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SOCIOLOGICAL ANALYSIS OF REPRODUCTIVE HEALTH OF WOMEN IN DHURALA VILLAGE OF KURUKSHETRA DISTRICT

Dissertation submitted to the Jawaharlal Nehru University
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MASTER OF PHILOSOPHY

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CERTIFICATE

Certified that the dissertation entitled "SOCIOLOGICAL ANALYSIS OF REPRODUCTIVE HEALTH OF WOMEN IN DHURALA VILLAGE OF KURUKSHETRA DISTRICT" submitted by Ms SHIVANI in partial fulfilment of the requirement of the degree of MASTER OF PHILOSOPHY, has not been previously submitted for any degree of this or any other University. This is her own work.

We recommend this dissertation be placed before the examiners for evaluation.

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C O N T E N T S

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ABBREVIATIONS

1.	ANM	Auxiliary Nurse Midwife
2.	BC	Backward Caste
3.	CHC	Community Health Centre
4.	GAD	Government Ayurvedic Dispensary
5.	KKR	Kurukshetra
6.	MCH	Maternal and Child Health
7.	Other	Other Caste
8.	NA	Not Applicable
9.	PHC	Primary Health Centre
10.	PRECA	Precautions
11.	QP	Qualified Practitioner
12.	RMP	Registered Medical Practitioner
13.	SC	Schedule Caste
14.	SES	Socio-Economic Status
15.	TP	Traditional Practitioner
16.	UNFPA	United Nations Family Planning Association
17.	UNICEF	United Nation International Children Fund
18.	WHO	World Health Organisation

CHAPTER-I

INTRODUCTION AND REVIEW OF LITERATURE

Prevalence of poverty among majority of rural women in India cause high mortality and morbidity along with child mortality and morbidity. The prevalence of sheer hunger, insanitary environmental conditions are threat to the reproductive health of women. Apart from these poor conditions, the additional load of pregnancy, child-birth and child-rearing make women more vulenerable to ill-health and death. Social and cultural discrimination also play a contributory role in the depletion of reproductive health. Thus the study on reproductive health of rural women is one of the most urgent and important problem in the field of community health. In order to achieve Health For All - by 2000 AD a systematic study is required to understand the dynamics of reproductive health of the women.

Reproductive health according to Jodi L. Jacobson includes three components-motherhood and complications associated with maternal health issue like pregnancy, child-birth or unsafe abortion. Second aspect is the reproductive tract diseases, infections, chronic pain and cancer of reproductive organs that can be due to unsafe sexual activity, poor gynecological or obstetrics practices. The third component is the use of contraceptives and complications arise due to it.[1]

Fathalla has mentioned the reason for giving

importance to the women's health needs as women bearing the brunt of it. According to him, women face the health hazards of pregnancy and child-birth and most of the STD's also have serious impact on women than men. Social and psychological burden of infertility and its management is also more on women in most of the societies. In the same way contraceptive use is three times higher for women than men and these methods also carry potential hazards. Thus all these factors along with social discrimination against women pose serious reproductive health problems.[2]

According to the estimate as taken together illnesses and death from complications of pregnancy, child-birth, unsafe abortion, diseases of reproductive tract, improper use of contraceptive top the list of health threats to the women of reproductive age worldwide.[3] Death and illnesses from reproductive causes are highest among poor women everywhere and women in the developing countries suffer highest rates of complications from pregnancy, STD's and reproductive cancers. More of these deaths could be prevented and treated with strategies and technologies well within reach of even poorest countries. The present trend is to see the problem not in the approach of maternal and child health which is a narrow range to meet reproductive health needs but it should offer a more comprehensive and integrated approach to the current health needs of all in

human reproduction.[4]

According to World Health Organisaton, reproductive health is a condition in which reproduction is accomplished in a state of physical, mental and social well-being and not merely as the absence of disease or disorders of the reproductive process. It further says that it is the ability of women to regulate and control fertility in an integral component of the reproductive health care package.[5] Thus definition has ignored various social, cultural and political realities existing in a particular country and its impact on the lives of people living there while indirectly emphasis is again on fertility control. In this context the social, political and cultural background of the country is also need to understood.

In India at the time of independence the health conditions of the masses was very poor as the result of hundred years of colonial rules. Moreover, there was extensive exploitation of country's resources and people. There was high maternal mortality and morbidity. Women at the reproductive age were being exposed to the risk of pregnancy and child-bearing and morbidity due to cholera, small-pox, malaria and veneral diseases as well as endemic diseases like Tuberculosis, leprosy, filariasis. Thus government planned to give priority to this vulnerable section of the society through maternal and child health

services[6] while the whole question of improving their living conditions was ignored and moreover services provided was also inadequate in terms of staff and infrastructure. These conditions of scarce services in the field of maternal and child health further deteriorated with the starting of national programmes of family planning, nutrition, diarrohea control, prevention of blindness as these were being pushed into masses through maternal child health programme. These were implemented and suggested by international agencies. This resulted into the neglect of maternal & child health (MCH) services at the expense of these programmes. In place of this more and more stress was given to fulfill the target of family planning programmes without understanding the needs and problems of poor women for the same and it has made target to the women's womb for the control of population. Thus, these have negatively affected reproductive health of women.

The problem relating to the reproductive health are due to the life condition and status of women in the society. In order to understand these major illnesses of reproductive health one has to address the epidemiological base of these diseases and problems. Because of the phenomenal development of clinical medicine these wider epidemiological issues were neglected with the development of MCH services which were mostly seeking the solution through individual

patient, Hospital and other institutional based services, through doctors, nurses and paramedics. This MCH services were developed in an isolated manner without giving proper priority on an integrated "women's health". Reproductive health suffers from wider issues like poor status of women within family and society, exploitative social structure and other cultural, social, economical and political factors relating to the life condition of a girl or a women in all society.

The stress is on the study of various factors influencing the reproductive health of rural women. As rural women not only constitute 79% of the women's population but also play an important role in the rural economy by bearing the burden of tough household jobs and difficult occupations outside house to share their families economic burden. They are also subject to various socio-cultural and political disadvantages. Thus study would focus on these women and various factors affecting their reproductive health.

Growth of Reproductive Health

In 1972 WHO initiated the special programme of research development and research training in the human reproduction and became the main instrument of reproductive health research in United Nation System.[7] While the whole

emphasis of the programme was on fertility regulation through technological development while issues of socio-economic, cultural and political factors have been neglected and has not been taken into consideration. Programme got support from many developed and developing countries. In 1988, the programme was co-sponsored by United Nation Development Programme, the United Nation's population fund, the World Bank, WHO and UNFPA. In the biennial report on special programme of research, development and research training in human reproduction in 1990-91, the stress was again to more contraception introduction without considering the needs and problems of women with regard to these and their socio-economic conditions, and no suggestions regarding political changes with this respect. While in a report of an intercountry workshop of WHO South-East Asia region of safe motherhood initiative in 1989 November has identified various issues, Suggestions were made to improve social equity for women, to provide effective maternity care for all pregnant women, and also community based maternity care to all high risk-pregnant women to ensure availability of family planning services for all couples, and target for reducing maternal mortality by atleast 50% by 2000 AD.[8] Further participation of women was stressed. In the article on women's reproductive health : The silent emergency the various kinds of reproductive illnesses and

severity of the problem has enumerated . Author has looked into the causes of reproductive health problems such as low status of women, illiteracy, poverty, malnutrition, lack of access to prenatal, postnatal care, safe abortion devices, contraceptives and trained birth-attendants. The wider political aspects and its affect on reproductive health e.g. non-participation of women in policy making and cultural aspects of influencing reproductive health were described but wider political aspect was missing.[9]

Bang and Bang also studied reproductive health problems of rural women in Gadchiroli district of Maharashtra. While living with people and organizing camps for their treatment authors identified the type of gynecological problems or diseases these women had, identified and sign of nutritional deficiency anemia and weakness. Study also pivoted towards the unavailability of health services for these problem to the rural women so they stress on the training and also given training to the traditional birth attendants to deal with the gynecological problems of rural women; women's shyness in approaching male doctors and lack of government interest in providing services in this respect was discussed.[10] Authors have not looked into the life processes of these women and their day to day lives which had impact on their health nor they have related the problems with wider political aspects.

World Health Organisation, South-east Asia region has also conducted a survey of 16 countries to know the state of adolescent reproductive health in 1980. The objectives of the survey was to know the availability of sex-education and fertility related services. Finding confirmed the absence of such services.[11] Regarding India very superficial picture was presented with regard to reproductive health of adolescent. The lack of sex-education in the country was correlated with prevailing low literacy level. But not gone deep into the reasons of this low literacy and consider only cultural factors responsible for low-education of girls and also social stigma only as the reason for youth not using contraceptive services and they are going to quacks for abortion.

In 1977 MCH unit of WHO collaborated with International Plan Parenthood Federation to conduct cross-cultural survey on the country specific information on the reproductive health needs of adolescents and information, education & services available to them. It was based on a series of guides designed to allow flexibility and permit gathering of opinions based on factual evidence and it was not the scientific analysis. Result of survey was that the poor reproductive health services, non inclusion of adolescents in planning, education and inadequacy of health services.[12]

Adolescent Health :

Adolescents can be productive member of the society and responsible adult citizens being recognized by WHO.[13] Previously many global meetings have been conducted on adolescent reproductive health, on their pregnancy, abortion, contraceptions and their health needs. Research programme in this respect has also started since 1975. WHO's collaboration with other organisations also designed and implemented cross-cultural survey of different countries on adolescent reproductive health. Various intercountry workshops have been held. Meetings were also held related to the reproductive health of adolescents in South-east Asia region.[14] In its report, health infrastructure is also suggested for the improvement while actual conditions of adolescent girls their living conditions, availability and accessibility to the health services has hardly taken into considerations. Factors like social, cultural and political influencing the society in which they live and how it contribute to their health has not been discussed. Though lack of information, education on reproductive health of adolescents has been recognised and stress is given only on the training and imparting skills in this field.

Sathe in the article the adolescent in India. A status report has described the conditions of adolescent. According to him in India 60% of the total population is

below 25 years and inadequately provided with opportunities for education and self-employment. Patriarchal system prevalent among 80% of its rural population where cultural mores, norms, traditional beliefs influence social and sexual behaviour and dictates do's and don'ts. Large no of adolescent girls do not experience the pleasures and fears of adolescent as they thrown straight into marriage and motherhood. In the lack of education they could not develop scientific attitude towards family life and fertility.[15] The focus of the article is on the socio-cultural factors like high fertility among the married adolescent due to social pressure for having atleast two sons and described its health implications such as anemia, premature and difficult labour, toxemia, premature births and high infant mortality. Author, pointed towards the child marriage, problems of abortion by quacks, increasing pre-martial sex and its psychosocial and sexual repercussions i.e. unwanted pregnancies, teen-age marriage, divorce, veneral diseases, developmental of guilt complexes, sexual inadequacies, hatred towards opposite sex. The reason for increase in premarital sex is given to the industrialization and urbanization and reason for not using contraceptive is attributed to ignorance and lack of know-how. Thus there is total neglect of political and socio-economic conditions in relation to the cultural forces affecting the adolescent

reproductive life.

Poor conditions of adolescent girls has been described by Ranjana, Singh and Dubey in their book growing up in rural India. According to them adolescent girls in India have grossly been neglected and continue to live without recognition, status, education, employment and social rights and opportunities and have no participation in decision making and self-development. Due to denial of control over their own bodies, they often became mere instruments of reproduction. Education is also high for boys at different levels and there is higher drop-outs for girls especially during adolescent period as in 1981 girls in primary education were 54.32% falls to 24.32% at the middle level and 14.06% at secondary level. It was further described that restrictions are imposed on girls soon after puberty, notion of purity, pollution strictly introduced in connection with menstruation, restriction on taking hot foods. Early marriage in rural areas lead to strong sense of insecurity springing from the fear of abuse and sexual harassment. It was also pointed out that for each maternal death there are 46.5% illnesses related to pregnancy, child-birth and puerperium for this age group. Infant mortality is high for mothers under 20, lowest for mothers aged between 20 to 30 and pregnancy before 19 to 20 is marked by

a high incidence of pregnancy wastages through abortion, still birth and neonatal deaths. It has been said that girls in rural areas are strongly discriminated against in terms of access to food, health, education and nutrition.[16]

According to Batliwala in the article Women in Poverty : The energy, health and nutritional syndrome described that scarcity of resources in the rural areas lead to demand for human energy in survival related tasks and women contribute into it the greatest share but get a lower share of output i.e. food, and face nutritional deficit. Women also suffers energy deprivation due to repeated pregnancies, breast feeding, high morbidity and intestinal infestation along with the work burden. It has been further said that nature and structure of health services is such that these women have less access to health care facilities. It further mentioned that these factors affect all the poor but more to the women of this section because of their special biological, social and economic roles. Author defined women's deprivation at three levels : Social-cultural, the environmental level including poverty conditions, service programme level.

Author suggested political participation of women to foster these programmes.[17] Thus, study has tried to see the impact of various factors on the women's health. These

conditions can be more detrimental in case of adolescents.

According to Bhatnagar who reviewed the earlier studies has described that chronic malnutrition through early childhood and adolescent results in short statured mothers with a low prepregnancy weight and any nutritional intervention during pregnancy has a limited role in improving its outcome and there is a calorie gap and further said that malnourished girls who get married and produce children during adolescence have a much higher risk of adverse outcome of pregnancy.[18]

Seminar on problems and needs of rural adolescent girls presented in centre for social research has also highlighted that right from the childhood girls are inducted into social and familial work roles and rarely get noticed or valued, denied any control over their life, body. Pushed into early marriage and repeated pregnancy. Poverty stalks all through their lives they grow ill equipped to be socially productive, self restrained and creative. This has serious implications on their personality, biological activity, creative faculties, social productivity, intellectual and social competence. Repeated pregnancy, heavy burden of family work lead to biologically and socially crippled individual with low self-image.[19] Ganguli in the article health problems of rural adolescent girls also described their pathetic conditions as according to her they are

denied their rightful share of society resources such as food and health care from childhood and lack education, employment and political power and suffer from anemia, susceptible to respiratory diseases, live in badly ventilated houses, with high incidence of T.B., lack of knowledge about reproductive system, purity, pollution with regard to mensturation. Author suggested to impart them non-formal education, training in income generating activities, delay their marriages and telling parents to treat female adolescent on par with males.[20]

Apart from these Indian studies, WHO/UNICEF paper also dealt with the health implications of sex discrimination in childhood, and prevalent socio-cultural factors like need of son, preference of son as economic asset while daughter considered as drain on family resources, discriminated child rearing practices like variation in nutritional status, more care given to the boys during illness than girls, poorer education of girls, child-marriage etc. has been described without its relationship with their socio-economic conditions and wider aspects like political forces.

Jeffery et.al. has also described the poor conditions of girls since childhood affected by socio-cultural factors but also described this with their socio-economic background and as a part of overall political order as well as their

availability to the health services. She also described childhood for females is burdened with work, early marriage of daughters to save the family name; consideration of women as burden for family, hard jobs at inlaws place, Purdah system, wife-beating and how she cope up with child bearing in the adverse socio-economic and cultural conditions.[21] While Mukhi in the article problems of adolescent sexuality has stressed upon the need of counselling for adolescent regarding their interpersonal relationships and contraception and according to him very few efforts have been made to provide adolescent an understanding of an biological, psychological and social aspects of human growth and development. Again the suggestions have been provided without actually knowing their life process.[22]

Aras in her article teen-age pregnancy. An epidemiological perspective has described the problems of early child bearing and its implications on young women's health, socio-economic conditions and its impact on their children and society at large. It described the lack of supplementary nutrition and iron deficiency anemia common among them. According to the author teenage pregnancy can be reduced through better education and preventive services. It further said that teenage pregnancy in India may not be a serious problem as early marriage and early pregnancy are

accepted norms. It has demographic implication on India as 60% of girls between 15 to 19 years age are married. However, it pointed out that maternal and child health services are rudimentary. Maternal death rate is 60% higher for women who become pregnant before 15 years of age while rate for 15 to 19 years is 13% greater than the mothers in their twenties. Perinatal mortality is reported 6 to 8.3% for teen-agers.[23] Thus, the implications of teenage pregnancy has been counted on without looking into their life conditions and its various causes and factors influencing them.

Various studies have attempted to see the adolescent reproductive health by taking into consideration the different aspects but very few has tried to see the problem considering its various related issues.

Problems relating to the Newly Married Women :

Very few studies have been focussed on the reproductive life of women while few studies have described the life of rural women in a broader perspectives. According to Jaffery, the study of production process i.e. power acquisition, land acquisition, distribution of goods should be considered along with reproduction. As people's livelihood basically depend on the households to which they belong which are socially constituted and have common

interests and conflicts, where men, women, young and old have different rights. Household members are recruited in two ways – (i) in migration, (ii) birth. In both the young women have a distinct part from those of men. Women generally have to leave their birth place on marriage to join households where they are wives and daughter-in-laws. All this have serious implication on the lives of women. As early marriage is done to save the family from bad name, bride gets uprooted from parental home to the husband's home. These marriages are mostly arranged and also accompanied dowry. After marriage her movements, activities control by her inlaws. She has to play submissive role while considering husband as her master. In the in-laws place also she has to work hard; observer Purdah, thus it is a kind of labour migration. Author has further classified that women's conditions varies from class to class to which they belong. However, author has focussed only at the micro-level i.e. household politics while also considering the importance of wider socio-political order in which women live. She also described about the poor availability of health services to these women and their inhibition to get treatment from male staff of PHC's. A women cannot discuss her problems related to gynecological and pregnancy because of shyness.[24]

Study done by Singh, Dubey and Ranjana on problems and needs of rural adolescent girls has described that level of awareness of married girls on issues related to child birth, care and family planning and health care is low. They get information from friends, sister-in-law. While parents do not acquaint them about these matters. Very few girls were found to aware of birth control methods.[25] The women bear the suffering in silence as sex is taboo and its negative consequences even more. They cannot challenge socially sanctioned male promiscuity so they learn the danger of sex, the rigors of child-birth, burden of unwanted pregnancy, risk of contraceptives as part of their lives. There is lack of health services in this respect as power relation, competition for limited health resources is unfavourable for her. It was further elaborated that girls and women generally do not have the power to determine whether, when and with whom they have sex. Moreover, male promiscuity multiple partners and use of commercial sex workers are responsible for their diseases. They rarely have safer sexual practice and the consequences of infection in women is more serious. Due to underassessment of this problem there is lack of services for these illnesses and women are dependent upon traditional remedies which further can lead to the infection. Women powerlessness resulted due to complex norms and practice which shape sexual behaviour,

dependent upon men economically and social support for men to fulfill their sexual needs and desires as they wish. Women cannot say no to sex or require safe-sex for the fear of loosing an important source of financial support. It is found that thre is little or no political will to allocate resources for this purpose.[26]

Jacobson in their article on women's reproductive health, the silent emergency has rightly described the various factors like political, socio-economic and cultural affecting the women lives. It elaborations that women have no control over with whom, when she will engage in sexual relations and she cannot undergo it without the fear of infection or unwanted pregnancy. She cannot choose when and how to regulate her fertility free from dangerous or unpleasant side-effects of contraceptives. She does not obtain safe abortion on request, information and treatment of reproductive illness. The reason behind it were given in relation to each other as according to Acsaid & Ascadi in safe-motherhood in South Asia, fertility is highly value in third world especially the birth of son. So average young women became both wife and mother well before her 20th birthday. Thus, following a pattern of four too's (i) Too early (ii) too close, (iii) too many and (iv) too late, as she continue bearing till 40's and hardly get medical care. Vaginal discharge, discomfort during intercourse, even

chronic pelvic pain is a part of their lives due to lack of education, freedom, distance, cost, traditional beliefs and practices, poor relationship between professional and beneficiaries lead to women to live in a culture of silence.[27]

Faundes et al in the commentary on women's reproductive health : means or end ? have analysed the reason for not taking action to improve reproductive health problems of women. In this respect author described the unfavourable global policies towards women and said that maternal death is a reflection of general status of women in society. Their poor nutrition, health and education as in childhood and adolescence lack of attention given to them and the disregard for their contraceptives preferences and needs resulted into unwanted pregnancy and illegal abortion. Author further said that sexual abuse and discrimination is still prevalent and women have no control over their sexuality and when she decides to control she suffers from side-effects of contraceptives. If no method is available or method fails she left alone to decide and arrange for the interruption of pregnancy. Most of the developing countries consider it as illegal and turn their back on women's health needs.[28]

According to Chatterjee in the reproductive life of

Indian women, marriage is her only means of support and the sole justification of her existence with its focus on motherhood and household duties.[29] This was also supported by paper presented at the national workshop or girl-child held at NIPCCD, New Delhi.[30] Thus all this literature give an idea regarding the conditions or difficulties and newly married women face.

Pregnant and Nursing Mothers :

Most of the studies have taken into consideration of the antenatal, Prenatal care of the pregnant women, While vary few studies have been done on the nursing mothers. At national workshop on girl-child paper presented has highlighted girls discriminated in the field of nutrition and they are less entitled to health services and govt. allocation. In this field, emphasize her role as a future mother and stated giving attention at Prenantal natal and postnatal stages.[31] Recently safe motherhood initiative to reduce maternal mortality and disparities between developed and developing countries was established in WHO Southeast Asia region in 1989 to improve maternal health and to focus on all factors that expose women to health risk during pregnancy and child-birth. But the stress was on maternal health care and family planning in the primary health care setting. Data regarding India has been given as maternal

mortality is 4.5% and IMR is 95 per thousand. Birth attended by trained Dai is 40% and antenatal coverage is 40-45% while future hope for better coverage as a part of national health policy is suggested through expanded PHC and CHC.[32] Which seems to be very unrealistic picture. Stress is on improving maternal and child health services through trained birth attendants. It has been described that antenatal care is provided through PHC, and sub-centre level including early detection of pregnancy and identification of high risk mothers, 100% coverage of pregnant women for immunization and iron and nutrition supplementation admired. Postnatal care include daily check ups of mothers for 7 days following delivery, encouraging breast feeding, educating mothers on various aspects of hygiene, diet and family-planning. It has been further identified in one of meetings on reproductive health of adolescents in South-east Asian countries that adolescent undergoing child bearing not able to take responsibilities of rearing their children, it can lead to join their families into the poverty cycle and contribute to the rapid population growth.[33] While the reasons of their conditions has not looked into. A study on rural mothers is suggested regarding with the various events and consequences of teenage marriage in rural areas while overlooking the aspects contributing or related to it.

Reproductive Tract Infections :

Reproductive tract infection is the component of women's reproductive health. So, it is essential to know the various aspect of this problems being studied so far. Bang et. al. in their study of Gadchiroli district reported.

Regarding prvalence of gynecological diseases, It was found that 92% of women in village had one or more gynecological or sexual diseases. Among them are virginities, cervictis, vertical erosion, pelvic inflammatory diseases and dysmenorrohea. With this there was 91% anemia, 58% vitamin A deficiency 46$ unmarried girls have premarital sexual experiences reported. While only 7.8% women had ever received gynecological care. Unwanted pregnancies and forcing women for unsafe abortion found to be common. Further it was found that use of Intrauterine devices lead to gynae problems such as menstrual disorders, vaginal infections, and cervical diseases and the introduction of IUD or tubetomy further aggravate the pre-existing gynae problems. Para-medical in the village cannot deal with these problems. Authors pointed out the pathetic conditions of women with no or very less services available for dealing with these problems.[34]

Recently, campaign is there to prevent HIV and AIDS transmission and tend to emphasize women as potential

transmitter of the disease.[35] Faundes et al recognised this trend and described that women suffer more from STD than men, but there is no consideration for their problems in govt. programmes.[36] According to WHO, three quarter of maternal deaths attribute of five direct causes one of these is sepsis (infection) which is life threatening, systemic infection arise from dirty nails or hands of birth attendants, long labour, ruptured membranes, caesarean section, abortion, retained placenta.[37] In 1977 a cross cultural survey designed and implemented to provide country specific information reproductive health needs by WHO in collaboration with International plan parenthood federation. It was found through the survey that sexually transmitted disease are rising among women and there is shortage of educational health services for them.[38] Thus, the survey has identified these problems for adolescent but very superficially in the absence of assessment of their actual living conditions and other forces affecting their health.

Mueller et al further stressed that both bacterial and viral infections remain major health problems in developing countries but women accept vaginal discharge, discomfort during intercourse, even chronic pelvic pain as a part of their lives which author described as a culture of silence. These infections rife with stigmas, taboos and threat of

social ostracism due to low self-esteem, illiteracy and fear of violence or rejection by their partners prevent millions of women from reporting or discussing any symptoms. Moreover, infertility and chronic infections prevent women from sustaining pregnancies and bearing healthy children. Regarding the severity of the problem it has been said that deepening concern is there about population growth and emphasize is on fertility control than health estimates based on rising incidence of unsafe abortion, reproductive tract infection and AIDS and growing needs for family planning. It has been said that by the year 2000, reproductive causes will kill at least 2 million women each year.[39] Thus, the article has defined the urgency of attention for the problems.

