40)	10 (33.33)	8 (36.36)	1 (3.33)	13 (61.90)	8 (36.36)	7 (26.92)	4 (16.67)	76 (29.11)
10000 – more	2 (6.67)	0	0	0	0	0	0	0	0	0	2 (0.76)
Total	30 (11.49)	25 (9.58)	30 (11.49)	30 (11.49)	22 (8.05)	30 (11.49)	21 (8.05)	22 (8.43)	26 (9.96)	24 (9.20)	261 (100)

Table 4.7.2 shows that the family's income of rural women husband in which is 57.47 rural women's family income is up to 2000 monthly, followed by 26.11 rural women's income are between 5000-10000 monthly family incomes and 10000 more than is 0.76.

Table 4.8.3 Education Levels of Women

Option	Banda	Gadakota	Devori	Jaisinagar	Kesli	Khurai	Malthone	Rahatgarh	Shahgarh	Surkhi	Total
Illiterate	13 (43.33)	10 (40)	3 (10)	8 (26.67)	8 (36.33)	7 (23.33)	11 (52.38)	12 (54.55)	9 (34.62)	7 (29.17)	92 (35.24)
Primary	13 (43.33)	3 (12)	16 (53.33)	7 (23.33)	7 (31.82)	18 (60)	2 (9.52)	6 (27.27)	11 (42.31)	8 (33.33)	90 (34.48)
Secondary	4 (13.33)	9 (36)	6 (20)	6 (20)	6 (27.27)	5 (16.67)	1 (4.76)	4 (18.18)	5 (19.23)	8 (33.33)	55 (21.07)
Higher Secondary	0	2 (8)	1 (3.33)	5 (16.67)	1 (4.55)	0	5 (23.81)	0	1 (3.85)	0	14 (5.36)
Graduate	0	1 (4)	0	4 (13.33)	2 (9.09)	0	2 (9.52)	0	0	1 (4.16)	10 (3.83)
Total	30 (11.49)	25 (9.58)	30 (11.49)	30 (11.49)	22 (8.05)	30 (11.49)	21 (8.05)	22 (8.43)	26 (9.96)	24 (9.20)	261 (100)

The Table 4.8.3 shows the education level of rural women in which 35.24 rural women are illiterate, 34.48 rural women have primary education, and 21.07 of rural women have secondary level education and 5.36 rural women are having higher secondary education, and 3.38 rural women having graduation.

Table 4.8.4 Marital Status of Women

Option	Banda	Gadakota	Devori	Jaisinagar	Kesli	Khurai	Malthone	Rahatgarh	Shahgarh	Surkhi	Total	Percentage
Married	30 (100)	25 (100)	30 (100)	30 (100)	21 (100)	30 (100)	21 (100)	22 (100)	26 (100)	24 (100)	261	100
Unmarried	0	0	0	0	0	0	0	0	0	0	0	0
Total	30 (11.49)	25 (9.58)	30 (11.49)	30 (11.49)	21 (8.05)	30 (11.49)	21 (8.05)	22 (8.43)	26 (9.96)	24 (9.20)	261 (100)	100

The table above 4.8.4 shows the marriage status of rural women. It was found that 100 percent of women are married in CHC.

Table 4.8.5 Occupation of the Rural Women's Husband

Option	Banda	Gadakota	Devori	Jaisinagar	Kesli	Khurai	Malthone	Rahatgarh	Shahgarh	Surkhi	Total
Agriculture	17 (56.67)	12 (48)	20 (66.67)	18 (60)	12 (54.55)	14 (46.67)	17 (77.27)	8 (36.36)	10 (38.46)	12 (50)	140 (53.64)
Govt. Employee	0	0	0	0	1 (4.55)	0	0	0	0	0	1 (0.38)

No Employment	3 (10)	2 (8)	2 (6.67)	4 (13.33)	2 (9.09)	0	2 (9.09)	6 (27.27)	6 (23.08)	10 (41.67)	37 (13.79)
Farm Worker	0	0	0	2 (6.67)	1 (4.55)	5 (16.67)	0	0	0	1 (4.17)	9 (3.45)
Private	10 (33.33)	11 (44)	5 (16.67)	6 (20)	3 (13.64)	5 (16.67)	3 (13.64)	6 (27.27)	10 (38.46)	0	59 (22.99)
Driver	0	0	0	0	3 (13.64)	0	0	0	0	0	3 (1.15)
Business	0	0	3 (10)	0	0	2 (6.67)	0	2 (9.09)	0	1 (4.17)	8 (3.07)
Others	0	0	0	0	0	4 (13.33)	0	0	0	0	4 (1.53)
Total	30 (11.49)	25 (9.58)	30 (11.49)	30 (11.49)	22 (8.05)	30 (11.49)	21 (8.05)	22 (8.43)	26 (9.96)	24 (9.20)	261 (100)

Table 4.8.5 shows the occupations of rural woman's husbands in which 53.83 rural women's husbands are doing agriculture, while 23.07% are rural women's husbands are doing private work, followed by 3.46 are farm workers and 13.84% are rural women husband are unemployed.

Table 4.8.6 Housing and living Status of rural women

Options	Categories	Banda	Gadakota	Devori	Jaisinagar	Kesli	Khurai	Malthone	Rahatgarh	Shahgarh	Surkhi	Total
Type of House	Hut	21 (11.48)	21 (16.28)	25 (14.29)	28 (19.58)	19 (13.48)	18 (10.98)	20 (19.05)	22 (17.32)	22 (16.67)	17 (10.12)	213 (14.51)
	Tiled	0	0	0	0	0	3 (1.83)	0	0	0	2 (1.19)	5 (0.34)
	Concrete	0	1 (0.78)	5 (2.86)	0	2 (1.42)	9 (5.49)	0	0	0	5 (2.98)	22 (1.49)
Ownership of House	Rented	0	0	0	0	0	0	0	2 (1.57)	0	0	2 (0.13)
	Own	29 (15.85)	25 (19.38)	30 (17.14)	28 (19.58)	22 (15.60)	27 (16.46)	17 (16.19)	21 (16.54)	22 (16.54)	24 (14.29)	245 (16.70)
	Others	0	0	0	0	0	0	0	0	0	0	0
Number of Rooms	One	15 (8.20)	11 (8.53)	13 (7.43)	12 (8.39)	11 (7.80)	7 (4.27)	11 (10.48)	12 (9.45)	9 (6.82)	9 (5.36)	110 (7.49)
	Two	13 (7.10)	9 (6.98)	11 (6.29)	7 (4.90)	8 (5.67)	19 (11.59)	5 (4.76)	6 (4.72)	11 (8.33)	12 (7.14)	101 (6.88)
	Three	2 (1.09)	0	5 (2.86)	1 (0.70)	0	3 (1.83)	2 (1.90)	4 (3.15)	0	0	17 (1.15)
	Four	0	1 (0.78)	1 (0.57)	1 (0.70)	0	0	2 (1.90)	0	1 (0.76)	0	6 (0.40)
	More than	0	4 (3.10)	0	0	0	0	0	0	0	3 (1.79)	7 (0.47)
Toilet	Not Available	10 (5.46)	9 (6.98)	8 (4.57)	6 (4.20)	9 (6.38)	8 (4.88)	8 (7.62)	15 (11.81)	18 (13.64)	6 (3.57)	97 (6.61)
	Available	20 (10.93)	12 (9.30)	21 (12)	19 (13.29)	13 (9.22)	16 (9.76)	12 (11.43)	6 (4.72)	4 (3.03)	18 (10.71)	141 (9.61)
Drinking water	Tap	10 (5.46)	5 (3.88)	0	5 (3.50)	2 (1.42)	4 (2.44)	5 (4.76)	4 (3.15)	0	6 (3.57)	41 (2.79)

	Hand Pump	28 (15.30)	8 (6.10)	25 (14.29)	16 (11.19)	15 (10.6 4)	16 (9.76)	6 (5.71)	4 (3.15)	19 (14.39)	18 (10.71)	155 (10.5)
Electricity	Not Available	2 (1.09)	4 (3.10)	4 (2.29)	2 (1.40)	5 (3.55)	1 (0.61)	0	7 (5.51)	0	4 (2.38)	29 (1.29)
	Available	28 (15.30)	18 (13.95)	25 (14.29)	16 (11.19)	19 (13.4 8)	19 (11.59)	17 (16.19)	14 (11.02)	20 (15.15)	20 (11.90)	196 (13.36)
Leisure time	Television	3 (1.64)	1 (0.78)	2 (1.14)	2 (1.40)	4 (2.84)	7 (4.27)	0	0	0	10 (5.95)	29 (1.97)
	Radio	0	0	0	0	1 (0.71)	0	0	0	0	7 (4.17)	8 (0.54)
	News paper	2 (1.09)	0	0	0	0	0	0	0	0	3 (1.79)	5 (0.34)
	No activity	0	0	0	0	11 (7.80)	7 (4.27)	0	10	6 (4.55)	4 (2.38)	38 (2.59)
Total		183 (12.47)	129 (8.79)	175 (11.93)	143 (9.75)	141 (9.61)	164 (11.18)	105 (7.16)	127 (8.66)	132 (9)	168 (11.45)	1467 (100)

The data presented in the table 4.8.6 shows the housing and living status of rural women, which is 14.15 percentage of rural women, were living in Huts house, whereas 16.70 are percentages of rural women have their own home. 7.49% of rural women are living in a double room, whereas 6.88 rural women live in a single room, followed by 1.15 rural women living in a three-room set room. Overall 9.61% of women have Toilet facility and 6.61 are not having. The drinking water facility for rural women shows that there is 10.5 are using hamd pump and 2.97 is having taps for water facility. Around 13.36% said they have electricity and 1.97 are not having electricity. Television, Newspapers and leisure activities are not done by them.

Table 4.8.7 Awareness about Health Literacy

Awareness Health Literacy	Banda	Gadakota	Devori	Jaisina gar	Kesli	Khurai	Malthone	Rahatgarh	Shahgarh	Surkhi	Total
Yes	16 (53.33)	21 (84)	28 (93.33)	26 (86.67)	14 (63.64)	24 (80)	8 (36.36)	18 (81.82)	19 (73.08)	11 (45.83)	189 (72.41)
No	14 (46.67)	4 (16)	2 (6.67)	4 (13.33)	6 (27.27)	6 (20)	14 (63.64)	4 (18.18)	7 (26.92)	13 (54.17)	72 (27.58)
Total	30 (11.49)	25 (9.58)	30 (11.49)	30 (11.49)	22 (8.43)	30 (11.49)	22 (8.43)	22 (8.43)	26 (9.96)	24 (9.20)	261 (100)

Table 4.8.7 shows that the awareness of health literacy among rural women was good. It was found that 72.14 of women were aware of health literacy, whereas 27.58 of women were unaware of health literacy.

Table 4.8.8 Reason for Non Awareness about Health Literacy

Option	Banda	Gadakota	Devori	Jaisinagar	Kesli	Khurai	Malthone	Rahatg arh	Shahg arh	Surkhi	Total
Lack of education	13 (48.15)	4 (50)	2 (50)	4 (50)	6 (50)	5 (45.45)	12 (46.15)	3 (42.86)	7 (50)	13 (50)	69 (48.25)
Lack of Health Information	14 (51.85)	4 (50)	2 (50)	4 (50)	6 (50)	6 (54.55)	14 (53.85)	4 (57.14)	7 (50)	13 (50)	74 (51.75)
Not interested	0	0	0	0	0	0	0	0	0	0	0
On opinion	0	0	0	0	0	0	0	0	0	0	0
Total	27	8	4	8	12	11	26	7	14	26	143

	(18.88)	(5.59)	(2.80)	(5.59)	(8.39)	(7.69)	(18.18)	(4.90)	(9.79)	(18.18)	
--	---------	--------	--------	--------	--------	--------	---------	--------	--------	---------	--

Table 4.8.8 shows that majority of rural women i.e. 51.75 were not aware of health literacy due to the lack of health information, whereas 48.25 of rural women were unaware of health literacy due to lack of education.

Table 4.8.9 Provision of Health Information, Resources, and Services

Option	Banda	Gadakota	Devori	Jaisinagar	Kesli	Khurai	Malthone	Rahatgarh	Shahgarh	Surkhi	Total
In CHC	30 (68.18)	18 (47.37)	28 (35.44)	30 (36.14)	18 (30.51)	19 (36.54)	16 (30.77)	17 (34.69)	23 (29.49)	20 (30.30)	219 (36.5)
Sub-Center	0	5 (13.16)	6 (7.59)	8 (9.64)	8 (13.56)	5 (9.62)	6 (11.54)	4 (8.16)	8 (10.26)	7 (10.61)	57 (9.5)
At home	0	0	0	2 (2.41)	0	0	0	0	9 (11.54)	5 (7.58)	16 (2.66)
In ASHA	12 (27.27)	13 (34.21)	29 (36.71)	28 (33.73)	22 (37.29)	19 (36.54)	20 (38.46)	20 (40.82)	25 (32.05)	26 (39.39)	214 (35.6)
At PHP	0	0	7 (8.86)	10 (12.05)	5 (8.47)	3 (5.77)	3 (5.77)	5 (10.20)	8 (10.26)	3	44 (7.33)
District hospital	2 (4.55)	2 (5.26)	9 (11.34)	5 (6.02)	6 (10.17)	6 (11.54)	7 (13.46)	3 (6.12)	5 (6.41)	5	50 (8.33)
Any other please specify	0	0	0	0	0	0	0	0	0	0	0
Total	44 (7.33)	38 (6.33)	79 (13.17)	83 (13.83)	59 (9.83)	52 (8.67)	52 (8.67)	49 (8.67)	78 (13)	66 (13)	600

Table 4.8.9 shows the provision of health information, resources, and service provided by CHC for rural women. It was found that 36.5 rural women access health information, resources, and service from the CHC, followed by 35.6 from AASHA, followed by 9.5 from sub-center, followed by 8.33 from the district hospital, 7.33 from PHP, and 2.66 from at home.

Table 4.8.10 Awareness, Source and Uses of immunization

Option	Category	Banda	Gadako t a	Devori	Jaisin agar	Kesli	Malthone	Rahatgar h	Shahgarh	Surakhi	Total
Awareness about Immunization	No Awareness	6 (4.23)	3 (2.31)	7 (4.86)	4 (2.47)	3 (2.70)	5 (3.23)	4 (3.51)	2 (1.71)	16 (24.62)	50 (4.39)
	Is	26 (18.31)	22 (16.92)	23 (15.97)	26 (16.05)	19 (17.12)	25 (16.13)	17 (14.91)	20 (17.09)	6 (9.23)	184 (16.14)
Source of Information on Immunization	Doctors	30 (21.13)	20 (15.38)	25 (17.36)	30 (18.50)	20 (18.02)	28 (18.06)	20 (17.54)	22 (18.80)	9 (13.85)	204 (17.89)
	Health visitors	0	10 (7.69)	0	12 (7.41)	6 (5.41)	7 (4.52)	10 (8.77)	9 (7.69)	6 (9.23)	60 (5.26)
	AASHA	30 (21.13)	25 (19.23)	30 (20.83)	30 (18.52)	21 (18.92)	30 (19.35)	21 (18.42)	22 (18.80)	6 (9.23)	215 (18.86)
	Nurse	20 (14.08)	25 (19.23)	29 (20.14)	30 (18.52)	21 (18.92)	30 (19.35)	21 (18.42)	22 (18.80)	3 (4.62)	201 (17.63)
Awareness about Diseases prevented by Immunization	Fully aware		0	0	0	0	0	0	0	2 (3.08)	2 (0.18)
	Partially aware	20 (14.08)	18 (13.85)	28 (19.44)	20 (12.35)	16 (14.41)	28 (18.06)	13 (11.40)	14 (11.97)	13 (20)	170 (14.91)
	Not aware	10 (7.04)	7 (5.38)	2 (1.39)	10 (6.17)	5 (4.50)	2 (1.29)	8 (7.02)	6 (5.13)	4 (6.15)	54 (4.74)

Total	142 (11.26)	130 (11.40)	144 (12.63)	162 (14.21)	111 (9.74)	155 (13.60)	114 (10)	117 (10.26)	65 (5.70)	1140 (100)
--------------	------------------------------	------------------------------	------------------------------	------------------------------	-----------------------------	------------------------------	---------------------------	------------------------------	----------------------------	-----------------------------

Table 4.8.10 shows the Awareness about Immunization, sources of information on immunization, and awareness about diseases prevented by immunization among rural women. It was found that the highest percentage of Jaisinagar which is 14.21, followed Khurai which was 13.60, followed by Devori which was 12.63, followed by Banda which was 11.26, followed by Gadakota which was 11.40, followed by Shahgarh which was 10.26, followed by Rahatgarh which was 10, followed by Kesli which was 9.74, followed by Surkhi which 5.70 were aware of the Immunization, sources of information on immunization and awareness about diseases prevented.

Table 4.8.11 Availability and Accessibility of Health Care Services Provided by CHC

Variable	Categories	Banda	Gadakota	Devori	Jaisinagar	Kesli	Khurai	Malthone	Rahatgarh	Shahgarh	Surkhi	Total
Distance to Community Health Center (in km)	1.00-5.00	0	0	2 (1.22)	0	0	0	1 (1.32)	0	0	5 (3.47)	8 (0.63)
	6.00-10.0	10 (7.41)	0	12 (7.32)	0	0	5 (5.56)	5 (6.58)	10 (10)	0	8 (5.56)	50 (3.97)
	11.0-15.0	20 (14.81)	5 (4)	8 (4.88)	20 (12.05)	14 (12.73)	10 (11.11)	10 (13.16)	2 (2)	5 (3.57)	2 (1.39)	96 (7.62)
	16.0-20.0	0	20 (16)	10 (6.10)	10 (6.02)	7 (6.36)	10 (11.11)	6 (7.89)	2 (2)	11 (7.86)	9 (6.25)	85 (6.75)
	21.0-25.0	0	0	0	0	0	5 (5.56)	0	8 (8)	10 (7.14)	24 (16.67)	47 (3.73)
Reasons for visiting Community Health Centers	For free Medicine	30 (22.22)	25 (20)	30 (18.29)	30 (18.07)	21 (19.09)	30 (33.33)	22 (28.95)	22 (22)	26 (18.57)	24 (16.67)	260 (20.63)
	Emergency	25 (18.52)	17 (13.60)	30 (18.29)	30 (18.07)	21 (19.09)	25 (27.78)	22 (28.95)	20 (20)	25 (17.86)	20 (13.89)	235 (18.65)

	Minor Illness	5 (3.70)	8 (6.40)	12 (7.32)	16 (7.32)	15 (13.64)	5 (5.56)	9 (11.84)	2 (2)	15 (10.71)	4 (2.78)	91 (7.22)
	Not visiting	0	0	0	0	0	0	0	0	0	0	0
Visiting Private Clinic	Minor Illness	15 (11.11)	10 (8)	10 (6.10)	20 (12.05)	14 (12.73)	0	1 (1.32)	0	20 (14.29)	15 (10.42)	105 (8.33)
	Partially	0	15 (12)	20 (12.20)	10 (6.02)	7 (6.36)	0	0	12 (12)	2 (1.43)	9 (6.25)	75 (5.95)
Distance to Medical Shop(in km)	00.-.50	30 (22.22)	25 (20)	30 (18.29)	30 (19.09)	21 (19.09)	0	0	22 (22)	26 (18.57)	24 (16.67)	208 (16.51)
	1.00-2.00	0	0	0	0	0	0	0	0	0	0	0
	3.00.-more than	0	0	0	0	0	0	0	0	0	0	0
Total		135 (10.71)	125 (9.92)	164 (13.02)	166 (13.17)	120 (9.52)	90 (7.14)	76 (6.03)	100 (7.94)	140 (11.11)	144 (11.43)	1260 (100)

Table 4.8.13 Barriers to Health Treatment

Option	Banda			Gadakota			Devori			Jaisinagar			Kesli			Malthone			Rahatgarh			Shahgarh			Surkhi			Total			Total & %
	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good				
Social status	21 (14)	9 (7.2)	15 (13)	18 (15)	7 (2.5)	0	2 (1.4)	8 (8.5)	0	2 (1.8)	1 (.9)	0	2 (1.4)	5 (3.8)	0	19 (16.38)	2 (2.2)	0	2 (1.6)	1 (.6)	0	2 (1.5)	6 (4)	0	1 (.9)	5 (2.7)	0	1 (.8)	4 (2.5)	0	229 (16.67)

	2 9)			8)		4 7)	7)		1 0)			9 7)	6)			2)		6 7)	7)		2 7)		8 4)	3)		5. 4 7)	7 2)			
Self- perceiv ed health	2 5 (1 7. 0 1)	5 (1 5.1 5)	12. 61	15 (12. 61)	1 0 (3 2. 2 6)	0	2 5 (1 7. 8 6) 4 5)	0	1 9 (1 6. 3 8)	2 (1 8. 1 8)	0	2 8 (1 6. 7 7)	2 (1 5. 3 8)	0	20 (17. 24)	1 (1 1. 1 1)	0	2 0 (1 6. 6 7)	1 (1 6. 6 7)	0	2 1 (2 0)	5 (1 0)	0	2 0 (1 8. 5. 6 3)	4 (1 8. 1 8)	0	1 9 3 (1 6. 1 6 4)	3 5 (1 9. 6 6 1 6)	0	228 (16.59)
Able to pay for Medicat ion	2 4 (1 6. 3 3)	6 (1 8.1 8)	16. 81	20 (16. 81)	5 (1 2. 9 0)	0	2 6 (1 7. 2 1 9) 1)	0	1 8 (1 5. 2 5 2)	3 (2 7. 2 7)	0	2 8 (1 6. 7 7)	2 (1 5. 3 8)	0	18 (15. 52)	2 (2 2. 2 2)	0	1 9 (1 5. 8 3)	2 (3 3. 3 3)	0	2 4 (1 8. 3 2)	2 (8)	0	1 8 (1 4. 0 6)	6 (2 7. 2 7)	0	1 9 5 (1 6. 3 8 0)	3 2 (1 7. 9 3 8)	0	227 (16.52)
Able to afford doctor	2 6 (1 7. 6 9)	4 (1 2.1 2)	17. 65	21 (17. 65)	4 (9 .6 8)	0	2 5 (1 7. 8 6) 4 5)	0	1 8 (1 8. 2 5 2)	3 (2 7. 2 7)	0	2 9 (1 7. 3 7)	1 (7 .6 9)	0	19 (17. 24)	2 (2 2. 2 2)	0	2 0 (1 6. 6 7)	1 (1 6. 6 7)	0	2 3 (1 2)	0	2 2 (1 8. 7. 1 9)	4 (1 8. 1 8)	0	2 0 3 (1 5. 6. 9 7)	2 7 (1 5. 1 7)	0	230 (16.74)	
Monthl y househo ld	2 7 (1 8.)	3 (9. 09)	18. 49	22 (18. 49)	3 (9 .6 8)	0	2 6 (1 4. 2 7)	0	1 9 (1 6. 1 6)	2 (1 8. 1 1)	0	2 9 (1 7. 1 9)	1 (7 .6 9)	0	20 (17. 24)	1 (1 1. 1 1)	0	2 0 (1 6. 6 6)	1 (1 6. 6 6)	0	2 0 (2 4)	0	2 4 (1 8. 9)	2 (9 .0 9)	0	2 0 7 (1 2.	2 3 (1 2.	0	230 (16.74)	

income	3 7)					1 1)	9)		3 8)	8)		3 7)				1)		6 7)	7)		2 7)			7 5)			7. 3 1)	9 2)		
Unable to reach out to CHC	2 4 (1 6. 3 3)	6 (1 8.1 8)	19. 33	23 (19. 33)	2 (6 .4 5)	0	2 2 (1 8. 4 2)	2 (7 .1 4)	0	2 1 (1 8. 1 0)	0	2 8 (1 6. 7 7)	2 (1 5. 3 8)	0	20 (17. 24)	1 (1 1. 1 1)	0	2 1 (1 7. 5)	0	0	2 3 (1 2)	0	2 5 (1 9. 5 3)	1 (4 .5 5)	0	2 1 3 (1 7. 5 8 1)	1 7 (9 .5 5)	0	230 (16.74)	
Total	1 4 7 (1 2. 3)	33 (1 9)	0	119 (9.9)	3 1 (1 7. 4)	0	1 2 (1 5. 7)	2 8 (1 5. 7)	0	1 1 (6 .1 8)	0	1 6 7 (1 4)	1 3 (7 .3 0 3)	0	116 (9.7)	9 (5 .0 5)	0	1 2 0 (1 7)	6 (3 .3 7)	0	1 3 1 (1 4)	2 5 (1 4)	0	1 2 8 (1 2. 4)	2 2 (1 2. 4)	0	1 1 9 6 (8 7. 0 4)	1 7 8 (1 2. 9 5)	0	1374 (100)

Table 4.8.13 shows that the barriers to health treatment faced by rural women. The poor social status, Self-perceived health, able to pay for Medication, able to afford doctor, limited activities because of health problems, monthly household income able to pay for medication condition was found to be the main barriers 167 (14) percentage in Kesli, followed by 152 (12.7) in Devori, followed by 147 (12.3) in Banda, followed by 121 (14) Shahgarh, followed by 120 (10) in Rahatgarh, followed by 119 (9.9) in Gadakota and Jaisinagar and Malthone both have the lowest poor percentage of 116 (6.18).

Table 4.8.14 Awareness about Nutritious diet taken by Rural Women

Option	Banda	Gadakota	Devori	Jaisinagar	Kesli	Khurai	Malthone	Rahatgarh	Shahgarh	Surkhi	Total
Yes	14 (46.67)	3 (12)	2 (6.67)	4 (13.33)	3 (13.64)	3 (10)	2 (9.09)	4 (18.18)	4 (15.38)	3 (12.5)	40 (15.33)
No	16 (53.33)	22 (88)	28 (93.33)	26 (86.67)	19 (86.36)	27 (90)	20 (90.91)	18 (81.82)	22 (84.62)	21 (87.5)	221 (84.67)
Total	30 (11.49)	25 (9.58)	30 (11.49)	30 (11.49)	22 (8.43)	30 (11.49)	22 (8.43)	22 (8.43)	26 (9.96)	24 (9.20)	261

The table 4.8.14 show that the awareness about the full nutritious diet taken by rural women. It was found that 84.67% of rural women were not aware of the full nutritious diet.

Table 4.8.15 Reasons for Non-awareness of nutritious diet by Rural Women

Option	Banda	Gadakota	Devori	Jaisinagar	Kesli	Khurai	Malthone	Rahatgarh	Shahgarh	Surkhi	Total	Percentage
Monthly Income	25 (83.33)	22 (88)	24 (80)	26 (86.67)	21 (95.45)	28 (93.33)	20 (90.91)	20 (90.91)	25 (96.15)	23	236	90.42
Not	5	3	6	4	1	2	2	2	1	1	30	11.49

Aware	(16.67)	(12)	(20)	(13.33)	(4.55)	(6.67)	(9.09)	(9.09)	(3.85)			
Total	30 (11.49)	25 (9.58)	30 (11.49)	30 (11.49)	22 (8.43)	30 (11.49)	22 (8.43)	22 (8.43)	26 (9.96)	24 (9.20)	261	100

The table 4.8.15 show that the reason for not awareness about nutritious diet and foods by rural women. It found that the 90.42 % of rural women were not taking nutritious diet due to lack of monthly income and the lowest 11.49 percentage of rural women were not aware of the nutritious diet.

Table 4.8.16 Chosen Places for Delivery of their Child by Rural Women

Option	Banda	Gadakota	Devori	Jaisinagar	Kesli	Khurai	Malthone	Rahatgarh	Shahgarh	Surkhi	Total
Home	4 (13.33)	1 (4)	1 (3.33)	1 (3.33)	1 (4.55)	2 (6.67)	2 (4.55)	1 (4.55)	6 (23.08)	1 (4.17)	17 (6.51)
Government facility	26 (86.67)	24 (96)	29 (96.67)	29 (96.67)	21 (95.45)	28 (93.33)	21 (95.45)	21 (95.45)	20 (76.92)	23 (95.83)	244 (93.48)
Accredited private facilities	0	0	0	0	0	0	0	0	0	0	0
Other private facilities	0	0	0	0	0	0	0	0	0	0	0
Total	30 (11.49)	25 (9.58)	30 (11.49)	30 (11.49)	22 (8.43)	30 (11.49)	22 (8.43)	22 (8.43)	26 (9.96)	24 (9.20)	261 (100)

The above table 4.8.16 shows that the Chosen Places for Delivery of their Child by Rural Women. It was found that the 93.48 percentage of rural women have chosen a government facility for delivery, followed by 6.51 chosen home for delivery of their child.

Table 4.8.17 Awareness about contraception

Option	Banda	Gadakota	Devori	Jaisinagar	Kesli	Khurai	Malthone	Rahatgarh	Shahgarh	Surkhi	Total
Yes	16 (53.33)	21 (84)	28 (93.33)	26 (86.67)	18 (81.82)	24 (80)	8 (36.36)	18 (81.82)	19 (73.08)	11 (45.83)	189 (72.41)
No	14 (46.67)	4 (16)	2 (6.67)	4 (13.33)	4 (18.18)	6 (20)	14 (63.64)	4 (18.18)	7 (26.92)	13 (54.17)	72 (27.58)
Total	30 (11.49)	25 (9.58)	30 (11.49)	30 (11.49)	22 (8.43)	30 (11.49)	22 (8.43)	22 (8.43)	26 (9.96)	24 (9.20)	261 (100)

The table 4.8.17 shows that awareness about contraception among rural women. It was found that the percentage of awareness about contraception was 72.41 CHC, whereas 27.28% of rural women were not aware of contraception.

Table 4.8.18 Use of Contraception by Rural Women

Use of Contraception	Banda	Gadakota	Devori	Jaisinagar	Kesli	Khurai	Malthone	Rahatgarh	Shahgarh	Surkhi	Total
Yes	8 (26.67)	5 (20)	10 (33.33)	9 (30)	8 (36.36)	8 (26.67)	5 (22.73)	4 (18.18)	6 (23.08)	8 (33.33)	71 (27.20)
No	22	20	20	21	14	22	17	18	20	16	190

	(73.33)	(80)	(66.67)	(70)	(63.64)	(73.33)	(77.27)	(81.82)	(76.92)	(66.67)	(72.80)
Total	30	25	30	30	22	30	22	22	26	24	261
	(11.49)	(9.58)	(11.49)	(11.49)	(8.43)	(11.49)	(8.43)	(8.43)	(9.96)	(9.20)	(100)

The table 4.8.18 shows the uses of contraception by rural women. It was found that the percentage of rural women never used contraception use was 72.80% in CHC, whereas 27.20 percent of rural women used contraception.

Table 4.8.19 Reason for not using Contraception by Rural Women

Option	Banda	Gadakota	Devori	Jaisinagar	Kesli	Khurai	Malthone	Rahatgarh	Shahgarh	Surkhi	Total
Lack of information	10 (33.33)	6 (24)	9 (30)	15 (50)	8 (36.36)	14 (46.67)	8 (36.36)	12 (54.55)	9 (34.62)	10 (41.67)	101 (38.69)
Husband not agree	6 (20)	13 (52)	10 (33.33)	8 (26.67)	9 (31.82)	9 (30)	6 (27.27)	8 (36.36)	8 (30.77)	6 (25)	83 (31.80)
Side effect	14 (46.67)	6 (24)	11 (36.67)	7 (23.33)	7 (31.82)	7 (23.33)	8 (36.36)	2 (9.09)	9 (34.62)	8 (33.33)	77 (29.50)
Total	30 (11.49)	25 (9.58)	30 (11.49)	30 (11.49)	22 (8.43)	30 (11.49)	22 (8.43)	22 (8.43)	26 (9.96)	24 (9.20)	261

The table 4.8.19 shows that the reason for not using concentration by rural women. It was found 38.69 the rural women did not use contraception due to lack of information, followed 31.80% of their husbands are not agree, the side effect is the total percentage is 29.50 in all CHC.

Table 4.8.20 Health Information received by rural women

Option	Banda	Gadakota	Devori	Jaisinagar	Kesli	Khurai	Malthone	Rahatgarh	Shahgarh	Surkhi	Total
Health Community health Center	30 (40)	25 (39.06)	30 (36.59)	30 (40)	22 (37.29)	30 (43.48)	23 (34.33)	22 (36.67)	25 (35.71)	24 (38.10)	261 (38.16)
Sub-Center	5 (6.67)	0	5 (6.10)	4 (5.33)	6 (10.17)	3 (4.35)	5 (7.46)	7 (11.67)	8 (11.43)	7 (11.11)	50 (7.31)
Primary Health Center	10 (13.33)	12 (18.75)	15 (18.29)	12 (16)	8 (13.56)	10 (14.49)	14 (20.90)	10 (16.67)	13 (18.57)	12 (19.05)	116 (16.96)
Districts hospital	20 (26.67)	22 (34.38)	25 (30.49)	23 (30.67)	18 (30.51)	25 (36.23)	20 (29.85)	21 (35)	22 (31.43)	19 (30.16)	215 (31.43)
Television	0	0	5 (6.10)	2 (2.67)	3 (5.08)	1 (1.45)	5 (7.45)	0	0	0	16 (2.34)
Newspapers	10 (13.33)	5 (7.81)	2 (2.44)	4 (5.33)	2 (3.39)	0	0	0	2 (2.86)	1 (1.59)	26 (3.80)
Adult education officials	0	0	0	0	0	0	0	0	0	0	0
Total	75 (10.96)	64 (9.36)	82 (11.99)	75 (10.96)	59 (59)	69 (10.09)	67 (9.80)	60 (8.77)	70 (10.23)	63 (9.21)	684 (100)

The above table 4.8.20 shows that health Information is received by rural women. It was found that 38.16 percent of rural women were received to health information from CHC, followed by 31.43 access information from district hospital, 16.96 accesses from sub-center, and followed by 7.3receivedfrom television.

Table 4.8.21 Treatment taken during pregnancy by Rural Women

Option	Banda	Gadakota	Devori	Jaisinagar	Kesli	Khurai	Malthone	Rahatgarh	Shahgarh	Surkhi	Total
Yes	30 (100)	25 (100)	30 (100)	30 (100)	24 (100)	30 (100)	19 (95)	21 (95.45)	24 (92.31)	23 (95.83)	256 (98.08)
No	0	0	0	0	0	0	1 (5)	1 (4.55)	2 (7.69)	1 (4.17)	5 (1.91)
Total	30 (11.49)	25 (9.85)	30 (11.49)	30 (11.49)	24 (9.20)	30 (11.49)	20 (7.66)	22 (8.43)	26 (9.96)	24 (9.20)	261 (100)

The above table 4.8.21 shows that the chosen treatment taken during pregnancy. It was found that the 98.08 percentage of rural women taken treatment during pregnancy, while 1.91 not taken treatments during their pregnancy time from the CHC.

Table 4.8.22 Types of Hospitals preferred by Rural Women

Option	Banda	Gadakota	Devori	Jaisinagar	Kesli	Khurai	Malthone	Rahatgarh	Shahgarh	Surkhi	Total
Community health	30 (78.95)	25 (78.13)	30 (71.43)	30 (75)	22 (78.57)	30 (75)	22 (88)	22 (84.62)	22 (91.67)	26 (86.67)	259 (79.69)

center												
Sub-Center	0	5 (15.63)	7 (16.67)	3 (7.50)	0	0	0	0	2 (8.33)	1 (3.33)	18 (5.54)	
Private hospital	8 (21.05)	2 (6.25)	5 (11.90)	7 (17.50)	6 (21.43)	10 (25)	3 (12)	4 (15.38)	0	2 (6.67)	47 (14.46)	
Ayurvedic hospital	0	0	0	0	0	0	0	0	0	0	0	
Traditional local health person	0	0	0	0	0	0	0	0	0	1 (3.33)	1 (0.32)	
Total	38 (11.69)	32 (9.85)	42 (12.92)	40 (12.31)	28 (8.62)	40 (12.31)	25 (7.69)	26 (8)	24 (7.38)	30 (9.23)	325 (10)	

The above Table 4.8.22 shows the Types of Hospitals preferred by Rural Women in case of health issues. It was found that 79.69% of rural women were preferred to CHC, followed by 14.46% of rural women preferred to private hospitals, and 5.54 of rural women were preferred sub-center, followed by 0.32% rural women were preferred to traditional local health person in case of health needs.

Table 4.8.23 Availability of Medical Staff in CHC

Option	Banda		Gadakota		Devori		Jaisi		Kesli		Khurai		Malthone		Rahatgarh		Shahgarh		Surkhi		Total		Total (Y+N)
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
Doctor	30 (17.65)	0	25 (17.99)	0	25 (12.32)	5 (13.51)	30 (15.87)	0	17 (15.45)	7 (8.54)	27 (19.01)	300 (3.022)	20 (22.22)	0	20 (18.87)	0	24 (18.9)	2 (2.47)	24 (20.69)	0	242 (13.39)	17 (2.45)	259 (12.41)

												6)												
Nurse	30 (17.65)	0	25 (17.99)	0	30 (14.78)	0	30 (15.87)	0	22 (20)	2 (2.44)	30 (21.13)	0	20 (22.22)	0	22 (20.75)	0	26 (20.47)	0	24 (20.69)	0	259 (18.61)	2 (18.61)	261 (12.51)	
Compounder	30 (17.65)	0	20 (14.39)	5 (8.20)	28 (13.79)	2 (5.41)	25 (13.23)	5 (9.80)	20 (18.18)	4 (4.88)	30 (21.13)	0	10 (11.11)	10	22 (20.75)	0	26 (20.47)	0	24 (20.69)	0	235 (16.88)	26 (3.75)	261 (12.51)	
Health inspector	10 (5.88)	20 (28.27)	8 (5.76)	17 (27.87)	20 (9.85)	10 (27.03)	25 (5.29)	5 (9.80)	5 (4.55)	19 (23.17)	0	30 (30.61)	0	20	0	22 (32.35)	0	26 (32.10)	0	24 (31.58)	68 (4.89)	193 (27.81)	261 (12.51)	
Health assistant (Male)	10 (58.8)	20 (28.27)	6 (4.32)	19 (31.15)	20 (9.85)	10 (27.03)	10 (4.76)	20 (39.22)	4 (3.64)	20 (24.39)	0	30 (30.61)	0	20	0	22 (32.35)	0	26 (32.10)	0	24 (58.31)	50 (3.59)	211 (30.40)	261 (12.51)	
Health assistant (Female)	5 (2.94)	25 (35.71)	5 (3.60)	20 (32.79)	20 (9.85)	10 (27.03)	9 (15.87)	21 (41.18)	0	24 (29.27)	0	30 (30.61)	0	20	0	22 (32.35)	0	26 (32.10)	0	24 (31.58)	39 (2.80)	222 (31.99)	261 (12.51)	
Lab technician	30 (17.65)	0	25 (17.99)	0	30 (14.78)	0	30 (15.87)	0	22 (20)	2 (2.44)	30 (21.13)	0	20 (22.22)	0	22 (20.75)	0	26 (20.47)	0	24 (20.69)	0	259 (18.61)	2 (0.29)	261 (12.51)	
Peon	25 (14.71)	5 (7.14)	25 (17.99)	0	30 (14.78)	0	30 (15.87)	0	20 (18.18)	4 (4.88)	25 (17.61)	5 (5.10)	20 (22.22)	0	20 (18.87)	2 (2.94)	25 (19.69)	1 (1.23)	20 (17.24)	4 (1.23)	240 (17.24)	21 (3.03)	261 (12.51)	
Total	170 (12.21)	70 (10.09)	139 (9.99)	61 (8.79)	203 (14.58)	37 (5.33)	189 (13.58)	51 (7.35)	110 (7.90)	82 (11.82)	142 (10.20)	98 (14.12)	90 (6.47)	70 (10.09)	106 (7.61)	68 (9.80)	127 (9.12)	81 (11.67)	116 (8.33)	76 (10.95)	139 (66.73)	694 (33.27)	208 (10.0)	

Table 4.8.23 shows that the overall availability of medical staff in CHC. It was found that the availability of nurse staff was maximum i.e 18.51, same as followed by a lab technician with 18.51, followed by a doctor with 1.49, followed by Peon with 17.24, followed by compounder with 16.18. While less availability of health assistant of the female with 31.99, followed by health assistant male 30.40, a health inspector with 27.18 percentages of medical staff were not available in a regular way.

It was also found that the availability of complete maximum staff in Devori CHC 203 (14.58) and least was in Rahatgarh CHC with 106 (7.61).