Family Planning Measures :

Sathyamala in a background paper gave the argument that generally the side of contraceptives and sterilization is taken by saying that mortality due to these is very low as compared to maternal mortality due to pregnancy and child-birth and patient should be sterilized in order to prevent from this risk. Author stressed that child-bearing can be risk for women belonging to poor socio-economic conditions and already having high overall mortality rates and through the use of contraceptive reduce the possibility of pregnancy

related deaths, but the quantum of morbidity it produce is too high to justify its wider use in developing countries, as it adds to the maternal mortality. Author further described the morbidity load due to contraception as calculated in 1980-81. Morbidity due to Intra Uterine devices are bleeding, pain and infertility spontaneous abortion, perforation of uterus, pelvic inflammatory diseases and ectopic pregnancies. While tubectomy cause post-operative menorrahagia and pelvic infections, morbidity due to oral-pills based on data available from other countries are-stroke, hypertension, kidney infection, heart attack, Rheumatic heart diseases etc. and an added problem is that the morbidity and mortality not only confine to women but can also extend to their progeny.[40]

These show the prevalent trend with respect to the family planning services. The socio-cultural aspect as pointed by Jeffery at al 'that women sometimes need contraceptives but it is not in their hand as it is decided by their husbands and it is their opinion which has to be taken into consideration so they cannot take-unilateral action to limit their family size and generally comply with the wishes of husband. While women staying with parents can insert IUD or got abortion and also women living in nuclear families have more control over their fertility. Author also mentioned the use of traditional medicine for the

fertility control and gap between children. Author further described the ANM's role in making the women to undergo sterilization and lack of follow up by them. It was also mentioned that males generally stressed their wives to undergo sterilization as they have to do hard work. It was reported that women suffers lots of health problems after sterilization. Abortion facilities are inadequate and women generally do not undergo operations and thus they have to bear child and also mentioned the lack of health services. It was further mentioned that use of modern techniques are very less and women are anxious of their side-effects.[41] The family planning programme has been so much stressed by the government that it is reaching even to remotest tribal and rural block of Andhra Pradesh a reported by Ramalingaswami and women are aware of this.[42]

Study done by Bang and et al pointed towards the need for good and safe family planning measure for women and also mentioned this as a government failure of planning and service in this respect.[43]

Studies which have tried to explore the actual field conditions are as such : a study done by Banerji on the aspects of socio-cultural status and socio-cultural change among women in rural India. In a paper presented at the national conference on women's studies he described the

class issues with respect to health of women. Priviledge class has better living conditions so their women as compared to underprivileged masses. Rich class has moulded the health service according to their needs and problems. Hunger, poor sanitation and housing, contaminating source of drinking water, infestations by insects and parasites, lack of protection from various elements of nature, poor educational status, limited access to mass media have major consequences and lead to high under and malnutrition among underprivileged class and cause high maternal and child mortality and morbidity among underprivledge. Author also pointed towards the alienation of health workers from the actual problems of the people due to their training and belongingness to middle class. Further described the lower status of ANM, nurses and exploitation of women workers by men employers. But in article on socio-cultural change author pointed towards a positive change among conditions and more women beneficiaries are benefitting through adopting MCH practices was reported.[44]

Ramalingaswami in her study in the six villages of tribal block of Paderu and six villages of rural block of Sabbarvaram of Vishakhapatnam district of Andhrapradesh included 375 tribal & 285 rural women in the age group 15 to 45 yrs. women interviewed from each household to know their

awareness regarding primary health centres, MCH services given by ANM, and their utilization. Findings were that people living in remote areas were aware of developmental and health programmes even though these are not reaching to them. The programme like Family Planning and malaria were reaching to them, but the accessibility of MCH services was poor to them.[45]

In the book labour pains and labour power women and child bearing in India Patricia et al have focussed towards the urgency to look at the maternal deaths occurring in India which constitute 1/3rd of the world population but 1/2 of the world's maternal deaths. These occur more in north. So the study in the Bijnor district in western U.P. has been done to look into the process with its social, economic, political and cultural, and health services aspects. She has given the case studies of a pregnant women being delivered. However, she has not much described about the availability of health services during antenatal period. While description about post-netal period is there. She described that being pregnant is a matter of shame for rural women and she rarely mention about it and work hard till the last day of delivery and do not get much rest or food from husband or inlaws during pregnancy. Most of the births attended by dais and delivery takes place at home. In case of

obstructed labour it is very difficult and unaffordable for poor family to take the women to the nearby civil hospital where health staff is non-considerate to their illness. She also elaborately describe the traditions and practices related to delivery and pregnancy. Author also reported death of mother or still birth common among them.[46]

Study done by Jesudason, Chatterjee, on Interrelationship of health indices of women in two rural community in two community development blocks of Madhya Pradesh, Specially to see the influence of selected socio-economic and demographic variables on pregnancy, nutritional status and morbidity. A sample of 479 rural women in the age group 15-45 yrs were selected to examine interrelationship among their pregnancy behaviour, nutrition status and morbidity experience. Findings were that there is vitamin deficiency, iron and poor nutritional status among women increasing with their age. Nutritional deficiency increase with increase in parity, the knowledge of conception was low, pregnancy after three years was the norm, there was impact of no.of wastages on pregnancy. More, the wastage more is the no. of pregnancies. It was found higher socio-economic status has lower nutritional deficiency.[47]

Chatterjee, in the article reproductive life of Indian

women has given the reason for high fertility. According to the author the concentration of the burden of child-bearing on the most youth part of their life 20 to 34 years is due to (i) the utility of child as a contribution to family income, as a source of security in old age; due to prevalence of child labour and lack of social security, children are regarded as reserve pool of cheap man-power and source of help in domestic work this lead to neglect of their education, while the cost of their bringing up is low with less prenatal care, thus high fertility cause high rate of maternal morbidity leading to protein malnutrition and other complications due to high fertility were discussed.[48] According to Jacobson through out the third world, reproductive risks are excessive because of the low status of women perpetuated through cultural and legal traditions and it keeps birth rates high and places of health services out of reach. According to him the root cause of poor health are low status of women, illiteracy, poverty, malnutrition, lack of access to prenatal, postnatal care, safe abortion devices, contraceptives and trained birth attendants and their complications of pregnancy, child birth and unsafe abortion. It was further described that food taboos relating to the diet of pregnant mothers lead to prevalence of anemia among mothers. Poor nutrition often Worsen later in women's life because of heavy workload, loss

of iron store through menstruation and demand of child bearing lead to increase disposition to illness, low weight and stunted physical and mental development and physical immaturity due to stunted growth leads to higher rates of frequency related problems. Women never receive medical care as lack of effective basic maternal health care system - is too far from home, too few trained birth attendants, too poorly equipped to identify or handle complications and too deficient in quality of care. Prenatal care which include preventing complications from obstructed labour, toxemia and infection, nutrition education and birth by trained attendants women are hardly able to make use of this which theoretically accessible to them.[49]

According to Gulhati, in India there is an inadequacy of health services as reflected in the mortality rates of young women aged 15-19 years and 20-24 years, which is 50% and 80% higher than males of same age respectively. Author further said that prevalence of malnutrition and strenuous work performance enhance the health risks during pregnancy and child-birth.[50] Thus article has further pointed towards the inadequacy of health services. Germain in the article new partnership in reproductive health care also tried to see the women's reproductive health problem in a wider perspective. According to him as global economic crisis,

requirement for developing countries to cope with mounting debts through structural adjustment and to macro-economic policies have led third world countries to cut their health budget as much as 50% and women's reproductive health is generally given low priority in national budget. Author further said that in many countries, socio-cultural and behaviour patterns within household and community compound by problems of resources scarcity and prevent women from exercising their right to reproductive health and dignity. Critical problems women facing are high level of maternal morbidity and mortality, death from illegal abortions, reproductive tract infections, infertility and lack of safe and acceptable methods of contraception.[51]

John in article cultural dimensions of mothers contribution to child survival has stressed that reason for high child mortality are high birth order inadequate spacing between births and the number of children already in the family. Author suggested that in a culture where women is told that it is normal to lose a child so they prepare for that.[52] Here author has not gone into the reason for high fertility but focussed only on cultural factors related to mother which affect child care. In the same way Prasad has analysed socio-cultural aspects including habits, taboos related to reproductive health of women.[53]

Aras has pointed out the lack of nutritional supplement to the pregnant mothers and according to her the personal impact of pregnancy on the teenagers can be reduced through better maternity, abortion and social services. According to the statistics given only 40-50% of pregnant women get anatenatal case, less than 15% delivered by trained birth attendants and only 20% receive tetanus toxoid. 30% are covered by nutritional supplements of Iron and folic acid.[54]

Ghosh in the article challenges and opportunities maternity and child care has pointed out that high crude birth rate also associated with the highest rates of infant mortality with lowest level of education and endemic poverty. As poor are not sure of the survival of their children and cause one of the reason of high fertility among them.[55] According to Key, Women receive inadequate health care and more exposed to illness and spend many years of their lives in pregnancy and lactation, receive inadequate diet which put further strain on their health and they have less access to health care.[56]

Various studies have been conducted on the reproductive health of women or on its related aspects. Inequalities in pregnancy outcome as study done by Rutter and Quine, in which it was found tht post neonatal mortality was related to social class. Women who work outside their homes and

also have small children face more problems, stress anxiety and unfavourable life - events which have impact on their reproductive health e.g. during pregnancy, child-birth and also on the neonatal infant. Thus, this shows the negative impact of working of poor women on their reproductive health.[57] On the other hand, John studied the cultural dimensions of mothers contribution to child survival as presented at the ford foundation workshop. He accused the belief of mothers regarding their control on their own health and child's health as affected child survival. He stressed upon the locus of control of women without considering their socio-economic conditions incluencing their belief. Along with this he studied their food habits and practices.[58] On the same line, Cleland et al on the basis of survey data of developing countries, studied impact of maternal education on child survival. Authors tried to adjust the impact of socio-economic conditions and suggested only mother's education for reducing infant mortality.[59]

Poerksen and Petti in the study of employment and low birth weight in black women reviewed the earlier studies on the impact of work on pregnancy. Authors studied the pregnancy outcome of the women involved in various occupations. It was found that women working long hours in

a stressful occupation will have little impact on birth weight of child. While studies own result have shown low birth weight among women working on low-paid jobs as compared to highly paid working-women.[60] Thus, authors only stressed upon employment affect on the pregnancy outcome while ignoring the other aspects related to employment i.e. socio-economic, cultural and political which also determine the type and nature of job a woman performs.

Research on the wider socio-political aspects affecting society is done by Chattopadhyay in the study of eastern India i.e. Bihar, West Bengal and Orissa by adopting system approach. The topic of study was the interface between the socio-economic status and the health and nutritional status of women and preschool children of the rural and urban poor in eastern India. According to study ecological and physiogrphic sub-systems are stable and thus arised a specific configuration of food system. Information based on ecological sub-system is input into socio-economic sub-system and generates a structure of production and social forces exercise different degree of control over distribution of food with different degree of control over access to food and lead to food insecurity among SC,ST and landless labourers, which inturn became information input for nutritional and health sub-system. Project also identified the importance of multifactor analysis including

accessibility to health services, health culture and habits, community habits and taboos, practices of prenatal and postnatal case. Qualitative data was collected through survey at the microlevel comprising of four rural districts and two urban areas in each of three states. It also involved the diagnostic study of diseases profiles and access to health care delivery system and also reported the findings back to the community through audio-visual means. Data was collected with the help of team of professionals and subjected to multivariate analysis.[61]

Study done by Wildschut et al on predictors of foetal and neonatal mortality in Curacao in Netherlands with the help of multivariate analysis. Three factors were involved Socio-economic, Socio-demographic and medico-obstetrics, 5 risk factors i.e. gestational age, birth weight, sex foetal presentation and congenital anomalies were identified as responsible for foetal and neonatal mortality[63] but these were not understood in association with social class, marital status, maternal age and parity. Meeting at Italy on reproductive tract infections in the third world women in May, 1991 has identified the reason of high rate of reproductive tract infections due to male promiscuity and lack of proper health services. However, related factors like sexuality and gender discrimination, economic

inequality and poverty and political forces has been discussed along with reproductive tract infections.[64] Moreover, the concerned for the problems was more as the threat to the family planning objectives and burden on health services due to increase rate of reproductive tract infections.

Another study conducted by Gupte et al in Maharashtra reported the cultural practices regarding menstruation age at marriage, pregnancy (food taboos during pregnancy), no.of abortion, Anatantal care received, age at delivery, place of delivery, obstructed labour and poor access to health services. Further, cost of delivery, post-partum problem,[65] but all these practices have not been seen in relation to the different socio-economic conditions. Use of contraception and after effects of sterilization was reported. Study also described the knowledge and awareness of people regarding health worker's role. However, use of primary health centre and village RMP's has been seen in relation to Socio-Economic Status of the people. Study revealed that women's control over her own sexuality fertility as well as on the major decisions regarding upbringing of her own children is low. Inadequate stocks of medicines at PHC, lethargic health workers, government health services are invariably linked with family planning programme were reported. Study stressed upon the need of

political consciousness among women and demand for community kitchen, Crechs and government should bear the expenditure to question all norms, institutions, concept of sexual division of work.

Sahu in his study on Oraons and their health culture in selected six different socio-economic settings tried to see the health culture of these Oraons living in different kinds of situations and with different access to health institutions. For the remote village author described witch doctor, village priest and dai as health institutions, RMPs, healer for snake bite and other institutions situtated at the remote areas. Practices concerning pregnancy, child birth and indepth data on specific delivery cases was reported. Deliveries of the child at work place among poor women was also reported while well-off sections reported of getting rest and food during pregnancy. Health personnel were described as mainly putting emphasize on family planning and conduct deliveries of rich and non-tribal women. The conditions of poor, living in the subcentre and PHC villages was also reported to be bad, being wage earners, they could not afford to go to the PHC and take treatment from ANM and those who went there turned back either by prescription or useless medicines. Further, post delivery complications found to be less among well-off sections. More frequent abortion, still-birth lack of ante-

netal care reported among not-so-rich, poor women. Oraons women in slums was found not to practice that traditions as that of village women but due to poverty, they also have to depend on dai.

Oraons women living in the re-settlement colonies and industrial township had more availability and accessability to the health services but poor women living there have to rely on the services of medical aid centre, RMP and in case of not getting treatment and relief then to the traditional healers. Thus, the life process of the Oraons is different in different settings and so there health seeking behaviour according to their socio-economic conditions, availability of health services to them.

It is also essential to review the different factors influencing the reproductive health of the women after examining the various studies conducted on various stages of reproductive period. These various factors are socio-cultural, socio-economic, political factors etc.

Socio-Cultural Factors :

These play an important role in influencing the reproductive health of rural women. It includes the way of life, their traditional practices, taboos, beliefs and various aspects of reproduction. But these cultural factors

cannot be studied in the vacuum of other factors like socio-economic, political as all these are interrelated to each other and cannot be isolated. Jeffery et al in their study of women and child bearing in the Bijnor district in western Uttar Pradesh in India supported data with case studies described that the poor socio-economic conditions and nevative cultural factors affects and form the background of child bearing and birth among poor rural women and that too lead to the poor accessibility and availability of merely existing health services to them.

Study has focussed mainly on the cultural aspects like non-egalitarian nature of society in which women is dependent on men and do not have an access to productive resources. This lead to their vulnerability, insecurity and lower status. Their childhood is generally spend doing child-care, scour dishes, take food to the household members in the fields, clear up cow dung with very few opportunities for education, early marriage with the onset on puberty is on their way in order to same the family from bad name. This include the burden of work, observance of shame, lack of control on their own sexuality, fertility and poor accessibility of health services. Author describe that these women are not even allow to visit their kin without permission, they have no say in the matter of number of children they want, moreover, local definition of pregnancy

is a condition not normally needing medical care. Unless a pregnant women is seriously incapiciated, she keeps on working hard and serving her family and do not tell her problems as it is shameful to discuss the matters concerned to reproduction. So cultural factors denied women's existence as a person with independence assertiveness moreover they live very marginal lives in rural areas and this negatively influence their reproductive health.[66] The fact is further supported by the paper presented by Dube. In which she has described the concept of considering women as field or ground for fertility and men as cultivator which provides satisfaction for patterns of behaviour belief and institutionalization of relationships which favours male domination and unrecognized women's contribution in social reproduction.[67]

Jones in his article on how daughter's suffer also enumerate the health implications of various socio-cultural factors observed in the majority of cultures. He further described that need of son, preference of son as economic asset while daughters consider as a drain on family resources, discriminated child rearing practices like variation in nutritional status, care given to the boys during illness more than girls, poorer education of girls, child marriage etc. are all prevalent practices unfavourable

for the reproductive health of women.[68] However, author has not taken into consideration the political, socio-economic factors affecting their health. Paper presented at the national workshop on girl child organised by NIPCCD from 27th to 29th Dec. 1987 also highlighted the discrimination against girls in the field of nutrition and health and they are less entitled to health services government allocation of services emphasize on her future role of mother while no attention is paid towards her health as a right for human-being.[69]

Jacobson in his article women's reproductive health has mentioned the culture of silence among women due to which they accept all the problems related to reproductive health in silence in the fear of rejection from their husbands. This further complicate their reach for treatment. Author also pointed towards the food taboos prevalent in the culture related to the diet of pregnant mothers, which lead to the poor nutritional condition in later years.[70] Shoba has also suggested that women should fight against oppression within and outside their households.[71]

Banerji in their study of 19 villages from eight states reportede that early marriage, prevalence of Pardah, polygamy and a woman without children become a special victim of oppression, restriction on remarriage of widow.

The reason for this discrimination has been found in the biological characteristics of women and thus cause an unjust order. The problem has become more complicated in the overall extensive economic, social and cultural exploitation of one group of human beings by another. Poverty conditions inturns generate social and cultural tensions which have biological consequences.[72]

There is need to understand the culture of the women with their background of socio-economic and political forces. Health culture relate to reproductive health including tradition, beliefs and practices prevailing among different strata of women at the time of menarche, conception, pregnancy, child-birth, menopause; Along with this there is need to study their own system of medicare for the treatment and prevention of illnees.

Socio-economic Factors :

Socio-economic conditions directly or indirectly affects the reproductive health of women. Though socio-economic conditions are very important still there is need to see these in relation to cultural and political factors which bear an impact on women's reproductive health. The childhood spend in the poverty and under negative cultural forces lead to the poor physical, social and psychological development of women which further affects their health

during reproductive age. They are weak, anemic and according to Jesudason and Chatterji in their study of Interrelationship of health indices of women in two rural community the morbidity among poor women is high along with poor nutritional conditions.[73] According to Jacobson women living in poverty have lack of access to prenatal, postnatal care, safe abortion device, contraceptives and trained birth attendants. As they cannot bear time and cost of scarce health services, and also due to lack of education, freedom, distance and traditional beliefs and practices, poor relationship between professional and beneficiaries, among some worst-economic conditions may lead to prostitution and thus cause various gynecological problems and complications to their health.[74]

Rutter and Lynguine in their study of inequalities in pregnancy outcome has described the impact of social class on mortality and women's reproductive health. He stated that post neo-natal mortality is high in Britain's lower social class, working women have low birth weight, pre-term babies as they face more frequent stress, anxiety, life-events and have lower self-esteem. Life stresses predicts gestational difficulty while emotional disequlibrium is associated with complications of infant's health (Norbeck J.S. & Tilden V.P.). According to the author, women living in poverty must have negative feelings due to their poor

conditions and thus poor cognitive conditions i.e. knowledge belief of a woman regarding how vulnerable she is to the complications, severity of diseases and how she weighs the benefits and cost of taking action.[75]

Study done by Jeffery et al also described the poor reproductive health of rural women who cannot avail health services due to poverty and whose life has no importance at the crucial period of delivery due to lack of money and negative cultural factors. They undergo all pathetic conditions due to poverty and also not able to got attention of health professionals.[76] Poor socio-economic conditions also indirectly affects women's reproductive health. In order to ensure the survival of children, they have to bear many children. While child mortality is high among them and immunization services are also least available to them as predicted by Bhardwaj, Singh and Singh in the study of socio-economic factors affecting child-immunization in rural areas of Varnasi.[77] According to Chatterjee this need of more children lead to high fertility among women and affect their health adversely.[78] Study done by Poerksen et al on employment and low birth weight in black women has indicated that women involved in labour and low paid jobs has high risk of low birth weight or preterm babies than those involved in high paid jobs.[79]

Education :

Education also play an important role in influencing the reproductive life of rural women according to Sarma education can conteract the foundation of deep inequality built in our society. But female literacy is only 32.1% as compared to 52.63% male literacy (according to 1981 census) and female dropouts are also more than males. This contributed due to burden of household on women, care of siblings moreover cultural subordination discourage their education.[80] Banerjee also confirmed the poor literacy of women in rural India.[81] Study by Jacobson pointed out that lack of education is due to poor socio-economic conditions and which inturn can be responsible for unsafe sexual activity, poor gynecological and obstetrics practices due to lack of knowledge and awareness regarding appropriate measures.[82]

Education among girls prevent them for various pregnancy related risks,as they reproduce at the low risk age due to postponement of the marriage, and have early cessation of child-bearing. While illiterate women experienced early marriage and thus have all the complications related to pregnancy and child-birth. Early marriage also affects their own growth and development adversely. These women may experience high parity which inturn badly affects their overall health and may cause

morbidity. Study done by Cleland and Ginneken on the maternal education and child-survival in the developing countries has described the inverse relationship between education and mortality. It was mentioned that educated women can make use of preventive health services and have better knowledge of health requirements, have willingness to make use of govt. health services, and have greater decision making regarding their own health. Findings have also supported that uneducated and poor women often receive little consideration from officials including health services. In this article stress has been given to provide education to the women for improving their own and children's health.[83] While this study has identified the impact of socio-economic conditions with education still the recommendations were made only to provide education.

Political factors :

Political factors play an important role in deciding and influencing the conditions of a various members of the society. Political forces within and outside the household are very important in affecting the reproductive health of rural women. Conditions of powerlessness due to cultural factors as well as political factors inside the household dictates female subordination and inaccess to productive resources and make her dependent on males as being reported

by Patrica in her study.[84] Whereas in the constitution and through various provisions government has stressed upon the equality of sexes and also provide reservation for them in Panchayat in rural areas to make them participate in decision making process related to their health and wider social aspects. But in reality class and caste issue affect their participation.

Women's reproductive health also affected by the policy decisions. According to Banerjee privileged class influence decision in their benefit and affect policy regarding wages and health services. As a result health services are not responsive to their needs.[85] As reported by Bang et al. According to them reproductive health needs of women are not met through government health services. As policy makers and health planners have not understood these needs and stressed only on maternal and child health. So women have to suffer from these problems.[86] According to Maithreyi women's related issues are showhow missing in the Indian census. These is lack of accurate and reliable data on their health, nutrition, education, fertility, migration crimes and work participation which reflects their subordination and underevaluation of their contribution in the society. This also lead to the lack of policy for them.

Political decisions related to the medical education and health services are unfavorable towards them as these

are oriented towards needs Again as pointed by Maithreyi women's health and well being are compromised or actively harmed by high technological solutions. Population control policies imposed by many, white supermist governments. Drug companies are driving and determining the status and well-being of women in collaboration with the state or global power. All this has negatively affected women's health as decisions has been taken without studying or realizing their needs or problems.[87]

Noeleen in article gender, economic growth and poverty has stressed upon the need of developing gender sensitive planning in the Asian region, going deep into each of the major sectors of agriculture, health, education, industry and to ask what is perspective of poor women in each. Realities of these women's lives and their priorities must be considered when planning and implementing development programmes.[88]

Experiments are being done to empower women through self-employment, or by making their association or their participation in policy and decision making bodies These have shown positive result as reported by Sandbergen.[89] Opportunities of employment or any other authority given to them has led to the improvement in their own health as well as it lead to the allocation of resources to the needed sectors of households like nutrition, education health etc.

as pointed by Gail.[90] Thus in order to improve the reproductive health of rural women there should be an just social, economic and political order. As political factors influence social and economic justice to them, exploitation and other oppression, lack of sanitation, housing, contaminated source of drinking water, infestation by insects and parasites, poor educational status, limited access to media of communication all this cause high morality and morbidity among them. There may be evidences of negative impact of political forces on the health of women. As medical care availed only by rich section may have contributed to widening of the mortality differences between different socio-economic groups. Thus there is need to influence national and international decisions in favour of women's health.

The Present Study

The study has intended to look into the various factors like sociol, economic, cultural and political relating to reproductive health of rural women. These factors are not to be studied in isolation but in relation to each other. Impact of health services aspect is also to be taken into consideration. Rural women has been decided for the study as they are most deprived due to many socio-cultural and political disadvantages, they don't even have basic minimum

amenities for their day to day life.

Haryana state has been selected for this purpose since it is one of the developed state of the country. Thus, women are supposed to be subjected to better living conditions and improved reproductive health.

Having this as the hypothesis, we wanted to study a village Dhurala of the block Thaneswar in Haryana. Because of the time and resource constraint and as per the requirement of a M.Phil dissertation this study was carried out in a village with a total population of 3238.

The objectives identified in this study are:

(1) To study the actual living condition of women between the age group of 15 to 45 yrs. and their day-to-day life process.

(2) To study the status of women in high, middle and low socio-economic classes in the family and in society.

(3) To study the reproductive health of the women between 15 to 45 yrs age group in the category of adolescents, newly married pregnant and nursing mothers and woman with one on more children.

(4) A systematic attempt would be made to study the reproductive health of the women in the context of health services available and accessible to them.

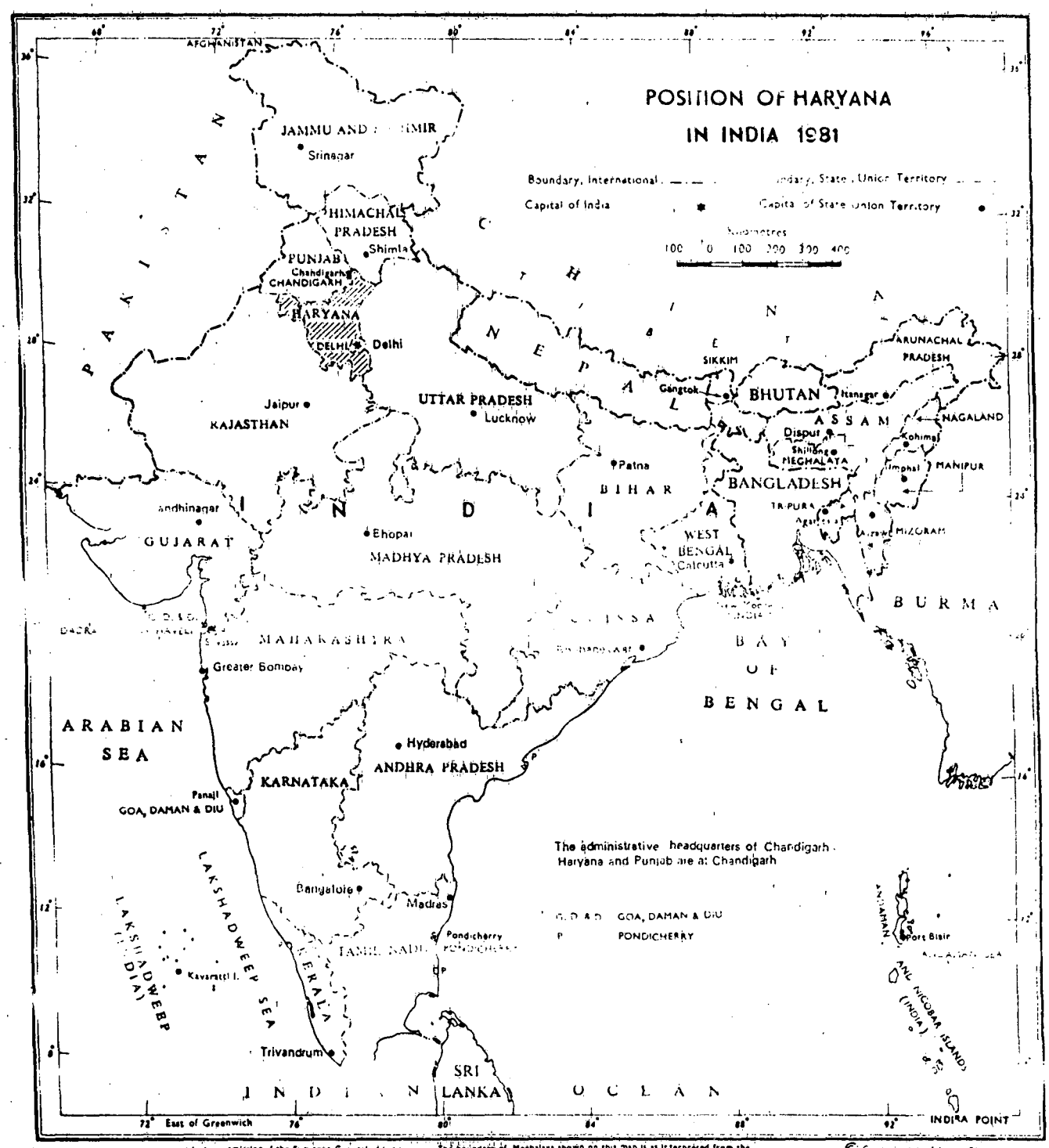
CHAPTER-II

DESIGN OF THE STUDY

Selection of the study area :

Based on the objectives the design for the study was made. Haryana state was selected for this purpose. Since its bifurcation from Punjab, this state developed in all respects, health infrastructure and services has gone up since its independent statehood. Overall, life process of people in rural areas has been improved by overall improvement such as supply of drinking water, roads and communications, educational institutions and Agricultural production. Like the other states in India, most of its population live in rural areas i.e. 75.21% with its rural based female population 75.33%. Very few of them are main workers i.e. 6.97% as compared to the country's rural average of 19.07%. While most of them who work are marginal workers i.e. 6.24% in the state nearest to, the country's average of 7.99%, while most of them considered as non-workers. Among the category of main workers 29.04% are agricultural labourer as compared to country's average of 47.94%, 57.17% as cultivator compared to 38.98%, 1.71% in household industry as compared to 3.76% and 12.08% in other works as compared to country's 9.32% average (Census of India 1991, Series-8, Haryana, Paper I of 1991 supplement, provisional population total). In comparison to other states, Haryana has average no. of women involved in occupations like agricultural labourer household industry

MAP 1



Based upon Survey of India map with the permission of the Surveyor General of India.

The territorial waters of India extend into the sea to a distance of twelve nautical miles measured from the appropriate base line

The boundary of Meghalaya shown on this map is as interpreted from the North-Eastern Areas (Reorganisation) Act, 1971, but has yet to be verified

MAP 2.

HARYANA

ADMINISTRATIVE DIVISIONS 1991

BOUNDARIES

STATE .....

DISTRICT .....

TAHSIL .....

STATE CAPITAL ★

DISTRICT HEADQUARTERS ⊙

TAHSIL HEADQUARTERS ○

POCKET OF PEHOWA TAHSIL P

POCKET OF BHIWANI TAHSIL B

HIMACHAL PRADESH

KALKA

CHANDIGARH

PANCHKULA

NARAINGARH

AMBALA

BARARA

CHHA-CHHRAULI

JAGADHRI

AMBALA

P

(KURUKSHETRA)

YAMUNA-NAGAR

GUHLA

PEHOWA

THANESAR

MANDI DABWALI (DABWALI)

KAITHAL

RATIA

TOHANA

NARWANA

KARNAL

RANIA

ELLENABAD

SIRSA

FATEHABAD

ASSANDH

SAFIDON

PANIPAT

NAR-NAUND

JIND

HISAR

HANSI

GOHANA

GANAUR

BAWANI KHERA

MAHAM

SONIPAT

SIWANI

TOSHAM

B

ROHTAK

BHIWANI

BAHADUR-GARH

DELHI

CHARKHI DADRI (DADRI)

JHAJJAR

LOHARU

GURGAON

FARIDABAD

KOSLI

MAHENDRAGARH

PATAUDI

BALLAB-GARH

REWARI

NUH

PALWAL

NARNAUL (MAHENDRAGARH)

BAWAL

HATHIN

FEROZEPUR JHIRKA

UTTAR PRADESH

UTTAR PRADESH

KILOMETRES

10 5 0 10 20 30 40 50

DISTRICT HEADQUARTERS ARE ALSO TAHSIL HEADQUARTERS

WHERE THE DISTRICT/TAHSIL NAME DIFFERS FROM ITS HEADQUARTERS' TOWN NAME, THE FORMER APPEARS WITHIN BRACKETS.

75° East of Greenwich

Based upon Survey of India map with the permission of the Surveyor General of India

and in other works. Thus, it will provide the opportunity to study the reproductive health of these women living in different socio-economic conditions involved in various occupations and thus impact of their living conditions on their reproductive health.

Description of the State :

It is a North-west state surrounded by other states like Himachal Pradesh in the north, Uttar Pradesh and Delhi in the east, Rajasthan in the south & southwest and Punjab & Chandigarh in the north-west (Map-I) Haryana has an area of 44212 square kilometers with population of 16317715 (MAP II). Area and population wise it forms 1.35% and 1.89% of the country and rank 15th in population size and 17th in the area among 25 states of the country. It has sex-ratio of 874 as compared to India's average of 929 female per thousand with female literacy rate 40.94% as compared to average of 39.42% for the country. State has predominantly rural agricultural economy. It has 16 districts (Census of India 1991, Series-8, Haryana, Part I of 1991, Provisional population totals).

Selection of District :

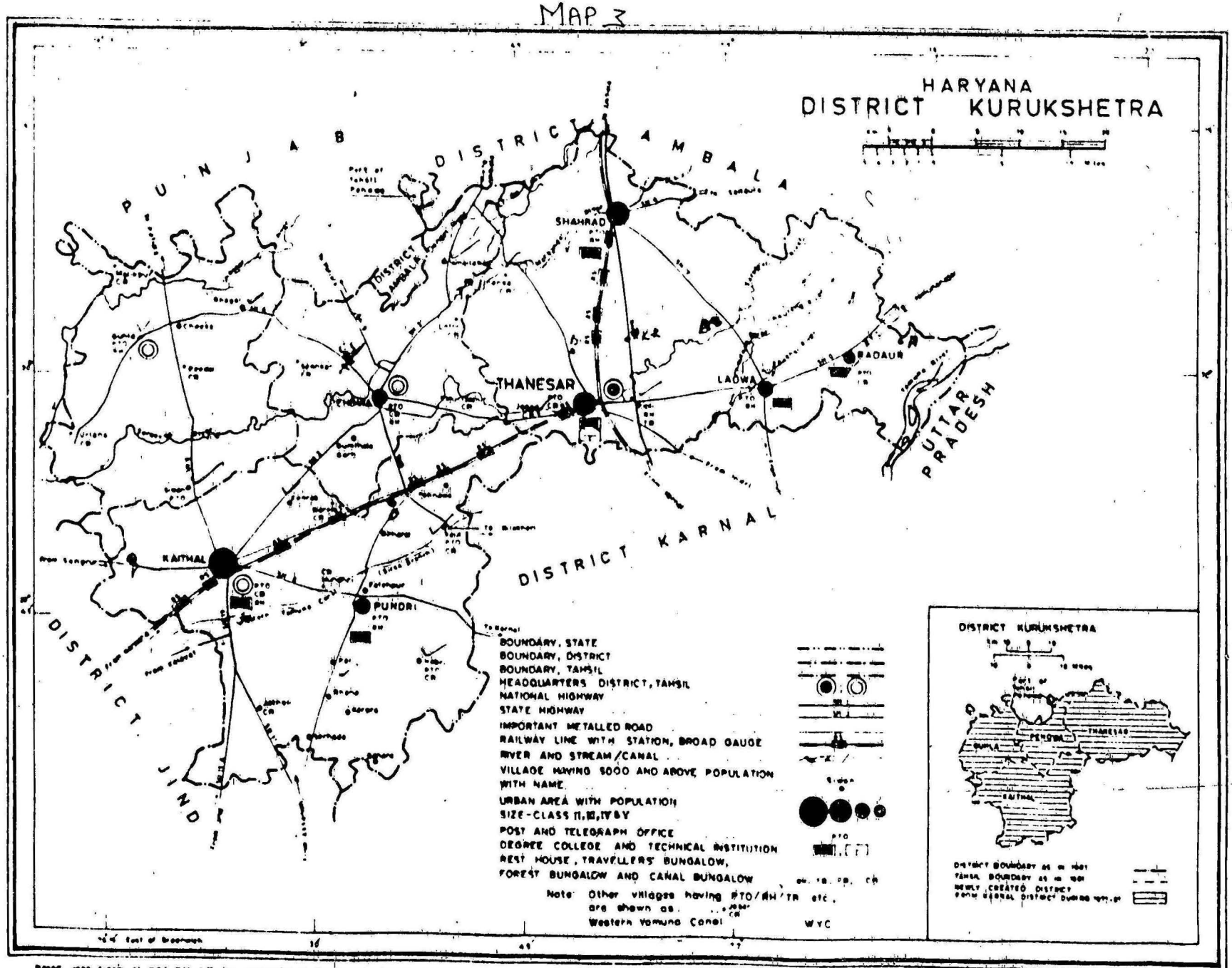
Out of 16 districts Kurukshetra has been selected for

the study. District has maximum no. of female agricultural labourers i.e. 56.08% which is more than state and country's average, and 2.55% marginal workers which is also high, while very few women are overall main workers i.e. 2.13% only. Thus, most of the women are non-workers and those who work are mainly as marginal workers and in this category most of them work as agricultural labourers and involved in other works as well as few in the household industry. Less of them work as cultivator i.e. 11.92% compared to state average of 57.17% and country's rural average of 38.98% (Census of India 1991, Series-8, Haryana, Paper-I of 1991 Supplement, Provisional population totals). This pointed towards the general conditions of rural women most of them live in their houses and do house related work and those who work outside are mostly poor involved in low paid jobs. Thus it will provide a range of analysis of women belonging to different backgrounds.

District Kurukshetra : A Glance

Kurukshetra has an area of 1217 km^2 and population of 635658 this comprised of 2.75% area and 3.90% of population of the state with high density of population i.e. 522 and sex-ratio of 889. It has 75.75% population living in rural areas (Census of India 1991, Series-8, Haryana, Part I of 1991, provisional population total) (Map III). District has

MAP 3



Based upon Survey of India map with the permission of the Surveyor General of India

a sub-tropical continental monsoon climate. It is plane, Saraswati, Markanda and Ghaggar are main rivers of the district. It receives rainfall from monsoon and a few showers from cyclones. Network of canal provide irrigational facilities and underground waterlevel is also high. Tubewell irrigation is common and it is one of the prosperous districts from agricultural point of view.

Economy of the district is primarily agricultural. District has an ideal locational benefits as national highway passes through it. It is a railway junction on mainlines connecting important towns of northern India and of great mythological importance (Census of India 1981, Series-6, Part XII, Census Atlas).

Geographical location :

District lies between 29°34'15" and 30°15'15" north latitude and 76°10'10" and 77°17'5" east longitude. On its north lies the district of Ambala and Patiala, in west lies Kaithal district and southwest lies Jind district, on its south and south east lies Karnal district. Yamuna river makes the eastern boundary of the district and their at the boundary is Saharanpur district of Uttar Pradesh (MAP III). District has four tehsil i.e. Thaneswar, Ladwa, Pehawa and Shahabad (Census handbook 1981, Series-6, Haryana,6 XIII

A&B, Village & townwise primary census abstract, Kurukshetra District).

Selection of Study Village :

One of the objectives of this study was to analyse the availability and accessibility of health services to the women and its impact on their reproductive health. Thus, a village either near to or with primary health centre was needed for this study. As on that basis, the availability and accessibility of health services to the women of this village would be studied. It was found that district has more on less similar geographical conditions and not much cultural variations thus selection of study village on the basis of primary health centre would be appropriate. Along with this condition, other infrastructural facilities would also needed. This village should represent the typical rural background and thus should not be on national highway or near to urban or suburban areas. Moreover the place should be approachable for the ease of researcher thus communicable by bus.

It was found that district Kurukshetra has 12 primary health centre located in rural areas. Out of these, two PHC villages were near to urban and suburban areas and one on the national high way. Thus these three were not

considered. Among the remaining 9 PHC village it was found that five PHC villages were not well connected with bus or other communication and far away from city. While one PHC village has very big population and near to urban areas. Among remaining three, two PHC villages having one caste only thus excluded from the study. Finally, the PHC village Dhurala was selected for the study purpose.

Description of the Block :

Thaneswar block has a total population of 445,380 (According to Census of India 1981, District Census handbook, Series-6, Haryana, Part XIII, A&B village and town directory) with 237,542 males & 207,838 females with rural population of 346,796 as compared to the urban 98,584. Block has total no.of 396 villages while inhabitated villages are 389 and 4 towns. It has an area of 127,129.37 hectares 89.19% land is cultivable. The no. of villages having amenities like education is 327 i.e. 84.06%, medical 136 (34.96%). Drinking water 389 (100%), Post & telegraph 94 (24.16%) and communication facility 130 i.e.33.42%, Approach to the village by pacca road is in 354 i.e.91% villages and power supply is 389 (100%). While 1 bed is available for per thousand population in medical institutions. Important commodity prepared in the block is rice bran oil and wheat

is exported while vegetable ghee is imported by the tehsil. Most of the villages in the block fall into the range of population 500 to 1,1999 and i.e.59.15% while 17.76% fall in the population range of 200-499. Thaneswar block has 4 PHCs. These are Khanpurkolian, Barna, Kirmich & Dhurala and it has one civil hospital, one dispensary, one T.B. hospital. Literarcy rate for Thaneswar is 59.38%. Staple crop are rice and wheat.

Description of Study Village :

Village Dhurala has total population of 3238 comprising of 454 households. This include various hamlets of population nearby the village. While village itself comprised of 237 households with population 1691 and area of 788 hectares. It is situated on the important metalled road from Thaneswar to Ambala district and 8 kms away from the Kurukshetra town. Communiation to the village is through state transport bus services and private vehicle. The village has same climate as that of district.

As underground waterland is high so tubewell irrigation is there. As economy of the village is agricultural the main crops are wheat and rice, along with this sugar cane, cotton, sunflower, various vegetables also grown to boost the economy. Outskirt of the village has a pond where fish-

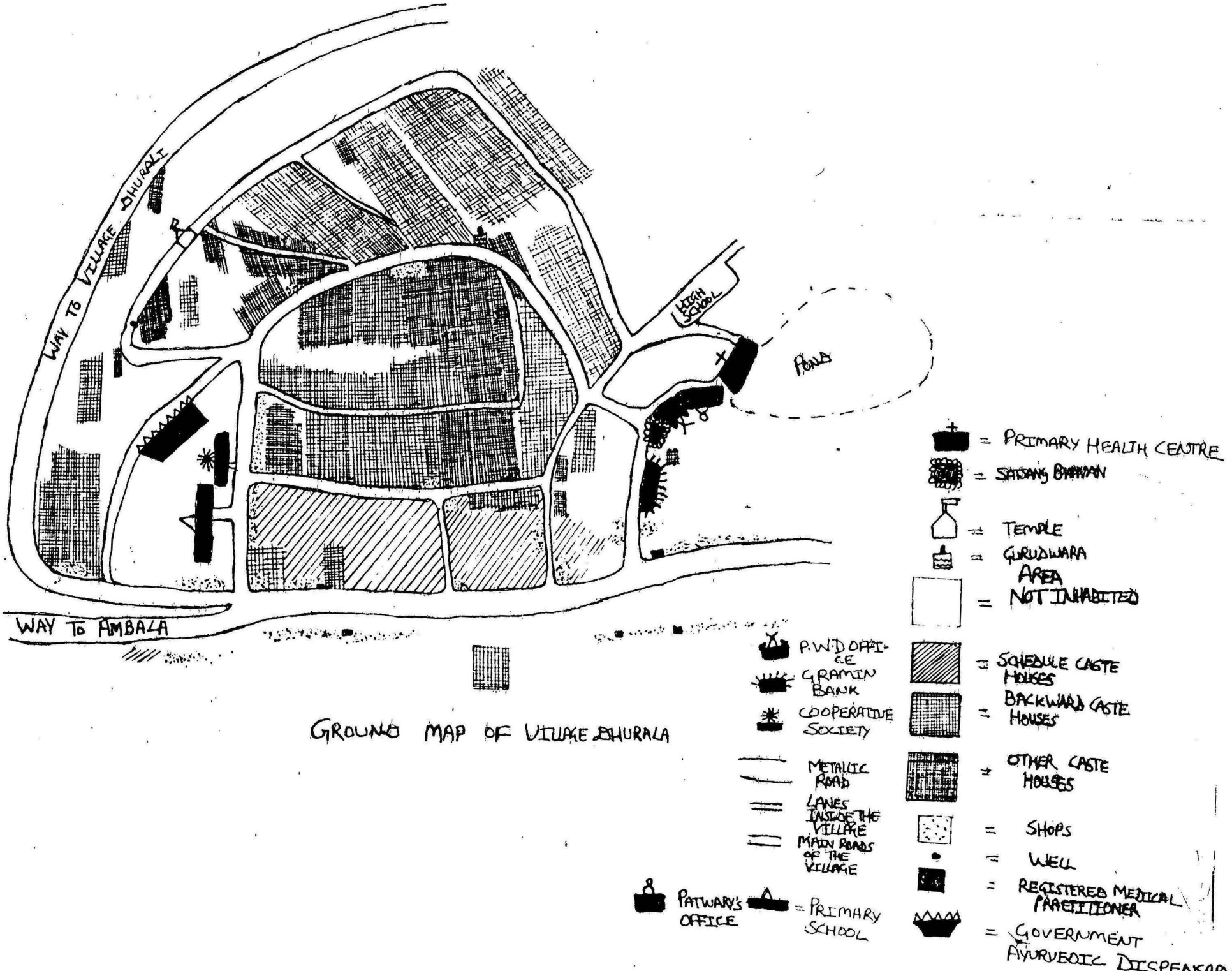
rearing is done and there is a furnace for brick making which also provide employment to the villagers. Beside these there is a market in the village along with the sides of metalled road crossing the village. Market has small and big business shops like grocery, sweet shop, tailor, barbar, cloth shops, medical private practitioner, chemist shop, electronic shop, cycle repairing, ironsmith, blacksmith, cobbler. Apart from this, people in this village are involved in government services, big business at Thaneswar city, milk seller, hawkers, making bore for tubewells, maison, linemen. Apart from this many involved in labour and work as daily wage earner either in the fields or at the construction sites. Socio-economic conditions can be categorised on the basis of land holdings also. According to Patwari's record the maximum land holding in the village is 40 acres by any household. Thus rich socio-economic status is of those who have land more than 10 acres, or petty businessmen or people having land not less than 10 acres and also involved in a job or doing and business along with this or having income of Rs. 5,000/- or above per month.

Not-so-rich socio-economic condition of the people those who have 5 to 10 acres of land or middle businessmen or have land not more, less than 5 acres and doing job or business along with the agriculture or doing service alone

and having income between Rs.2500 to 5000 per month. Poor socio-economic status consist of people having land less than 5 acres or small-businessmen or in service. Very poor are those who do not own land, nor have business or permanent jobs but they work as labourers on other's farm or at work sites. Daily wages for men is Rs. 35/- for a women Rs.25/- for a child is Rs.15/-

Houses in the village are behind the market. Few shops are there inside the village. Village has pucca, mixed and kuccha houses and it has pucca and kuccha lanes and roads. Drinking water is available to the villagers through 100 taps being installed by Panchayat in the lanes while few also have hand pumps and taps inside their homes. Electricity facility is there in the houses while those who cannot afford have taken connection from their neighbours. Village has institutional facilities like one co-educational high school, one private primary school, primary health centre or with one subcentre at the village level, Govt. Ayurvedic dispensary, post office, Patwari office, one cooperative society to give loans to the villagers on low interests and one Krishi bank for their benefits.

Village is rich in caste variation. As there are 121 households of backward caste, 43 of schedule caste/Harijan and others/high caste having 73 households. Different



GROUND MAP OF VILLAGE DHURALA

backward caste are Zhimmer 45 households, Lohar 2, Julahe 5, Barbar 5, Saini 26, Mistri 2, Ahir 3, Sikh 1, Gaderia 9, Gujjar 25. Among schedule castes there are Harijans 29 households and Balmiki 14 households and in the others caste there are Brahmin 9, Baniya 15, Rajput 3, Sunar 3, Kshatriya 33, JatSikh 10. Different castes grouped and live together in the village. Harijan households are on the outskirt of the village near to the metalled road (Map IV). While other caste live in the middle or center of the village surrounded by backward castes. Maximum no. of houses are of backward caste while sequence is like this Zhimmer > Kshatriya > Harijans > Saini > Gujjar > Baniya > Balmiki > Jatsikh > Brahmin > Gaderia > Nai > Julahe > Ahir > Rajput > Sunar. Classwise distribution of caste shows that very poor class of 38 households consist of 25 households of backward caste and schedule caste 12 households and one other caste household. Poor category has 116 households consist of 68 backward caste, 27 schedule caste and 21 others caste. In the not-so-rich socio-economic status category there are mainly 30 other caste. Backward caste and 4 schedule caste households. while in the 28 rich socio-economic category households there are mainly other caste i.e. 23 and 5 backward caste households. Village has pacca drainage facility only with the rich and not-so-rich class households. While poor has kaccha drains outside their

houses. While very poor do not have any such facility, open field defecation is there. Only rich have the facility of septic tank in their houses. There is one consumer store provide goods to the villagers at fixed prices. Apart from this village has one veterinary hospital, one agriculture inspector, village has one traditional/spiritual man, and one is another nearby village named Ingakheri from where people get treatment for fever, typhoid and chickenpox among children.

Village has Panchayat with Sirpanch as head being unanimously selected and belongs to Saini i.e. backward caste, with rich socio-economic status. While Panch having one female member belonging to lower caste and five panches from different castes. There is one telephone booth for the service of people and for Panchayat use. Gram Schiv supervises the work of sirpanch and belong to high caste and appointed by Government. While patwari takes care of village statistics and also deliver pensions to the old people. There are 3 Numberdar's and one chowikdar who takes care of death and birth in the village and its recording as well as keep watch on the village at night.

Selection of the Sample :

Baseline survey of the village was done by visiting

house to house and collected information on socio-economic and demographic conditions of people which included - Type of family i.e. nuclear or joint, religion, caste, family composition along with the age, sex, education, occupation and income of each member, total family income, acquisition of land, cattles and other items in the house; type of house i.e. kaccha/pacca or mixed, no. of rooms excluding kitchen, electricity facility, water and toilet, bathing facilities. After this survey, the population was categorised into different socio-economic groups as per the objectives of the study and also the total no. of female population under the category of different age groups i.e. (15 to 25), 26-35 and 36-45 yrs. belonging to different socio-economic status. It was found that 312 women were there in village of age group 15 to 45 years. 48 women from very poor category households, 147 from poor socio-economic status, 75 from not-so-rich socio-economic category and 42 from rich socio-economic category were there. Among 312 women 21 were nursing mothers, 6 pregnant, 8 newly married women 22 adolescent girls and 83 mothers of one or more children. Sample was selected based on the objectives of analysing the impact of various factors including socio-economic conditions on their reproductive health as well as taking care of time limitation for the study. So out of 237 households 140 households were randomly selected. Covering

the women belonging to different socio-economic status groups and also different age groups as per the objectives of the study.