Table 4.8.24 Satisfaction Level with CHC Staff

Option	Banda			Gadakota			Devori			Jaisinagar			Kesli			Khurai			Malthone			Rahatgarh			Shahgarh			Surkhi			Total			Total
	Poor	Good	Very Good	Poor	Good	Very Good	Poor	Good	Very Good	Poor	Good	Very Good	Poor	Good	Very Good	Poor	Good	Very Good	Poor	Good	Very Good	Poor	Good	Very Good	Poor	Good	Very Good	Poor	Good	Very Good				

Doctors	20 (20)	10 (1 2. 5)	0	5 (7 .1 4)	2 (0 2 5)	0	2 (0 2 1 0 5)	1 (0 1 7 6)	0	2 (0 2 4 7)	1 (0 1 0 9)	0	1 (2 1 6 2)	1 (0 1 7 2)	0	8 (1 1 4 3)	2 (2 2 0)	0	1 (1 1 7 4 6)	1 (1 1 5 4)	0	6 (1 0 7 1)	1 (6 2 1 0 5)	0	1 (0 1 2 0)	1 (6 2 1 6 2)	0	6 (1 0 3 4)	1 (8 2 0 9 3)	0	1 (1 8 1 5 9)	14 (1 7. 68)	0	26 1 (16 .66)
Nurse and Compou nder	10 (10)	20 (2 5)	0	5 (7 .1 4)	2 (0 2 5)	0	1 (0 1 0 3 3)	2 (0 2 3 3)	0	4 (4 9)	2 (6 2 8 5)	0	1 (0 1 3 5 1)	1 (2 2 0 6 9)	0	2 (2 8 6)	2 (2 5 4)	0	8 (1 2 7 0)	1 (4 2 0 2 9)	0	4 (7 .1 4)	1 (8 2 3 6 8)	0	8 (8 7 6)	1 (8 2 4 3)	0	4 (6 9 0)	2 (0 2 3 6)	0	6 (5 5 9)	19 (2 4. 23)	0	26 1 (16 .66)
Labor rooms	10 (10)	20 (2 5)	0	4 (5 .7 1)	2 (1 2 6. 2 5)	0	0 (0 3 5 2)	3 (0 3 7 9)	0	3 (7 3 7 6)	2 (7 2 9 6)	0	5 (6 7 6)	1 (7 8. 6 2)	0	0 (0 2 7 2)	3 (0 2 7 2)	0	0 (0 3 1 8 8)	2 (2 3 1 6 3 2)	0	2 (3 .5 7)	2 (0 2 6 0 3 2)	0	5 (6 1 0)	2 (1 2 8. 3 8)	0	0 (4 2 7 9 1)	2 (0 2 3 8)	23 (2 6. 68)	0	26 1 (16 .66)		
Radiogr aphers & X- Ray Machine	30 (30)	0	0	2 (5 3 5. 7)	0	0	3 (0 3 1)	0	0	3 (0 3 3)	0	0	2 (2 2 9)	0	0	3 (4 3 2)	0	0	2 (2 3 4)	0	0	2 (3 9. 2)	0	0	2 (6 3 1)	0	0	2 (4 4 1)	0	2 (6 1 3)	0	26 1 (16 .66)		

s				1)		.2 8)		.7 1)		7 3)		8 6)		9 2)		9)		7 1)		3 8)		4 .4 8)												
Lab Technici an & Patholog y Labs	0	30 (3 7. 5)	0	6 (8 .5 7)	1 9 (2 3. 7 5)	0	5 (5 .2 6)	2 (2 9. 4 1)	0	2 (2 5 0. 7)	2 (3 0. 7)	0	3 (4. 0 5)	1 (3 2. 7 6)	0	0	3 (2 7. 2 7)	0	0	2 (3 1. 8 8)	0	0	2 (2 8 .9 5)	0	7 (8. 5 4)	1 (2 5 2 0 8)	0	0	2 (4 2 7. 9 1)	0	2 (3 3 .0 4)	23 8 (2 9. 42)	0	26 1 (16 .66)
Generat ors	30 (30)	0	0	2 5 (3 5. 7 1)	0	0	3 0 (3 1 .5 8)	0	0	3 0 (3 3. 7 1)	0	0	2 2 (4 2. 8 6)	0	0	3 0 (4 2. 8 6)	0	0	2 2 (3 4. 9 2)	0	0	2 6 (3 1. 7 1)	0	0	2 4 (4 1. 3 8)	0	0	2 6 1 (3 4 .4 8)	0	0	26 1 (16 .66)			
Total	100 (13 .2))	80 (9. 89)	0	7 0 (9 .2 9.)	8 0 (9.	0	9 5 (1 1	0	8 9 (1 1	9 1 (1 1	0	7 5 (9. 7.)	0	7 0 (0 (9.)	0	1 0 (8. 8.)	0	6 3 (8. 8.)	0	5 6 (7. 4 9.)	0	7 0 (1 9.)	0	8 7 (1 9.)	0	5 8 (7. 1 1)	0	7 5 7 (1. 1.)	80 9 (5 1.)	0	15 66 (10 0)			

Malarial fever	25 (10.12)	24 (11.82)	25 (8.12)	17 (10.12)	18 (14.4)	20 (11.36)	14 (10.85)	22 (10.58)	20 (10.99)	24 (13.41)	209 (10.86)
Eye infections	22 (8.91)	14 (6.90)	25 (8.12)	14 (8.33)	0	5 (2.84)	5 (3.88)	18 (8.65)	4 (2.20)	18 (10.06)	125 (6.49)
Cough	22 (8.91)	18 (8.87)	25 (8.12)	14 (8.33)	18 (14.4)	20 (11.36)	8 (6.20)	20 (9.62)	20 (10.99)	23 (12.85)	188 (9.77)
Body pains	22 (8.91)	19 (9.36)	23 (7.47)	11 (6.55)	13 (10.4)	20 (11.36)	10 (7.75)	20 (9.62)	19 (10.44)	19 (10.61)	176 (9.14)
Knee pains	23 (9.31)	10 (4.93)	22 (7.14)	12 (7.14)	16 (12.8)	18 (10.23)	8 (6.20)	20 (9.62)	17 (9.34)	18 (10.06)	164 (8.52)
Problems of menopause	22 (8.91)	6 (2.96)	23 (7.47)	11 (6.55)	1 (0.8)	4 (2.27)	3 (2.33)	4 (1.92)	1 (0.55)	0	75 (3.90)
Cancer	23 (9.31)	0	23 (7.47)	8 (4.76)	0	0	0	0	0	0	54 (2.81)
Blood pressure	0	10 (4.93)	8 (2.60)	0	5 (4)	0	10 (7.75)	20 (9.62)	20 (10.99)	0	73 (3.79)
Total	247 (12.83)	203 (10.55)	308 (16)	168 (8.73)	125 (6.49)	176 (9.14)	129 (6.70)	208 (10.81)	182 (9.45)	179 (9.30)	1925 (100)

The above table 4.8.25 shows that the overall aspect of visit CHC by rural women. It was found that the aspect of family planning was maximum i.e 11.53 immunization, followed by family planning I .e.10.90, followed by natal care with 10.70, followed by malarial fever with 10.85, followed by cough with 9.76, followed by body pains with 9.14, followed by knee pain with 8.51, followed by postnatal with 8.36, followed by

eye infection with 6.49, followed by problems of menopause with 3.89, followed by blood pressure with 3.79 and least was cancer with 2.89 were aspect for visiting CHC by rural women.

It was also found that the availability of aspects for visited CHC, maximum in Devori CHC 203 (10.55) and least was in Kesli CHC with 125 (6.49) availabilities of medical staff.

Table 4.8.26 Social Empowerment status of Rural Women

Option	Banda			Gadakota			Devori			Jaisinagar			Kesli			Khurai			Malthone			Rahatgarh			Shahgarh			Surkhi			Total			Total
	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good	Poor	Good	V. Good				
Using Toilets	20 (8.70)	1 (.14)	0 (.02)	2 (.90)	5 (1.94)	0 (.04)	2 (.81)	2 (.73)	0 (.01)	2 (.87)	1 (.37)	0 (.01)	4 (1.68)	1 (.41)	4 (1.64)	0 (.00)	2 (.80)	2 (.80)	0 (.00)	1 (.40)	4 (1.60)	0 (.00)	2 (.80)	6 (2.40)	0 (.00)	1 (.40)	5 (2.00)	0 (.00)	20 (8.00)	52 (20.80)	0 (.00)	261		

To increase hygiene in their area	25 (10.87)	5 (.71)	0	1 (.81)	7 (.44)	0	2 (.10)	6 (.10)	0	2 (.14)	4 (.50)	0	2 (.09)	2 (.4)	0	1 (.9)	1 (.1)	0	1 (.6)	7 (.9)	0	1 (.0)	3 (.14)	0	1 (.2)	9 (.16)	0	1 (.4)	10 (.29)	0	19 (.94)	64 (.16)	0	261
Steps to take safe drinking water	18 (7.83)	1 (.71)	0	2 (.89)	3 (.62)	0	2 (.85)	9 (.5)	0	2 (.7)	1 (.3)	0	1 (.8)	4 (.8)	0	2 (.52)	1 (.1)	0	1 (.69)	1 (.5)	0	2 (.14)	2 (.76)	0	1 (.74)	1 (.29)	0	1 (.8)	7 (.10)	0	18 (.28)	77 (.22)	0	261
Family planning methods	20 (8.70)	1 (.42)	0	2 (.80)	4 (.33)	0	2 (.91)	8 (.3)	0	2 (.83)	6 (.33)	0	2 (.93)	2 (.4)	0	2 (.84)	8 (.1)	0	1 (.69)	1 (.56)	0	5 (.95)	0	1 (.75)	1 (.58)	0	2 (.16)	4 (.71)	0	19 (.69)	69 (.95)	0	261	
Supporting equal status for	25 (10.87)	5 (.71)	0	2 (.8)	3 (.62)	0	2 (.85)	5 (.3)	0	2 (.69)	5 (.99)	0	1 (.93)	3 (.1)	0	2 (.4)	6 (.26)	0	1 (.8)	6 (.38)	0	1 (.9)	6 (.42)	0	2 (.09)	6 (.79)	0	1 (.3)	8 (.43)	0	20 (.49)	53 (.1)	0	261

Decision with regard to family Affairs	20 (8.70)	1 (.41)	0	1 (.92)	6 (.50)	0	2 (.33)	1 (.67)	0	1 (.76)	1 (.88)	0	1 (.92)	5 (3.5)	0	1 (.85)	1 (.71)	0	1 (.97)	8 (2.50)	0	1 (.69)	6 (4.9)	0	1 (.50)	1 (4.2)	0	1 (7.56)	13 (18.57)	0	16 (8.53)	94 (4.92)	0	261
Decision with regard to health at home	25 (10.87)	5 (.71)	0	1 (.63)	1 (.92)	0	2 (.83)	1 (.65)	0	1 (.83)	1 (.55)	0	1 (.87)	7 (8.9)	0	1 (.85)	1 (.71)	0	1 (.83)	9 (4.6)	0	2 (1.4)	2 (.76)	0	1 (.84)	8 (1.39)	0	1 (8.17)	6 (57)	0	18 (9.08)	81 (1.86)	0	261
Total	230 (11.6)	71 (1.11)	0	24 (1.71)	40 (.66)	0	24 (.92)	60 (.52)	0	22 (1.15)	72 (1.11)	0	18 (1.13)	37 (5.87)	0	21 (1.06)	90 (4.3)	0	16 (7.82)	64 (1.02)	0	17 (8.93)	42 (.63)	0	17 (8.67)	72 (11.11)	0	198 (5.88)	630 (2.41)	0	2612			

The above table no. 4.8.26 shows the overall social status of rural women. It is clear that the activities like security the rights women with 229 (11.55), Voicing against social injustice 213 (10.75), Supporting equal status for women, using toilet 209 (10.54), 208 (10.49), Supporting widow

remarital 201 (10.14), to increase hygiene in their area 197 (9.94), family planning 192 (9.69), steps to take safe drinking water 184 (9.28), decision regards with health at home 180 (9.08), a decision with regards to family affairs 169 (8.53) were in poor condition.

It was found that the overall social empowerment status maximum 240 (12.10) percentage of rural women reported poor in Devori, while the minimum in Khurai is 156 (7.87).

Table 4.9: Sample Size of Bhopal (Central Zone)

Questionnaire Distributed in CHC	Questionnaire Distributed	Questionnaire Received	Questionnaire's Analyzed
Gandhinagar (Bhopal)	30	30	30
Total	30	30	30

The above table no. 4.9 shows that the totals of 30 questionnaires were distributed among rural women and out of these 30 received back.

Table 4.9.1 Types of Category/ Population

Category	Gandhinagar	Percentage
General	0	0
OBC	8	26.66
SC	12	40
ST	10	33.33
Total	30	100

OBC= Other Backward Class, SC=Scheduled Caste, ST=Scheduled Tribal

Above Table 4.9.1 shows that the type of category among rural women which shows that the highest category of rural women is that 40 % rural women belong to SC, followed by 33.33 belongs to ST, and 26.66 are OBC.

Table 4.9.2 Family's Monthly Income

Option	Gandhinagar	Percentage
Up to 2000	2	6.66
2000-4000	22	73.33
5000-10000	6	20
10000 - more	0	0
Total	30	100

Table 4.9.2 shows that the family's income of rural women husband in which 73.33% rural women family income is up to 2000 monthly, followed by 20% rural women are between 5000-10000 monthly family income, followed by 6.66 are 2000.

Table 4.9.3 Education Levels of Women

Status	Gandhinagar	Percentage
Illiterate	10	33.33
Primary	16	53.33
Secondary	4	13.33
Higher Secondary	0	0
Graduate	0	0
Total	30	100

Table 4.9.3 shows that the education level of rural women which in 53.33% of rural women are having primary education, 33.33% of rural women have illiterate, and 13.33% rural women have secondary education.

Table 4.9.4 Marital Status of Women

Option	Gandhinagar	Percentage
Married	30	100
Unmarried	0	0
Total	30	100

The table above 4.9.4 shows the marital status of rural women. It was found that 100 percent of women are married in CHC.

Table 4.9.5 Occupation of the rural women's husband

Option	Gandhinagar	Percentage
Agriculture	15	50
Govt. Employee	0	0
No Employment	1	3.33
Farm Worker	0	0
Private	14	46.66
Driver	0	0
Business	0	0
Others	0	0
Total	30	100

This table 4.9.5 shows the occupations of rural woman's husband in which 50% rural women husband are doing agriculture work, while 46.66% are rural women 's husband is doing private work, and 3.33% are rural women husband is unemployed,

Table 4.9.6 Housing and Living Status of rural women

Variable	Categories	Gandhinagar	Percentage
Type of House	Hut	29	96.66
	Tiled	0	0
	Concrete	1	3.33
Ownership of House	Rented	0	0
	Own	30	100
	Others	0	0
Number of Rooms	One	2	6.66
	Two	27	90
	Three	1	3.33
	Four	0	0
	More than	0	0
Toilet	Not Available	28	93.33
	Available	2	6.66
Drinking water	Tap	0	0
	Hand Pump	30	100
Electricity	Not Available	0	0
	Available	30	100
Leisure time	Television	11	36.66
	Radio	0	0
	News paper	0	0
	No activity	2	6.66
Total		193	100

Table 4.9.6 shows the housing and living status of rural women, which is 15.1 percentages of rural women, were living in Huts house, whereas 15.4 are percentages of rural women have their own home. 10.1% of rural women are living in a double room, whereas 4.91 found that rural women live in a single room. Overall 10.7% of women have toilet facility and 6.64 are not having. The drinking water facility for rural women

shows that there is 15.4% have hand pump for water facility, around 15.4% said they have electricity. Television, Newspapers' and leisure activities are not done by them.

Table 4.9.7 Awareness about Health Literacy

Awareness Health Literacy	Gandhinagar	Percentage
Yes	16	53.33
No	14	46.66
Total	30	100

The table 4.9.7 show the awareness of health literacy among rural women It was found that 53.33women were aware of health literacy whereas 46.66 women were not aware of health literacy.

Table 4.9.8 Reasons for Non- Awareness about Health Literacy

	Gandhinagar	Percentage
Lack of education	15	50
Lack of Health Information	18	60
Not interested	Option	43.33
On opinion	2	6.66
Total	48	100

Table 4.9.8 shows the majority of rural women i.e. 60% were not aware of health literacy due to lack of health information, whereas 50% of rural women were unaware of health literacy because of a lack of health education, and 43.33% are not interested.

Table 4.9.9 Provision of Health Information, Resources, and Services provided by CHC

Option	Gandhinagar	Percentage
Yes	10	33.33
No	20	66.66
Total	30	100

The above table 4.9.9 Show the provision health information, resources, and service by CHC for rural women. It was found that the highest 66.66 rural women did not access health information, resources, and service from the CHC, and 33.33 were received.

Table 4.9.10 Awareness, Source and Uses of immunization

Source	Category	Gandhinagar	Percentage
Awareness about Immunization	No Awareness	7	23.33
	Is	23	76.66
Source of Information on Immunization	Doctors	9	30
	Health visitors	10	33.33
	AASHA	24	80
	Nurse	26	86.66

Awareness about Diseases prevented by Immunization	Fully aware	0	0
	Partially aware	23	76.66
	Not aware	7	23.33
Total		129	100

The table 4.9.10 shows that the most of rural women get health information about sources of information on Immunization 76.66 know immunization from ASHA worker, followed by Nurse with 23.33% don't know, followed by Nurse with 87.66% Rural Women have health information on Awareness about Immunization around 80% and 33.33% are of rural women not have information about immunization, whereas awareness about diseases prevented by immunization is 76.66% are partially aware and 23.33% is not aware.

Table 4.9.11 Availability and Accessibility of Health Care Services by CHC

Variable	Categories	Gandhinagar	Percentage
Distance to Community Health Center (in km)	1.00-5.00	0	0
	6.00-10.0	2	6.66
	11.0-15.0	25	83.33
	16.0-20.0	3	10
	21.0-25.0	0	0
Reasons for visiting Community Health Centers	For free Medicine	30	100
	Emergency	30	100
	Minor Illness	0	6.99
	Not visiting	0	0

Visiting Private Clinic	Minor Illness	5	6.66
	Partially	25	83.33
Distance to Medical Shop(in km)	00.-.50	30	100
	1.00-2.00	0	0
	3.00.-more than	0	0
Total		645	100

The table 4.9.11 shows Availability and Accessibility of Health Care Services in CHC for rural women. It was found that the 83.33 maximum distance and reasons for visiting community health centers it was found that 100% visit to CHC and for emergency purpose.

Table 4.9.12 Access to the Satisfactory Road Network in Rural Areas

Option	Gandhinagar	Percentage
Yes	19	63.33
No	11	36.66
Total	30	100

The table 4.9.12 shows the satisfactory road network in Gandhinagar CHC. It was found that the satisfactory road network is highest 63.33 and the lowest is 36.66 with satisfied rural women to the road network.

Table 4.9.13 Barriers to Health Treatment

Option	Gandhinagar			Total	Percentage
	Poor	Average	Good		
Social status	17	0	13	30	14.29
Self-perceived health	18	6	6	30	14.29
Able to pay for Medication	16	4	10	30	14.29
Able to afford doctor	18	5	7	30	14.29
Limited activities because of health problems	10	14	6	30	14.29
Monthly household income	18	8	4	30	14.29
Unable to reach out to CHC	20	6	4	30	14.29
Total	117 (60.94)	43 (39.45)	50 (73.53)	210	100

Table 4.9.13 shows that the barriers to health treatment faced by rural women. The poor social status, Self-perceived health, not able to pay for Medication, not able to afford doctor, limited activities because of health problems, monthly household income, Unable to reach out to CHC were found that 56.66% poor, 60% self-perceived health, 53.33% not able to pay for medication, 60% not able to afford doctor, 117 (60.94), percentage in Gandhinagar, followed by 75 (39.06) in Tarana. Moving forward Tarana has the second-lowest poor (good) percentage of 66 (60.55).

Overall it is found that the barrier for the health treatment faced by rural women 192 (52.03) percentage are poor, followed by 109 (29.54) percentages are good and 68 (18.43) percentages are good.

Table 4.9.14 Awareness about Nutritious diet taken by Rural Women

Option	Gandhinagar	Percentage
Yes	16	53.33
No	14	46.66
Total	30	100

Table 4.9.14 shows that the awareness about the nutritious diet taken by rural women. It was found that the 53.33% rural women were aware of a nutritious diet, whereas 46.66 percent of rural women were not aware of nutritious diet.

Table 4.9.15 Reasons for Non- awareness nutritious diet by rural women

Option	Gandhinagar	Percentage
Monthly Income	25	83.33
Not Aware	5	16.66
Total	30	100

Table 4.7.15 shows that the Reasons for not awareness of nutritious diet and foods by rural women. It found that 83.33 percentage of rural women were not taking nutritious

diet, due to lack of monthly income and the lowest 16.66 percentage of rural women were not aware of the nutritious diet.

Table 4.9.16 Chosen Places for Delivery of their Child by Rural Women

Option	Gandhinagar	Percentage
Home	0	0
Government facility	30	100
Accredited private facilities	0	0
Other private facilities	0	0
Total	30	100

The above table 4.8.16 shows that the Chosen Places for Delivery of their Child by Rural Women. It was found that the 100 percentage of rural women have chosen a government facility for delivery.

Table 4.9.17 Awareness about contraception

Option	Gandhinagar	Percentage
Yes	19	63.33
No	11	36.66
Total	30	100

Table 4.9.17 shows that awareness about contraception among rural women. It was found that the percentage of awareness about contraception was 63.33% CHC. Whereas 36.66% of rural women were not aware of contraception.

Table 4.9.18 Use of Contraception by Rural Women

Use of Contraception	Gandhinagar	Percentage
Yes	8	26.66
No	22	73.33
Total	30 (56.60)	100

Table 4.9.18 shows the uses of contraception by rural women. It was found that the percentage of never use of contraception was 73.33 in CHC, whereas 26.66% of rural women used contraception.

Table 4.9.19 Reason for not using Contraception by Rural Women

Option	Gandhinagar	Percentage
Lack of information	22	37.28
Husband not agree	19	32.20
Side effect	20	33.89
Total	59	100

Table 4.9.19 shows that the reasons for not using contraception by rural women. It was found that 37.28% in Gandhinagar, rural women did not use contraception due to lack of information, 33.89% side effect, and 32.20% because their husband are not agree for same.

Table 4.9.20 Health Information received by Rural Women

Option	Gandhinagar	Percentage
Community health center	30	37.03
Sub-center	7	8.64
Primary Health Center	14	17.28
Districts hospital	30	37.03
Television	0	0
Newspapers	0	0
Adult education officials	0	0
Total	81 (56.86)	100

The above table 4.9.20 shows that health Information received by rural women, whereas 37.03% information from CHC, 28% from PHC, 37.03 from districts hospital and 8.64 from sub-center.

Table 4.9.21 Treatment taken during pregnancy by Rural Women

Option	Gandhinagar	Percentage
Yes	1	3.33

No	29	96.66
Total	30	100

The above table 4.9.21 shows that the chosen treatment taken during pregnancy. It was found that the 98.11 percentage of rural women have chosen to CHC, followed by 1.89 rural women who have not taken treatment during their pregnancy time from the CHC.

Table 4.9.22 Types of Hospitals preferred by Rural Women

Type of Hospital	Gandhinagar	Percentage
Community health centre	28	93.33
Sub-centre	12	40
Private hospital	0	0
Ayurvedic hospital	0	0
Traditional local health person	0	0
Total	40	100

The above table 4.9.22 shows the types of hospitals preferred by Rural Women in case of health issues. It was found that 93.33 % prefer CHC. And 40% preference private hospital in Gandhinagar.

Table 4.9.23 Availability of Medical Staff in CHC

Option	Gandhinagar		Total & Percentage
	Yes	No	
Doctor	28	2	30 (12.5)
Nurse	30	0	30 (12.5)

Compounder	15	15	30 (12.5)
Health inspector	0	30	30 (12.5)
Health assistant (Male)	0	30	30 (12.5)
Health assistant (Female)	0	30	30 (12.5)
Lab technician	29	1	30 (12.5)
Peon	28	2	30 (12.5)
Total	130 (54.17)	110 (45.83)	240 (100)

The above table 4.9.23 shows that the medical staff was available in CHC. It was found that the availability of nurse staff was maximum i.e 100%, same as followed by a lab technician with 96.66% followed by a doctor with 93.33%, followed by peon 93.33%, followed by compounder 50% availability in CHC.

Table 4.9.24 Satisfaction level with CHC Staff

Option	Gandhinagar			Total & Percentage (P+G+VG)
	Poor	Good	V. Good	
Doctors	10	20	0	30 (16.66)
Nurse and Compounder	8	22	0	30 (16.66)
Labor rooms	10	20	0	30 (16.66)
Radiographers & X-Ray Machines	30	0	0	30 (16.66)
Lab Technician & Pathology Labs	1	29	0	30 (16.66)
Generators	29	1	0	30

				(16.66)
Total	88 (54.66)	92 (58.60)	0	180 (100)

The table 4.9.24 shows that overall satisfaction level with medical staff available in CHC. 92 (58.60) and the maximum rural women were satisfied in Gandhinagar and 73 (45.34) percentage of rural women are not satisfied with CHC staff in Tarana.

Table 4.9.25 Aspects of visiting to CHC by Rural Women

Option	Gandhinagar	Percentage
Family planning	22	73.33
Natal care	25	83.33
Immunization	30	100
Communicable diseases	0	0
a) Malarial fever	24	80
b) Eye infections	10	10.33
c) Cough	20	20.66
d) Body pains	22	73.33
e) Knee pains	21	70
f) Problems of menopause	8	26.66
g) Cancer	0	0
h) Blood pressure	22	73.33
Total	204 (54.69)	100

The above table 4.9.25 shows that the overall aspect of visiting CHC by rural women. It was found that rural women were maximum visited for Immunization, and 83.33% are natal care, and family planning with 73.33% is visited, body pain with 73.33%, followed by blood pressure with 73.33%, followed by malaria fever 80%, followed by

cough 20.66%, followed by knee pain with 70%, followed by eye infections with 10.33% were aspect for visiting CHC by rural women.

Table 4.9.26 Social Empowerment status of Rural Women

Status of Social Empowerment	Gandhinagar		
	Poor	Good	V.Good
Using Toilets	17	13	0
To increase hygiene in their area	12	11	0
Steps to take safe drinking water	12	18	0
Family planning methods	11	19	0
Supporting equal status for women	22	8	0
Securing ty rights for Women	21	11	0
Voicing against social injustice	20	10	0
Supporting widow remarital	17	13	0
The decision about family Affairs	21	9	0
The decision about health at home	20	10	0
Total	173	122	0
	(52.27)	(58.10)	

The above table no. 4.9.26 shows the overall social status of rural women. The poor activities like voicing against social justice are 14.02, followed by 13.91 Supporting widow remarital, followed by 13.36 Supporting equal status for women, followed by 12.22 Decision about family Affairs, followed by 12.72 Decision about health at home,

followed by 10.30 Family planning methods, followed by 10.30 using the toilet, followed by 9.52 water facilities are poor condition.

The overall social statuses of rural women are poor which is 52.27, whereas 58.10 percentage of social status is good.

Table 4.10: Sample Size (District wise data analysis)

Questionnaire Distributed in CHC	Questionnaire Distributed	Questionnaire Received	Questionnaire's Analyzed
Gwalior	60	48 (4.47)	48
Indore	120	115 (10.71)	115
Shivpuri	169	169 (15.08)	169
Dewas	150	130 (12.10)	130
Ujjain	60	53 (4.93)	53
Mandsour	90	89 (8.29)	89
Satna	210	186 (17.32)	186
Sagar	300	261 (24.30)	261
Bhopal	30	30 (2.79)	30
Total	1230	1074 (100)	1081

The above table no.4.10 shows that a total of 1230 questionnaires were distributed among rural women and out of these 1081 received back.

Table 4.10.1 Types of Category/ Population

Category	Gwalior	Indore	Shivpuri	Dewas	Ujjain	Mandsour	Satna	Sagar	Bhopal	Total	Percentage
General	0	4	1	1	0	4	4	33 (12.64)	0	47	4.35
OBC	6	35	63	51	21	26	58	149 (57.09)	8 (26.67)	417	38.58
SC	16	52	59	47	18	40	85	77 (29.50)	12 (40)	406	37.56
ST	26	24	46	31	14	19	39	2 (0.77)	10 (33.33)	211	19.52
Total	48	115	169	130	53	89	186	261 (24.30)	30 (2.79)	1081	100

OBC= Other Backward Class, SC=Scheduled Caste, ST=Scheduled Tribal

Above Table 4.10.2 shows that the type of category among rural women which shows that the highest category of rural women is that 38.11 % rural women belong to OBC, followed by 37.56 belongs to SC, and 19.52 are ST, and 4.35 are General.

Table 4.10.2 Family's Monthly Income

Income (in Rs)	Gwalior	Indore	Shivpuri	Dewas	Ujjain	Mandsour	Satna	Sagar	Bhopal	Total	Percentage
Up to 2000	0	3 (2.61)	9 (5.33)	1 (0.77)	3 (5.66)	0	19 (10.22)	33 (12.64)	2 (6.67)	70	6.48
2000-4000	35 (72.92)	65 (56.52)	132 (78.11)	95 (73.08)	44 (83.05)	59 (59.55)	130 (69.89)	150 (57.47)	22 (73.33)	732	67.72
5000-10000	13 (27.08)	46 (40)	28 (16.57)	34 (26.15)	6 (11.35)	29 (32.58)	37 (19.89)	76 (29.12)	6 (20)	275	25.44
10000 - more	0	1 (0.87)	0	0	0	1 (1.12)	0	2 (0.77)	0	4	0.37
Total Response	48 (4.47)	115 (10.71)	169 (15.63)	130 (12.10)	53 (4.93)	89 (8.29)	186 (17.32)	261 (24.30)	30 (2.79)	1081	100

The Table 4.10.2 shows that the family's income of rural women husband in which 67.22% rural women family income is up to 2000 monthly, followed by 25.44% rural women are between 5000-10000 monthly family income, followed by 6.48% of rural women income is up to 2000 only and 0.37 are 10000-more.

Table 4.10.3 Education Levels of Women

Status	Gwalior	Indore	Shivpuri	Dewas	Ujjain	Mandsour	Satna	Sagar	Bhopal	Total	Per
Illiterate	27 (56.25)	52 (45.22)	73 (45.06)	54 (41.54)	16 (30.19)	27 (30.34)	78 (41.94)	92 (35.25)	10	429	39.94
Primary	15 (31.25)	50 (43.48)	44 (27.16)	53 (40.77)	27 (50.94)	36 (43.48)	69 (37.10)	90 (34.48)	16	400	37.24
Secondary	3 (12.5)	13 (11.3)	39 (3.70)	16 (12.31)	9 (16.98)	23 (25.84)	28 (15.05)	55 (21.07)	4	191	17.78
Higher Secondary	0	0	6 (3.70)	7	1 (1.89)	3 (3.37)	11 (5.91)	14 (5.36)	0	44	4.09
Graduate	0	0	0	0	0	0	0	10 (3.83)	0	10	0.93
Total	48 (4.47)	115 (10.71)	162 (15.08)	130 (12.10)	53 (4.93)	89 (8.29)	186 (17.32)	261 (24.30)	30 (2.79)	1074	100

Table 4.3.3 shows the education level of rural women in which 39.94 rural women are illiterate, followed by 37.24 rural women have primary education, followed by 17.78 percentage of rural women have secondary education level and 4.10 percentage of rural having Higher Secondary while only 0.93 percentage of rural women have graduation.

Table 4.10.4 Marital Status of Women

Option	Gwalior	Indore	Shivpuri	Dewas	Ujjain	Mandsour	Satna	Sagar	Bhopal	Total	Percentage
Married	48 (100)	115 (100)	169 (100)	130 (100)	53 (100)	89 (100)	186 (100)	261 (100)	30 (100)	1081	100
Unmarried	0	0	0	0	0	0	0	0	0	0	0
Total	48 (4.47)	115 (10.71)	169 (15.08)	130 (12.10)	53 (4.93)	89 (8.29)	186 (17.32)	261 (24.30)	30 (2.77)	1081	100

The table above 4.10.4 shows the marital status of rural women. It was found that 100 percent of women are married in CHC.

Table 4.10.5 Occupation of the Rural Women's Husband

Occupation	Gwalior	Indore	Shivpuri	Dewas	Ujjain	Mandsour	Satna	Sagar	Bhopal	Total	Per.
Agriculture	22 (31.88)	74 (48.38)	86 (44.10)	68 (43.31)	35 (50.72)	50 (56.18)	136 (55.28)	140 (53.64)	15 (50)	626	49.33
Govt. Employee	0	1 (0.65)	0	0	0	1 (1.12)	0	1 (0.38)	0	3	0.24

No Employment	12 (19.39)	13 (8.50)	33 (16.92)	16 (10.19)	6 (8.70)	6 (6.74)	10 (4.07)	37 (13.79)	1 (3.33)	133	10.48
Farm Worker	2 (2.90)	0	0	2 (1.27)	0	0	0	9 (3.45)	0	13	1.02
Private	32 (46.38)	64 (41.83)	76 (38.97)	66 (42.04)	28 (40.58)	32 (35.96)	99 (40.24)	59 (22.99)	14 (46.67)	471	32.86
Driver	0	0	0	4 (2.55)	0	0	0	3 (0.77)	0	6	0.47
Business	1 (1.45)	1 (0.65)	0	1 (0.64)	0	0	1 (0.41)	8 (3.07)	0	12	0.95
Others	0	0	0	0	0	0	0	4 (1.53)	0	4	0.32
Total	69 (5.44)	153 (12.06)	195 (15.37)	157 (12.37)	69 (5.44)	89 (7.01)	246 (19.39)	261 (20.57)	30 (2.36)	1269	100

This table 4.10.5 shows the occupations of rural woman's husband in which 49.33% rural women husband are doing agriculture work, while 32.86% are rural women 's husband is doing private, followed by 1.02% are farmworker and 10.48% rural women husband are unemployed,

Table 4.10.6 Housing and Living Status of Rural Women

Variable	Categories	Gwalior	Indore	Shivpuri	Dewas	Ujjain	Mandsour	Satna	Sagar	Bhopal	Total	Percentage
Type of House	Hut	48	100	141	123	52	67	126	213	29	899	13.30
	Tiled	0	5	3	4	0	0	4	5	0	21	0.31
	Concrete	0	6	18	2	0	22	59	22	1	130	1.92

Ownership of House	Rented	0	1	2	0	0	0	0	2	0	5	0.07
	Own	48	106	160	130	53	89	186	245	30	1047	15.49
	Others	0	0	0	0	0	0	0	0	0	0	0
Number of Rooms	One	33	51	100	67	17	44	73	110	2	497	7.35
	Two	14	51	55	59	35	42	104	101	27	488	7.22
	Three	1	6	4	2	1	2	11	17	1	45	0.67
	Four	0	0	2	0	0	2	0	6	0	10	0.15
	More than	0	0	1	0	0	0	0	7	0	8	0.12
Toilet	Not Available	20	35	72	72	37	36	67	97	28	464	6.86
	Available	28	73	90	58	16	53	107	141	2	568	8.40
Drinking water	Tap	21	16	33	22	0	21	50	41	0	204	3.02
	Hand Pump	27	92	108	108	53	68	136	155	30	777	11.49
Electricity	Not Available	16	2	45	16	0	7	30	29	0	145	2.14
	Available	35	106	115	114	53	82	156	196	30	887	13.12
Leisure time	Television	1	38	34	37	25	29	44	29	11	248	3.67
	Radio	0	3	9	0	0	10	7	8	0	37	0.55
	News paper	0	5	0	0	0	8	0	5	0	18	0.27
	No activity	38	34	41	54	2	17	36	38	2	262	3.88

Total	169 (2.87)	730 (12.41)	1033 (17.56)	130 (2.21)	345 (5.87)	599 (10.18)	1216 (20.67)	1467 (24.94)	193 (24.94)	6760	100
--------------	----------------------	-----------------------	------------------------	----------------------	----------------------	-----------------------	------------------------	------------------------	-----------------------	-------------	------------

Table 4.10.6 shows that the housing status of rural women. It is clear that the overall type of houses, Ownership of House, Number of Rooms, toilet facility Drinking water, electricity availability, leisure time spent were highest in Sagar which is 1467 (24.49), and lowest in Dewas which is 2.21.

Table 4.10.7 Awareness about Health Literacy

Awareness	Gwalior	Indore	Shivpuri	Dewas	Ujjain	Mandsour	Satna	Sagar	Bhopal	Total	Per.
Health Literacy											
Yes	15 (31.25)	60 (52.17)	45 (26.63)	38 (26.23)	20 (37.7)	47 (52.81)	75 (40.32)	189 (72.4)	16 (53.33)	505	46.71
No	33 (68.75)	55 (47.83)	124 (73.37)	92 (70.77)	33 (62.3)	42 (47.19)	109 (58.6)	72 (27.6)	14 (46.67)	574	53.09
Total	48 (4.47)	115 (10.71)	169 (15.08)	130 (12.10)	53 (4.93)	89 (8.29)	186 (17.32)	261 (24.30)	30 (2.79)	1081	100

The table 4.10.7 shows that the awareness of health literacy among rural women was low. It was found that 574 (i.e. 53.09%) women were unaware of health literacy whereas 505 (i.e. 46.71%) women were aware of health literacy.

Table 4.10.8 Reason for not Awareness about Health Literacy

Reasons	Gwalior	Indore	Shivpuri	Dewas	Ujjain	Mandsour	Satna	Sagar	Bhopal	Total	Percentage
Lack of education	30 (42.25)	52 (49.52)	119 (47.41)	84 (35.59)	33 (40.2)	38 (47.5)	100 (46.9)	69 (48.3)	15 (31.25)	540	43.94
Lack of Health Information	21 (29.58)	53 (50.48)	118 (47.02)	89 (37.71)	32 (39)	42 (52.5)	108 (50.7)	74 (51.7)	18 (37.50)	555	45.16
Not interested	20 (28.17)	0	14 (6.78)	47 (19.92)	15 (18.3)	0	2 (0.9)	0	13 (27.08)	111	9.03
No opinion	0	0	0	16 (6.78)	2 (2.44)	0	3 (1.4)	0	2 (4.17)	23	1.87
Total	71 (5.78)	105 (8.54)	251 (20.42)	236 (19.20)	82 (6.67)	80 (6.51)	213 (17.33)	143 (11.64)	48 (3.91)	1229	100

Table 4.10.8 shows that the majority of rural women i.e. 45.16% were not aware of health literacy because of a lack of health information, whereas 43.94% of rural women were unaware of health literacy because of lack of health information, 9.03 not interest and 1.87 on given information health awareness.

Table 4.10.9 Provision of Health Information, Resources, and Services

Option	Gwalior	Indore	Shivpuri	Dewas	Ujjain	Mandsour	Satna	Sagar	Bhopal	Total	Percentage
Yes	27 (56.25)	78 (67.83)	102 (60.36)	62 (47.69)	16 (30.19)	64 (71.91)	75 (40.32)	40 (15.53)	10 (33.33)	475	43.94
No	21 (43.75)	37 (32.17)	66 (39.05)	68 (52.31)	37 (69.81)	25 (28.09)	111 (59.68)	221 (84.67)	20 (66.67)	606	56.06
Total	48 (4.44)	115 (10.64)	169 (15.63)	130 (12.03)	53 (4.90)	89 (8.23)	186 (17.21)	261 (24.14)	30 (2.78)	1081	100

The above table 4.10.9 shows that provision of health information, resources, and services provided by CHC for rural women. It was found that the highest 56.06% of rural women not have to access health information, resources, and service from the CHC, and 43.94% were received it from CHC.

Table 4.10.10 Awareness, Source and Uses of immunization

Option	Category	Gwalior	Indore	Shivpuri	Dewas	Ujjain	Mandsour	Satna	Sagar	Bhopal	Total &Per.
Awareness about Immunization	No Awareness	13	53	83	61	18	30	68	50	7	383 (8.28)
	Yes	35	65	78	70	35	59	118	184	23	667 (14.41)
Source of Information on Immunization	Doctors	10	47	62	36	19	62	91	204	9	540 (11.67)
	Health visitors	0	25	19	24	15	2	17	60	10	172 (3.72)
	AASHA	42	113	142	110	45	89	186	215	24	966 (20.87)
	Nurse	2	112	145	71	43	85	176	201	26	861 (18.60)
Awareness about Diseases prevented by Immunization	Fully aware	0	0	0	0	0	0	0	2	0	2 (0.04)
	Partially aware	39	95	141	111	41	70	147	170	23	837 (18.09)
	Not aware	9	15	21	27	11	19	37	54	7	200 (4.32)
Total		150	525	691	510	227	416	840	1140	129	4628

	(3.24)	(11.34)	(14.93)	(11.02)	(4.90)	(8.99)	(18.15)	(24.63)	(2.79)	(100)
--	--------	---------	---------	---------	--------	--------	---------	---------	--------	-------

Table 4.10.10 shows Awareness about Immunization, source of information on immunization, and awareness about diseases prevented by immunization among rural women. It was found that the highest percentage of Sagar district are aware about Immunization, sources of information on immunization, and awareness about diseases prevented are 24.63. The lowest percentage was the Ujjain Zone which is 4.90 only.