Table No.1

No. of Households and Women belonging to different Socio-Economic Status Categories as selected in the sample

SES	No. of House-hold in vill.	No. of House-hold selected	No. of Women in age group 15-45 yrs	No. of Women selected of age gp 15-45	Nursing mothers	Pregnant women	Newly married women	Adole-scent girls	Mother of 1 or more child.
Very Poor	38	23 60.5	48	23 47.9	6	1	2	2	12
Poor	116	67 57.7	147	67 45.5	10	3	3	13	38
Not-so-rich	55	31 56.3	75	31 41.3	4	1	1	3	22
Rich	28	19 67.8	42	19 45.2	1	1	2	4	11
Total	237	140 59.0	312	140 44.8	21	6	8	22	83

In table no. 1 Out of 48 very poor women of age group 15 to 45 years belonging to 38 households of very poor category, 23 women from 23 households were selected. Out of 116 poor socio-economic status households comprised of 147 women, 67 were selected from 67 households out of 55 not-so-rich income category households comprise of 75 women, 31 were taken from the same no. of households and among rich socio-economic status group 28 households having 42 women. 19 were selected from the same no. of households. All nursing, pregnant and

newly married were included in the sample as focus will also be on them. Proportional no. of caste group also represented through this sample.

Table No.2

Women of different age groups belonging to different Caste categories selected in the sample from various Socio-Economic Category in the sample

SES	No. of SC Women in age gp 15-45 yrs	No. of SC women selected in age gp 15-45	No. of BC Women in age 15-45 yrs	No. of BC women selected in age gp 15-45	No. of other caste women in age 15-45	No.of other caste women selected age 15-45 yrs.
Very Poor	12	7 58.3	25	15 60	1	1 100
Poor	27	17 62.9	68	42 61.7	21	8 38.09
Not-so-rich	4	3 75	21	14 66.6	30	14 46.6
Rich	0	0 0	5	4 80	23	15 65.2
Total	43	27 62.7	119	75 63.02	75	38 50.6

In table no.2, out of 43 schedule caste women household 27 were taken, out of 119 backward caste 75 were included, among 75 other caste category 38 were taken. Different age groups belonging to different socio-economic status were also covered.

Table No.3

Number of Women from various Socio-Economic categories belonging to different age groups as selected in the sample

SES	No. of Women in age group 15-25 yrs	No. of Women selected in age gp 15-25	No. of Women in age group 26-35 yrs	No. of Women selected in age gp 26-35	No. of Women in age group 36-45	No. of women selected in age 36-45 yrs.
Very Poor	20	5 25	24	15 62.5	4	3 75
Poor	80	39 48.7	37	14 37.8	30	14 46.6
Not-so-rich	31	12 38.7	28	13 46.4	16	6 37.5
Rich	17	7 41.1	13	6 46.1	11	6 54.5
Total	148	65 43.9	102	48 47.05	61	29 47.5

In table no.3. as among very poor class out of 20 women of 15 to 25 years,24 in 26 to 35 years and 4 in 36 to 45 yrs. group the no. of women selected were 5,15 and 3 respectively for different age groups. Among poor socio-economic category 80 women of age group 15 to 25 yrs, 37 from 26 to 35, and 30 women of 36-45 yrs. 39, 14 and 14 respectively were selected. Among not-so-rich income group out of 31 women of age group 15 to 25, 28 from 26 to 35 yrs and 16 from 36 to 45 yrs, 12,13 and 6 were selected respectively from different age groups. Among rich socio-economic category 17 women of age group 15 to 25 yrs, 13 from 26 to 35 yrs and 11 from 36-

45 years thus 7, 6, 6 were selected respectively from different age groups. In table no. 1, among rich socio-economic status there were 1 nursing, 1 pregnant, 2 newly married, 4 adolescent and 11 mothers of 2 or 3 children were there. Among not-so-rich each category there were 4 nursing, 1 pregnant, 1 newly married, 3 adolescent and 22 mothers of 1 or more children. Among poor socio-economic status category 10 nursing, 3 pregnant, 3 newly married, 13 adolescent and 38 mothers of 1 or more children were included. Among very poor category there were 6 nursing, 1 pregnant, 2 newly married, 2 adolescent and 12 mothers of two or three children were there.

Data Collected :

As data on demographic and socio-economic conditions of sample was already collected during base-live survey. Again for the cross-checking of this information questions were asked on these aspects during actual study. Information on various aspects related to their reproductive health was collected from different age group women i.e. 15-25, 26-35, 36 to 45 yrs. There were various illnesses as women faced e.g. minor illnesses, major illnesses, chronic illnesses, illnesses related to child, birth, accidents and the services sought for these different health problems from different health institutions. e.g. services sought for minor, major,

reproductive health problems, accidents, awareness of these women about their reproductive role, complications or difficulties women faced/experienced during menstruation, pregnancy, child birth and child rearing, steps taken by them for preventing these difficulties, cultural beliefs and practices prevalent among them related to periods, pregnancy, child-birth and child rearing, health institutions which provide them services for these problems, their satisfaction regarding these services, care and help of the family members these women get during illness, agencies and personal who confirm and predict, pregnancy, Action taken by them, after confirmation of pregnancy, difficulties faced during pregnancy, and if faced then action taken in this regard. Place of conducting deliveries and by whom deliveries are being conducted; Breast-feeding practices, difficulties experienced during child-birth, weaning practices, care of the new born and infants in case mother is working, illnesses of the children, child deaths in the family, daily routine of these women and their living conditions and their needs and problems according to them, feeling of tiredness, status of women in their families, consideration of their opinion in their families, their view regarding difference between literate/educated and illiterate.

Women's perception of their environment, family environment, family support, work, health services available to

them and on their own health. All there aspects or information also need to be collected from health functionaries how they perceive women's health and what they do in this regard. panchayat member and their opinion on women's condition in village and services available to them and their participation in decision making process and their role in village. Records of Primary Health Centre, and Government Ayurvedic Dispensary to be seen to know the trend and amount of illnesses and benefitted people. Family Planning services accepted to them, satisfaction with these services, immunization of children and from where they get them immunized, Gynaecological problems they have and steps taken to cure that, their views regarding government health services, and regarding their ability to avail these services and suggestions from them to improve health services and for better health, status of women in the society at large and no. of children they want i.e. sons and daughters no. of male and female infant deaths in the family.

Methods adopted for Data Collection :

Various techniques e.g. observation, informal discussion, group discussion, house to house survey were used for daa collection. Tools-An interview schedule was prepared in Hindi after exploring the various issues during baseline

survey, to quantify all the needed information. Field diary was maintained in order to note the views and other information, discussion that had taken place between researcher and sample women on various aspects related to their lives and observation were noted donw. Interview schedule was filled just after the discussion with respondents. It was an extensive schedule which took 20 to 25 minutes per women. Apart from the sample women researcher discussed the women's reproductive health problems and other needs and problems and related aspects with health staff of primary health centre and sub-centre, Ayurvedic dispensary and taken their informal interview on these aspects. Information on village was cross-checked with Patwari's records. While information on the various programmes run in the village was collected from cooperative society and Bank manager and discussion with other health functionaries like registered medical practitioners, traditional healer and their treatment, regarding these problems of women. Elder women were also involved in the discussion about the changes which has taken place in the women's health and village since their time. Case studies were done in order to know about the women's life processes and difficulties they faced and their way of dealing with these problems. Thus case studies of pregnant, nursing, young and women of one or more children was done for that purpose. In this way case studies

enlightened the kind of problems faced by these women at different stage of reproductive life.

Rapport Building :

At the time of base-line survey researcher tried to establish rapport with study population. As reached at the village first time through state bus service researcher approached to the house situated along with the road and gave her introduction to the women in the house who was about 30 years old and told her about the purpose of her visit to village. She welcome her and asked the researcher to sit. Through informal talks regarding her children and their health the researcher tried to collect socio-economic and demographic information regarding the household through the informal discussion. In this way researcher approached to many nearby houses and gave her introduction and purpose of visit some of them first considered her as Census worker while discussing on health issues, they thought of her as primary health centre staff. But later they started recognising researcher as a student on work as some students have previous visited the village for their field work purpose. In this way through informal discussion with women researcher tried to establish rapport with them and discussed with them their routine, reproductive health problems, condition of women in village their difficulties and needs

gradually. Researcher also told them about her own background. Communication was not difficult as researcher knew the language.

Researcher also approached Sirpanch in order to know about the village and also through him to approach the villages. Since Mahila Mandal at the village level was not functioning thus through it, reaching the population was not possible. Researcher also contact primary health centre staff, govt. Ayurvedic dispensary staff and establish rapport with them and get information regarding various facilities available at PHC and Govt. Ayurvedic dispensary and its functioning and also observe the type of services it rendered to the beneficiaries and also contact Patwari to know and collect information on village, its population, ammenities and other welfare progarmmes. In this way, establishing rapport with study population through informal and formal discussions. During base line survey researcher had informed these women about the detailed discussion which was to be administered in the form of interview schedule on reproductive health aspect of these women. So women would prepare and able to give their precious times for the interview. Moreover, researcher choose the time around the lunch time or the evenings to talk with them and for interview so they might devote time easily. While some of

women asked the researcher why she enquired on the reproductive health as it is not generally the matter to talk about, then researcher explained the purpose to them which might convinced them to the extent.

Time Period Devoted :

It was decided to devote 25 days for base-line survey in the month of Sept. i.e. from 15 to October 10th. After coming back, interview schedule was finalised and then sample selection was done then time denoted for actual study was from 25th November to 11th January i.e. 1-1/2 months. Prior going to the field, literature was reviewed and collected on the work already done in this field and on its related aspects. After coming back data was arranged for analysis.

Data Analysis :

Classification of quantitative data was done according to different variables in the study and the responses were given code and coded in the code sheets and then fed into the computer for further analysis.

Frequencies for various variables in the form of tables along with their percentages were get and analysed. Cross-tabulation between important variables was analysed in order to know the trend regarding variables in relation to each

other.

Qualitative data was also handled carefully and scrutinized and rewritten the facts and analysed them. Case studies were also written from the field diary. All the observations, discussions informal interviews were seen properly and given shape in the form of analysis. Difficulties during study - very poor women could not be contacted easily due to work, thus difficulties faced in their follow up by researcher. Two houses of Gujjar women refused to respond due to denial of the male members for their response. Due to non-numbering of village houses, after the sample selection researcher has to find the household but not much difficulties faced due to caste group living of the villagers. Overall not much difficulties faced by researchers. As rapport was good with villagers except few women raised the question about inquiry of reproductive health which accroding to them was not appropriate.

Limitation of the Study :

The study was only done on the single village due to time constraints since it was for M.Phil. dissertation work. So one village may not be representative of the conditions of all the women in rural areas.

CHAPTER-III

DATA PRESENTATION
(Part I)

Village Dhurala

Village Dhurala had 237 total households. These households divided into various caste groups and divided into four Socio-economic categories i.e. Rich, not-so-rich, poor and very poor. After the survey it was found there were 312 women in this village of the age group 15 and 45 years. Out of this 312, 48 were from very poor category households, 147 from poor category, 75 from not-so-rich category and 42 from rich tegory.

140 women were selected for the detailed study of reproductive health in this village. These women were from 140 households. Table 1.

In the sample of 140 women. 21 (i.e. 15%) nursing mothers, 6 (i.e. 3.6%) pregnant, 8 (i.e. 5%) newly married, 22 (i.e. 15.7%) adolsecent girls, and 83 (i.e. 60.7%) mother of one or more children were there. Among the rich category, 1 each nursing and pregnant women and 2 newly married, 4 young girls and 11 mother of two or three children were there. Among not-so-rich, 4 nursing mothers, 1 each in pregnant and Newly married, 3 adolescent girls, and 22 mothers of one to three children were there. Among poor 10 nursing mothers. 3 each in pregnant and newly married 3 each, 13 adolescent girls and 38 mothers of one to three children were there. Among very poor 6 nursing, 1 newly married, 2 adolescent

girls, 12 mother of two to three children were there. (Table No.1) In the age group of 15-25 yr. 17.5% were nursing, 6.3% pregnant, 11.1% newly married, 34.9% adolescent girls and 30.2% mothers. 26 to 35 yr. age group 20.8% nursing, 2.1% pregnant. 77.1% mothers of one to three children. In the age group of 36 to 45 yr. all were mothers of one to three children, 21.1% nursing, 3.5% pregnant, 7% newly married, 22.8% adolescent girls and 45.6% mothers were educated while among the uneducated 10.8% nursing, 3.6% pregnant, 3.6% newly married, 10.8% adolescent girls and 71.1% mothers of one to three children. Thus more mothers were illiterate then other category.

Type of Housing

Table No.4

Type of Housing Across Caste

Caste	Pacca	Kacha	Mixed
Scheduled Caste	26 96.3	-	1 3.7
Backward Class	70 93.3	3 4.0	2 2.7
Others	38 100.0	-	-
Total	134 95.7	3 2.1	3 2.1

Table No.5

Type of Housing Across Socio-Economics Categories

Categories	Pacca	Kaccha	Mixed
Rich	19 100.0	-	-
Not so rich	31 100.0	-	-
Poor	65 97.0	-	2 3.0
Very poor	19 82.6	3 13.0	1 4.3
Total	134 95.7	3 2.1	3 2.1

Out of 140 households, 134 (95.7%) houses were Pucca and 3 (2.1%) were kaccha and 3 (2.1%) households were mixed table no.4. So maximum houses were Pucca, among 140 houses of the sample. In table no.4, out of 27 scheduled caste households 96.3% i.e. 26 households were having Pucca houses while only one was having mixed kind of house. Among 75 backward caste households, 93.3% i.e. 70 were having pucca while 3(4%) having kuccha , 2(2.7%) were having mixed kind of housing. While in the category of others all the 38 houses were Pucca. As shown in table no. 5, all the rich as well as not-so-rich houses were pucca, while among poor 97% were pucca middle i.e. 31, while poor pu are Pucca while 3% were mixed houses. Among very poor category 82.6% had Pucca, 13% Kaccha and 4.3% had mixed kind of houses.

No. of Rooms in the House excluding Kitchen

Out of 140 households, 35(25%) houses were having 1 room 61 (43.6%) houses with 2 rooms 22 (15.7%) houses with 3 rooms 13 (9.3%) with 4 rooms constitute while 5 or more than 5 rooms were there in 9 (6.4%) houses. So maximum no. of houses were having 2 rooms. Among rich 36.8% households had 4 rooms, 31.8% had 3 rooms, 10.5% had 2 and 5 rooms each, 5.3% each had 6 and 8 rooms in their houses. Among not-so-rich 45.2% had 2 rooms, 16.1% each had 3 and 1 room, 12.9% had 4 rooms, 6.5 had 7 rooms, and 3.2% had five rooms. Among poor 50.7% had two rooms, 28.4% had 1 room, 14.9% had 3 and 3% each had 4 and 5 rooms in the house. Among very poor category 47.8% each had 1 and 2 rooms while 4.3% had 1 room. Thus among rich maximum households had 3 or 4 rooms while not-so-rich had 2 rooms.

Household Gadgets

Table No.6
Household Gadgets as reported by Women beloging to different SES Categories

Category	No gadgets	T.V.	Refrigerator	Cooler	Tape Recorder	V.C.R.	Motor Cycle
Rich	-	2 10.5	6 31.6	3 15.8	-	3 15.8	5 26.3
Not-so-rich	7 22.6	14 45.2	3 9.7	3 9.7	-	1 3.2	3 9.7
Poor	35 52.2	26 38.8	-	1 1.5	2 3.0	-	3 4.5
Very Poor	20 87.0	3 13.0	-	-	-	-	
Total	62 44.3	45 32.1	9 6.4	7 5.0	2 1.4	4 2.9	11 7.9

In table no.6, Out of 140 households, 62 (44.3%) were not having any household gadgets like T.V., Refrigerator etc. while 45 (32.1%) households were having T.V., 9 (6.4%) households havd refrigerators, 7 (5%) households had access to cooler 2 (1.4%) households had Taperecorders and 4 (2.9%) havd V.C.R., while 11 (7.9%) own motor vehicle. So 78 (55.7%) households own one or another gadgets in their houses. Among Schedule Caste households, 66.7% had no luxury households item, 29.6% had Television on, 3.7% had cooler. Among backward caste 60% had no household item, 30.7% had T.V., 2.7% had Refrigerator, cooler and taperecorder each, 1.3% had V.C.R. Among high caste 36.8% had T.V., 26.3% had no items 18.4% had refrigerator, 10.5 had cooler, 7.9% had V.C.R. In table no.6, among rich 31.6% houses had refrigerator, 15.8% each had V.C.R., and cooler and 26.3% own motor vehcle, 10.5 own only T.V.while among not-so-rich 45.2% own only T.V., 22.6% had nothing 9.7% each had refrigferator, cooler and motor cycle. Among poor 52.2% had no gadgets, 38.8% own T.V., 3% taperecorder, 4.5% motor cycle and 1.5% cooler. Among very poor 87% had no gadget, 13% had T.V. Thus more rich had luxurious items.

Type of Water Facility

Table No.8

Type of Water facility reported by Women of different Caste

Caste	Panchayati Tap	Own Tap	Handpump	Tubewell	Panchyati tap and tubewell
SC	24 88.9	-	1 3.7	1 3.7	1 3.7
BC	73 97.3	1 1.3	-	1 1.3	-
Others	30 78.9	5 13.2	2 5.3	-	1 2.6
Total	127 90.7	6 4.3	3 2.1	2 1.4	2 1.4

Table No.9

Type of Water facility availed by Women of different Socio-Economic Status Category

Category	Panchayati Tap	Own Tap	Handpump	Tubewell	Panchyati tap and tubewell
Rich	13 68.4	4 21.1	2 10.5	-	-
Not-so-rich	27 87.1	1 3.2	1 3.2	1 3.2	1 3.2
Poor	65 97.0	1 1.5	-	1 1.5	-
Very poor	22 95.7	-	-	-	1 4.3
Total	127 90.7	6 4.3	3 2.1	2 1.4	2 1.4

Among 140 households 127 (90.7%) utilize water being provided by the taps installed by Panchayat in their lanes, only 6 (4.3%) households had taps being installed inside their homes, while 3 (2.1%) also availed handpump water along with Panchayati tap; 2 (1.4%) availed tubewell only and 2 (1.4%) availed tap and tubewell waer. So maximum no. of household took water from the taps in their lanes which had fixed timings for the water to come. While few avail handpump or tubewell water while some also had taps inside their homes. In table no.8, among SC 88.9% took water from Panchayati tap while 3.7% each took water from handpump, tubewell, handpump and panchayati tap. Among backward caste 97.3% used Panchayati tap water outside their houses. Only 1.3% had own tap while 1.3% used tubewell water. Among other caste 78.9% used water from panchayati taps, 13.2% had their taps inside their homes, 5.3% had handpumps, 2.6% used handpumps as well as Panchayati tap. Refer to table no. 9 among rich 68.4% got water from Panchayati tap, 21.1% had own taps, 10.5% had handpump and also got water from Panchayati tap. Among not-so-rich 87.1% used Panchayati tap water, 3.2% each used own tap, handpump, tubewell and tap and tubewell water. Among poor 97% used taps installed by Panchayat and 1.5% each from own tap and tubewell, while among very poor, 95.7% used Panchayati tap water and 4.3% used tubewell tap water. Thus rich had own source of water i.e. taps inside

their houses along with Panchayati tap in their lanes. While poor were solely depend upon Panchayati tap or tubewell water.

Type of Family

Table No.10

Type of Family Across Socio-Economic Status (SES) Category

SES Category	Nuclear	Joint
Rich	8	11
	42.1	57.9
Not so rich	21	10
	67.7	32.3
Poor	48	19
	71.6	28.4
Very poor	22	1
	95.7	4.3
	99	41
	70.7	29.3

In table no.10, out of the sample of 140 households 99 (70.7%) women from nuclear families, while 41 (29.3%) were from joint families. Among rich category 42.1% were from nuclear families and 57.9% from joint. Among not-so-rich 67.7% women were from nuclear, while 32.3% were from joint families. While among poor 71.6% were from nuclear families and 28.4% were from joint families and among very poor 95.7% were having nuclear families only 4.3% were from joint families. This shows that among rich more percentage of joint families in comparison to very poor. They had more

percentage of nuclear families.

Size of the Family

Since among the rich maximum no. of joint families were there the no. of family members were high among the rich group i.e. 8 to 9 where as among the poor and very poor maximum no. of nuclear families were there so maximum percentage of households were having 6 to 7 members.

Table No.11

Total no. of Family Members as reported by Women belonging to different Socio-Economic Status Category

Category	2.0	3.0	4.0	5.0	6.0	7.0	8.0	9.0	10.0	11.0+
Rich	–	1		2	3	3	4	4	1	1
		5.3		10.5	15.8	15.8	21.1	21.1	5.3	5.3
Not so rich	–	1	7	6	6	3	1	2	2	3
		3.2	22.6	19.4	19.4	9.7	3.2	6.5	6.5	9.7
Poor	–	3	8	12	14	13	10		3	4
		4.5	11.9	17.9	20.9	19.4	14.9	–	4.5	6.0
Very poor	1	1	3	5	9	1	2	1	–	–
	4.3	4.3	13.0	21.7	39.1	4.3	8.7	4.3	–	–
Total	1	6	18	25	32	20	17	7	6	8
	.7	4.3	12.9	17.9	22.9	14.3	12.1	5.0	4.3	5.7

Number of Children in the Family

Total No.12

No. of Children in the Household according to the women from different caste

Caste	No child	1.0	2.0	3.0	4.0	5.0	6.0	7.0	8.0	10.0	12.0
SC	3	2	3	4	7	4	3	–	–	–	–
	11.5	7.7	11.5	15.4	26.9	15.4	11.5				
BC	8	9	14	15	16	2	6	2	1	1	1
	10.7	12.0	18.7	20.0	21.3	2.7	8.0	2.7	1.3	1.3	1.3
Others	3	7	7	8	4	5	2	2			
	7.9	18.4	18.4	21.1	10.5	13.2	5.3	5.3	–	–	–
Total	14	18	24	27	27	11	11	4	1	1	1
	10.1	12.9	17.3	19.4	19.4	7.9	7.9	2.9	0.7	0.7	0.7

In table no. 12, among the Schedule caste households 26.9% were having average no. of 4 children, while 15.4% had average of 3 to 5 each children and 11.5% had no child, rest 11.5% had two and other 11.5% had 6 children, while only 7.7% had 1 child only. Among backward caste households 21.3% had 4 children, 20% had 3, 18.7% had 2, 12% had 1, 10.7% had no child, 8%, had six children, 2.7% had 5 and 7 children each. 1.3% had 8 to 10 children. Among other caste maximum no. of households i.e. 21.1% had 3 children, 18.4% had 1 and 2 children each, 13.2% had 5 children, 7.9% had no child, 5.3% had 6 to 7 children each and 10.5% had 4 children.

Caste Distribution

Table No. 13

Distribution of Different Caste Women within different Socio-Economic Categories

Categories	SC	BC	Others
Rich	-	4	15
		21.1	78.9
Not so rich	3	14	14
	9.7	45.2	45.2
Poor	17	42	8
	25.4	62.7	11.9
Very poor	7	15	1
	30.4	65.2	4.3
Total	27	75	38
	19.3	53.6	27.1

In the table no. 13, the caste composition among 140 sample households was found in the following way - Maximum

no. of of backward caste which constitute 53.6% of the sample, other caste constitute 27.1%, while the schedule caste constitute 19.3% of the total sample women. Among rich 78.9% were from other caste, 21.1% were backward caste and no women from SC, while among not-so-rich category 45.2% women each from backward and other caste, while 9.7% women were from schedule caste category. Among poor 62.7% were backward caste, 25.4% schedule caste and 11.9% were from other caste category. Among very poor categories maximum no. of SC and BC women were there i.e. 30.4% and 65.2%, and only 4.3% other caste next to it among the poor i.e 25.4% and 62.7% and among not-so-rich only 9.7% and 45.2% schedule caste and Backward Caste women were there and no schedule caste women were there among rich and only 21.1% of BC among rich.

Religion

Table No.14

Distribution of Sample Women religionwise among varoius Socio-Economic Category

Category	Hindu	Sikh
Rich	15	4
	78.9	21.1
Not-so-rich	30	1
	96.8	3.2
Poor	66	1
	98.5	1.5
Very poor	23	-
	100.0	
Total	134	6
	95.7	4.3

In table no.14, out of 140 households, 134 which constitute 95.7% of the total sample were Hindu, while only 6 households constitute 4.3% of the sample were Sikh. So the maximum no. of population was of Hindus. Among rich 78.9% were Hindu, while 4 (21.1%) were sikh. Among not-so-rich 30 (96.8%) were Hindu, while 1 (3.2%) were Sikh, among poor 66 (98.5%) were Hindu and 1 (1.5%) were Sikh, and among very poor all were Hindu.

Education

Table No.15

Education among Women at Different Reproductive stages in the sample

	Literate	Illiterate
Nursing	12 57.1	9 42.9
Pregnant	2 40.0	3 60.0
Newly married	4 57.1	3 42.9
Adolescent	13 59.1	9 40.9
Mother of 2 or 3 children	26 30.6	59 69.4
	57 40.7	83 59.3

Table No.16

Education of Women Belonging to Different Socio-Economic Status Category

Category	Literate	Illiterate
Rich	13 68.4	6 31.6
Not so rich	19 61.3	12 38.7
Poor	23 34.3	44 65.7
Very poor	2 8.7	21 91.3
Total	57 40.7	83 59.3

Among 140 women sample 57 (40.7%) were educated while 83 (59.3%) were uneducated. In table no. 15, among nursing mother 12 (57.1%) were educated and 9 (42.95) were illitrate. Among Pregnant 2 (40%) educated and 3 (60%) uneducated. Among newly married 4 (57.1%) educated and 3 (42.9%) uneducated. Among adolescent girls 13 (59.1%) educated, 9 (40.9%) uneducated, mother of 1 to 3 children 26 (30.6%) educated, 59 (69.4%) uneducated. So maximum illiterate were mothers of one to three children. In the age group 15-25 yrs 57.1% educated while among 26 to 35 yrs 27.1% educated, 36-45 yrs 25% educated women were there. Thus younger age group was more educated. In table no. 16, among rich category 13

(68.4%) women were educated while 6 (31.6%) women were illiterate, among not so rich 19 (61.3%) were educated and 12 (38.7%) were illiterate. Among poor 23 (34.3%) were educated, while 44 (65.7%) were illiterate, while among very poor only 2 (8.7%) women were educated while all other 21 (91.3%) were illiterate. Thus with lowering of Socio-economic status literacy also decreases.

Occupation

Table No. 17

Different Occupation of Women Across Different Socio-Economic Status Categories

Category	Student	Household Job	Service	Wage Labour/work in their own farm
Rich	2 10.5	16 84.2	1 5.3	-
Not so rich	-	30 96.8	-	1 3.2
Poor	3 4.5	45 67.2	-	19 28.4
Very poor	-	6 26.1	-	17 73.9
Total	5 2.5	97 69.3	1 .7	37 26.4

Table No. 18

Women at different Reproductive Stages involved in different occupations

Category	Student	House Job	Service	Wage labour
Nursing	–	13 61.9	–	8 38.1
Pregnant	–	5 100.0	–	–
Newly married	–	6 85.7	1 14.3	–
Young	4 16.1	12 54.5	–	6 27.3
Mother of one or more children	1 1.2	61 71.8	–	23 27.1
Total	5 3.5	97 69.3	1 .7	37 26.4

In table no.17, only 5 were students 97 were doing household jobs, one was doing service, 37 work as wage labourers, thus 5 (3.5%) were student, 69.3% doing household job only, 0.7% in service, 26.4% were wage labourer along with doing household job. Among rich 2 (10.5%) were students, 16 (84.2%) doing household work, 1 (5.3%) doing service. Among not-so-rich 30 (96.8%) were doing housejob, 1 (3.2%) was working in their own field. So most of them stay at home. Among poor 3 (4.5%), were students, 45 (67.2%) were doing household job and 19 (28.4%) were wage labourer, Among

very poor 6 (26.1%) were doing housejob and 17 (73.9%) were wage labourers. Thus maximum no. of wage earners were there in poor and very poor household while in the rich and not-so-rich most of the women were doing household jobs. In table no.18 among nursing mothers 61.9% were doing household job, 38.1% were wage-labourers, among pregnant mothers all were doing housejob. The women who were doing household jobs did not mention that by doing various household jobs, they were contributing to the family income.

Income and Socio-Economic Status

Table No.19

Socio-Economic Status of Women in the Sample

Category	Frequency	Valid Percent
Rich	19	13.6
Not-so-rich	31	22.1
Poor	67	47.9
Very poor	23	16.4
Total	140	100.0

In table no.19, 19 (13.6%) women were from rich income group, 31 (22.1%) were from not-so-rich group, 67 (47.9%) weree belong to poor category. While 23 (16.4%) women were from very poor category. Thus maximum no. of women were in poor category.

As far their monthly income, among 140 women, 102 had no income as they were not employed or working outside the house, While 5 among wage earners had income of Rs. 100/- per month, 19 had Rs. 200/- per month, 11 had Rs. 300/- per month, two earn Rs. 400/- per month and only one who was a lecturer had a salary 3000/- per month.

Socio-cultural life process of the people is the outcome of their socio-economic conditions. As on the basis of income and land holding the households divided into the socio-economic categories of rich, not so rich, poor and very poor. The life process of the women belonging to these categories also varies greatly.

Women belonging to the rich category generally had land and cattle. Due to high productivity and its return they could afford a luxurious life style very much similar to that of the cities. As they own all the modern household gadgets e.g. T.V., refrigerator, cooler, V.C.R., Washing machine, Tape recorder etc. They used LPG gas for cooking purpose. They also had toilet, bathroom and own water facilities inside their homes. These women remain inside their homes and do household jobs only and also get help from other women belonging to poor category in their household work such as desposing off garbage. So they are involved mainly in the cooking, cleaning, washing and taking

care of the household members and lead an easy life.

"Harvinder Kaur, a women of 45 yrs belongs to the rich socio-economic category. She has to wake up early in the morning. As one of the servants milk their buffalows, So she has to boil the milk and also ferment it to make curd out of it. After doing her daily tasks like bathing etc.she cooks food for the family. In that her daughter also helps her who is doing a professional course i.e. Ayurvedic medicine in the city. They cook for the family members but during harvest season they cook separately for the farm workers also and one of the worker took the food to the fields. In that case they have to cook for longer period. The rich household own pucca houses so she found not much difficulties in sweeping and cleaning the floor and wash the utensils and cloths inside their homes by tap water or stored water. In the spare time they watch T.V. or movies on V.C.R. She was also the member of Mahila Samaiti. On discussing the matters related to the reproductive health, she said that they observed traditions related to mensturation, the child-birth and child-rearing. She also reported the infections as gynaecological problem for which she started taking treatment from gynaecologists but could not continue. Food of these households include chapaties and seasonal cooked vegetable, curd and salad and they use ghee with that. She also complaint of weakness in the body. For minor illness they consult PHC and ANM in the village. Regarding the no. of children she was suppose to have. She told that she was being told by her mother-in-law to have more children specially sons as her husband was the only child who could survive. So she had 4 children but after that she herself undergone sterlization and satisfied with that. On discussion with her it was found that she was in the favour of girl's education and employment and also considered bad to do discrminiation against girls. Thus her views were modern. She herself was an educated lady".

Women belonging to the not so rich category also lead more or less similar kind of life to that of women of rich category. They also have modern gadgets in their households like refrigerator, TV., LPG gas but few also cook on

smokless chullah, gobergas chullah, these women also do the similar kind of jobs inside their homes as that of rich women but they also milk their animals and take care of them. Some of them even work in their farms to save family income. These women also encourage girls' education but rarely girls are encouraged for higher or techical education. After their completing schooling, they learn household jobs and subsequently get married by their parents. These women also observed purdah.

> "Sunita, a 30 years old women belonging to this category, her husband was a small business man (cloth shop), wakes up very early in the morning, milk their cattles, do cooking, prepared children for school, after that cleaning the house and utencils again prepared the food. Bring water from the tap being installed in their lanes and for toilet they have to go out of their homes into the fields. Which she considered as major problem as she finds this as embarrasing. Sunita used to prepare food on smokless chullah and cook seassonal vegetables. She remains busy through out the day. She does not keep well because of her poor health, does not take part in the activities of mahila simiti. She took precautions to prevent illnesses. She entirely depends for all kinds of decisions on her husband, her opinion in the family was poor. She also reported to take treatment from PHC, village, quack, ANM and specialist in the city. Some of the housewives also shown the interest for learning skills or trainig for self-employment as they wanted to add to their family incomes".

Among poor socio-economic status, people involved in the low paid jobs. The women of this section also work hard in order to sustain their lives. Some of them also work outside their homes as wage labourer at the construction

Means of Cooking

Table No.7

Means of Cooking adopted by Women Across Socio-Economic Categories

Categories	Chullah	Gobar	LPG	Smokeless Chullah	Stove
Rich	6 31.6	1 5.3	11 57.9	–	1 5.3
Not so rich	21 67.7	1 3.2	6 19.4	1 3.2	2 6.5
Poor	60 89.6	–	–	3 4.5	4 6.0
Very poor	20 87.0	–	–	1 4.3	2 8.7
Total	107 76.4	2 1.4	17 12.1	5 3.6	9 6.4

Out of 140 households, maximum no. i.e. 107 cook on chullah which constitute 76.4% of the total sample and 17 (12.1%) had L.P.G. 2 (1.4%) had Gober gas 5 (3.6%) cook on smokeless chullah i.e. 3.6%, while 9 (6.4%) had stoves for cooking purpose. In table no. 7 among rich 57.6% of household cook on LPG, 31.6% on chullah and 5.3% each on stove and gobergas, among not-so-rich 67.7% cook on chullah, 19.4% on LPG, 6.5% on stoves while 3.2% each on gobergas and smokeless chullah. Among poor 89.6% cook on chullah, 4.5% on smokeles chullah, and 6% on stove. Among very poor 87% cook on chullah, 8.7% on stove and 4.3% on smokeless chullah.

site or in the fields or in the houses of rich.

> "Rumali is a women of 35 years old belonging to this category. She also gets up early in the morning bring grass and fodder from the fields for the cattles.
>
> She cuts that into pieces and give it to the cattles. Milk them and sell this milk to the milkmen. She cooks food for the family, washes clothes, utensils. After that she along with her 15 years old daughter goes to the household of rich landlord to make cake out of cowdung for them. They had taken this work for six to seven houses and thus by the time they come back from work to their home it gets evening and then they cook and also go out to bring fodder for their cattles and does other work. Girls of this socio-economic category hardly get primary or middle education and they generally get marry early in their adolescent. Most of the drop-outs are found among girls and they involved in the household jobs as well as work outside and help their families. They hardly observe any traditions related to menstruation child-birth, pregnancy and child-rearing. Some reported to oberve food related practices during menstruation and pregnancy. They mostly rely on village RMP for their treatment and rarely consult specialist at city".

Among the very poor category. Most of the family numbers involved in earning except small children. Women belonging to this category had special responsiblities as she has to bear and nurture children along with household jobs as well as tough labour outside the household. Throughout the day she remains busy and gets tired due to overburden of the work. They have to live on the subsistence level of living. They hardly eat food properly. Due to lack of time and money they could not even take care of their small children properly as they have to leave their homes in search of daily labour. They do not own cattles and live in the mixed or kaccha houses. Most of the time

women are outside house either in the fields or at the construction site like brick klin.

> "Bharto is a women of 26 years old belongs to very poor category. She has three small children. She told the investigator that she used to left her children at home without any supervision and one of her child was died at the working site due to negligence as the infant fell down from the swing into mudpitch without her knowledge. She has also not immunized her children. Poverty is being reported as the main problem by her.. She worked hard throughout the day under the sun in the fields to get six monthly grain, as well as inside home she has to cook, clean, washing apart from this take care of small children. She also suffered from irregular periods, abortion but did not get spare time and money to get treatment for the same. She eats chapati with tea while vegetables, dal and milk is luxary for their household".

Thus, it evident that the life-process of the women except the rich section, women from the other three sections had not improved much with the progress and development of village. Status of these women in the family and village life was not found to be improved because of the misery, scarcity, lack of resources, employment and over and above illiteracy. It has been already said earlier literacy rate among the village is much below the national average, though they were from a developed village of Haryana with high illiteracy and lack of resources for employment and production in the family had facilitative exploitation, misery and diplorable life for the women in the poor and very poor section. With this background of the cultural and social life of the women the reproductive health of the

women had been analysed systematically.

Socio-Cultural change in the village Dhurala

Before going into the detail analysis of the reproductive health of the women in Dhurala village, it was necessary for us to study the micro and macro level socio-cultural change in this village. Like the other village in Haryana this village is also undergoing rapid change at socio-cultural level. This village being under the community development block Thaneswar, a lot of developmental work have been done.

The village has been well communicated by road with the neighbouring village and town resulting thereby a lot of communication and interaction between the villagers and the outsiders. A lot of commercial activities has been improved over years because of expansion of the village market. Over and above the mass-media expansion and the availability and accessibility to TV & Radio to the large no. of villagers has opened the opportunities for the men and women for latest informations and ideas. Specially among the younger group mass-media has provided a large no. of new modern values and because of these new values and ideas, a lot of traditional values and ideas have been discontinued.

In this village no doubt the backward caste is in large no. Still the higher caste being the numerically low occupied the post of "Gram Schiv". This Gram Schiv controls

and manipulate the decision-making of the village through village Panchayat headed by a Sirpanch who comes from a backward caste.

The life of this village is more or less very close to the life-style of the neighbouring town because of constant interaction and communications. Over the years, because of the availability and accessibility of educational institutions like; primary school and high school, the female education has increased and a large number of girls to these institutions and also it has been seen some of the girls now trying to go out of the village for studying into the other institutions for the higher education in the neighbouring towns and villages.

Regarding the major socio-economic change, the lower income group households have more employment opporunities in the village as well as outside the village. It has also been seen that because of the migration of the labourers from outside to the village the landlords have preferred to engage more migrant labourers than the villagers. This has happened because the migrant labourers can be engaged in a low wage. Since the daily wage earner of the village demands more. Because of the multiple crop and irrigation facilities the productivity of the land has gone up and the profit margin has gone up in the different agricultural practices resulting better life conditions of the landlords who are

small in number.

It was very interesting to observe inspite of so much change and development in the village, a lot of old traditions and values have been still protected and practised in various day to day life process of the villagers. Because of the old traditions and values in the village the status of the woman was not satisfactory in consonance with the development of the village.

The women were found mostly engaged in the household jobs and were having very little role in the decision making of the family. Though the women in the rich households have lot household gadgets like LPG, Refrigerator, TV, Radio, Cooler, Washing machine, VCR still their social status has not improved significantly. The life condition of the women in the backward caste and wage earner was very miserable since their family income is confined to daily wage earning which is not very sufficient. Because of this acute poverty, misery, deprivation and also the exploitation, which has created a lot of favourale situation for unhealthy life for the women as well as the other among poor. It was found that the development which has been confined to the richer section is yet to be seen among the large socio-economically poor households. It can be said that the fruits of little development which has been taken place in the village has

yet to be reached to the poorer section as well as mostly women and children of this group. Keeping this a broad background view of socio-cultural change of the village Dhurala a detailed analysis is made for the reproductive health of the women.

Health Institutions

In order to analyse the reproductive health of women, it was required to develop a brief account of the availability of different health institutions functioning in this village. This village has one primary health centre and one subcentre at the village level, apart from this there is one government Ayurvedic dispensary (GAD), it was there in the village since long time.

On 4 April 1990, the village subcentre was modified to the PHC. It has malaria clinic also, staff of PHC consisting of 2 male medical officers, one staff nurse, one health inspector, pharmacist, laboratory technician and fourth class employee. At the subcentre level there is one ANM and one male multipurpose worker. Timings for PHC are 8 to 12.30 pm and 5 to 6 pm. Ayurvedic dispensary also has one doctor and one nurse. Apart from govt. health services there are five quacks in the village and among them one used to run gynaecologial clinic but it was closed shortly afterwards. Some of these quacks trained in homeopathy

as well as allopathy medicines. Chemist shop was there in the village, village has dai for providing services to the women and traditional medicine men who also give treatment to the pregnant women and to the children in case of fever, typhoid and chicken-pox.

Women suffering from minor illnesses like cold, cough, fever took treatment from village quack, PHC and ANM. While rich women also consult PHC, ANM and quack along with the treatment from trained city practitioner or specialist. For major illnesses poor people or women depend on village or city quack, some consulted civil hospital while few could aford specialist treatment. While rich generally take specialist private treatment or from civil hospital. At primary health centre also women go for the treatment of minor illness where most of the time one or other doctors remains absent due to the some other works. So most of the time they get treatment from pharmacist, staff nurse is being appointed in the PHC but women hardly went there for prenatal check-ups or treatment for their reproductive health problems. As staff nurse is not a specialist for those problems moreover health centre is devoid of the medicine related to these problems and also for children related problems, so they have to buy medicine from market. Thus they prefer to consult quack who charge the money six monthly or sometimes take grains in return to their

treatment. ANM also hardly do prenatal check-ups or visiting home while she runs her private practice as she bought medicine or collect it from health centre and sell to the villagers at the time of their illnesses. She rarely note the referral cases or deliveries taken place at civil hospital as she hardly do any check-up by her own or refer cases to the civil hospital. She charged Rs. 250 or 300 for a delivery, which is unaffordable for poor women who mostly take assistance of dai for that purpose. At the time of complications during pregnancy also, very few women who are rich consult ANM while others either consult the dai or village quack. Very few women approach to the male doctors at PHC for their reproductive health problems. Male doctors also not able to diagnose them properly and generally prescribe the medicine which they have to buy from market. Thus women hardly consult them and also feel shy in approaching them for their gynaecological problems. So most of the time women have to rely on village quack, dai, ANM, traditional practitioner and city quack. Very few relied on specialist for their reproductive health problems. Thus lack of government policy for the reproductive health care of rural women is seen along with poor functioning of health staff in this respect. Even proper record keeping was not there of the type of gynaecological problems faced by women and prenatal check-ups.

Women hardly use family planning measures just after their marriage as pressure is there on them to bear atleast 3 or 4 children. It is only among the middle aged women permanent sterlization is prevalent with ANM's suggestion who provide incentive of Rs. 130/- to the women undergoing this operation. Women hardly use oral contraceptives and complain about the side-effects of intrauterine devices or oral contraceptives and it is only used by rich women. Women generally undergo sterlization only after having one or two sons. There is also lack of follow-up for these sterlized cases. These women generally complaint of abdominal-pain, irregular periods, or other problems but they do not get any treatment for that.

Private Practitioners

In the village, private practitioners play an important role in the treatment of minor, major and reproductive health realted problems. Women go to these quacks for treatment of the problems of irregular periods, bleeding during pregnancy as reported by one quack who practice homeopathy. There is also quacks practising western medicine (Allopathy) and they also give treatment for the gynaecological diseases, weakness, abdominal pain during periods etc. If the patient is poor. These practitioners did not take current fees of their treatment, but take their

fees in kind or cash six monthly as already being mentioned. Thus, their treatment is cheap as well as easily accessible to the villagers. They remain open their shops throughout the day, so women can take treatment any time, while timings for PHC are fixed and it remained closed during-afternoons when most of the women get time and get free from their household jobs. Thus these women mostly aparoach to these quacks due to economic reasons as well as due to unsuitability of PHC timings. Some of these quacks are there in the village since long time and have established good reputation. So the villagers prefer to take their treatment from them.

(Part II)

PART II

Before understanding the reproductive health of women in detail, the investigator made an attempt to look into the reproductive health of the women as a part of overall health problems of women inthis village. A systematic effort was made to understand minor, major, chronic, psychosomatic and accident related health problems encountered by women belonging to the various socio-economic groups. Apart from this the investigator also had opportunities to understand the health practices relating to these health problems. Thereafter the reproductive health of women has been dealt in greater detail.

Minor Illeness

Investigator has observed and found that women in this village generally suffered from backache, fever, gas problem, bodyache with fever, chest pain. The percentage of women suffering from fever is highest i.e. 38.6% and then the percentage of women suffering from bodyache and fever i.e. 16.4% and after that cold, cough and fever i.e.14.3%, then 12.1% reported fever and headache.

Among rich 7 had fever, cough, 2 had cold, cough and fever, two had headache, 2 had faver and headache 2 had bodyache and fewer 2 had weakness, tension, gastic problem,

one reported of having anemia. Among not-so-rich, 1 had headache, 1 had backache, 14 had fever, 3 had cold, cough and fever, 4 had fever and headache, 6 reported bodyache and fever, each one had body ache, weakness, gastric problem, tension and fever. Among poor, 25 had fever, 1 had cold and cough, 5 had backache and fever 11 had cold, cough & fever, two had gas problems, 7 had fever and headache, 14 had bodyache and fever and one had chest pain. Among very poor, one had backache, 8 had fever, 2 had backache and fever, 4 had cold, cough and fever one had gas problem, 4 had fever and headache, 2 had bodyache and fever and one had backache and got faint. The maximum percentage was of fever which was there among all classes.

Treatment sought for minor illness

In table no. 20, among 140 sample women, 69 reported to consult Registered Medical Practitioners (RMP) at Dhurala 6 consulted Parimary Health Cetnre (PHC), 4 consulted Govt. Ayurvedic Dispensary (GAD). One consult ANM, two consulted qualified private practitioner in the city, 37 consulted RMP and trained practitioner at Kurukshetra, 3 consulted Dhurala RMP and city RMP, one reported to take no treatment, 4 used the services of traditional practitioiner, PHC and GAD, one each from PHC, GAD and dai, two consulted civil hospital and private practitioner at city, one used traditional

practitioner services, PHC and RMP. Five reported to consult traditional practitioner and one consulted traditional practitioner and one relied on home treatment. So maximum percentage of women 49.3% consulted only RMP at Dhurala and 26.4% consulted both RMP and PHC, 4.3% consulted PHC, 3.6% consulted RMP and GAD, 2.9% each consulted traditional practitioner, GAD, 2.1% consulted Dhurala RMP and city RMR.

Table No. 20

Measure taken for the treatment of Minor Illnesses Across Socio-Economic Categories

Categories	RMP	TP	PHC	Home treat-ment	GAD	ANM	QPR	RMP & PHC	RMP & QPR
Rich	5 26.3		3 15.8	1 5.3	1 5.3	1 5.3	1 5.3	6 31.6	-
Not so rich	17 54.8		2 6.5	-	-	-	1 3.2	7 22.6	1 3.2
Poor	35 52.2	1 1.5	1 1.5		2 3.0		-	18 26.9	-
Very poor	12 52.2	-	-		1 4.3		-	6 26.1	-
Total	69 49.3	1 .7	6 4.3	1 .7	4 2.9	1 .7	2 1.4	37 26.4	1 .7

Categories	Vill.RMP & City RMP	No Treat-ment	TP+ PHC+ GAD	PHC & GAD	Dai	Civil hosital & QPR at city	TP+PHC + RMP	RMP + GAD
Rich	-	-	-	-	-	-	1 5.3	-
Not so rich	-	-	1 3.2	-	-	2 6.5	-	-
Poor	2 3.0	1 1.5	3 4.5	1 1.5	1 1.5	-	-	2 3.0
Very poor	1 4.3	-	-	-	-	-	-	3 13.0
Total	3 2.1	1 .7	4 2.9	1 .7	1 .7	2 1.4	1 .7	5 3.6

Among rich maximum percentage of women 31.6% consulted both RMP and PHC at Dhurala for the treatment of minor illness, 26.3% depended on RMP at village only, 15.8% depended on PHC, while 5.3% each depended upon home treatment, GAD, ANM trained practitioner at city and traditional practitioner, PHC & RMP. Among not-so-rich 54.8% depended on RMP at village, 22.6% on RMP and PHC, 6.5% each depended on PHC and Civil hospital and qualified practitioner in city, 3.2% each consulted qualified practitionier at city, RMP and traditional practitioner and PHC and GAD. Among poor 52.2% reported to take treatment from RMP at village, 26.9% from RMP and PHC and 3% each from GAD, RMP and GAD, 4.5% from traditional practitioner, PHC and GAD, 1.5% each from traditional practitioner PHC, no treatment, PHC & GAD

and dai. Among very poor 52.2% depended on RMP at village, 26.1% on RMP & PHC, 4.3% each on GAD, RMP Dhurala and RMP at Kurukshetra. 13% had relied on RMP and GAD. Thus, all other socio-economic status depended upon RMP at Dhurala but the rich mostly depended upon both RMP and PHC in the village for the treatment of minor illnesses.

Major Illnesses

In table 2.1, 17 had fever, seven reported stomach ache, one had polio, 60had no major illness, 3 reported having T.B., 4 typhoid, 4 fits, 7 malaria,2 had diarhohea, 3 reported stomach ache and fever, one had sterlity, 7 had Asthma, 4 had blood pressure problems,4 had eye sight problem, two had typhod and blood pressure, two reported arthrities, two had swelling in feet, 7 had pain in hands, 2 reported epilepsy, one had Jaundice. So the maximum no. of women had no major illness and maximum had fever.

Table No. 21

Type of Major Illnesses faced by Women of Different Socio-Economic Category

	Fever	Stomach ache	Polio	No Ill-ness	T.B.	Tyhoid	Fits	Malaria	Diarahea	Stomach ache+fever	Sterlity
Rich	2 10.5	-	-	5 26.3	1 5.3	1 5.3	-	1 5.3	-	2 10.5	-
Not-so-rich	2 6.5	-	-	19 61.3	-	-	1 3.2	2 6.5	1 3.2	1 3.2	-
Poor	8 11.9	6 9.0	-	25 37.3	2 3.0	2 3.0	3 4.5	3 4.5	-	-	1 1.5
Very poor	5 21.7	1 4.3	1 4.3	11 47.8	-	1 4.3	-	1 4.3	1 4.3	-	-
Total	17 12.1	7 5.0	1 .7	60 42.9	3 2.1	4 2.9	4 2.9	7 5.0	2 1.4	3 2.1	1 .7

Count and Percentage

	Asthma	B.P.	Weak Eye Sight	Typhoid + B.P.	Swell-ing in feet	Arthrities	Pain in hand	Epilepsy	Swelling in hand	
Rich	2 10.5	2 10.5	2 10.5	-	-	-	1 5.3	-	-	-
Not so rich	1 3.2	-	1 3.2	-	-	-	1 3.2	1 3.2	1 3.2	-
Poor	4 6	2 3.0	1 1.5	2 3.0	1 1.5	2 3.0	3 4.5	1 1.5		1 1.5
Very poor	-	-	-	-	-	-	2 8.7	-	-	-
Total	7 5	4 2.9	4 2.9	2 1.4	1 .7	2 1.4	7 5	2 1.4	1 .7	1 .7

Among rich 10.5% had fever, 26.3% had no major illness, 5.3% each had T.B., typhoid, malaria and pain in hands 10.5% each had stomach ache and fever, asthma, blood pressure, eye sight problem. Among not so rich 6.5% each had fever and malaria, 61.3% had no illness, 3.2% had fits, 6.5% had malaria, 3.2% each had Diarrohea, stomach ache fever, asthma, eye sight problem, pain in the hands, epilespy and swelling in the feet. Among poor 11.9% had fever, 9% had stomach ache, 57.3% had no illness, 3% each T.B., typhoid, B.P., asthma, eye sight, 4.5% each had fits, malaria, pain in the hands, 1.5% each had sterlity, weak eye sight, swelling in the feet and epilepsy. Among very poor 21.7% had fever, 4.3% stomachache,4.3% Polio, typhoid, malaria, Diarrohea, 47.8% had no problem 8.7% had pain in hands.