Table 4.10.11 Awareness, Source and Uses of immunization

Awareness	Categories	Gwalior	Mohana	Shivpuri	Dewas	Ujjain	Mandsour	Satna	Sagar	Gandhinagar	Total	Percentage
Distance to Community Health Centre (in km)	1.00-5.00	0	0	4	0	0	0	2	8	0	14	0.31
	6.00-10.0	20	69	74	32	2	60	112	50	2	421	9.32
	11.0-15.0	23	39	82	90	46	29	66	96	25	496	10.98
	16.0-20.0	5	3	3	11	6	0	14	85	3	131	2.90
	21.0-25.0	0	0	0	0	0	0	0	0	0	0	0
Reasons for visiting Community	For free Medicine	41	105	160	123	53	89	186	47	30	834	18.46
	Emergency	15	43	76	35	53	70	126	260	30	709	15.70

Health Centers	Minor Illness	8	24	35	11	20	20	42	235	0	395	8.74
	Not visiting	0	0	0	0	0	0	0	91	0	78	1.73
Visiting Private Clinic	Minor Illness	0	0	2	0	8	0	1	0	5	16	0.35
	Partially	18	0	5	19	45	59	52	105	25	328	7.26
Distance to Medical Shop(in km)	00.-.50	48	115	160	129	53	89	186	75	30	885	19.59
	1.00-2.00	0	0	0	1	0	0	0	208	0	210	4.65
	3.00.- more than	0	0	0	0	0	0	0	0	0	0	0
Total		178 (3.94)	398 (8.81)	601 (13.31)	451 (9.98)	286 (6.33)	416 (9.21)	787 (17.42)	1260 (27.67)	150 (3.32)	4517	100

Table 4.10.11 shows Availability and Accessibility of Health Care Services in CHC for rural women. It was found that the overall availability and accessibility is highest in Sagar rural women with (27.67), which the lowest in Gwalior was where it was 3.94.

Table 4.10.12 Access to the Satisfactory Road Network in Rural Areas

Option	Gwalior	Indore	Shivpuri	Dewas	Ujjain	Mandsour	Satna	Sagar	Bhopal	Total	Percentage
Yes	26 (54.17)	67 (58.26)	113 (66.86)	71 (54.62)	32 (60.38)	50 (56.18)	116 (62.37)	189 (72.41)	19 (63.33)	683	63.18
No	22	48	56	59	21	39	70	72	11	398	36.82

	(45.83)	(41.74)	(33.14)	(45.38)	(39.62)	(43.82)	(37.63)	(27.59)	(36.67)		
Total	48 (4.44)	115 (10.63)	169 (15.63)	130 (12.02)	53 (4.90)	89 (8.23)	186 (17.20)	261 (24.14)	30 (2.77)	1081	100

The table 4.3.12 shows that the satisfactory road network was found in Gwalior, Indore, Shivpuri, Dewas, Ujjain, Mandsour, Satna, Sagar CHC.

It shows satisfaction about road networks highest 63.18 and the lowest is 36.82 among rural women.

Table 4.10.13 Barriers to Health Treatment

Option	Gwalior			Indore			Dewas			Ujjain			Mandsour			Satna			Sagar			Bhopal			Total			Total & Per.
	P	E	D	P	E	D	P	E	D	P	E	D	P	E	D	P	E	D	P	E	D	P	E	D	P	E	D	
Social status	17 (19.32)	22 (32.35)	9 (25.71)	70 (22.26)	62 (22.67)	9 (16.98)	18 (26.47)	45 (34.6)	36 (27.3)	31 (25.8)	8 (15.5)	1 (4.4)	65 (23.55)	15 (33.71)	10 (25.6)	126 (24.56)	28 (29.79)	32 (23.36)	185 (23.84)	44 (31.1)	0 (0)	17 (26.6)	0 (0)	13 (36.11)	529 (23.93)	224 (28.79)	123 (25.84)	876 (25.35)
Self-perceived health	21 (23.86)	17 (25)	10 (28.57)	77 (25.58)	61 (22.85)	11 (20.75)	18 (26.47)	35 (26.9)	31 (23.5)	20 (16.7)	2 (4.2)	9 (5.7)	64 (23.19)	14 (33.33)	11 (28.2)	130 (25.34)	25 (26.6)	31 (22.36)	193 (24.87)	35 (25.36)	0 (0)	18 (26.0)	6 (4)	6 (16.67)	541 (24.47)	216 (27.76)	109 (84.50)	866 (25.06)
Unable to reach out to CHC	18 (20.45)	20 (29.41)	9 (25.71)	81 (29.91)	42 (18.80)	25 (41.17)	22 (35.35)	33 (25.4)	34 (25.8)	36 (30)	1 (2.0)	5 (4.3)	71 (25.72)	8 (10.05)	10 (25.6)	130 (25.34)	22 (23.4)	36 (26.28)	195 (25.13)	32 (23.19)	0 (0)	16 (23.1)	4 (2.67)	10 (27.78)	569 (25.73)	172 (22.11)	129 (27.62)	870 (25.17)
Able to afford doctor	32 (36.36)	9 (13.24)	7 (25.71)	73 (25.25)	71 (26.08)	8 (10.09)	10 (14.71)	17 (23.4)	31 (23.5)	33 (27.5)	1 (2.7)	7 (5.4)	76 (27.54)	5 (1.90)	8 (20.5)	127 (24.76)	19 (20.21)	38 (27.74)	203 (26.16)	27 (19.57)	0 (0)	18 (26.0)	5 (3.33)	7 (19.44)	572 (25.87)	166 (21.34)	106 (22.70)	844 (24.42)

))))))))							
Total	88 (3.9 8)	68 (8.7 4)	35 (7. 49)	30 1 (1 3. 61)	23 6 (3 0. 33)	53 (1 1. 34)	68 (3 .0 8)	13 0 (1 6. 7)	132 (28. 3)	12 0 (5 .4 3)	5 5 (7 .0 6)	3 5 (7 .4 9)	27 6 (1 2. 5)	42 (5. 4)	39 (8. 35)	513 (23. 2)	94 (12 .1)	137 (29. 3)	776 (35. 1)	13 8 (1 8)	0	69 (3. 12)	15 (1. 93)	36 (7.7 1)	2211 (63.9 7)	778 (22. 51)	467 (13. 51)	3456 (100)

Note=Poor. A=Average, D=Good

Table 4.10.13 shows the barriers to health treatment faced by rural women. The poor social status, Self-perceived health, not able to pay for Medication, not able to afford doctor, limited activities because of health problems, monthly household income, unable to reach out to CHC were found to be the main barriers 35.1% Sagar, followed by 23.3 in Satna. 13.61% Indore has the second-lowest poor and Mandsour has the lowest poor percentage of 12.5, followed by 5.43 in Ujjain, followed by 3.98 in Gwalior CHCs were faced by rural women for health treatment.

It is clear that the overall barriers to health treatments faced by 63.67 rural women were not able to afford doctor, medicine, and their social status.

Table 4.10.14 Awareness about nutritious diet taken by Rural Women

Options	Gwalior	Indore	Shivpuri	Dewas	Ujjain	Mandsour	Satna	Sagar	Bhopal	Total & Percentage
Yes	20 (41.67)	61 (53.04)	112 (66.27)	59 (45.38)	29 (54.72)	41 (46.07)	65 (34.95)	40 (15.53)	16 (53.33)	443 (40.98)

No	28 (58.33)	54 (46.96)	57 (33.73)	71 (54.62)	24 (45.28)	48 (53.93)	121 (65.05)	221 (84.67)	14 (46.67)	638 (59.01)
Total	48 (4.44)	115 (10.63)	169 (15.63)	130 (12.02)	53 (4.90)	89 (8.23)	186 (17.20)	261 (24.14)	30 (2.77)	1081

Table 4.10.14 shows that the awareness about the nutritious diet taken by rural women. It was found that the 59.01% rural women were not aware of nutritious diet, whereas 40.98% percent of rural women were not aware of nutritious diet.

Table 4.10.15 Reason for Non aware of Nutritious diet by Rural Women

Option	Gwalior	Indore	Shivpuri	Dewas	Ujjain	Mandsour	Satna	Sagar	Bhopal	Total & Percentage
Monthly Income	34 (70.83)	91 (79.13)	149 (80.77)	105 (88.65)	47 (46.07)	41 (46.07)	65 (34.95)	236 (90.42)	25 (83.33)	793 (73.02)
Not Aware	14 (29.17)	24 (88.17)	20 (19.23)	25 (11.32)	6 (53.93)	48 (53.93)	121 (65.05)	30 (9.58)	5 (16.67)	293 (26.97)
Total	48	115	169	130	53	89	186	261 (24.03)	30	1086

	(4.41)	(10.58)	(15.56)	(11.97)	(4.88)	(8.19)	(17.12)		(2.76)	
--	--------	---------	---------	---------	--------	--------	---------	--	--------	--

The table 4.10.15 show that the reason for not aware about the full nutritious diet and foods by rural women. It found that the 73.02 percentage of rural women were not taking nutritious diet due to lack of monthly income and the lowest 26.97 percentage of rural women were not aware of the full nutritious diet.

Table 4.10.16 Chosen Places for Delivery of their Child by Rural Women

Option	Gwalior	Indore	Shivpuri	Dewas	Ujjain	Mandsour	Satna	Sagar	Gandhi	Total & Per.
Home	0	1 (0.87)	4 (2.47)	14 (10.77)	0	0	0	17 (6.51)	0	36 (3.34)
Government facility	48 (100)	114 (99.13)	158 (97.53)	116 (89.23)	53 (100)	89 (100)	186 (100)	244 (93.49)	30	1038 (96.46)
Accredited private facilities	0	0	0	0	0	0	0	0	0	0
Other private facilities	0	0	0	0	0	0	0	0	0	0
Total	48	115	162	130	53	89	186	261	30	1074

	(4.46)	(10.68)	(15.05)	(12.08)	(4.92)	(8.27)	(17.28)	(24.25)	(2.78)	(100)
--	--------	---------	---------	---------	--------	--------	---------	---------	--------	-------

The table 4.10.16 the chosen places for delivery. It found that the highest 96.46 percentage of rural women were chosen government hospitals, while 3.34 percentage of rural women chosen at home for delivery of their child.

Table 4.10.17 Awareness of Contraception

Options	Gwalior	Indore	Shivpuri	Dewas	Ujjain	Mandsour	Satna	Sagar	Bhopal	Total	Percentage
Yes	37 (77.08)	90 (78.26)	110 (65.09)	104 (80)	35 (66.04)	66 (74.16)	121 (65.05)	189 (72.41)	19 (63.33)	771	71.32
No	11 (22.92)	25 (21.74)	59 (34.91)	26 (20)	18 (33.96)	23 (25.84)	65 (34.95)	72 (27.59)	11 (36.67)	310	28.68
Total	48 (4.44)	115 (14.99)	169 (15.63)	130 (12.03)	53 (4.90)	89 (8.23)	186 (17.21)	261 (23.14)	30 (2.66)	1081	100

The above table 4.10.17 shows that the uses of contraception by rural women. It was found that the 71.32% of use of contraception in CHC, whereas, 28.68% of rural women never used contraception.

Table 4.10.18 Use of Contraception by Rural Women

Use of Contraception	Gwalior	Indore	Shivpuri	Dewas	Ujjain	Mandsour	Satna	Sagar	Bhopal	Total	Percentage
Yes	7 (14.58)	90 (78.26)	110 (65.09)	16 (12.31)	14 (26.42)	32 (35.96)	75 (40.32)	71 (27.20)	8 (26.67)	423	39.13
No	41 (85.42)	25 (21.74)	59 (34.91)	4.1.18114 (87.69)	39 (73.58)	57 (64.04)	111 (59.68)	190 (72.80)	22 (73.33)	658	60.87
Total	48 (4.44)	115 (14.99)	169 (15.63)	130 (12.03)	53 (4.90)	89 (8.23)	186 (17.21)	261 (23.14)	30 (2.66)	1081	100

The table and 4.10.18 show the Use of Contraception by Rural Women. It was found 60.87 percent of contraception never used by rural women. While 39.13 percent of rural women were used contraception.

Table 4.10.19 Reason for not Using Contraception by Rural Women

Option	Gwalior	Indore	Shivpuri	Dewas	Ujjain	Mandsour	Satna	Sagar	Bhopal	Total	Percentage
Lack of information	34 (46.58)	78 (43.09)	128 (43.39)	83 (44.15)	39 (37.86)	57 (44.19)	107 (37.68)	101 (38.70)	22 (36.07)	649	41.21
Not agree husband	26 (35.62)	30 (16.57)	79 (26.78)	43 (22.87)	27 (26.92)	26 (20.16)	64 (2254)	83 (31.80)	19 (31.15)	397	25.21
Side effect	13 (17.81)	73 (40.33)	88 (29.83)	62 (32.98)	37 (35.92)	46 (35.66)	113 (39.79)	77 (29.50)	20 (32.79)	529	33.59

Total	73 (4.63)	181 (11.49)	295 (18.73)	188 (11.94)	103 (8.19)	129 (8.19)	284 (18.03)	261 (16.57)	61 (3.87)	1575	100
--------------	----------------------------	------------------------------	------------------------------	------------------------------	-----------------------------	-----------------------------	------------------------------	------------------------------	----------------------------	-------------	------------

The table 4.10.19 shows that the reason for not using contraception by rural women. It was found that 18.03% in Satna of rural women was not using contraception due to lack of information because their husband are not agree, followed by 18.03% the side effect, followed by 18.73% in, followed by 16.57% in Sagar, followed by 11.94% in Dewas, and 8.19% in Mandsoor, followed by 6.54% in Ujjain, followed by 4.63% in Gwalior and lowest 3.87% in Bhopal 3.87%. It is found that the all over the reasons for not using of contraception by rural women due to lack of information which is 41.21%, followed by 33.59% due to side effects, 25.21% as husband are not agree ready for same.

Table 4.10.20 Health Information received by Rural Women

Options	Gwalior	Indore	Shivpuri	Dewas	Ujjain	Mandsour	Satna	Sagar	Bhopal	Total	Percentage
Community health center	42 (87.50)	115 (100)	156 (77.23)	116 (89.23)	53 (36.55)	89 (100)	186 (68.89)	261 (38.16)	30 (37.04)	1048	59.41
Sub-center	0	0	9 (4.46)	0	17 (11.72)	0	9 (3.33)	50 (7.31)	7 (8.64)	92	5.22
Primary Health Center	2 (4.17)	0	18 (8.91)	4 (3.08)	22 (15.17)	0	18 (16.96)	116 (17.28)	14 (17.28)	194	11.00
Districts hospital	4 (8.33)	0	17 (8.42)	8 (6.15)	53 (36.55)	0	55 (31.43)	215 (37.04)	30 (37.04)	382	21.66
Television	0	0	1 (0.50)	2 (1.54)	0	0	1 (2.34)	16 (3.80)	0	20	1.13
Newspapers	0	0	1 (0.50)	0	0	0	1 (3.80)	26 (3.80)	0	28	1.59

Adult education officials	0	0	0	0	0	0	0	0	0	0	0
Total	48 (2.72)	115 (6.52)	202 (11.45)	130 (7.37)	145 (8.22)	89 (5.05)	270 (15.31)	684 (38.78)	81 (4.59)	1764	100

The above Table 4.10.20 shows that health information is received by rural women. It was found that 59.14 percentage of rural women were receiving health information from CHC, Gwalior, followed by 21.66 accesses to district hospital, 5.22 accesses to sub-center, and followed by 1.59 received from television.

Table 4.10.21 Treatment taken during pregnancy by Rural Women

Options	Gwalior	Indore	Shivpuri	Dewas	Ujjain	Mandsour	Satna	Sagar	Bhopal	Total	Percentage
Yes	48 (100)	115 (100)	112 (66.27)	130 (100)	1 (1.89)	89 (100)	186 (100)	256 (98.08)	1 (3.33)	938	86.77
No	0	0	57 (33.73)	0	52 (98.11)	0	0	5 (1.92)	29 (96.67)	143	13.23
Total	48 (4.26)	115 (14.99)	169 (115.63)	130 (12.03)	53 (4.90)	89 (8.23)	186 (17.21)	261 (23.14)	30 (2.66)	1081	100

Table 4.10.21 shows that the chosen treatment taken during pregnancy. It was found that 87.32 percent of rural women have taken treatment during pregnancy, while 12.68 percentages of rural women were not taken treatment.

Table 4.10.22 Types of Hospitals preferred by Rural Women

Options	Gwalior	Indore	Shivpuri	Dewas	Ujjain	Mandsour	Satna	Sagar	Bhopal	Total	Percentage
Community health center	48 (78.69)	115 (100)	159 (91.19)	127 (97.69)	51 (69.86)	89 (100)	186 (100)	259 (79.69)	28 (70)	1062	89.09
Sub-center	1 (1.64)	0	11 (6.36)	1 (0.77)	22 (30.14)	0	0	18 (5.54)	12 (30)	65	5.45
Private hospital	12 (19.67)	0	3 (1.73)	2 (1.54)	0	0	0	47 (14.46)	0	64	5.37
Ayurvedic hospital	0	0	0	0	0	0	0	0	0	0	0
Traditional local health person	0	0	0	0	0	0	0	1 (0.31)	0	1	0.08
Total	61 (5.12)	115 (9.65)	173 (14.51)	130 (10.91)	73 (6.12)	89 (7.47)	186 (15.60)	325 (27.27)	40 (2.35)	1192	100

Table 4.10.22 shows the Types of Hospitals preferred by Rural Women in case of health issues. It was found that 89.09 % of rural women were preferred CHC, followed by 5.45 percentage of rural women were preferred sub-center, followed by 5.37 percentages of rural women were preferred private hospitals in case they were facing any health issue. It was found that the overall preferred hospital by rural women was maximum i.e 15.60 in Sagar and lowest 5.12 in Gwalior.

Table 4.10.23 Availability of Medical Staff in CHC

Options	Gwalior		Indore		Shivpuri		Dewas		Ujjain		Mandsour		Satna		Sagar		Bhopal		Total		Total & Percent age	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No		
Medical Staff																						
Doctor	43 (19.91)	5 (2.81)	107 (18.94)	8 (2.95)	159 (18.91)	9 (1.87)	117 (17.54)	16 (4.19)	48 (24.74)	5 (2.17)	82 (19.71)	7 (2.36)	175 (18.08)	21 (3.78)	242 (18.89)	17 (2.33)	28 (21.54)	2 (1.82)	1001 (18.97)	90 (3.00)	1091 (13.17)	
Nurse	46 (21.30)	2 (1.12)	114 (20.18)	2 (0.74)	162 (19.26)	7 (1.46)	117 (17.54)	16 (4.19)	53 (27.32)	0	88 (21.15)	1 (0.34)	186 (19.21)	10 (1.80)	259 (20.22)	2 (0.27)	30 (23.08)	0	1055 (19.99)	40 (1.33)	1095 (13.22)	
Compounder	31 (14.35)	17 (9.55)	54 (9.56)	19 (7.01)	110 (13.08)	59 (12.27)	124 (18.59)	9 (2.36)	36 (18.56)	17 (7.39)	55 (13.22)	34 (11.49)	127 (13.12)	75 (13.49)	235 (18.35)	26 (3.56)	15 (11.54)	15 (13.64)	787 (14.91)	40 (1.33)	827 (827)	
Health inspector	18 (8.33)	40 (22.47)	65 (11.50)	36 (13.28)	77 (9.16)	82 (17.05)	83 (12.44)	47 (12.30)	6 (3.09)	47 (20.43)	7 (1.68)	82 (27.70)	73 (7.54)	113 (20.32)	68 (5.31)	193 (26.44)	0	30 (27.27)	397 (7.52)	670 (22.31)	1067 (12.88)	
Health assistant (Male)	8 (6.48)	40 (22.47)	7 (1.24)	80 (29.52)	46 (5.47)	123 (25.57)	52 (7.80)	78 (20.42)	0	53 (23.04)	47 (11.30)	42 (14.19)	39 (4.02)	127 (22.84)	50 (3.90)	211 (28.90)	0	30 (27.27)	249 (4.72)	784 (26.11)	1033 (12.47)	
Health assistant (Female)	14 (6.48)	34 (19.10)	61 (10.80)	53 (19.56)	77 (9.16)	92 (19.13)	23 (3.45)	107 (28.01)	0	53 (23.04)	29 (6.97)	60 (20.27)	53 (5.47)	143 (25.75)	39 (3.04)	222 (30.41)	0	30 (27.27)	296 (5.61)	794 (26.44)	1090 (13.16)	
Lab technician	46 (21.30)	2 (1.12)	110 (19.47)	5 (1.85)	162 (19.26)	7 (1.46)	34 (3.45)	96 (25.13)	51 (26.29)	2 (0.87)	86 (20.67)	3 (1.01)	186 (19.21)	10 (1.80)	259 (20.22)	2 (0.27)	29 (22.31)	1 (0.91)	963 (18.25)	128 (4.26)	1091 (13.17)	

Attendance	10 (4.63)	38 (21.35)	47 (8.32)	68 (25.09)	48 (5.71)	102 (21.21)	117 (17.54)	13 (3.40)	0	53 (23.04)	22 (5.29)	67 (22.64)	129 (13.33)	57 (10.25)	129 (10.07)	57 (7.81)	28 (21.54)	2 (1.82)	530 (10.04)	457 (15.22)	987 (11.92)
Total	216 (4.09)	178 (5.93)	565 (10.7)	271 (9.02)	841 (15.9)	481 (16)	667 (12.6)	382 (7.26)	194 (3.68)	230 (4.36)	416 (7.88)	296 (5.61)	968 (18.3)	556 (19)	1281 (24.3)	730 (24.3)	130 (2.46)	110 (3.66)	5278 (63.74)	3003 (36.26)	8281 (100)

Table 4.10.23 shows availability of medical staff present in CHC. It was found that the availability of nurse staff was maximum i.e 19.99, followed by a doctor with 18.97%, followed by a lab technician with 18.25%, followed by a compounder with 14.91% of staff were available in CHC. While 26.44% health females, followed by 26.11% health males, followed by 22.31% health inspectors, followed by 15.22% of attendance staff were not available in a regular way. It was also found that the availability of complete staff was maximum in Sagar CHC 24.3 and least was in Bhopal CHC with 2.46.

Table 4.10.24 Satisfaction Level with CHC Staff

Options Indicator	Gwalior			Indore			Shivpuri			Dewas			Ujjain			Mandsour			Satna			Sagar			Bhopal			Total			Total & Per.(P+G+V)
	P	G	V	P	G	V	P	G	V	P	G	V	P	G	V	P	G	V	P	G	V	P	G	V	P	G	V	P	G	V	
Doctors	17 (12.78)	31 (20)	0	14 (5.98)	101 (23.60)	0	31 (15.58)	72 (17.48)	0	31 (15.58)	72 (17.48)	0	24 (14.91)	29 (8.47)	0	13 (6.25)	76 (32.53)	0	57 (12.95)	12 (5.35)	2 (0)	11 (5.59)	14 (7.68)	0	10 (1.36)	20 (1.74)	0	315 (13.02)	671 (20.40)	2 (50)	988 (17.30)

Nurse and Compounder	19 (14.29)	29 (18.71)	0	25 (10.68)	90 (21.03)	0	25 (12.56)	10 (24.76)	0	2 (12.56)	10 (24.76)	0	13 (8.07)	40 (25.48)	0	17 (8.17)	72 (22.29)	0	58 (13.18)	12 (2.40)	2 (5.00)	65 (8.59)	19 (6.24)	0	8 (9.09)	22 (3.29)	0	255 (10.54)	665 (20.22)	2 (50)	922 (16.14)
Labor rooms	1 (0.75)	47 (30.32)	0	5 (2.14)	11 (25.70)	0	15 (7.54)	10 (25.97)	0	1 (7.54)	10 (25.97)	0	15 (9.32)	38 (24.20)	0	0	89 (27.55)	0	1 (0.23)	18 (3.69)	0	29 (3.83)	23 (2.68)	0	10 (1.36)	20 (2.17)	0	91 (3.76)	825 (28.43)	0	916 (17.96)
Radio graphs & X-Ray Machines	43 (32.33)	5 (3.26)	0	10 (4.48)	10 (23.4)	0	11 (5.67)	12 (29.2)	0	1 (5.67)	12 (29.2)	0	53 (32.92)	0	0	89 (42.79)	0	0	186 (42.27)	0	0	26 (3.48)	0	0	30 (3.49)	0	0	993 (41.05)	39 (1.19)	0	1032 (18.07)
Lab Technician & Pathology Labs	5 (3.76)	43 (27.74)	0	11 (4.70)	10 (24.30)	0	15 (7.54)	10 (26.21)	0	1 (7.54)	10 (26.21)	0	4 (2.48)	49 (31.21)	0	3 (1.44)	86 (26.63)	0	12 (2.73)	17 (3.69)	0	23 (3.04)	23 (2.94)	0	1 (1.14)	29 (3.15)	0	89 (3.68)	939 (28.55)	0	1028 (18)
Generators	48 (36.09)	0	0	74 (31.62)	13 (3.04)	0	0	11 (2.67)	0	0	11 (2.67)	0	52 (32.30)	1 (0.64)	0	86 (41.35)	0	0	126 (28.64)	3 (0.60)	0	26 (3.48)	0	0	29 (3.29)	1 (1.09)	0	676 (27.95)	40 (1.22)	0	720 (12.54)

fever	(13.22)	(10.29)	(11)	(12.02)	(11.8)	(10.16)	(10.84)	(14.20)	(11.76)		
b) Eye infections	19 (5.23)	24 (2.87)	40 (3.36)	38 (4.04)	14 (3.75)	22 (3.85)	29 (2.08)	125 (6.55)	10 (4.90)	321	4.13
c) Cough	25 (6.89)	74 (8.85)	111 (9.32)	89 (9.47)	38 (10.19)	59 (10.33)	122 (8.76)	188 (9.85)	20 (9.80)	726	9.33
d) Body pains	43 (11.85)	107 (12.8)	148 (12.43)	113 (12.02)	42 (11.26)	77 (13.49)	185 (13.28)	176 (9.22)	22 (10.78)	913	11.74
e) Knee pains	36 (9.92)	71 (8.49)	130 (10.92)	101 (10.74)	41 (10.99)	42 (7.36)	143 (10.27)	164 (8.59)	21 (10.29)	749	9.63
f) Problems of menopause	24 (6.61)	28 (3.34)	35 (2.94)	35 (3.72)	9 (2.41)	7 (1.23)	30 (2.15)	75 (3.93)	8 (3.92)	251	3.23
g) Cancer	5 (1.38)	0	1 (0.08)	5 (0.53)	0	0	0	54 (2.83)	0	65	0.84
h) Blood pressure	19 (5.23)	100 (11.96)	120 (10.08)	74 (7.87)	41 (10.99)	49 (8.58)	175 (12.56)	73 (3.82)	22 (10.78)	673	8.65
Total	363 (4.67)	836 (10.75)	1191 (15.31)	940 (12.08)	373 (4.79)	571 (7.34)	1393 (17.90)	1909 (24.54)	204 (2.62)	7780 (100)	100

The above table 4.3.25 shows that the overall aspect of visiting CHC by rural women. It was found that the aspect of immunization was maximum 15.14, followed by 12.84 Natal care (Pre and Postnatal), followed by 11.90 malaria, followed by 11.77 body pain, followed by 9.63 knee pain, followed by 9.33 cough, followed by 8.65 blood pressure, followed by 4.13 eye infection, followed by 3.23 menopause are some important aspect to visit CHC by rural women. It was also found that the availability aspect of visit to CHC is 25.54 maximum in Sagar district, while a minimum of 4.79 in Ujjain CHC was visit by rural women.

Table 4.10.26 Social Empowerment status of Rural Women

Status	Gwalior	Indore	Shivpuri	Dewas	Ujjain	Mandsour	Satna	Sagar	Bhopal	Total	Total
--------	---------	--------	----------	-------	--------	----------	-------	-------	--------	-------	-------

of Social Empowerment	P o r	G o d	V. G o d	P o r	G o d	V. G o d	P o r	G o d	V. G o d	P o r	G o d	V. G o d	P o r	G o d	V. G o d	P o r	G o d	V. G o d	P o r	G o d	V. G o d	P o r	G o d	V. G o d	P o r	G o d	V. G o d	P o r	G o d	V. G o d	P o r	G o d	V. G o d	P o r	G o d	V. G o d	P o r	G o d	V. G o d	P o r	G o d	V. G o d	(P+G+V)			& Per.
Using Toilets	25 (8.45)	23 (12.50)	0	6 (7.79)	52 (16.8)	4 (2.90)	65 (6.21)	88 (1.49)	4 (5.97)	4 (4.89)	64 (2.85)	11 (14.67)	32 (9.67)	21 (1.0)	0	53 (8.46)	36 (1.64)	0	10 (7.61)	62 (1.94)	3 (6.52)	20 (1.054)	52 (8.25)	0	17 (9.83)	13 (1.066)	0	604 (9.73)	41 (13.79)	22 (10.05)	1037 (9.78)															
To increase hygiene in their area	21 (7.09)	27 (14.67)	0	4 (5.87)	66 (21.4)	2 (6.45)	59 (5.64)	91 (1.12)	19 (2.36)	4 (5.72)	65 (2.17)	11 (14.67)	21 (6.34)	25 (1.90)	0	49 (7.82)	40 (1.15)	0	11 (8.59)	68 (1.20)	4 (8.70)	19 (9.94)	64 (1.16)	0	12 (6.94)	11 (9.02)	0	567 (9.14)	45 (15.33)	36 (16.44)	1060 (10.00)															
Steps to take safe drinking water	19 (6.42)	29 (15.76)	0	6 (8.05)	40 (12.9)	5 (6.13)	64 (6.1)	85 (1.86)	11 (1.42)	7 (8.4)	44 (1.33)	11 (14.67)	26 (7.85)	29 (1.81)	0	53 (8.46)	36 (1.64)	0	99 (7.46)	82 (1.12)	7 (15.22)	18 (9.28)	77 (1.22)	0	12 (6.94)	18 (1.75)	0	591 (9.52)	44 (14.76)	34 (15.53)	1065 (10.02)															
Family planning methods	18 (6.08)	30 (16.30)	0	6 (8.05)	49 (15.9)	5 (6.13)	74 (7.07)	75 (1.42)	11 (1.42)	6 (7.51)	43 (1.01)	9 (12.55)	25 (7.18)	30 (1.29)	0	45 (7.18)	44 (1.67)	0	15 (1.14)	32 (6.68)	10 (21.74)	19 (9.69)	69 (1.95)	0	11 (6.36)	19 (1.57)	0	642 (10.35)	39 (13.12)	35 (15.98)	1068 (10.07)															
Supporting equal status for women	32 (1.250)	11 (5.98)	0	9 (1.88)	20 (6.47)	5 (6.13)	12 (5.1)	28 (1.88)	10 (1.93)	9 (1.8)	15 (4.89)	9 (12.18)	37 (1.18)	18 (8.27)	0	67 (1.07)	22 (8.33)	0	14 (1.1)	37 (7.72)	3 (6.52)	20 (1.049)	53 (8.41)	0	22 (12.72)	8 (6.56)	0	829 (13.36)	21 (7.11)	27 (12.33)	1068 (10.07)															
Securing ty rights for Women	31 (1.82)	13 (7.07)	0	1 (1.33)	13 (4.21)	3 (9.68)	13 (1.99)	19 (3.99)	7 (1.45)	1 (1.7)	10 (3.26)	8 (10.67)	35 (1.57)	22 (1.48)	0	80 (1.278)	9 (3.41)	0	15 (1.13)	31 (6.47)	5 (10.87)	22 (1.155)	32 (5.08)	0	21 (12.14)	11 (9.02)	0	891 (14.36)	16 (5.37)	23 (10.50)	1074 (10.13)															

Voicing against social injustice	37 (12.50)	11 (5.98)	0	10 (3.15)	13 (4.21)	2 (.645)	13 (4.180)	21 (5.97)	4 (1.19)	1 (.315)	12 (3.91)	4 (1.33)	37 (11.18)	18 (8.57)	0	73 (11.66)	16 (6.06)	0	14 (4.09)	36 (7.52)	6 (1.04)	21 (3.175)	48 (7.62)	0	20 (11.56)	10 (8.20)	0	870 (14.02)	185 (9.21)	16 (7.31)	1071 (10.10)
Supporting widow remarital	39 (13.88)	9 (4.89)	0	9 (1.88)	22 (7.12)	0	14 (1.347)	19 (3.99)	1 (.49)	1 (.435)	13 (4.23)	4 (1.33)	39 (11.78)	16 (7.62)	0	75 (11.98)	14 (5.30)	0	14 (4.09)	43 (8.98)	2 (.435)	20 (1.14)	60 (9.52)	0	17 (9.83)	13 (1.66)	0	863 (13.91)	209 (7.01)	7 (3.20)	1079 (10.18)
Decision with regard to family Affairs	32 (11.081)	16 (8.70)	0	8 (1.04)	32 (10.4)	2 (.645)	12 (1.65)	33 (6.93)	0	8 (1.001)	26 (8.47)	4 (1.33)	40 (12.08)	15 (7.14)	0	68 (10.86)	21 (7.95)	0	14 (1.06)	43 (8.98)	2 (.435)	16 (8.53)	94 (14.52)	0	21 (12.14)	9 (7.38)	0	758 (12.22)	289 (9.96)	8 (3.65)	1055 (9.95)
Decision with regard to health at home	33 (11.15)	15 (8.15)	0	7 (.96)	2 (0.65)	3 (.968)	13 (1.99)	17 (3.57)	0	1 (.428)	15 (4.89)	4 (1.33)	39 (11.78)	16 (7.62)	0	63 (10.06)	26 (9.85)	0	13 (7.03)	45 (9.70)	4 (.870)	18 (9.08)	81 (12.86)	0	20 (11.56)	10 (8.20)	0	789 (12.72)	227 (7.61)	11 (5.02)	1027 (9.95)
Total	296 (3.99)	184 (6.17)	0	78 (1.058)	309 (10.4)	31 (4.14)	104 (1.1497)	476 (11.597)	67 (3.06)	83 (1.133)	307 (1.133)	75 (34.25)	331 (4.04)	210 (7.04)	0	626 (8.45)	264 (8.86)	0	1327 (17.92)	479 (11.6)	46 (21)	1982 (26.77)	630 (2.11)	0	173 (2.33)	12 (4.09)	0	740 (69.82)	298 (28.11)	219 (2.07)	10604 (100)

The above table no. 4.3.26 shows the overall social status of rural women. The poor activities like voicing against social justice are 14.02, followed by 13.91 supporting widow marriage, followed by 13.36 supporting equal status for women, followed by 12.22 decision about family

Affairs, followed by 12.72 decision about health at home, followed by 10.30 family planning methods, followed by 10.30 using the toilet, followed by 9.52 water facilities are poor condition.

The overall 68.82% of social statuses of rural women are poor which, whereas 28.11 percentage of social status is good.

Conclusion

Indian females, particularly rural women, need to be empowered to receive higher education and training. If they are aware about health literacy village will obtain more income. As rural women earn more income, they spend it on their children's and health. Adequate nutritious for rural women would assist them to serve as productive members of society to create the resulting generation of health. Rural women's empowerment is hindered in many fields by limited autonomy that has a powerful impact on growth. Their institutional incapacity due to the low rates of literacy, limited exposure to mass media, and access to that money and restricted mobility result in limited fields of expertise and control. As rural women economic condition gets better, they will achieve higher status in the community and village and have a higher voice in the society.

Reference

- Bano, S., & Wani, K. A. (2012). The Health Conditions of Rural Localities of Madhya Pradesh. *European Journal of Biological Sciences*, 4(1), 20–25. <https://doi.org/10.5829/idosi.ejbs.2012.4.1.62139>
- iMedPub Journals Assessment of Health Status and Monitoring of Healthcare Systems in Rural Areas of Gwalior District , Madhya Pradesh , India Abstract. (2018), 1–5.
- Indian, T., & Charter, H. (2007). THE INDIAN WOMEN ' S HEALTH Women of Age Women with Disabilities Women Living in Custody of State Institutions, (March), 1–41.
- Kamalapur, S. M., & Reddy, S. (2013). Women Health in India: An Analysis. *International Research Journal of Social Sciences*.ISSN Int. Res. J. Social Sci, 2(10), 2319–3565. Retrieved from <http://www.isca.in/IJSS/Archive/v2/i10/3.ISCA-IRJSS-2013-135.pdf>
- Manoharan, S. (2017). Health Status of the Indian Women - A Brief Report. *MOJ Proteomics & Bioinformatics*, 5(3), 109–111. <https://doi.org/10.15406/mojpb.2017.05.00162>
- Reddy, P. B. (2016). Status of Women and Social Opportunities in Madhya Pradesh , India *Social Science Status of Women and Social Opportunities in Madhya Department of Economics , Govt . PG College , Shujalpur , India*, (January 2014), 1–6. <https://doi.org/10.13140/RG.2.1.4667.7520>
- Team, E., Submission, A., Informations, S., Ethics, P., & Us, C. (2018). Guidelines for article submission, 19–21.
- Title, J. (2019). Indian journals indexed in Web of Science Energy for Sustainable Development Indian journals indexed in Web of Science, (0975).
- U.C., S., & K.B., S. (2010). A trend in women's health in India--what has been achieved and what can be done. *Rural and Remote Health*, 10(2), 1260. Retrieved from <http://www.embase.com/search/results?subaction=viewrecord&from=export>

&id=L359876997

Bano, S., & Wani, K. A. (2012). The Health Conditions of Rural Localities of Madhya Pradesh. *European Journal of Biological Sciences*, 4(1), 20–25. <https://doi.org/10.5829/idosi.ejbs.2012.4.1.62139>

iMedPub Journals Assessment of Health Status and Monitoring of Healthcare Systems in Rural Areas of District , Madhya Pradesh , India Abstract. (2018), 1–5.

Indian, T., & Charter, H. (2007). THE INDIAN WOMEN ' S HEALTH Women of Age Women with Disabilities Women Living in Custody of State Institutions, (March), 1–41.

Kamalapur, S. M., & Reddy, S. (2013). Women Health in India: An Analysis. *International Research Journal of Social Sciences*.ISSN Int. Res. J. Social Sci, 2(10), 2319–3565. Retrieved from <http://www.isca.in/IJSS/Archive/v2/i10/3.ISCA-IRJSS-2013-135.pdf>

Manoharan, S. (2017). Health Status of the Indian Women - A Brief Report. *MOJ Proteomics & Bioinformatics*, 5(3), 109–111. <https://doi.org/10.15406/mojpb.2017.05.00162>

Reddy, P. B. (2016). Status of Women and Social Opportunities in Madhya Pradesh , India *Social Science Status of Women and Social Opportunities in Madhya Department of Economics , Govt . PG College , Shujalpur , India*, (January 2014), 1–6. <https://doi.org/10.13140/RG.2.1.4667.7520>

Team, E., Submission, A., Informations, S., Ethics, P., & Us, C. (2018). Guidelines for article submission, 19–21.

Title, J. (2019). Indian journals indexed in Web of Science Energy for Sustainable Development Indian journals indexed in Web of Science, (0975).

U.C., S., & K.B., S. (2010). A trend in women's health in India--what has been achieved and what can be done. *Rural and Remote Health*, 10(2), 1260. Retrieved from

<http://www.embase.com/search/results?subaction=viewrecord&from=export&id=>

L359876997

Bano, S., & Wani, K. A. (2012). The Health Conditions of Rural Localities of Madhya Pradesh. *European Journal of Biological Sciences*, 4(1), 20–25.
<https://doi.org/10.5829/idosi.ejbs.2012.4.1.62139>

iMedPub Journals Assessment of Health Status and Monitoring of Healthcare Systems in Rural Areas of District , Madhya Pradesh , India Abstract. (2018), 1–5.

Indian, T., & Charter, H. (2007). THE INDIAN WOMEN ' S HEALTH Women of Age Women with Disabilities Women Living in Custody of State Institutions, (March), 1–41.

Kamalapur, S. M., & Reddy, S. (2013). Women Health in India: An Analysis. *International Research Journal of Social Sciences*.ISSN Int. Res. J. Social Sci, 2(10), 2319–3565. Retrieved from

<http://www.isca.in/IJSS/Archive/v2/i10/3.ISCA-IRJSS-2013-135.pdf>

Manoharan, S. (2017). Health Status of the Indian Women - A Brief Report. *MOJ Proteomics & Bioinformatics*, 5(3), 109–111.
<https://doi.org/10.15406/mojpb.2017.05.00162>

Reddy, P. B. (2016). Status of Women and Social Opportunities in Madhya Pradesh , India *Social Science Status of Women and Social Opportunities in Madhya Department of Economics , Govt . PG College , Shujalpur , India*, (January 2014), 1–6. <https://doi.org/10.13140/RG.2.1.4667.7520>

Team, E., Submission, A., Informations, S., Ethics, P., & Us, C. (2018). Guidelines for article submission, 19–21.

Title, J. (2019). Indian journals indexed in Web of Science Energy for Sustainable Development Indian journals indexed in Web of Science, (0975).