Treatment sought for Major Illnesses

In table no.22, out of 140 women in the sample, 9 reported to consult RMP at Durala for the treatment for major illnesses, 4 consulted PHC, one to Govt. Ayurvedic dispensary, 10 to civil hospital, 37 consulted qualified private practitioner, one reported to consult Dhurala RMP and PHC, 17 reported to consult Dhurala RMP and trained practitionier at Kurukshetra city, one reported of consulting RMP at Kurkshetra, 17 reported to cosult Dhurala

RMP and RMP at Kurukshetra. One reported to take no treatment, two reported to consult traditional practitioner, PHC and Govt. Ayurvedic dispensary, 31 had no problems, one consulted PHC and Govt. Ayrvedic dispensary 4 consulted civil hospital and qualified practitioner, 2 reported to consult traditional practitioner, PHC and RMP, one reported to consult traditional practitioner and qualified city practitioner and one consulted RMP and GAD for the treatment of big illnesses.

Table No.22

Steps taken for the treatment of Major Illnesses Across Socio-Economic Categories

	RMP Dhurala	PHC	GAD	Civil hospi-tal	QPR	Dhurala RMP+ PHC	Dhurala RMP+QPR at KKr	RMP at KKR	Dhurala RMP+KKR RMP	No treat-ment
Rich	-	-	-	2 10.5	13 68.4	-	1 5.3	-	-	-
Not so rich	-	1 3.2	-	3 9.7	8 25.8	-	3 9.7	1 3.2	2 6.5	-
Poor	5 7.5	2 3.0	1 1.5	4 6.0	14 20.9	1 1.5	10 14.9	-	10 14.9	-
Very poor	4 17.4	1 4.3	-	1 4.3	2 8.7	-	3 13.0	-	5 21.7	1 4.3
Total	9 6.4	4 2.9	1 .7	10 7.1	37 26.4	1 .7	17 12.1	1 .7	17 12.1	1 .7

	TP+ PHC+ + RMP	N.A.	PHC+ GAD	Civil hospital +QRP in city	TP + PHC +RMP	TP + QP at city	RMP+ GAD
Rich	-	2 10.5	-	1 5.3	-	-	-
Not so rich	-	11 35.5	-	2 6.5	-	-	-
Poor	1 1.5	13 19.4	1 1.5	1 1.5	2 3.0	1 1.5	1 1.5
Very poor	1 4.3	5 21.7	-	-	-	-	-
Total	2 1.4	31 22.1	1 .7	4 2.9	2 1.4	1 .7	1 .7

Chronic Illness

During study, attempt was made to accont the chronic diseases among women. It was found 9 had fever, 15 reported to have Gynae problems, 4 had constipation for long time, 95 had no chronic illness, one had anxiety, 2 reported cancer, 4 reported stone in the gallbladder, 4 reported blood pressure for long, 3 reported skin infection, one reported partial paryalysis, one reported piles, one blindness.

Accident

Besides the chronic illnesses during study, the investigator was reported the instances of accidents in women of various socio-economy categories. Among sample of 140 women 17 reported to have accident while cutting grass,

2 from motor vehicle, 121 experienced no accident i.e. 86.4%. Among rich women 5.3% had motor vehicle and 10.5% while cutting fodder by thrasher. Among not-so-rich 3.2% each cutting fodder, motor vehicle and cutting grass fodder by thrasher. Among poor 14.9% reported to have it while cutting grass while among very poor 17.4% reported accidents while cutting grass. Thus accidents due to thrasher is highest among very poor while motor vehicle among rich category women. SC had 29.6% accidents while cutting grass, BC 9.3% and others 5.3% each while cutting grass and by motor vehicle. So maximum accidents occur among SC while cutting grass. Among students 33.3% reported accidents while cutting grass, housewives 6.2% while cutting grass, 2.1% motor vehicle accident reported. Service women had not reported any accident, wage labourer 21.6% reported accidents while cutting grass.

Treatment sought for Accident

Out of 140 sample women, four reported to get treatment for RMP, two from PHC, one from civil hospital, two reported to take from trained private practitioner at city, one each from Dhurala RMP and PHC, RMP at city, Dhurala RMP and Kurukshetra RMP, 9 took no treatment for minor accident.

Information on Future Reproductive Role

Out of 140 women, 23 reported to have previous

knowledge of menstruation before it onset, two had knowledge or experience of child-rearing before marriage, 96 had no knowledge or information regarding this, twelve reported to had prior knowledge regarding menstruation, child-birth and child-rearing. So maximum percentage is of women who had knowledge of periods in advance i.e. 16.4% while 68.6% had no information on future reproductive role. 8.6% had prior knowledge of periods and child-rearing. 5% had knowledge of periods, child-birth and child-rearing.

Table No. 23

Information on Various Reproductive Roles among Women of Different SES categories

SES	Menstruation	Child-rearing	No knowledge	Periods& child-rearing	Period & child-birth &child-rear.
Rich	5 26.3	-	9 47.4	2 10.5	3 15.8
Not-so-rich	2 6.5	-	24 77.4	3 9.7	2 6.5
Poor	14 20.9	2 3.0	43 64.2	6 9.0	2 3.0
Very poor	2 8.7	-	20 87.0	1 4.3	-
Total	23 16.4	2 1.4	96 68.6	12 8.6	7 5.0

In table no. 23, 47.4% women of high socio-economic status had no information while 52.6% had one or another information on future reproductive role. As 26.3% had knowledge regarding periods, 10.5% on periods and child-rearing, 15.8% on periods, child birth as well as child-rearing.

Among rich 47.4% had no prior knowledge while 26.3% had information of periods, 10.5% of periods and child rearing and 15.8% of periods, child-birth and child-reaaring. Among not-so-rich 6.5% had periods related information, 77.4% had no information and 6.5% had information on period, child-birth and child-rearing. Among poor 64.2% had no prior information,20.9% had period related information, 9% had period, child-rearing and 3% had information on child-rearing and period, child-birth and child-rearing. As per table no. 23, 87% women of very poor category had no prior information, 8.7% on periods, while 4.3% on periods and child-rearing. Thus, percentage of women with no information on all aspects found to be highest for very poor women and information on all aspects found to be higher maong rich category. Among nursing mother 64.3% aware of periods and child-rearing while 4.8% each had all information regarding future reproductive role, child-rearing, period, child-birth only. Among newly married 28.6% aware of periods, 14.3% of child-rearing, period, child-birth and child-rearing 42.9% are aware of

periods and child-rearing. Among adolescent girls 40.9% had information of periods, 9.1% on periods and child-rearing. Among mothers 9.4% aware of periods, 5.9% of period, child-birth and child rearing, 4.7% periods and child-rearing mothers are more unaware adolescent girls are mostly aware of periods only.

Table No. 24

Information on Future Reproductive Roles as reported by Women doing Different Occupations or jobs

SES	Period	Child-rearing	No know-ledge	Periods& child-rearing	Period & child-birth &child-rear.
Student	1 33.3	–	2 66.7	–	–
Housejob	19 19.6	2 2.1	63 64.9	8 8.2	5 5.2
Service	1 100.0	–	–	–	–
Wage Earner	2 5.4	–	30 81.1	3 8.1	2 5.4
Student & Housejob	–	–	1 50.0	1 50.0	–
Total	23 16.4	2 1.4	96 68.6	12 8.6	7 5.0

Occupation wise, in table no.24, more information on all aspects of reproduction found among housewives while more about periods among students. As 33.3% students had information on periods, 19.6% housewives on periods. 8.2% on

periods and & child-rearing, 5.2% on periods, child-rearing and child-birth, 2.1% on child-rearing, wage earner women 8.1% had information on periods and child-rearing 5.4% had information on all aspects.

Table No. 25

Information on Furture Reproductive Role reported by Educated or Illiterate Women

SES	Period	Child-rearing	No know-ledge	Periods& child-rearing	Period & child-birth &child-rear.
Educated	11 19.3	1 1.8	33 57.9	7 12.3	5 8.8
Illiterate	12 14.5	1 1.2	63 75.9	5 6.0	2 2.4
Total	23 16.4	2 1.4	96 68.6	12 8.6	7 5.0

In table no.25, more educated women had knowledge on every aspect of reproduction. As more illiterate had no knowledge on these aspects i.e. 75.9% as compared to literate women i.e. 57.9%. Moreover, educated women have knowledge on periods i.e. 19.3% as compared to 14.5% illiterate, 12.3% on periods and child-rearing as compared to 6% illiterate women, 8.8% on all aspects as compared to 2.4%.

Tradition related to Menstruation

Out of 140 sample only 31 reported to observe practices related to periods like not taking sour food while 109 found not to have any practices related to periods. Only 22.1% have observed some practices while 77.9% observed no practices. Women do not cook, prey during mensturation and not suppose to lift weight.

Among rich 36.8% had observed some practices like not to cook, not to do prayers, not to eat curd and rice during periods, while among not-so-rich 25.8% had some practices while 74.2% observed no such practices. Among poor category 18.4%, had practices, while 80.6% do not observe any such practices. While among very poor 13.0% observe some practices. Among students, all reported such practices, housewives 24.7% reported such practices, no service women, only 8.1% wage earner reported such traditions. Thus all students and some housewives observed and ware of such practices while very fe wage earner observe such practices.

Table No. 26

Traditions related to menstruation reported to be observed by women involved in different Occupations

Occupation	Observed	Not observed
Student	3 100.0	
Housejob	24 24.7	73 75.3
Service	-	1 100.0
Wage earner	3 8.1	34 91.9
Student + housejob	1 50.0	1 50.0
Total	31 22.1	109 77.9

Table No. 27

Traditions observed related to menstruation among Educated/ Illiterate Women of Poor SES Category related to periods

Occupation	Observed	Not observed
Educated	6 26.1	17 73.9
Illiterate	7 15.9	37 84.1
Total	13 18.4	54 80.6

In poor socio-economic category students of low SES category reported to observe such traditions 20.0% housewives also had such traditions, 10.5% wage earner also reported to observe such traditions, More housewives and student had such traditions than wage-earner women of low SES category.

Among very poor category it was found that housewives reported to observe such traditions related to periods, while 94.1% wage labourer women observed no practice, only 5.9% had such practices. Thus more housewives of very poor category observed such practices as compared to wage labourer women.

Difficulties during menstruation

Out of 140 women, 18 reported to have irregular periods, 4 experienced exceessive bleeding, 20 complaint of abdominal pain while 91 had no problems, two ddi not have periods due to manopause, four reported to have irregular periods with abdominal pain. So 14.3% experienced abdominal pain and 12.9% had irregular periods 65% had no problems, 2.9% each had excessive bleeding and irregular periods with abdominal pain.

Table No. 28

Difficulties faced by Women during mensturation
as reported by Women of different Socio-Economic Category

Category	Irregular Periods	Excessive Bleeding	Abdominal pain	No Problem	Mano pause	Irregular Periods + Stomach ache
Rich	3 15.8	1 5.3	3 15.8	11 57.9	1 5.3	-
Not so rich	5 16.1	1 3.2	2 6.5	20 64.5	-	3 9.7
Poor	6 9.0	3 4.5	13 19.4	43 64.2	1 1.5	1 1.5
Very poor	4 17.4	-	2 8.7	17 73.9	-	-
Total	18 12.9	5 3.6	20 14.3	91 65.0	2 1.4	4 2.9

In table no. 28, among rich women 15.8% each suffered from problems of irregular period, abdominal pain each and 5.3% suffered from excessive bleeding. Among not so rich 16.1% suffered from periods, 3.2% from excessive bleeding and 6.5% from abdominal pain. Among poor women 19.4% had abdominal pain, 3% had excessive bleeding, irregular periods and abdominal pain. Among very poor 17.4% had irregular periods, 8.7% had abdominal pain and 73.9% faced no. problems. The maximum percentage of women had problem of abdominal pain i.e. 14.3% and it is highest among poor women

and after that the problem of Irregular periods i.e. 12.9% and this was highest among very poor women.

Table No. 29

Difficulties during mensturation reported by Educated/illiterate Women

	Irregular Periods	Excessive Bleeding	Abdominal pain	No Problem	N.A.	Abdominal pain & Exc. bleed. Irr. Periods	Irregular Periods + Abdominal pain
Educated	11 19.3	2 3.5	8 14.0	33 57.9	1 1.8	1 1.8	1 1.8
Illiterate	7 8.4	2 2.4	12 14.5	58 69.9	1 1.2	-	3 3.6
Total	18 12.9	4 2.9	20 14.3	91 65.0	2 1.4	1 .7	4 2.9

Educated 19.3% had irregular periods, 14% had abdominal pain, 3.5% excessive bleeding. Illiterate women 14.5% had abdominal pain, 8.4% women had irregular periods.

Table No. 30

Difficulties during mensturation as reported by Women involved in various Occupation

Category	Irregular Periods	Excessive Bleeding	Abdominal pain	No Problem	N.A.	Abdom.pain Exc.Bleed. Irr.Periods	Irregular Periods + Abdominal pain
Student	-	-	3 60	2 40	-	-	-
Housejob	14 14.4	4 4.1	12 12.4	62 63.9	1 1.0	-	4 4.1
Service	-	-	-	1 100.0	-	-	-
Wage earner	4 10.8	-	5 13.5	26 70.3	1 2.7	1 2.7	-
Total	18 12.9	4 2.9	20 14.3	91 65.0	2 1.4	1 .7	4 2.9

Occupation wise as refer to table no. 30, students i.e. 60% reported abdominal pain, housewives 12.4% reported abdominal pain, 14.4% irregular periods, 4.1% excessive bleeding, 4.1% irregular periods and abdominal pain. Service doing women had no problems. Wage earner women 13.5% had abdominal pain, 10.8% irregular periods, 2.7% each had excessive bleeding, abdominal pain with irregular periods. Thus, housewives and wage labour reported, various kind of periods related problems while most of the students had reported abdominal pain during mensturation. The following case study provided a detail data on various problems

arising out of menstruation.

Case Study

"A young girl Hukami aged 15 years belonging to Harijan caste and wage earner socio-economic category. Throughout the day she used to do household work and as helping her mother inside the home beside this she used to go landlord's houses to make cowdungs cakes in return they used to get six monthly grain and sometimes food for everyday's work. In the informal discussion with researcher, she revealed that she had been suffering from fever for long and on asking about problems related to mensturation. She said that she used to have abdominal pain during periods. On asking whether she took treatment for that she replied that for the fever she was been shown to the doctor in the village who was a quack practicing western medicine. She said that she was getting cure. Again enquiring on her menstruation problems, whether she informed her mother regarding that. She replied that she used not to tell her mother about the pain and even her starting of periods. It was only when the pain became unbearable her mother came to know about that while she used to discuss all this with her friends. Through talking to other girls researcher came to know that discussion about the onset of the periods and related problems was being done among girls themselves without letting know their mothers about it as they are not suppose to talk about these things openly or even to their mothers as it is not considered good and they feel shy indiscussing that and shameful too. On discussing this with mothers it was found that mother's tried to show ignorance regarding the onset of periods of her daughter and also reported that girls don't tell on talk about these to their mothers, but indirectly they came to know about it but still they don't talk or discuss about it with their daughters as it is shameful to discuss and bad to discuss these matters. Hukami also said that her mother told her to take precautions in taking foods like she should avoid taking rice, curd, lassi, pickle and all sour things to prevent the pain during menstruation. So she has started taking precautions while pain still prevails sometimes.

Thus, it has been seen that due to socio-cultural factors the girls do not reveal the onset of periods as well as its related problems unless it became very painful, then the mothers came to know about it and the only measure suggested is to avoid some foods. While few also taken to the quacks for treatment from where they get temporary treatment. Lack of money and time on the part of their

parents does not permit their treatment from qualified practitioner at city, registered medical practitioner at city or at PHC or to consult ANM. Going to PHC is avoided as they felt shy to talk about it with male doctors and moreover doctors prescribe the medicines which they have to buy from market and the same is true with Auxillary nurse midwife. So they avoid consulting them. In this way there is a lack of services for the treatment of the period related problems of girls in the village.

Treatment received for the problems related to Menstruation

Table No.31

Steps taken for the treatment of menstruation related problems among Women belonging to different Socio-Economic Categories

Category	ANM	PHC	RMP	RMP at KKR	No treat-ment	TRAD. Pract.	No Pr.	Preca.	ANM+ TPR city	PHC+RMP	PHC+QPR
Rich	2 10.5	1 5.3	1 5.3	-	-	1 5.3	12 63.2	1 5.3	1 5.3	-	-
Not so rich	1 3.2		2 6.5	-	5 16.1	2 6.5	16 51.6	4 13.1	-	-	1 3.2
Poor	7 10.4	1 1.5	2 3.0	-	7 10.4	2 3.0	42 62.7	3 4.5	1 1.5	2 3	-
Very poor	1 4.3	-	-	1 4.3	6 26.1	-	14 60.9	1 4.3	-	-	-
Total	11 7.9	2 1.4	5 3.6	1 .7	18 12.9	5 3.6	84 60.0	9 6.4	2 1.4	2 1.4	1 .7

In table no. 31, out of 140 women, 11 reported to consult ANM when faced problems related to periods, two reported to consult PHC, 5 consulted RMP at Dhurala, 1 reported to consult RMP at Kurukshetra city, 18 took no treatment for this problem, 5 took treatment from traditional practitioner, 9 take precaution like not taking

sour foods,2 consult ANM and qualified practitioner, 2 reported to take treatment from PHC and RMP at village and one from PHC and qualified practitioner. So most of the women do not take treatment for these problem and those who take mostly from ANM.

Table No.32

Treatment for menstruation related problems as reported by Educated/Illiterate Women

Category	ANM	PHC	RMP	RMP at KKR	No treat-ment	TP	No Pro-	Preca.	Preca.	ANM+ TPR city	PHC & RMP	PHC GP
Educated	5	1	3	-	5	4	31	1	3	2	1	1
	8.8	1.8	5.3		8.8	7.0	54.4	1.8	5.3	3.5	1.8	1.8
Illiterate	6	1	2	1	13	1	53	-	5	-	1	-
	7.2	1.2	2.4	1.2	15.7	1.2	63.9		6.0		1.2	
Total	11	2	5	1	18	5	84	1	8	2	2	1
	7.9	1.4	3.6	.7	12.9	3.6	60.0	.7	5.7	1.4	1.4	.7

In table no 32, among educated 8.8% took treatment from ANM, 7% from traditional practitioner, 5.3% tooke precautions and consult RMP, among illiterate 15.7% took no treatment, 7.2% consulted ANM,6% took precautions. Thus more illiterate did not seek treatment for their problems.

Prediction of Pregnancy

95 (67.9%) reported self prediction, 4 (2.9%) reported of being predicted by ANM, 3 (2.1%) from dai, 7 (5%)

predicted by nursing home or others. Among rich category 63.2% self predicted and 5.7% with the help of ANM. Among not-so-rich 80.6% predicted self, while 3.2% predicted by ANM and 3.2% by others and nursing home. Among poor 61.2% self predicted, 3% by dai, 7.5% from other source 1.5% by ANM. Among very poor 73.9% self predicted, 4.3% each with the help of ANM, Dai and from others. So most of the women continued their pregnancies by themselves. Among nursing mother 76.2% predicted self 14.3% from nursing home and other and 4.8% from ANM. Pregnant women 80% self and 20% by ANM. Newly married 14.3% from nursing home or others. Mother of 2 or 3 children 87.1% self predicted, 2.4% ANM, nursing home or other, 3.5% from Dai and 1.2% from other and nursing home.

Tradition related to Pregnancy

Out of 140 sample women, one (0.7%) reported to observe practice like not to visit dead during pregnancy, 3 (2.1%) observed of food related practices, 12 (8.6%) did not lift weight, 119 (85.0%) reported to observe no tradition or practices, 3 (2.1%) reported to observe all the practices like not to visit dead, food practices and not to lift weight, two (1.4%) do not allow mother and child to go out of the home.

Table No. 33

Traditions related to Pregnancy As observed by Women of Different Socio-Economic Categories

Category	Not to visit the place of dead	Food related	Don't lift weight	No	Not to go to place of dead+food prac.+Not lift weight	Do not go out of home
Rich	1 5.3	–	1 5.3	15 78.9	1 5.3	1 5.3
Not so rich	–	1 3.2	7 22.6	22 71.0	–	1 3.2
Poor	–	2 3.0	3 4.5	60 89.6	2 3.0	–
Very poor	–	–	1 4.3	22 95.7	–	–
Total	1 .7	3 2.1	12 8.6	119 85.0	3 2.1	2 1.4

Among rich category, 1 (4.3%) each observed practices like not to see the dead body, not to lift heavy weight, food related practices, do not to go out of home, while among not-so-rich category 7 (22.6%) did not lift weight, 1 (3.2%) each observe food related practices, and did not go out of home. Among poor 89.6% of women observe no practices and 2 (3%) each observed food related practices and other all practices 3 (4.5%) do not lift weight. Among very poor only 1 (4.3%) did not lift weight. This shows that rich observe and not-so-rich category women of such traditions related to pregnancy. While very few among poor

and very poor were found to observe such practices.

Table No. 34

Traditions related to Pregnancy as observed by various Caste Women

Caste	Not to visit the place of death	Food related	Don't lift weight	No Trad.	All Pract.	Not allow mother & child to go out
SC	-	-	1	25	1	-
			3.7	92.6	3.7	
BC	-	2	6	65	1	1
		2.7	8.0	86.7	1.3	1.3
Others	1	1	5	29	1	1
	2.6	2.6	13.2	76.3	2.6	2.6
Total	1	3	12	119	3	2
	.7	2.1	8.6	85.0	2.1	1.4

As refer to table no. 34 , more women from other caste observe such practices than backward and schedule caste. 76.3% had no traditions in comparison to the 92.6% SC and 86.7% backward caste. As 13.2% other caste women did not lift weight and also observed other traditions.

Table No. 35

Traditions related to Pregnancy as reported by women involved in different Occupations

Caste	Not to visit place of death	Food related	Don't lift weight	No Trad.	All Pract.	Not allow mother & child to go out
Student	–	–	–	3 100.0	–	–
Housejob	1 1.0	1 1.0	11 11.3	79 81.4	3 3.1	2 2.1
Service	–	–	–	1 100.0	–	–
Wage earner	–	2 5.4	1 2.7	34 91.9	–	–
Student+ Housejob	–	–	–	2 100.0	–	–
Total	1 .7	3 2.1	12 8.6	119 85.0	3 2.1	2 1.4

As refer to table no. 35, wage labour women observed less such practices as compared to the housewives. While they only observe food related practices i.e. 5.4%, and 2.7% did not lift weight. Housewives 11.3% did not lift weight, 10% had food related practices,3.1% observed all practices. Thus wage labourer women only observed food related practices.

Table No. 36

Traditions related to Pregnancy as reported by Illiterate/Literate Women

Caste	Not to visit place of death	Food related	Don't lift weight	No Trad.	All Pract.	Not allow mother & child to go out
Illiterate	1 1.8	1 1.8	6 10.5	46 80.7	1 1.8	2 3.5
Educated	-	2 2.4	6 7.2	73 88.0	2 2.4	-
Total	1 .7	3 2.1	12 8.6	119 85.0	3 2.1	2 1.4

Education wise as refer to table no.36, more educated women observed such practices as compared to the illiterate. As 88% illiterate women do not observe such practices as compared to the 80.7% educated women.

Difficulties during Pregnancy

Out of 140, 61 (43.6%) women had no problems, 11 (7.9%) experienced abdominal pain during pregnancy, 14 (10%) had bleeding, 10 (7.1%) had abortion, 27 (19.3%) had not experienced pregnancy, five (3.5%) had experienced vomitting during pregnancy, five (3.6%) experienced abdominal pain, weakness and vomitting at the time of pregnancy, three (2.1%) had abnormal position of foetus, three (2.1%) had preterm babies, while one exprience blood pressure problem during pregnancy.

Table No. 37

Difficulties During Pregnancy faced by Women belonging to different Socio-Economic Categories

Category	Abdominal pain	Bleeding	Abortion	No Problem	N.A.	Vomitting during Preg.	Abdominal pain+weak-ness+vomit.	Abnormal position foctus	Preterm babies	B.P. during Preg.
Rich	1 5.3	2 10.5	3 15.8	6 31.6	4 21.1	-	1 5.3	1 5.3	-	1 5.3
Not so rich	2 6.5	3 9.7	2 6.5	15 48.4	4 12.9	1 3.2	3 9.7	-	1 3.2	-
Poor	8 11.9	5 7.5	4 6.0	27 40.3	17 25.4	2 3.0	1 1.5	2 3.0	1 1.5	-
Very poor	-	4 17.4	1 4.3	13 56.3	2 8.7	2 8.7	-	-	1 4.3	-
Total	11 7.9	14 10.0	10 7.1	61 43.6	27 19.3	5 3.6	5 3.6	3 2.1	3 2.1	1 .7

Among rich category of women 15.8% had abortion, 10.5% bleeding during pregnancy and 5.3% each had abdominal pain, weakness, vomitting and abnormal position of foctus. Among not so rich category 9.7% each had abortion, abdominal pain, weakness and vomitting, 6.5% had abortion, abdominal pain and 3.2% had vomitting during pregnancy and preterm babies. Among poor category 11.9% had abdominal pain, 7.5% had bleeding 6% abortion and 3% each had vomitting during pregnacy and abnormal foetus position and 1.5% each had preterm babies and abdominal pain weakness and vomitting feeling. Among very poor category 17.4% had bleeding during pregnancy, 8.7% vomitting,4.3% each had preterm babies and

abaortion. Thus, the of problem was more due to bleeding and abdominal pain during pregnancy i.e. 10% and 7.9% respectively. Abdominal pain is highest among poor category 11.9%, while bleeding was among very poor.

Table No. 38

Difficulties faced during Pregnancy by rich Women of different Caste

Category	Abdominal pain	Bleeding	Abortion	No Problem	N.A.	Abdominal pain+weak-ness+vomit.	Abnormal position foetus	B.P. during Preg.
BC	-	1 25.0	-	2 50.0	-	-	-	
Others	1 6.7	1 6.7	3 20.0	4 26.7	3 20.0	1 6.7	1 6.7	1 6.7
Total	1 5.3	2 10.5	3 15.8	6 31.6	4 21.1	1 5.3	1 5.3	1 5.3

As refer to table no. 38, 50% women from backward caste belonging to the rich category reported no problems, 25% bleeding during pregnacy, while women from other caste 26.7% had no problems, 20% had abortion, 6.7% had bleeding, 6.7% abdominal pain, 6.7% had abdominal pain, weakness & vomitting, 6.7% reported abnormal position of foetus; 6.7% blood pressure during pregnancy. More varied problems reported by other caste women.

Table No. 39

Difficulties during Pregnancy as reported by Educated/Illiterate Women of Rich Socio-Economic Status

Category	Abdominal pain	Bleeding	Abortion	No Problem	N.A.	Abdominal pain+weakness+vomit.	Abnormal position foetus	B.P. during Preg.
Educated	1 7.7	1 7.7	2 15.4	3 23.1	4 30.8	1 7.7	-	1 7.7
Illiterate	-	1 16.7	1 16.7	3 50.0	-	-	1 16.7	-
Total	1 5.3	2 10.5	3 15.8	6 31.6	4 21.1	1 5.3	1 5.3	1 5.3

As referred to table no.39, 37.5% housewives belonging to rich category had reported on pregnancy related problems 18.8% reported abotion, 12.5% bleeding, 6.3% stomach ache, 6.3% vomitting stomach ache and weakness, 6.3% abnormal foctus position and 6.3% blood-pressure problem during pregnancy. So more than 50% housewives of rich SES faced one or another problems in during pregnancy.

Among educated women wo are more in no of rich category mainly complaint of abortion i.e.15.4% but among the illiterates 16.7% each had the complaints of abortion, bleeding and abnormal foetus position.

Table No. 40

Difficulties faced during Pregnancy as reported by not-so-rich Socio-Economic Status Women belonging to different Caste group

Category	Abdominal pain	Bleeding	Abortion	No Problem	N.A.	Vomitting during Pregn.	Stomach-ache+weak-ness+vomit.	Preterm babies
SC	-	-	-	1 33.3	1 33.3	-	1 33.3	-
BC	-	2 11.3	-	7 50.0	3 21.4	1 7.1	-	1 7.1
Others	2 14.3	1 7.1	2 14.3	7 50.0	-	-	2 14.3	-
Total	2 6.5	3 9.7	2 6.5	15 48.4	4 12.9	1 3.2	3 9.7	1 3.2

As referred to table no.40, among SC women from not-so-rich category 33.3% had no such pregnancy related problems, 33.3% had abdominal pain, weakness and vomitting. 50% Backward Caste women had no problems, 14.3% had bleeding during pregnancy, 7.1% had vomitting during pregnancy, 7.1% had preterm babies. While other caste women 14.3% had abdominal pain, weakness & vomitting, 14.3% had abortions, 7.1% had bleeding, 50% had no problems. Backward caste and other caste women reported more problems as compared to the schedule caste women of not so rich category.

Table No. 41

Difficulties during Pregnancy as reported by not-so-rich Socio-Economic Status Women doing different jobs

Category	Stomach ache	Bleeding	Abortion	No Problem	N.A.	Vomitting during Pregn.	Stomach-ache+weak-ness+vomit.	Preterm babies
Housewife	2 6.7	3 10.0	2 6.7	14 46.7	4 13.3	1 3.3	3 10.0	1 3.3
Farm worker	-	-	-	1 100.0	-	-	-	-
Total	2 6.5	3 9.7	2 6.5	15 48.4	4 12.9	1 3.2	3 9.7	1 3.2

Referred to table no. 41, 10% housewives reported bleeding during pregnancy, 10% each vomitting, abdominal pain and weakness, 6.7% had abdominal pain, 6.7% had abortion, 3.3% had vomitting, 3.3% had preterm baby. Farm worker reported no problem.

Table No.42

Difficulties faced during Pregnancy by Educated/Illiterate Women of not-so-rich Socio-Economic Status Category

Category	Abdominal pain	Bleeding	Abortion	No Problem	N.A.	Vomitting during Pregn.	Abdominal pain+weak-ness+vomit.	Preterm babies
Educated	1 5.3	1 5.3	2 10.5	10 52.6	2 10.5	-	2 10.5	1 5.3
Farm worker	1 8.3	2 16.7	-	5 41.7	2 16.7	1 8.3	1 8.3	-
Total	2 6.5	3 9.7	2 6.5	15 48.4	4 12.9	1 3.2	3 9.7	1 3.2

As refer to table no.42, 10.5% literate women reported abortion, 10.5% abdominal pain, weakness and vomitting, 52.6% had no problems, 5.3% had only abdominal pain, 5.3% had bleeding, 5.3% had preterm babies. While 16.7% illiterate reported bleeding 8.3% had abdominal pain, 8.3% had vomitting during pregnancy, 8.3% had abdominal pain, weakness and vomitting. Thus illiterate women reported to have bleeding. While educated women reported abortion and other complications.

Table No. 43

Difficulties during Pregnancy as reported by poor Socio-Economic Status Women of different Caste group

Category	Stomach ache	Bleeding	Abortion	No Problem	N.A.	Vomitting during Pregn.	Stomach-ache+weak-ness+vomit.	Abnormal foctus position	Preterm babies
SC	3 17.6	-	2 11.8	6 35.3	4 23.5	-	-	2 11.8	-
BC	4 9.5	3 7.1	1 2.4	19 15.2	12 28.6	1 2.4	1 2.4	-	1 2.4
Others	1 12.5	2 25.0	1 12.5	2 25.0	1 12.5	1 12.5	-		
Total	8 11.9	5 7.5	4 6.0	27 40.3	17 25.4	2 3.0	1 1.5	2 3.0	1 1.5

In table no. 43, among 17.6% Schedule Caste women reported abdominal pain during pregnancy. 11.8% each abnormal foctus position and abortion. Among backward caste

9.5% women had abdominal pain, 7.1% bleeding 2.4% abortion, 2.4% vomitting during pregnancy, 2.4% abdominal pain, weakness and vomitting, 2.4% had preterm babies. Among other caste, 12.5% had abdominal pain, 12.5% abortion, 12.5% had vomitting during pregnancy, 25% had bleeding during pregnancy.

Table No. 44

Difficulties faced during Pregnancy among poor Socio-Economic Status Women involved in different Occuppation

Category	Abdominal pain	Bleeding	Abortion	No Problem	N.A.	Vomitting during Pregn.	Abdominal pain+weak-ness+vomit.	Abnormal foctus position	Preterm babies
Student	-	-	-	-	1 100.0	-	-	2 11.8	-
Housewife	7 15.6	3 6.7	1 8.9	17 37.8	9 20.0	2 4.4	1 2.2	1 2.2	1 2.2
Wage earner	1 5.3	2 10.5		9 47.4	6 31.6	-	-	1 5.3	-
Student + Housejob	-	-	-	1 50.0	1 50.0	-	-	1 1	-
Total	8 11.9	5 7.5	4 6.0	27 40.3	17 25.4	2 3.0	1 1.5	2 3.0	1 1.5

In table no. 44, 37.8% housewives had no problem as compared to 47.4% wage-labourer had no problems, 15.6% housewives had abdominal pain as compared to 5.3% wage labourer reported, 8.9% abortion reported by housewives, 6.7% bleeding during pregnancy reported by them as compared

to 10.5% wage labourers reported so. 4.4% housewives had vomitting during pregnancy, 2.2% had abnormal foetus position, 2.2% had preterm babies. 5.3% wage labourer reported abnormal foctus position. Thus housewives had problems of abdominal pain mostely while more wage labourers had bleeding during pregnancy.

Table No. 45

Difficulties during Pregnancy faced by Educated/Illiterate Women of Poor Socio-Economic Status Category

Category	Abdominal pain	Bleeding	Abortion	No Problem	N.A.	Vomitting during Pregn.	Abdominal pain+weak-ness+vomit.	Abnormal foctus position	Preterm babies
Education	2 8.7	2 8.7	1 4.3	8 34.8	7 30.4	1 4.3	1 4.3	1 4.3	-
Illiterate	6 13.6	3 6.8	3 6.8	19 43.2	10 22.7	1 2.3	-	1 2.3	1 2.3
Total	8 11.9	5 7.5	4 6.0	27 40.3	17 25.4	2 3.0	1 1.5	2 3.0	1 1.5

As table no.45, 34.8% literate women as compared to 43.2% illiterate women reported no problems, 13.6% illiterate women, had abdominal pain as compared 8.7% educated women 6.8% among illiterate women had bleeding as compared to 8.7% literate. Thus overall more problems like abdominal pain along with weakness, vomitting during pregnancy abnormal position of foctus were reported by literate women than illiterate women. While abortion, abdominal pain were more among the illiterate women.

Table No. 46

Difficulties during Pregnancy among Educated/Illiterate Women of Very Poor Socio-Economic Category

Category	Bleeding	Abortion	No Problem	N.A.	Vomitting during Pregn.	Stomach-ache +weakness+ vomitting
Educated	-	-	1 50.0	1 50.0	-	-
Illiterate	4 19.0	1 4.8	12 57.1	1 4.8	2 9.5	1 4.8
Total	4 17.4	1 4.3	13 56.8	2 8.7	2 8.7	1 4.3

Among very poor SES category housewives of very poor category reported to have bleeding during pregnancy, 16.7% reported to have preterm babies. While 33.3% had no problems. 11.8% wage labourer women had bleeding during pregnancy, 11.8% had vomitting during pregnancy, 15.9% wage-labourer women reported abortion. Thus, wage labourer women reported various kinds of problems related to the pregnancy like abortion, vomitting during pregnancy. While housewives reported more problems than wage earner women. In table no. 46 educated women of very poor category.57.1% illiterate women had no problems while 19% reported bleeding, 9.5% vomitting during pregnancy, 4.8% abortion 4.8% abdominal pain, weakness and vomitting. Thus, problems like bleeding during pregnancy, vomitting reported by illiterate very poor women.

Case Study

"Kusum an expecting mother of age 17 years belonging to Harijan caste and very poor category living with her husband and mother-in-law in a mixed i.e. Kaccha & Pucca kind of house. During the time of interview her mother-in-law did not want her interview but wanted herself to get interviewed. As according to her she knew better than her daughter-in-law. Researcher started informal discussion with mother-in-law and tried to know their living conditions and livlihood and problems faced by women and through that rapport was also developed with that women. So she told researcher about the non-availability of work to them as labour in the village is called from outside state. This has led to their further poverty. Researcher also managed to talk to Kusum who was at first reluctant to give the interview but later started revealing her conditions and told that she had abdominal pain during pregnancy. On enquiring about the treatment she replied that no treatment was taken. While discussing this with mother-in-law it was found that she considered this as the excuse on part of her daughter-in-law to avoid household work due to which, she has to do it alone while she was old. She said that she called dai for her examination but found everything right. So her daughter-in-law does not have any actual problem. The interview with Kusum was interrupted as her elder brother-in-law entered the house. She stopped talking and run off to other room and did not reply after that. On talking about consulting ANM. The mother-in-law replied that she would expect some fees which is unaffordable for them to pay, move over the daughter-in-law was not having any serious problems. Continous visit to the house found the same conditions of Kusum.

Thus negative socio-cultural conditions like Purdah system and domination of mother-in-law and poverty conditions which prevent the proper care and treatment of pregnant mother. As she had no check ups after detection of pregnancy and not even after having complications. These conditions forced her to live in the pathetic condtitions.

Treatment sought for Pregnancy related problems

Out of 140 women, 10 took treatment from ANM for pregnancy related problems, one from PHC, three from Dhurala

RMP, 3 from RMP at KKR, 15 reported to take treatment from trained practitioner at KKR, two reported to consult civil hospital, 5 take no treatment, 12 reported to consult dai, three to take treatment from traditional practitioner, 58 did not face problem, 6 took precaution and have remedy, 25 reported to take treatment from civil hospital and trained practitoners four taken treatment from ANM and trained practitioner, one from PHC and RMPat Dhurala, four from ANM and dai, one from RMP at KKR and traditional practitioner, 5 reported to take treatment from traditional practitioner, ANM and dai, two reported to take no. measure or treatment for their problem.

Table No. 47

Measures taken for the treatment of Pregnancy related problems by Women belonging to different Socio-Economic Status Category

Category	ANM	PHC	Dhurala RMP	RMP at city	GP at city	Civil hosp.	No Treat-ment	Dai	TP	N.A.
Rich	-	-	-	-	4	-	-	-	-	9
					21.1					47.4
Not-so-rich	2	-	-	-	7	-	-	1	-	11
	6.5				22.6			3.2		35.5
Poor	6	-	2	1	4	1	3	10	3	27
	9.0		3.0	1.5	6.0	1.5	4.5	14.9	4.5	40.3
Very poor	2	1	1	2	-	1	2	1	-	11
	8.7	4.3	4.3	8.7		4.3	8.7	4.3		47.8
Total	10	1	3	3	15	2	5	12	3	58
	7.1	.7	2.1	2.1	10.7	1.4	3.6	8.6	2.1	41.4

Category	Prac	Civil hosp.+	ANM+ TPR	RMP at city	Trad.	Trad.	ANM+ Dai	No measure Treatment
Rich	1	1	1	-	-	1	1	1
	5.3	5.3	5.3			5.3	5.3	5.3
Not so	1	3	2	1	3	-	-	-
rich	3.2	9.7	6.5	3.2	9.7			
Poor	2	1	1	-	1	-	4	1
	2.0	1.5	1.5		1.5		6.0	1.5
Very poor	2	-	-	-	-	-	-	-
	8.7							
Total	6	5	4	1	4	1	5	2
	4.3	3.6	2.9	.7	2.9	.7	3.6	1.4

In table no. 47, among rich 21.1% took treatment from qualified practitioner at city, and 5.3% each from civil hospital and qualified city practitioner, ANM and trained practitioner, traditional practitioner, ANM and dai, no treatment. Among not so rich 22.6% took private specialist treatment in the city. 9.7% each from civil hospital trained city practitioner, traditional practitioner 6.5% each from ANM and specialist at city, 3.2% each took precaution, consulted dai and RMP at city and also traditional practitioner. Among poor 14.9% and consulted dai, 9% to ANM, 6% from trained practitioner at city, ANM and dai,4.5% each from traditional practitioner and taken no treatment, 1.5% each from RMP at city, civil hospital and trained city practitioner, ANM and trained city practitioner, traditional practitioner and 15% taken no treatment, 3% take precautions. Among very poor 8.7% each consult ANM, Dhurala R.M.P, civil hospital dai, Except wage earnees all other

maximally causult trained practitioner at city and this % is very low for poor category is 6% only.

Table No. 48

Treatment for Pregnancy related problem as taken by Women of different Caste

Category	ANM	PHC	Dhurala RMP	RMP at city	QP at city	Civil hosp.	No Treat-ment	Dai	Trad.	N.A.
SC	1 3.7	-	2 7.4	2 7.4	1 3.7	1 3.7	3 11.1	4 14.8	-	12 44.4
BC	6 8.0	1 1.3	1 1.3	-	5 6.7	1 1.3	2 2.7	8 10.7	3 4.0	34 45.3
Others	3 7.9	-	-	1 2.6	9 23.7	-	-	-		12 31.6
Total	10 7.1	1 .7	3 2.1	3 2.1	15 10.7	2 1.4	5 3.6	12 8.6	3 2.1	58 41.4

Category	Prec	Home treat.	Civil hosp.+ QP	ANM+ QP	RMP at city	Trad.	Trad.	ANM+ Dai	No measure Treatment
SC	-	-	-	-	-	-	-	1 3.7	-
BC	-	4 5.3	2 2.7	-	1 1.3	2 2.7	1 1.3	3 4.0	1 1.3
Others	2 5.3		3 7.9	4 10.5		2 5.3		1 2.6	1 2.6
Total	2 1.4	4 2.9	5 3.6	4 2.9	1 .7	4 2.9	1 .7	5 3.6	2 1.4

Caste wise, as refer to table no. 48, more other caste women took treatment and that too from trained practitioner

or specialist i.e. 23.7% from trained city practitioner as compared to 6.7% backward caste women and 3.7% schedule caste. While 11.1% for the pregnancy related problems as compared to backward caste i.e. 13%.

Table No. 49

Treatment for Pregnancy related problem as reported by Women with different Occupations

Category	ANM	PHC	Dhurala RMP	RMP at city	QP at city	Civil hosp.	No Treatment	Dai	Trad.	N.A.
Student	-	-	-	-	-	-	-	-	-	5
										100.0
Housejob	8		2	2	15	-	2	6	3	34
	8.2		2.1	2.1	15.5		2.1	3.1	3.1	55.1
Service	-	-	-	-	-	-	-	-	-	1
										100.0
Wage	2	1	1	1	-	2	3	6	-	18
earner	5.4	2.7	2.7	2.7		5.4	8.1	16.2		48.6
Total	10	1	3	3	15	2	5	12	3	58
	7.1	.7	2.1	2.1	10.7	1.4	3.6	8.6	2.1	41.4

Category	Prac	Treatment	Civil hosp.+	ANM+ QP	RMP at city	Trad.& ANM	Trad.	TP+ANM Dai	No measure Treatment
Student	-	-	-	-	-	-	-	-	-
Housejob	2	3	5	4	1	4	1	3	2
	2.1	3.1	5.2	4.1	1.0	4.1	1.0	3.1	2.1
Service	-	-	-	-	-	-	-	-	-
Wage	-	1	-	-	-	-	-	2	-
earner		2.7						5.4	
Total	2	4	5	4	1	4	1	5	2
	1.4	2.9	3.6	2.9	.7	2.9	.7	3.6	1.4

Occupation wise, as refer to table no. 49, more housewives took treatment from qualified practitioner i.e.

15.5% and from ANM 8.2%, 3.1% from dai, 5.2% from civil hospital and trained practitioner, 4.1% from ANM and trained practitioner 3.1% from ANM & dai. While some of the wage labourer did not take treatment i.e. 8.1%, 5.4% each from ANM and civil hospital, 5.4% from traditional practitioner, ANM and dai, 16.2% from dai. Thus, more wage wage labourer depended on dai than on trained practitioner like housewives.

Table No. 50

Treatment for Pregnancy related problems as taken by Educated or Illiterate Women

Category	ANM	PHC	Dhurala RMP	RMP at city	TPR at city	Civil hosp.	No Treat-ment	Dai	Trad.	N.A.
Educated	5 8.8	-	1 1.8	-	8 14.0	-	-	1 1.8	1 1.8	24 42.1
Illiterate	5 6.0	1 1.2	2 2.4	3 3.6	7 8.4	2 2.4	5 6.0	11 13.3	2 2.4	34 41.0
Total	10 7.1	1 .7	3 2.1	3 2.1	15 10.7	2 1.4	5 3.6	12 8.6	3 2.1	58 41.4

Category	Prac	Treat-ment	Civil hosp.+ QP	ANM+ TPR	RMP at city	Trad.	Trad.	ANM+ Dai	No measure Treatment
Educated	1 1.8	1 1.8	5 8.8	4 7.0	-	4 7.0	1 1.8	-	1 1.8
Illiterate	1 1.2	3 3.6	-	-	1 1.2	-	-	5 6.0	1 1.2
Total	2 1.4	4 2.9	5 3.6	4 2.9	1 .7	4 2.9	1 .7	5 3.6	2 1.4

In table no.50, more educated women i.e. 14.0% consulted trained city practitioner as compared to illiterate women who maximum consulted dai for their pregnancy related problems i.e. 13.3%, 8.8% educated women to ANM, 8.8% from civil hospital and trained city practitioner and from other sources like ANM and dai etc. Illiterate women also 60% from ANM, 6% taking no treatment, 1.2% from PHC, 1.2% PHC and village quack etc.

Place of Delivery
Caste, Occupation & Education WISE

Maximum women have home deliveries in case of women belonging to very poor category and maximum women of rich had deliveries at nursing home.

Table No. 51

Place of Delivery as reported by Women belonging to different Caste

Caste	Home delivery	Hospital deliery	N.A.	Nursing Home
SC	20 74.1	–	7 25.9	–
BC	56 74.7	1 1.3	17 22.7	1 1.3
Others	26 68.4	3 7.9	6 15.8	3 7.9
Total	102 72.9	4 2.9	30 21.4	4 2.9

As per table no. 51, among high caste or other caste 68.4% deliveries took pace at home, 7.9% at hospital and 7.9% at nursing home, among Backward caste 74.7% deliveries at home, 1.3% at hospital and 1.3% at nursing home. While among Schedule caste all 74.1% were home deliveries. Thus, it can be seen that among low caste most of the deliveries took place at home while among upper or high caste households some delivereis also took place outside home i.e. maximum for other caste and then for the backward caste.

Table No. 52

Place of Delivery as reported by Women involved in Various Occupation

Caste	Home delivery	Hospital deliery	N.A.	Nursing Home
Student	–	–	3 100.0	–
Housejob	71 73.2	4 4.1	18 18.6	4 4.1
Service	–	–	1 100.0	–
Wage earner	30 81.1	–	7 18.9	–
Student+ Housejob	1 50.0	–	1 50.0	–
Total	102 72.9	4 2.9	30 21.4	4 2.9

Occupation wise, as table no. 52, 73.2% housewives

reported home deliveries, 4.1% at the hospital and 4.1% at the nursing home, while wage labourers women all deliveries took place at home i.e. 81.1%. Thus it can be said that housewives were able to afford their delivereis outside home with its expanses. While wage earner women had no deliveries outside their homes.

Table No. 53

Place of Delivery as reported by Educated or Illiterate Women

Caste	Home delivery	Hospital deliery	N.A.	Nursing Home
Educated	36	3	16	2
	63.2	5.3	28.1	3.5
Illi-	66	1	14	2
terate	79.5	1.2	16.9	2.4
Total	102	4	30	4
	72.9	2.9	21.4	2.9

In table no. 53, Education wise it can be seen that educated women had 63.2% had home deliveries as compared to 79.5% in case of illiterate women. Thus more home deliveries were reported among illiterate women. While educated also had it in the hospital and nursing home more.

Who assisted Delivery ?

Investigator observed that most of the deliveries conducted by dai. During the field work incidentally the

investigator came across the delivery in the household of not-so- rich and found that ANM was called assist the delivery. for further information, out of 140 sample. Among sample women 73 (52.15%) deliveries were assisted by dai, 6 from ANM, 8 from nursing home and hospital, 23 (16.4%) by dai & ANM.

Table No. 54

Assistance taken from at the time of Delivery by Women of different Socio-Economic Status Category

Category	Dai	ANM	Nursing Home + Hospital	N.A.	Dai+ANM
Rich	2 10.5	4 21.1	3 15.8	6 31.6	4 21.1
Not so rich	13 41.9	-	4 12.9	4 12.9	10 32.3
Poor	40 59.7	2 3.0	1 1.5	17 25.4	7 10.4
Very poor	18 78.3	-	-	3 13.0	2 8.7
Total	73 52.1	6 4.3	8 5.7	30 21.4	23 16.4

In table no. 54, Among rich category 21.1% deliveries each assisted by ANM and dai and ANM, 15.8% from qualified personnel at nursing home and hospital and 10.5% conducted by for dai alone. Among not so rich 41.9% assisted by dai while 12.9% by qualified personnel at nursing home and hospital 32.3% from Dai and ANM. Among poor 59.7% assisted by dai,

while 10.4% from Dai and ANM, 1.5% at nursing home and hospital, 3% from ANM. Among very poor category 78.3% deliveries conducted by Dai alone and only 8.7% from dai and ANM. Thus among very poor and poor category most of the deliveries assisted by dai alone in comparison to rich and not so rich categories where deliveries mostly assisted by ANM or Dai with ANM and also at the nursing home.

Who assisted Deliveries across SES Caste

Among other caste 26.3% deliveries conducted by dai, 15% at nursing home, 34% from dai and ANM, 7.9% from.

Table No. 55

Person assisted Delivery as reported by Women of different Caste Group

Category	Dai	ANM	Nursing Home + Civil Hospital	N.A.'	Dai+ANM
SC	17 63.0	–	–	7 25.9	3 11.1
BC	46 61.3	3 4.0	2 2.7	17 22.7	7 9.3
Others	10 26.3	3 7.9	6 15.0	6 15.0	13 34.0
Total	73 52.1	6 4.3	8 5.7	30 21.4	23 16.4

ANM as referred to table no. 55, among backward caste 61.3% deliveries asisted by dai, 9.3% by dai as well as ANM,

4% from ANM, 2.7% at nursing home. While among schedule caste 63% deliveries assisted by dai and 11.1% by dai and ANM. Thus, it can be seen that most of the schedule caste women depended on dai and very few on ANM for deliveries. While among backward caste some relied on specialist services of nursing home and ANM also and this has increased among other caste category women who relied more on specialist services of ANM, nursing home and few depend on dai in comparison to backward and schedule caste. Thus, with upward caste of women there is more relaince on specialist services.

Table No. 56

Person assisted Delivery as reported by Women involved in Various Occupations

Category	Dai	ANM	Nursing Home + civil Hospital	N.A.	Dai+ANM
Student	–	–	–	3 100.0	–
Housejob	43 44.3	6 6.2	8 8.2	18 18.6	22 22.7
Service	–	–	–	1 100.0	–
Wage earner	29 78.4	–	–	7 18.9	1 2.7
Student+ Housejob	1 50.0	–	–	1 50.0	–
Total	73 52.1	6 4.3	8 5.7	30 21.4	23 16.4

Occupation wise as refer to table no.56, most of the wage earner women depend on dai than the housewives and very few of them i.e. 2.7% only take assistance of ANM and Dai as compared to housewives i.e. 22.7% and 6.2% from ANM. Thus wage earner women are not able to avail specialist assistance at the time of delivery.