U.C., S., & K.B., S. (2010). A trend in women's health in India--what has been achieved and what can be done. *Rural and Remote Health*, 10(2), 1260. Retrieved from

<http://www.embase.com/search/results?subaction=viewrecord&from=export&id=>

L359876997

FINDINGS, CONCLUSION, AND SUGGESTIONS

This chapter presents findings and conclusion based on the data analysis and subsequent inferences derived out of the analysis are as follows:

As stated in the literature review, it was unquestionable in several studies; Health care is also increasing health literacy and knowledge literacy. Therefore, knowledge literacy and health information education can be interpreted as a lifelong learning method through improving health literacy as individuals gain health information at every stage of life. Even then, the accessibility of health information should be considered difficult. It was noticed in the current study that most people had little basic knowledge about their health/ treatment.

As a result, the health information is sometimes difficult to understand, especially for the low literacy women/ patients, thus improving the literacy of health information by utilizing the printed material and pictures would be better if they were designed and used in such a way that even less educated women could simply regard.

The study brings out the fact that CHCs have not been able to render specialized health care services for which these were established. The constraints to the utilization of their services as identified are the inadequacies in infrastructure, non-availability of medical specialists and Paramedical staff, and non-functional complementary facilities. Apart from these constraints and sub-optimal utilization, the majority of the beneficiaries expressed their preference for the services of public health care institutions to those of other alternatives. As the effective utilization of a CHC as a referral center depends on its ability to provide the complete package of services required for specialized health care, efficient utilization of available resources warrants its use in closing the supply gap in infrastructure and manpower of the existing CHCs. The filling of facilities and manpower of health care institutions should get primacy over other considerations in the allocation of resources, as a thin spread of resources over a large number of health care institutions has led to sub-optimal utilization of facilities created. It is advisable to make in each district few CHCs completely equipped with all complementary facilities and manpower to discharge the intended functions of CHCs and disseminate the information about their

functionality among the villages of the district through PRIs so that the people in the district can take complete advantage of this well-equipped CHCs. Manpower at CHC includes medical specialists, paramedical staff, and support staff, while physical facilities include workroom, a pathology laboratory, and safe drinking water.

The scheme envisaged that CHCs should also be equipped with adequate health infrastructure, including physical facilities, equipment, and medicines, in addition to manpower, so that the specialized health care services can be provided in CHCs could be optimally utilized. This study suggests many number of implications that would affect the health literacy of rural women of Madhya Pradesh and resolve the barriers reported in study.

Some major finding based on the rural women questionnaire

- It has been found that 1230 questionnaires were distributed in overall 41 community centers out of which 1074 questionnaires have been received back. Most of the 24.16% questionnaires have been received from the Sagar district.
- It has been found that most of the rural women i.e 39.10 belong to OBC and 37.16 belong to SC category filled the questionnaires which are received back. While Sagar CHC and Satna district's questionnaire have been received from 24.30 OBC and 17.31 SC category candidates from the whole sample.
- 67.59% of the rural women had an average monthly family income from Rs. 2000-4000. While rural women of Ujjain district 83.01% and Gandhinagar district is 73.33% Bhopal have the lowest monthly income.
- Average monthly earnings of 25.41% of the rural women ranged from Rs. 5000-10000 and that of only 0.37% ranged between Rs. 10000-more.
- 39.94% of rural women were found to be illiterate. While 56.25 are the most illiterate women found in Gwalior district.
- A large majority of rural women, almost 37.24% of rural women were educated at only at primary level. A very marginal proportion of the entire sample, less than 0.93% were graduates among rural women in whole sample.
- 49.33% of the rural women's husband were doing agriculture and 37.12% of rural women's husband are doing private work, whereas 56.18% of rural women husband's are doing agriculture work in Mandasour.

- It is found that the types of houses, Ownership of House, Number of Rooms, toilet facility, drinking water, electricity availability, Leisure time spent were highest in Sagar which is 1467 (24.49%), and lowest in Dewas which is 2.21%.
- It was found that 574 (i.e. 53.09%) women were unaware of health literacy, whereas 505 (i.e. 46.71%) women were aware of health literacy.
- It is found that the most of 73.37% of rural were unaware of health literacy in Shivpuri.
- The majority of rural women i.e. 45.16% were not aware of health literacy because of lack of health information, whereas 43.94% of rural women were unaware of health literacy because of lack of health education, 9.03% are not have any interest in health information.
- It was found that the highest 56.06 of rural women are not accessing health information, resources, and services from the CHC and 43.94% were accessing the same.
- It was found that the highest percentage of Sagar district are aware of the knowledge about immunization, sources of information on immunization, and awareness about diseases prevention and the percentage is 24.63. The lowest percentage was found in the Ujjain zone which is 4.90%.
- It was found that the overall availability and accessibility is highest in Sagar, where rural women with (27.67%), lowest in Gwalior where it is only 3.94%.
- Women are satisfied with road network and percentage is 63.18 and the lowest is 36.82% women are satisfied with.
- The overall barriers for health treatments were faced by 63.67% rural women were because women were not able to afford doctor, medicine, and their social status.
- It was found that the highest 59.01% rural women were aware of the nutritious diet, whereas 40.98 percentage of rural women were not aware of about nutritious diet.
- Most of the 84.67 percentage of rural women were not aware of nutritious diet in the Sagar district.
- It found that the highest 73.02 percentage of rural women were not taking complete nutritious diet due to lack of monthly income and the lowest

26.97 percentage of rural women were not aware of the complete nutritious diet.

- It found that the highest 96.46 percentage of rural women chosen government hospitals, while 3.34 percentage of rural women chosen home for their child delivery.
- It is found that the overall 71.32 percentage of rural women were aware of contraception, while 28.68 were not aware of contraception.
- It is found that the most of 27.58 rural women of Sagar district was not aware about the use of contraception.
- It was found that 60.87 percentage of rural women were never using contraception. Whereas 39.13 percentages of rural women were using contraception.
- It is found that the reason for not using contraception by rural women was lack of information which is 41.21%, followed by 33.59% due to side effects, 25.21% percentage are not using because their husband are not agree.
- It was found that 59.14 percentage of rural women received to health information from CHC, Gwalior, followed by 21.66% received from district hospital, having 5.22% accessed it from sub-center, and whereas 1.59% accesses from television, women for getting health information.
- It was found that 87.32 percentage of rural women have taken treatment during pregnancy, while 12.68 percentage of rural women were not taken treatment during pregnancy.
- It is found that 89.09 % of rural women preferred CHC, 5.45 percentage of rural women preferred sub-center, 5.37 percentages of rural women were preferred private hospitals in case they were facing any health issue.
- It was found that the overall preferred hospital by rural women was maximum i.e 15.60% in Sagar and lowest 5.12% in Gwalior.
- It was found that the availability of nurse staff was maximum i.e 19.99%, doctors was 18.97%, lab technician 18.25, compounder 14.91% staff at CHC. While 26.44 health females worker, 26.11 health male worker, 22.31 health inspectors, 15.22 attendant staffs were not available in a regular mode.
- It is also found that the availability of staff was maximum in Sagar CHC 24.3 and least in Gandhinagar CHC with 2.46%.

- It is found that the availability of lab technician staff was maximum i.e. 28.55%, followed by a labour room with 28.43%, followed by a nurse with 20.22%, followed by a doctor with 20.22 percentage of medical staff available in CHC. While Radiographers & X-Ray Machines maintenance staffs are 41.05% are not available and the generators staff is also not available in CHC.
- It was also found that the availability of staffs maximum in Sagar CHC with 25% and the lowest staff was 4.7% available in Gwalior CHC.
- It was found that the aspect of immunization was maximum 15.14%, 12.84% Natal care (Pre and Postnatal), malaria with 11.90%, 11.77% body pain, 9.63% knee pain, followed by 9.33 cough, 8.65 blood pressure, 4.13 eye infection, followed by 3.23 menopause etc are some important reasons to visit CHC by rural women.
- It was also found that the availability of main aspect to visit CHC was maximum in Sagar district CHC 24.54, while a minimum of 4.79 in Ujjain CHC visited by rural women.
- It is clear that the poor activities like voicing against social justice are 14.02%, 13.91% Supporting widow remarriage, 13.36% Supporting equal status for women, 12.22% Decision about family Affairs, 12.72% Decision about health at home, 10.30 Family planning methods, 10.30 using the toilet, 9.52 water facilities are poor condition.
- The overall social statuses of rural women are poor which is 68.82%, whereas 28.11 percentage women are having good social status.

Major findings based on objectives of the study

Objective:1 To find out the key problems in accessing health-related information by the rural women of Madhya Pradesh.

- The poor social status, Self-perceived health, notable to pay for Medication, notable to afford doctor, limited activities, because of health problems, monthly household income were found to 35.1 percentage in Sagar, followed by 23.3 in Satna. Moving forward Indore has the second-lowest poor percentage of 13.61 and Mansour has the lowest poor percentage of 12.5, followed by 5.43 in Ujjain, followed by 3.98 in Gwalior faced by rural women for health treatment.

- The overall barriers for health treatments were faced by 63.67 rural women because women were not able to afford doctor, medicine, and their social status.(Table 4.10.13)

Objective:2 To determine the effectiveness of data collation and analysis work done in health community centers of Madhya Pradesh.

- It was found that the highest 56.06% of rural women were not having access to health information, resources, and service from the CHC, and 43.94 were having access to the same.(Table 4.10.9)
- It was found that 59.14 percentage of rural women were receiving health information from CHC, Gwalior, followed by 21.66 are accessing it from district hospital, 5.22 accesses from sub-center, and whereas 1.59 accesses from television, they are getting health information. (Table 4.10.20)
- It found that the highest 96.46 percentage of rural women have chosen government hospitals, while 3.34 percentage of rural women chosen a home for their child their delivery. (Table 4.10.16)

Objective: 3To study the relationship between literacy and health status of the rural women of Madhya Pradesh.

- It is found that the majority of rural women i.e. 45.16% were not aware of health literacy because of a lack of health information, whereas 43.94% of rural women were not aware of health literacy because of lack of health education, 9.03 not having interest and 1.87 given information of health awareness. (Table 4.10.8)

Objective: 4 To identify the awareness of the health literacy of rural women in health care center of in Madhya Pradesh.

- It was found that 574 (i.e. 53.09%) women were unaware of health literacy whereas 505 (i.e. 46.71%) women were aware of health literacy. (Table 4.10.7)
- the knowledge about immunization, sources of immunization information, and awareness about diseases prevention by immunization among rural women. It was found that the highest percentage of Sagar district were aware of the knowledge about immunization, sources of information on immunization, and

awareness about diseases prevention are 24.63. Following it the lowest percentage was the Ujjain zone which is 4.90. (Table 4.10.10)

- It was found that the highest 59.01 percent of rural women were aware of a complete nutritious diet, whereas 40.98 percentage of rural women were not aware of complete nutritious. (Table 4.10.14)
- It was found that 89.09 % of rural women were preferred CHC, followed by 5.45 percentage of rural women preferred sub-center, followed by 5.37 percentages of rural women preferred private hospitals in case are facing any health issue. (Table 4.10.22)

Objective: 5 To study the quality of life of the rural women of Madhya Pradesh.

- The activities like voicing against social justice are 14.02, followed by 13.91 Supporting widow remarriage, followed by 13.36 Supporting equal status for women, followed by 12.22 Decision concerning family Affairs, followed by 12.72 Decision about health at home, followed by 10.30 Family planning methods, followed by 10.30 using the toilet, followed by 9.52 water facilities are in poor condition. (Table 4.10.26), etc are very poor.

Objective: 6 To know, how rural women use information.

- It was found that 59.14 percent of rural women were receiving health information from CHC, Gwalior, followed by 21.66 accessing from the district hospital, 5.22 form sub-center, and whereas 1.59 form television, and they are getting health information. (Table 4.10.9)
- It was found that 59.14 percentage of rural women were receiving health information from CHC, Gwalior, followed by 21.66 accesses it from district hospital, 5.22 accesses to sub-center, and followed by 1.59 accesses to television, from all these places women are getting health information. (Table 4.10.20)

Testing of Hypotheses

Hypotheses 01-The growth of health literacy in the health information center of Madhya Pradesh is not satisfactory.

H₀= The growth of health literacy in the health center of Madhya Pradesh is not satisfactory

H1= The growth of health literacy in the health center of Madhya Pradesh is satisfactory.

Level of significant =05 (from table 4.10.20)

Chi-Square Tests				
		Value	df	Asymp. Sig. (2-sided)
Pearson	Chi-Square	56.000 ^a	49	.229

- a. 64 cells (100.0%) have expected count less than 5. The minimum expected count is .13.
- b. Since $p < .05$, therefore p-value of chi-square indicates that the difference is statistically significant. Therefore, the null hypothesis (Ho) is rejected and the alternate hypothesis (H1) is accepted.

The table described that most of the rural women accessing to health information from CHC, Primary Health Center, and staff.

Hypotheses 02-There is a lack of trained, qualified professionals to Health Care at Community HealthCenter.

H0= Theis lack of trained qualified professionals in CHC.

H1= Thetrained qualified professionals are available in CHC.

Level of significance .05 (from table 5.2.25)

$$\chi^2 = 14.011$$

$$df = 12$$

$$p = .301$$

Chi-Square Tests				
		Value	df	Asymp. Sig. (2-sided)
Pearson	Chi-Square	14.000 ^a	12	.301

Since $p < .05$, therefore p-value of chi-square indicates that the difference is significant. Therefore, the null hypothesis (Ho) is rejected and the alternate hypothesis (H1) is accepted.

Form the availability of staff maximum in Sagar CHC with 25% and the lowest staff was 4.7% available in Gwalior CHC.

Hypotheses 3- There is no significant relationship between literacy and quality of life of rural women.

H0= There is a significant relationship between literacy and quality of life of rural women.

H1= There is no significant relationship between literacy and quality of life of rural women.

Significant value=.05 (form table 4.10.26)

ANOVA						
		Sum of Squares	df	Mean Square	F	Sig.
Poor	Between Groups	40495097.136	9	4499455.237	257.340	.048
	Within Groups	17484.500	1	17484.500		
	Total	40512581.636	10			
Good	Between Groups	6646687.500	9	738520.833	46.098	.114
	Within Groups	16020.500	1	16020.500		
	Total	6662708.000	10			
Very Good	Between Groups	36397.636	9	4044.182	126.381	.069
	Within Groups	32.000	1	32.000		
	Total	36429.636	10			

$F=46.09$

$df=9$

$P=.0114$

Since $p < .05$, therefore p-value of chi-square indicates that the difference is statistically significant. Therefore, the null hypothesis (Ho) is rejected and the alternate hypothesis (H1) is accepted.

Therefore, the above hypothesis is accepted and proved as the social status of rural women is related with quality of life of rural women.

Conclusion

The research shows an intuitive awareness of the value of education for health information. The model is solely a function of the study's qualitative and quantitative results. The studies developed in this study by and broadly disclosed health literacy/health information literacy to be a new concept that needs to be substantiated in the Indian context to create a community of health literates. The study points out that the survey reflected on health literacy; by providing reliable health information/sources, it was more important to build health determinants and organizations and opportunities for living a healthy life and making healthy choices. In general, it was also pointed out that various important factors such as culture, customs, education, social and economic status, marketing, and behaviors educated and collective decision-making on health. It would be beneficial to have a more systematic assessment of human health information literacy, health systems, and the usefulness and integrity of current deliberative methodology, including higher-level practices. However, the study finding could be seen as an example of the Importance of health information literacy and rural women co-production of health in the process of democratizing health is an indication that the model is useful in structuring the thinking on how health information literacy, health care systems and user involvement might impact health policy. There is a need for additional recognition of evidence-based research in the field of libraries and health education for the entire state and country, and integration of the concept of health information literacy and its measurement into local or indigenous research, policy, and practice at the individual and community level. The literacy study on health information presents a new structure regarding the goal of establishing rural women, improving health information, and therefore health status.

Suggestions based on rural women questionnaire

1. For the successful implementation of women welfare programs, the participation of women Stakeholders is essential. Widespread awareness about the programs among groups of beneficiaries and other stakeholders including voluntary agencies etc. would be desirable.
2. The top-down approach in Planning and Implementation has led to the formulation of schemes without assessment of the need of the people. Thus the interests of the people in these programs have declined. Stakeholders would, therefore, need to be actively involved in the formulation and planning of all

schemes. This would facilitate not only better planning but also better monitoring of the programs.

3. Rationalization of objectives, specification of goals/sub-goals, their operationalization in terms of variables, preparation of a base-line/preparedness profile, identification of target group, existing or new organization of people at the local level, the process of intervention or service delivery, community participation, change over time in the socio-economic status of target groups (outcome/impact), conflicts are very important aspects to be looked upon.

4. Their resolution during the implementation of a scheme, bottlenecks and their correction, transparency of results and future leads, comparison of this data with those of other schemes in terms of opportunity, access, input, use, client satisfaction, social environment, and strains, cost-effectiveness, created assets (infrastructure/equipment) and impact, etc. should deserve attention.

5. Government should take in confidence to the Panchayats for the successful implementation of the programs at the village/block level. Similarly, the Nagar Palikas in the towns should also be empowered to implement welfare programs in towns and cities.

6. Local participation in monitoring and evaluation is suggested to counter the traditional top-down approach to monitoring and evaluation. It has been seen that the traditional approach does not give a clear picture of the various schemes and projects being monitored. The conventional monitoring technique has proved costly and ineffective in terms of measuring and assessing program achievements. A bottom-up strategy that employs participatory methodologies should be encouraged.

RECOMMENDATIONS

1. **Adequacy of Health Facilities:** Dedicated cells/ units/autonomous bodies should be considered (within states) to monitor the pace of all public constructions, including hospitals, perhaps with penalty clauses. An annual report of this cell should be presented in the state assembly. To further the idea of bringing care closer to where people stay - and Health and Wellness centers- the establishment of new Sub-centers needs the continued priority.

2. **Utilization and Continuum of Care:** Dedicated initiatives/programmes on technology-driven CMEs for peripheral providers and tele-consultations of patients at CHCs should be considered to address the issues related to undue referrals.
3. **District Hospital Strengthening:** States must be incentivized to propose general ICUs and Highdependency units for every 10-lac population region. This would ensure an emergency infrastructure- at first, shared by 2 or 3 districts within the government system. The use of district hospitals as training sites has been reported by 4 out of 15 Customer Relationship Management(CRM) states. Sourcing-in faculty from nearby government and credible private medical colleges should be considered to meet the demand of trainers. NHM should also be looking at possibilities of supporting credible not-for-profit missionary/trust hospitals for acting as training sites. Many such hospitals currently act as training sites and if provided sufficient autonomy, may agree to partner with the government.
4. **Procurement and availability of drugs: Disruptive solutions** –such as bulk procurement by center or prioritizing access to drugs as a special measure in broader agenda of NE. Other areas for continued focus are encouraging generic prescriptions, increasing general awareness on the use of antibiotics, and scaling up prescription audits.
5. **Free Diagnostics:** Strengthening Block PHCs/ Sector PHCs as hubs are required to ease the burden on higher facilities. The use of vaccine carriers as lab sample carriers could be proposed with additional incentives. The Madhya Pradesh States that have opted for private partnerships in the provision of lab services, now need to move towards assessing the outcomes of these partnerships, with support from NHSRC and other such institutions.
6. **Biomedical equipment maintenance:** Specific support will be needed by states to recruit biomedical engineers for the Programme to be implemented.
7. **.National Dialysis Program:** In States with models of Public-Private Partnership (PPP) and In-house schemes, the drugs and diagnostics related to

dialysis, should be provided free of cost to all beneficiaries. The National Dialysis Programme should be linked to free diagnostics initiative and drugs should be enlisted in the EDL directory.

8. **Access to Blood:** Here the recommendation is to bring sanctioning and licensing under a single department of CHC and increasing demand for blood and linking it to non-surgical care. This would involve better identification and assured transfusions for cases of severe anemia. Also, forming guidelines on the use of Unbanked Direct Blood Transfers for states that have made minimal could be explored for improving access to blood.
9. **AYUSH:** Moving forward, inter-ministerial collaboration to ease out apprehensions related to bridge course for AYUSH and to promote AYUSH systems through NHM would be required.
10. **Ambulances:** There is a need for ensuring uniformity in training of providers, scaling up emergency response teams, and solving the last-mile concerns in hilly and difficult regions. Support would be needed by states to foster local experiments in inpatient transfer from remote regions. Systems-level thinking is perhaps required, to move beyond the innovative ideas of bike ambulances and similar suggestions.

For Health care services, the following measures can be suggested:

Recommendations for CHC

1. Orientation and sensitization should be planned in phases from the center to increase understanding of district-level staff across the states on the concept, motivation, and requirements of CHC.
2. Specific evaluation could be planned for identifying these challenges and remedial measures should be ensured at the outset of rolling CHC interventions to ensure the fulfillment of key principles, viz. continuum of care.
3. Early rollout of measures such as training of providers on CPHC package, resource mapping, population enumeration, initiation of IT platforms, and digital tools or baseline assessments in states.

4. It should be also essential for states to develop clarity on the long-term state-specific vision for CPHC and a road map for states. This long-term plan would focus on- number and location of sub-centers that the state would prioritize as HWCs, activities for revamping PHCs, capacity building for service providers at different levels, and institutionalizing financing mechanisms that are responsive to caseloads and needs.
5. While the appointment of nodal officers is a positive step forward, states should also plan to build district and block-level capacities in program management and supportive supervision to ensure necessary change management for the delivery of CPHC services.
6. Overall proper location planning for health infrastructure has not done. It needs attention.
7. There was a lack of proper understanding which led the State to assume that they could not take up strengthening SHCs to HWCs despite having requisite HR in place in many CHCs.
8. Comprehensive Package of services includes Care in pregnancy and childbirth, immunization, Family planning, Contraceptive services, and Other Reproductive Health Care services, Screening and management of Communicable diseases, Prevention, Screening and Management of Non-Communicable diseases, Care for Common Ophthalmic problems through the monthly visit of Ophthalmic Assistant.
9. However, awareness about CHC was found to be low among the Programme Officers and no proposals have been submitted for operational these centers.
10. The state has selected both regular as well as contractual nurses for the training under the Health Course program.
11. The status of selection and training of ASHA was found satisfactory across all states, but ASHA workers were suffering from payment problems.
12. Only a few states have planned referral linkages for HWC with CHC and other health facilities.
13. Since the program is in the early stages of implementation, there is variable progress observed for other activities such as population enumeration, strengthening infrastructure support, building IT mechanisms, and ensuring necessary drug or diagnostic support.

14. There is a lack of availability of doctors, multi-purpose workers, village health guides in some primary health centers.
15. The government should take steps to fill in the vacancies so that the availability of complete health staff in the centers will yield better results in promoting health care awareness among the masses. At present, there is no proper utilization of health magazines.
16. Broadsheets and mass media like radio, television, and newspapers in promoting health care awareness. Steps should be taken by the district administration to effectively utilize them for promoting health awareness among the masses.
17. As only 43% of the required number of CHCs have been established (by June 1996), a significant increase in the allocation of plan resources for the health sector is needed to close the supply gap.
18. It seems unlikely that the resources required for closing the gap will be available from budgetary provisions alone. Alternative sources of funds and /or alternative modes of delivery of health care services need to be explored to meet the demand for specialized health care services in rural areas.

12. SUGGESTIONS FOR FURTHER RESEARCH

1. An exclusive research study may be carried out by considering the variables like motivation, personality factors on the health awareness of neo-literates.
2. A study may be carried out on the health awareness of adult education.
3. A study on the problems of health personnel working in the government and non-government sectors may be carried out.
4. A study on the effectiveness of mass media in promoting health awareness may be undertaken.
5. In depth studies relating to health issues touching upon policy Implications, training, and administration may be attempted.
6. A study on the health literacy among Urban Women.

BIBLIOGRAPHY

- Ali, P. M., & Nisha, F. (2011). Use of e-journals among research scholars at Central Science Library, University of Delhi. *Collection Building*, 30(1), 53-60.
- Bansode, S.Y., & Pujar, S. M. (2008). Use of Internet by research scholars at Shivaji University, Kolhapur.
- Biradar, B. S., & Kumar, B. T. (2008). Use of search engines by research scholars and faculty members of physics departments in the universities of Karnataka State.
- Brophy, J., & Bawden, D. (2005, December). Is Google enough? Comparison of an internet search engine with academic library resources. In *Aslib Proceedings* (Vol. 57, No. 6, pp. 498-512). Emerald Group Publishing Limited.
- Chen, H., Houston, A. L., Sewell, R. R., & Schatz, B. R. (1998). Internet browsing and searching: User evaluations of category map and concept space techniques. *Journal of the American society for information science*, 49(7), 582-603
- Chen, H., Houston, A. L., Sewell, R. R., & Schatz, B. R. (1998). Internet browsing and searching: User evaluations of category map and concept space techniques. *Journal of the American society for information science*, 49(7), 582-603.
- George C., Bright A., Hurlbert T., Linke E.C, St. Clair G. , and Stein J. (2006) "Scholarly use of information: graduate students' information seeking behavior," IR information research vol 11 No 4 July 2006.

- Gupta, V., & Lehal, G. S. (2009). A survey of text mining techniques and applications. *Journal of emerging technologies in web intelligence*, 1(1), 60-76.
- Kumah, C. H. (2015). A Comparative Study of use of the Library and the Internet as Sources of Information by Graduate Students in the University Of Ghana. *Library Philosophy and Practice (e-journal)*, 1298
- Liew, C. L., Foo, S. & Chennupati, K. R.(2000). “A Study of Graduate Student End-Users’ Use and Perception of Electronic Journals” *Online Information Review*
- Madhusudhan, M. (2007). Internet use by research scholars in University of Delhi, India. *Library Hi Tech News*, 24(8), 36-42.
- Module Three - Electronic Information Searching Techniques. (n.d.). from http://karibouconnections.net/medlibafrica/training_module/pdf/module3.pdf
- Niels, O.P, (2006) “The public library and students’ information needs”, *New Library World*, vol. 107 No.7/8.
- Ren, W. H. (2000). Library instruction and college student self-efficacy in electronic information searching. *The Journal of Academic Librarianship*, 26(5), 323-328.
- Robinson, J.W. (2005), “Internet use among African-American College students: an exploratory study”.
- Shukla, P., & Mishra, R. (2011). Use of e-resources by research scholars of Institute of Technology, Banaras Hindu University, India. *Researchers World*, 2(2), 184.

- Simon, C. E. (1995). Information Retrieval Techniques: The Differences in Cognitive Strategies and Search Behaviors among Graduate Students in an Academic Library.
- Tsai, M. J. (2009). Online Information Searching Strategy Inventory (OISSI): A quick version and a complete version. *Computers & Education*, 53(2), 473-483.
- Tsai, M. J., & Tsai, C. C. (2003). Information searching strategies in web-based science learning: The role of Internet self-efficacy. *Innovations in education and Teaching International*, 40(1), 43-50
- University, C. Q. (n.d.). Information searching techniques. <https://library-resources.cqu.edu.au>
- Manoharan, S. (2017). Health Status of the Indian Women - A Brief Report. *MOJ Proteomics & Bioinformatics*, 5(3), 109–111. <https://doi.org/10.15406/mojpb.2017.05.00162>
- Kamalapur, S. M., & Reddy, S. (2013). Women Health in India: An Analysis. *International Research Journal of Social Sciences*, 2(10), 2319–3565. Retrieved from <http://www.isca.in/IJSS/Archive/v2/i10/3.ISCA-IRJSS-2013-135.pdf>
- Reddy, P. B. (2016). *Status of Women and Social Opportunities in Madhya Pradesh , India Social Science Status of Women and Social Opportunities in Madhya Department of Economics , Govt . PG College , Shujalpur , India*. (January 2014), 1–6. <https://doi.org/10.13140/RG.2.1.4667.7520>
- Baba, Riyaz, and Jeelani, Suhail Shah. (2018). iMedPub Journals Assessment of Health Status and Monitoring of Healthcare Systems in Rural Areas of Gwalior District , Madhya Pradesh , *India Abstract*. (2018). 1–5.
- Indian, T., & Charter, H. (2007). *THE INDIAN WOMEN ' S HEALTH Women of Age Women with Disabilities Women Living in Custody of State Institutions*. (March), 1–41.

Care, H., Reviews, C., & Sa, T. (2019). *Health Care : Current Reviews Health Reform as Political Instrument : Achieving Universal Health Coverage*. 7(1), 1–5. <https://doi.org/10.4172/2375-4273.1000239>.

U.C., S., & K.B., S. (2010). A trend in women's health in India--what has been achieved and what can be done. *Rural and Remote Health*, 10(2), 1260. Retrieved from <http://www.embase.com/search/results?subaction=viewrecord&from=export&id=L359876997>

Indian, T., & Charter, H. THE INDIAN WOMEN ' S HEALTH Women of Age Women with Disabilities Women Living in Custody of State Institutions. 2007.March, 1–41.

Care, H., Reviews, C., & Sa, T. *Health Care : Current Reviews Health Reform as Political Instrument : Achieving Universal Health Coverage*. 2009.7(1), 1–5. <https://doi.org/10.4172/2375-4273.1000239>

iMedPub Journals Assessment of Health Status and Monitoring of Healthcare Systems in Rural Areas of Gwalior District , Madhya Pradesh , India Abstract. (2018). 1–5.

Manoharan, S. (2017). Health Status of the Indian Women - A Brief Report. *MOJ Proteomics & Bioinformatics*. 2017.5(3), 109–111. <https://doi.org/10.15406/mojpb.2017.05.00162>

Care, H., Reviews, C., & Sa, T. (2019). *Health Care : Current Reviews Health Reform as Political Instrument : Achieving Universal Health Coverage*. 2019.7(1), 1–5. <https://doi.org/10.4172/2375-4273.1000239>

Ahn, J., Abnet, C. C., Cross, A. J., & Sinha, R. Dietary intake and nutritional status. *IARC Scientific Publications*. 2011. 2(163), 189–198.

2019 @ www.omicsonline.org. (n.d.). Retrieved from <https://www.omicsonline.org/conferences/speaker-pdfs/lai-chu-see-chang-gung-university-taiwan.pdf> cited on 12 April 2019.

open-access-journals-list @ www.omicsonline.org. (n.d.). Retrieved from cited on 12 April 2019.

APPENDIX- I

Health Literacy among Rural Women with Special Reference to Community Health Centers of Madhya Pradesh: A Study

Questionnaire for the Women

Dear Sir/Madam I'm GulabDevi, a Ph.D. scholar, in Department of Library and Information Science, Babasaheb Bhimrao Ambedkar University (A Central University), Lucknow, doing a research work on the topic “**Health Literacy among Rural Women with Special Reference to Community Health Centers of Madhya Pradesh: A Study**”. In this context, I would like to request for your kind co-operation in filling this questionnaire for my study and giving some necessary suggestions. Spending some time, will help me to complete this research work. I assure you that the data provided by you will be used only for this research work and shall be kept confidential.

Thanking you

General Profile:

1. Name :

2. Village :

3. Block :

4. Name of the member:

5. Age :

6. Community:

Forward Community [] Backward Community []

Most Backward Community [] Scheduled Caste []

7. Religion:

Hindu [] Christian []

Muslim [] Sikkha []

8. Marriage Status

Married [] Unmarried []

9. Family's Monthly Income

Up to 2000 [] 2000 – 4000 []

5000-10000 [] 10000-more []

21	Leisure time	News paper	
22	Activity	No activity	

13. Providing health information, resources and Services by CHC for you?

A. Yes ()

B. No ()

14. What do you know Knowledge, Source and Uses of immunization of Health Literacy?

S. No	Source	Category	(√) Please Mark
1.	Knowledge about Immunization	No knowledge	
2.		Had	
3.	Source of Information on Immunization	Doctors	
4.		Health visitors	
5.		Village Health Nurse	
6.		Teacher	
7.	Awareness about Uses of Immunization	Not aware	
8.		Aware	
9.	Awareness about Diseases prevented by Immunization	Fully aware	
10.		Partially aware	
11.		Not aware	

15. Do you know Availability and Accessibility of Health Care Services?

S. No.	Variable	Categories	(√) Please Mark
1.	Distance to Community Health Centre (in km)	.50-1.50	
2.		2.00-3.00	
3.		4.00-5.00	
4.		6.00-7.00	
5.		8.00-9.00	
6.		10.0-11.0	
7.		12.0-13.0	
8.		14.0-15.0	
9.		Above 16	
10.		For free medication	

11.	Reasons for visiting Community Health Centers	Emergency	
12.		Minor Illness	
13.		Not visiting	
14.	Visiting Private Clinic	Minor Illness	
15.		Partially	
16.	Distance to Medical Shop(in km)	00.-.50	
17.		1.00-2.00	
18.		3.00.-more than	

16. Access to satisfactory road network:

Yes [] No []

17. Do you face barriers for health treatment form community health community center?

S. No.	Indicator	Very poor	Easy	Fairly difficult	very difficult	Severely limited
1.	Social status					
2.	Self-perceived health					
3.	Able to pay for Medication					
4.	Able to afford doctor					
5.	Limited activities because of health problems					
6.	Monthly household income					
7.	Unable to reach out to CHC					

18. Have you take Awareness about nutrition diet?

Yes () No ()

19. What is Reason for not aware full nutrition diet by you? (Please tick mark)

A. Monthly Income

B. Not Aware

20. Which source or option do you choose for delivery?

S. No.	Place of delivery	(√) Please tick mark
1.	Home	
2.	Government facility	
3.	Accredited private facilities	
4.	Other private facilities	

21. Did you know about contraception?

Yes [] No []

22. Do you use contraception?

Yes [] No []

23. If no then why?

Lack of information []

Husband's []

Side effect []

24. Did you know any other reason treatment during pregnancy?

Yes [] No []

25. Which hospital you preferred in case of health needs?

a) Community health centre []

b) Sub-centre []

c) Private hospital []

d) Ayurvedic hospital []

e) Homeopathy []

f) Traditional local health person []

26. Are you receiving health care information from the following agencies?

a) Community health centre []

b) Sub-centre []

c) Local voluntary agencies []

d) Radio []

e) Television []

f) Newspapers []

g) Adult education officials []

29. Are the following staff members available in the Community health centre?

- | | |
|------------------------------|----------|
| 1. Doctor | Yes / No |
| 2. Nurse | Yes /No |
| 3. Compounder | Yes / No |
| 4. Health inspector | Yes / No |
| 5. Health assistant (Male) | Yes / No |
| 6. Health assistant (Female) | Yes / No |
| 7. Lab technician | Yes / No |
| 8. Attended | Yes / No |
| 9. Others, if any | |

29 .Are you satisfied Available Facilities and Personnel at Community Health Centre?

S. No.	Indicator	Poor	Good	Very Good
1.	Doctors			
2.	Nurse and Compounder			
3.	Labor rooms			
4.	Radiographers & X-Ray Machines			
5.	Lab Technician & Pathology Labs			
6.	Generators			

27. What are the different aspects about which you visit the Community Health Centre?

- | | |
|-------------------------------------|-----|
| 1. Family planning | [] |
| 2. Natal care | [] |
| (Pre natal, natal and post - natal) | |
| 3. Immunization | [] |
| 4. Communicable diseases | |
| a) Malarial fever | [] |
| b) Eye infections | [] |

- c) Cough []
- d) Body pains []
- e) Knee pains []
- f) Problems of menopause []
- g) Cancer []
- h) Blood pressure []

31. Social Empowerment

State your opinion about the following:

S. No	Item	Poor	Good	Very Good
1.	Using Toilets			
2.	Steps to increase hygiene in their area			
3.	Steps to take safe drinking water			
4.	Family planning methods			
5.	Supporting equal status for women			
6.	Securing property rights for Women			
7.	Voicing against social injustice			
8.	Supporting widow remarriage			
9.	Decision with regard to family Affairs			
10.	Decision with regard to health at home			

33. Recommendations and Suggestions

- 1.....
- 2.....
- 3.....
- 4.....

Respondent Signature

Questionnaire -II

(For Medical Professional)

General Information about your College

- 1. Name of the Community Health Center:.....
- 2. Name of Medical Professional.....
- 3. Designation.....
- 4. Experience (in years) of the Medical Professional.....
- Telephone No. : Fax No. :
- E. Mail:..... Website:
- 5. Status:
- 6. Year of Establishment:
- 7. Funding organization: **GOVERNMENT / AUTO GOVTMENT /PRIVATE**
- 8. Staff Strength:

Category	Permanent	Temporary	No. of Staff
Teaching Staff			
Non-Teaching Staff			
Nurse			
Medical Trainee			

9. Beds Capacity:

S. No.	No. of Beds	(√) Please Tick
1.	1-5	
2.	6-10	
3.	11-15	
4.	16-20	
5.	21-25	

10. Number of rural women enrolled in the Health Information Center during the last two years:

Year	Poor women	Very Poor	Average
2014-15			
2016-17			

11. Whether the training on the Community Health Center is provided? YES/ NO

If yes, how frequently:

Half-Yearly [] Yearly []

Any other

12. Woman could express her opinion freely on any issue among family members:

Yes [] No []

13. How many availability of Medical Ambulance in your Community Center?

S. No.	Availability of Ambulance in CHC	(√)Please Tick mark
1.	0-1	
2.	2-3	
3.	3-4	
4.	5-more than	

Information Technology Infrastructure:

(Please specify the availability and Number as applicable):

14. HARDWARE

S. No.	Hardware	Number of items available	Number of items to be added
1	Computers / Workstations		
2	Printers		
3	Servers		
4	Scanners		
5	LCD Projectors		

6	Photocopiers		
7	Fax Machines		
8	CCTV		
9	Any other.....		

15. SOFTWARE (please tick mark)

S. No.	Software	Open Software	(√)Please Mark
1.	Operating System	Unix/Linux	
2.	Office Applications	Open Office	
3.	Database Management System	MySQL	
4.	Email Client	Mozilla Firefox	

16. Are you satisfied with the available IT infrastructure in the Community Health Center?

Yes [] No []

17. Budget of the Community Health Center (CHC) for the last two years:

S. No.	Year	CHC	Govt. Grant(Rs.)	Any others
1.	2014-15			
2.	2016-17			

18. Do training/workshop is provided to medical staff for effective communication, information tools handling and center management? If yes, please specify the periodicity?

S. No.	Periodicity	(√)Please Mark
1.	Every week	
2.	Every Month	
3.	Every Six	
4.	Every Year	

19. Any other information you wish to provide (publications; awards, etc). Please add Additional sheet if required:

.....

20. Whether the Community Health Centre is networked via the Local Area Network (LAN)?

YES [] NO []

If yes, please specify the coverage of the LAN (please tick mark)

1. Entire Health Center []

2. Only the Administration []

3. All the Departments []

4. Only the Library []

5. Any other []

21. Community Health Center (CHC) Activities (Please tick mark)

1. Health Orientation Programme []

2. Women's Motivation Programme []

3. Health Exhibition []

4. Health Contests []

22. What kind of security system is your Community Health Center using, if applicable?

A. Electronic Surveillance System []

B. Radio Frequency Identification System []

23. Overall attitude of the Health Committee towards IT implementation in the Community Health Center (CHC).

A. Knowledgeable and Keen []

B. Not very enthusiastic []

C. Satisfactory []

D. Average []

E. Not at all interested []

24. Which health center you referral women patient in case of health needs?

g) Community health centre []

h) Sub-centre []

i) Private hospital []

j) Ayurvedic hospital []

k) Homeopathy []

l) Traditional local health person []

25. Are you receiving health care information from the following agencies?

h) Community health centre []

i) Sub-centre []

j) Local voluntary agencies []

k) Radio []

l) Television []

m) Newspapers []

n) Adult education officials []

26. Are the following staff members available in the Community health centre?

10. Doctor Yes / No

11. Nurse Yes / No

12. Compounder Yes / No

13. Health inspector Yes / No

14. Health assistant (Male) Yes / No

15. Health assistant (Female) Yes / No

16. Lab technician Yes / No

17. Attended Yes / No

18. Others, if any

27. What are the different aspects according to you about which is reason to visit the Community Health Centre by womens?

1. Family planning []

2. Natal care []

(Pre natal, natal and post - natal

3. Immunization []

4. Communicable diseases

a) Malarial fever []

b) Eye infections []

- c) Cough []
- d) Body pains []
- e) Knee pains []
- f) Problems of menopause []
- g) Cancer []
- h) Blood pressure []

28. Who are providing you assistance in case of the following?

S. No	CHC	Voluntary agencies	Panchayats
1.	Family planning		
2.	Pre-natal and post-natal		
3.	Immunization		
4.	Diseases – Malarial Fever		
5.	Others		

29. What are the agencies that have provided you social awareness on the following aspects?

S. No.	CHC	Voluntary agencies	Panchayats
1.	Environmental Cleanliness		
2.	Drinking water		
3.	AIDS		
4.	Tuberculosis		
5.	Polio		
6.	Personal Cleanliness		
7.	Mother and child care		
8.	Information about doctors hospitals		
9.	Family planning methods		
10.	Information about births and deaths		

11.	Smoking/ Ghutka		
12.	Water pollution		
13.	Sanitary latrines		
14.	Heart problems		
15.	Cancer		
16.	others		

30. Suggestions

1.
2.
3.
4.

Signature / Name of Medical Professional