Table No. 57

Person assisted Delivery as reported by Educated and Illiterate Women

Category	Dai	ANM	Nursing Home + civil Hospital	N.A.	Dai+ANM
Educated	15 26.3	5 8.8	5 8.8	16 28.1	16 28.1
Illi-terate	58 69.9	1 1.2	3 3.6	14 16.9	7 8.4
Total	73 52.1	6 4.3	8 5.7	30 21.4	23 16.4

As referred to table no.57, illiterate women depended on dai i.e. 69.9% as compared to educated women 26.3%. 28.1% educated women depend on dai as well as ANM while only 8.4% illiterate, 8.8% educated women on ANM as compared to 1.2% uneducated women, 8.8% educated women relied on nursing home/hospital as compared to 3.6% of uneducated women. Thus more educated women took specialist services at the time of delivery than uneducated women.

Tradition related to Child-Birth

Out of 140 sample women, 54 reported not to work for some days just after child-birth, while 53 reported not to work for one month or more than a month, 18 reported to observe no practice, and one observed the practice of not to lift weight for some days and not to work after delivery. Thus, 38.6% did not work for some days while 37.9% not work for one months more than one month after delivery. 14 did not reply i.e. 12.9% reported to do it according to suitability.

In table no. 58, Among rich 68.4% did not work for one month or more, 5.3% each not work for some days and observed no practices. Among not so rich 48.4% did not work for one month or more and 32.3% for some days while 9.7% did not observe particular practice. This percentage of observing no such practices increase with lowering of SES i.e. 16.4% for poor 40.3% of then did not work for some days, 31.3% for one month or more. Among very poor 13% had no such practices. Thus, poor start working after some days of delivery unlike rich women who work after one month more.

Table No. 58
Traditions related to Child-Birth Across SES

Category	Not work for some days	1 month or more than	Not lift-ment weight	No practice	N.A.
Rich	1 5.3	13 68.4	-	1 5.3	4 21.1
Not-so-rich	10 32.3	15 48.4	-	3 9.7	3 9.7
Poor	27 40.3	21 31.3	1 1.5	11 16.4	7 10.4
Very Poor	16 69.6	4 17.4	-	3 13.0	-
Total	54 38.6	53 37.9	1 .7	18 12.9	14 10.0

In table no.58, it can be seen that most of the wage earner women are not able to take rest for more days' after their deliveries and has to start work after some days of delivery i.e. 69.6% women of this category reported so while more women in high and middle SES category started work only after one or more than one months period after delivery. So they were able to get much rest than others.

Difficulties During Child-Birth

Out of 140 women, 5 experienced problems during child-birth while 106 had no problems, 29 had no experience of child-birth. 75.7% had no problems, 3.6% found difficulties.

Table No. 59

Difficulties faced by Women during Child-Birth as reported by Women of Different Socio-Economic Categories

Category	Problem	No Problem	No Exper.
Rich	-	14 73.7	5 26.3
Not so rich	-	27 87.1	4 12.9
Poor	4 6.0	45 67.2	18 26.9
Very poor	1 4.3	20 87.0	2 8.7
Total	5 3.6	106 75.7	29 20.7

In table no. 59, among rich 73.7% had no problems and others are not applicable, among not-so-rich also no problem while among poor 4 i.e.6% reported to had problems, and among very poor i.e. 4.3% had problems. Thus poor and very poor women had problems related to child-birth.

Measure to prevent problems of Child-Birth

Out of 140 sample women, two reported to consult ANM,one each from registered medical practitioner and civil hospital, three from traditonal practitioner at KKR, 45 reported to consult dai, 41 reported no problem, 10 reported to consult traditional practitioner, ANM and PHC,one each reported to consult civil hospital and traditional

practitioner and ANM and traditional practitioner. 30 reported to consult ANM as well as dai, one consulted RMP in village and city trained practitioner, 4 reported to consult traditional healer, 1 from civil hospital and 1 from ANM and dai.

Treatment for Child-Birth problems across socio-economic conditions

Table No. 60

Measures taken at the time of Delivery By Women of Different Socio-Economic Status Category

Category	ANM	RMP	QP at city	Civil Hosp.	Dai	NA	TRAD+ ANM+PHC	Civil hos. + TP	ANM+ TP	ANM+ Dai	RMP+ QP	TP+ ANM+Dai
Rich	2 10.5		3 15.8	-	-	6 31.6	1 5.3	-	1 5.3	6 31.6	-	-
Not-so-rich	-		-	-	6 19.4	4 12.9	-	1 3.2	-	17 54.8	-	3 9.7
Poor	-	-	-	1 1.5	26 38.8	25 37.3	6 9.0	-	-	7 10.4	1 1.5	1 1.5
Very poor	-	1 4.3	-	-	13 56.5	6 26.1	3 13.0	-	-	-	-	-
Total	2 1.4	1 .7	3 2.1	1 .7	45 32.1	41 29.3	10 7.1	1 .7	1 .7	30 21.4	1 .7	4 2.9

As per table no.60, maximum women i.e. 32.1% consult dai. Among those maximum percentage of very poor i.e. 56.5%, then poor socio-economic status i.e. 38.8%, then not-so-rich socio-economic status i.e.19.4%. Thus, poor depend on dai.After that 10.4% women depend on ANM well as dai,

among these 54.8% maximum are from not-so-rich socio-economic status, 31.6% rich socio-economic status and then 10.4% i.e. poor socio-economic status. Thus rich mainly depend on ANM as well as dai or soely on specialist or gynaecologist as 15.8% of rich socio-economic status on qualified practitioner and 10.5% or ANM.

Table No. 61

Treatment for Child-Birth problems as reported By Women of Different Caste

Category	ANM	RMP	QP TP at city	Civil Hosp.	Dai	NA	TP ANM+PHC	Civil hos. + Trad.	ANM+ Trad.	ANM+ Dai		Trad+ ANM+Dai
SC	-	-	-	-	11	11	1	-	-	2	-	2
					40.7	40.7	3.7			7.4		7.4
BC	1	1	-	1	30	21	7	-	-	12	1	1
	1.3	1.3		1.3	40.0	28.0	9.3			16.0	1.3	1.3
Others	1	-	3	-	4	9	2	1	1	16	-	1
	2.6		7.9		10.5	23.7	5.3	2.6	2.6	42.1		2.6
Total	2	1	3	1	45	41	10	1	1	30	1	4
	1.4	.7	2.1	.7	32.1	29.3	7.1	.7	.7	21.4	.7	2.9

As refer to table no.61 , more schedule caste women consulted dai than backward caste and lastly then other caste women as 40.7%, 40% and 10.5% respectively while more other caste women took services of ANM and dai i.e.42.1% while 7.4% schedule caste did so. Thus other caste category took more treatment and more specialist services also taken by them.

Breast Feeding

Among 140 sample women, 84 replied to breast fed the babdy after 2 or 3 days of delivery, 25 reported to do after 12 hours, 31 did not reply. 60% reported to breast fed the baby after 2 or 3 days of delivery while 17.9% did it after 12 hours of delivery.

Table No. 62

Time of Starting Breast Feeding among Women of Different Socio-Economic Status Category

Category	2 or 3 Days	After 12 hours	N.A.
Rich	11 57.9	2 10.5	6 31.6
Not so rich	17 54.8	10 32.3	4 12.9
Very poor	37 55.2	12 17.9	18 26.9
Poor	19 82.6	1 4.3	3 13.0
Total	84 60.0	25 17.9	31 22.1

Among rich, 57.9% breast fed the baby after 2 or 3 days of delivery. 10.5% after 12 hours of delivery. Among not so rich 54.8% did it after 2 or 3 days, 32.3% after 12 hours. Among poor 55.2% after 2 or 3 days, 17.9% after 12 hours among very poor category, 82.6% after 2 or 3 days while 4.3% after 12 hours. So most of the %age of women breast

fed after 2 or 3 days of delivery and this is specifically high for very poor i.e. 82.6% as compared to women who breast fed that day only after 12 hours high for not so rich.

Immunization of Children

Out of 140 sample women, 70 replied in favour of the immunization of their children, 38 replied against immunization of their children, 32 did not like to response since they were unmarried and newly married women. 50% immunize their children, while 27.1% did not get immunization for their children.

Table No. 63

Immunization whether being done among Children Across Socio-Economic Status Category

Category	Immunization	Non-Immunization	N.A.
Rich	9 47.4	4 21.1	6 31.6
Not so rich	23 74.2	4 12.9	4 12.9
Poor	31 46.3	17 25.4	19 28.4
Very poor	7 30.4	13 56.5	3 13.0
Total	70 50.0	38 27.1	32 22.9

Among rich 47.4% answered positively while 21.1% women have not immunized their children. Among not so rich 74.2% immunized their children while 12.3% did not. Among poor 46.3% immunized while 25.4% did not. Among very poor only 30.4% immunized, while 56.5% did not immunize their children. So immunization coverage is worst among very poor and best among not-so-rich and rich after that among poor. Nursing women 81% reported immunization of their children, 60% pregnant, 58.8% mothers of two or 3 children reported to get immunization for their children.

From where got them Immunized

Out of 140, 71 reported to get their children immunized from PHC, 3 from qualified practitioner,5 from ANM, 24 reported no immunization, 35 did not respond since they were not having children, 2 reported to get immunization from civil hospital. So maximum children immunized from, PHC i.e. 50.7% while 17.1% did not get immunization.

Table No. 64

Place from where get Immunization for Different Socio-Economic Status Women

Category	PHC	QP	ANM	No Immu-nization	N.A.	Civil Hospital
Rich	4	2	3	2	7	1
	21.1	10.5	15.8	10.5	36.8	5.3
Not so	25	1	1	-	4	-
rich	80.6	3.2	3.2		12.9	
Poor	31	-	-	14	21	1
	46.3			20.9	31.3	1.5
Very poor	11		1	8	3	-
	47.8		4.3	34.8	13.0	
Total	71	3	5	24	35	2
	50.7	2.1	3.6	17.1	25.0	1.4

In table no. 64, Among rich 21.1% immunized from PHC, 10.5% from trained practitioner 15.8% from ANM 5.3% from civil hospital. Among not so rich get 80.6% immunized from PHC, 3.2% from TRP, 3.2% from ANM, among poor only 46.3% immunized from PHC and 1.5% from civil hospital, while among very poor percent of non-immunized is highest i.e. 34.8% as compared to low i.e. 20.9% and high 10.5%. While among who immunized 47.8% from PHC, 4.3% from ANM. Thus PHC maximum rendered immunization services to not-so-rich. While rich get immunization from qualified practitioner, ANM and civil hospital in contrast to poor and very poor class who rarely get immunized from ANM and not able to get immunization from qualaified practitioner due to poverty. Nursing mother 21.1% get immunization for their children from PHC, 10.5% each from trained practitioner and no immuniztion at all, 15.8% pregnant from ANM, 5.3% from civil hospital at all, each from trained practitioner and ANM, mother reportedly 94.1% from PHC and 4.3% from ANM. Educated 57.9% immunized their children from PHC and rest from others, like 1.8% from trained practitioner, 3.5% from ANM and civil hospital each and 5.3% no immunization, uneducated 45.8% from PHC,25.3% no immunization 2.4% from trained practitioner, 3.6% from ANM. Thus, more no. of educated women got accessible to PHC services than other service. Housejob doing women 56.7% get immunization from PHC while 12.4% no immunization. 4.1%

from ANM,3.1% from qualified practitioner, 2.1% from civil hospital while wage labourer 43.2% from PHC, 29.7% no immunization, 2.7% from ANM. Thus less immunization among wage labourer was found.

SC mostly get immunization 33.9% from PHC; 3.7% from civil hospital. BC from 52% from PHC, 1.3% from TRP,4% from ANM, other caste 60.5% from PHC, 5.3% TPR, 5.3% from ANM. Thus, the among high caste more is the percent of immunization and more is from PHC, ANM and trained practitioner i.e. from specialist.

Traditions related to Child Rearing

Out of 140 only 3 reported to observed the traditions or celebrations regarding child-birth while 137 observed no such practices. 97.9% observed no traditions related to child-rearing while ony 2.1% had these kinds of practices.

Among rich only 5.3% observed some practices or celebrations while 94.7% did not have such traditions. Among not-so-rich SES nobody observed, among poor SES only 3% observe, and amaong very poor no one observed. Only few poor and rich oberved such practices. Nursing pregnant and newly married and adolescent reported no such practices while mothers 3.5% had some related practices. Women of age group 15 to 25 yrs, 26 to 35 did not observe such tradition only 36 to 45 yrs group reported i.e. 10.7% of observing

such traditions.

Table No. 65

Traditons related to Child-Rearing as reported to be observed by Educated/Illiterate Women

	Observed Traditions	Not Observed Traditions
Educated	1	56
	1.8	98.2
Illiterate	2	81
	2.4	97.6
Total	3	137
	2.1	97.9

In table no. 65, educated 1.8% observe while 98.2% did not observe such practices. Uneducated 2.4% observed while 27.6% did not observe such practices. More uneducated oberved such traditions.

Table No. 66

Traditons related to Child-Rearing as observed by Women of Different Caste

	Observed	Not observed
SC	1	26
	3.7	96.3
BC	1	74
	1.3	98.7
Others	1	37
	2.6	97.4
Total	3	137
	2.1	97.9

In table no. 66 Only 3.7% Sc, 1.3% BC and 2.6% other caste women observed such traditions.

Problems related to Child-Rearing

Out of 140 sample women, 8 reported diarrhea in children, 24 had fever, one is having cold, 3 reported some other difficulties like, 44 had no problems in child-rearing, 3 reported to have pnenmonia, 26 had not responded, 1 complaunt of vomitting in-children, 2 of chickenpox, 9 reported fever and diarrhea among children, 11 reported to had cold, caugh and fever, 8 reported diarrhea, fever and caugh. During the study period 31.4% had not problems.

Table No. 67

Problems of Child-Rearing Reprted by Women of Different Socio-Economic Background

Category	Diarrhea	Fever	Cold	other Diffi.	No Prob.	Pnemonia	N.A.	Vomitting	Chicken-Pox	Fever & Diarrhea	Cold& Cough& Fever	Diarrhea Fever & Cough
Rich	-	-	1 5.3	-	9 47.4	1 5.3	6 31.6	-	-	1 5.3	1 5.3	1 5.3
Not so rich	-	5 16.1	-	-	15 48.4	-	4 12.9	-	-	1 3.2	3 9.7	-
Poor	6 9.0	15 22.4	-	1 1.5	17 25.4	2 3.0	14 20.9	1 1.5	1 1.5	5 7.5	3 6	5 7.5
Very poor	2 8.7	4 17.4	-	2 8.7	3 13.0	-	2 8.7	-	1 4.3	2 8.7	4 17.4	2 8.7
Total	8 5.7	24 17.1	1 .7	3 2.1	44 31.4	3 2.1	26 18.6	1 .7	2 1.4	9 6.4	11 7.9	8 5.7

Among rich 5.3% each had cold, fever, diarrhea and cought, among not-so-rich 16.1% had fever, 3.2% had fever and diarrhea and 9.7% each had cold, cough and fever and diarrhea, fever and cough. Among poor category 22.4% had fever, 9% diarrhea, 3% pnemonia, 1.5% each had vomitting, chicken pox and diarrhea cough and fever. 7.5% had fever and diarrhea, 6% cold, cough and fever. Among very poor 17.4% each had fever, cold cough with fever, 13% diarrhea and other problem. So maximum %age illness of fever i.e. 17.1% then and cold, cough and fever. 7.9% and then fever and diarrhea i.e.6.4% which is high among children of poor and very poor category household, i.e. 22.4%, 17.4% respectively fever, 6% and 17.4% fever cold and cough and then 7.5% and 8.7% diarrhea, fever respectively among poor and very poor category.

Measure to prevent Child-Rearing Problems

During the field work, out of 140, 4 reported to consult PHC, 20 consulted RMP at Kurukshetra, 10 took treatment from trained practitioner at KKR, one reported to take no treatment, 16 reported to consult traditonal practitioner, 29 had no problems, 3 reported to consult traditional practitioner, ANM and PHC, 7 reported to take home remedies, 3 reported to consult Civil hospital and qualified practitioner, 10 to city RMP and traditional practitioner, 11 to PHC and RMP Dhurala, 19 to RMP and city

qualified practitioner. Dhurala RMP and city trianed practitioner, 2 consulted PHC and trained practitioner. So maximum women did not consult RMP at Dhurala.

Table No. 68

Measures for the Treatment of problems related to Child-Rearing among Women of Different SES Categories

Category	PHC	RMP	QP KKR	TPR at KKR	No Treat-ment	TP	No Prob.	TP ANM&PHC	Home Remedies	Civil Hos.& TRP at city
Rich	-	1	1	3	-	-	7	-	-	2
		5.3	5.3	15.8			36.8			10.5
Not so rich	-	2	-	3	-	-	8	-	-	-
		6.5		9.7			25.8			
Poor	3	12	-	4	-	12	10	1	3	1
	4.5	17.9		6.0		17.9	14.9	1.5	4.5	1.5
Very poor	1	5	2	-	1	4	4	2	4	-
	4.3	21.7	8.7		4.3	17.4	17.4	8.7	17.4	
Total	4	20	3	10	1	16	29	3	7	3
	2.9	14.3	2.1	7.1	.7	11.4	20.7	2.1	5.0	2.1

Category	PHC+ RMP	City RMP + TP	PHC+ RMP	RMP +city QP	PHC QP
Rich	-	1	1	2	1
		5.3	5.3	10.5	5.3
Not-so-rich	2	2	4	10	-
	6.5	6.5	12.9	32.3	
Poor	-	7	6	7	1
		10.4	9.0	10.4	1.5
Very poor	-	-	-	-	-
Total	2	10	11	19	2
	1.4	7.1	7.9	13.6	1.4

Among rich 15.8% took treatment from qualified practitioner at city, 10.5% each from Dhurala RMP and city qualified, civil hospital and trained practitioner 5.3% each from RMP at village and city, city RMP and traditional healer. PHC & RMP at village, PHC and trained practitioner. Among not-so-rich category 9.7% from qualified practitioner, 12.9% from PHC and RMP at Dhurala, 32.3% from Dhurala RMP and city trained practitioner, 6.5% each from PHC and RMP, city RMP and traditional healer & RMP at village. Among poor category 17.9% each from RMP Dhurala, Traditional practitioner, 10.4% each from city RMP and trained practitioner,Dhurala RMP and city trained practitioner 9% from PHC and RMP Dhurala, 6% from qualified practitioner in city, 1.5% each,traditional healer city practitioner. Among very poor 21.7% consulted RMP at village, 17.4% each from traditional practitioner and home remedies,8.7% each RMP at city and traditional healer, ANM and PHC,4.3% from PHC. So rich depends on specialist while not so rich consulted RMP at village as well as specialist, while poor consult RMP at village and traditoinal practitioner mostly and very poor also do the same, very few took from PHC and ANM services.

Gynae Problems Prevailing Across Classes

Women in the study sample reported white discharge,

irritation, as kind of gynaecological problem.

Maximum percent of gynae problems are reported by women belonging to very poor socio-economic category i.e. 39.1% and least by rich i.e. 26.3%.

Caste wise, 39.5% other caste women reported of gynae problems as compared to 34.7% backward caste and 22.2% schedule caste women. Thus maximum women among high caste reported gynae problems after that in backward and lastly by schedule caste women.

Both educated and illiterate women are equally affected by these problems, 33.3% educated and 3.7% iliterate women also reported of suffering from these problems. Housewives 36.1% reported the gynae problems while 32.1% wage labourer reportd the same. Thus housewives reported more of these problems in comparison to wage earners.

Case Study

> "Shilpa a newly married women of age 25 yrs belonging to high caste and rich socio-ecdnomic category lived in a joint family with her inlaws. Most of the time taking rest on the bed as she was not feeling well. During interview she revealed that she had been suffering from gynaecological problems like infection and irregular periods for past many months. On enquring about the treatment she said that she referred to dai, ANM in the village and had taken their treatment but could not get cure. After that she consulted a city quack and could not get relief. Then she referred to the gynaecologist at city with whose treatment she got relief temporarily but again had the same problem and she also had abdominal pain during periods. She was looking sad and worried about her

conditions and she also felt bad as she could not do any household work due to her illness. Continous and inbetween visits to her home witnessed the same conditions of hers. This shows the inadequate services and the inability of the needed, newly married women to avail these. Even belonging to rich socio-economic category she was not able to afford again and again doctor's fees for her illness as she gets infected quite a number of times. Moreover, she used to feel shy and odd to reveal her problems to her husband. Not doing work at her inlaws place was also a kind of inappropriate thing for her".

Treatment of Gynae Problems Across Classes

As per table no. 69, maximum no. of women not taking treatment for gynae problems belonging to very poor category i.e. 34.3% while maximum no. of rich took gynaecologist treatment i.e. 10.5%.

Table No. 69

Treatment sought from in case of Gynae Problems By Women of Different SES Background

Category	ANM	RMP	QP at city	No Treatment	No Prob.	TP	Trad.& Dai	Dai & RMP & TPR	RMP&PHC	TRP& Civil Hospital	ANM& city RMP
Rich	1 5.3	1 5.3	2 10.5	-	14 73.7	-	-	1 5.3	-	-	-
Not so rich	2 6.5	-	1 3.2	6 19.4	18 58.1	-	-	1 3.2	1 3.2	1 3.2	1 3.2
Poor	4 6.0	1 1.5	1 1.5	18 26.9	42 62.7	-	1 1.5	-	-	-	-
Very poor	-	-	-	7 34.3	14 60.9	1 4.3	-	1 4.3	-	-	-
Total	7 5.7	2 2.1	4 3.6	31 22.5	88 62.9	1 .7	1 .7	3 2.1	1 .7	1 .7	1 .7

Caste wise - 15.8% women belonging to other caste did not take treatment as compared to 22.7% backward caste, and 14.8% schedule caste. While 5.3% other caste consulted ANM, 3.7% schedule caste women treatment from ANM, 6.7% backward women, 3.7% SC women from trained practitioner, 2.6% backward caste from trained practitioner and 7.9% other caste women took treatment from qualified practitioner. Thus, SC women least availed ANM and private practitioners services as compared to backward caste and other caste women.

Occupation wise - as refer to table no. , most of the wage labourer women and housewives did not take treatment for gynae problems, i.e. 21.6% and 19.6% respectively. While some housewives took treatment from ANM and trained practitioner in comparison to very few wage labourer taking treatment from ANM.

Education wise - most of the illiterate women do not get treatment i.e. 21.5% as compared to 17.5% educated women. While less illiterate women take treatment from ANM i.e. 4.8% as compared to educated women i.e. 7% but more rely on traditional practitioner than educated women.

Reasons for not getting treatment for gynae problems amaong poor women is the lack of money and time for the same. Moreover, they felt shy in approaching male doctor at PHC. Few of them go to the PHC but get only prescription of

the medicines, which they have to buy from market as PHC has no supply of these medicines. While not-so-rich women consulted ANM and get some medicines after paying her for the same and rich women consult gynaecologists but could not continue their treatment. The most of these women either don't get treatment and if get that too irregular and most of the time they cure themselves.

From PHC & private practitioner, the measures for family planning are available.

Maximum percentage of women not using family planning measures is in not so rich category i.e. 61.3% after that in very poor's category i.e. 47.8% while maximum very poor adopted these measures only with ANM's suggestion i.e. 39.1%, while maximum rich women adopt these on their own i.e. 42.1%.

Table No. 70

Family Planning Measures as taken by Women belonging to different Caste

Caste	ANM Suggest	Some other advice	Them-selves	Not taken treatment	N.A.
SC	6	1	-	15	5
	22.2	3.7		55.6	18.5
BC	15	1	12	33	14
	20.0	1.3	16.0	44.0	18.7
Others	6	-	12	16	4
	15.8		31.6	42.1	10.5
Total	27	2	24	64	23
	19.3	1.4	31.6	42.1	10.5

As per table no. 70, it can be seen that higher the caste more is the adoption of family planning services i.e. 42.1% other caste women not taking these measures as comparison to high percentage of schedule and backward caste. While high caste women took these measures themselves i.e. 31.6% which is more than 16% of backward caste, no one from schedule caste took these measures themselves and maximum schedule caste took measures with ANM's suggestion.

Table No. 71

Family Planning Measures taken by Women doing different Jobs

Caste	ANM Suggest	Some other advice	Them-selves	Not talen	N.A.
Student	–	–	–	–	3 100.0
Housejob	18 18.6	1 1.0	20 20.6	46 47.4	12 12.4
Service	–	–	1 100.0	–	–
Wage earner	9 24.3	–	3 8.1	18 48.6	7 18.9
Student & Householdjob	–	1 50.0	–	–	1 50.0
Total	27 19.3	2 1.4	24 17.1	64 45.7	23 16.4

Occupation wise most of the housewives and wage labourer do not take family planning measures as refer to table no.71, while more wage labourer women adopt these with

ANM's suggestion than housewives i.e. 24.3% in comparison to 18.6% for later and less wage labourer adopt these by themselves i.e. 8.1% as compare to 20.6% housewives. Service doing women reported to adopt these measures by herself. Thus more wage labourer women adopted these measures with ANM advice than themselves.

More illiterate women reported to adopt these with ANM's suggestion i.e. 22.9% as compared to 14% themselves i.e. 9.6%. Thus illiterate women less used family planning measures and if use mostly with ANM's suggestion.

Case Study

"Saroj a mother of three small children aged 30 yrs belonging to poor Socio-Economic conditons. She was four months pregnant as being revealed by her during interview very sadly. As she did not want another child as it was difficult for her to take care of already three small children as she used to remain weak and ill and was not finding herself fit to bear the burden of fourth child. She wanted to get sterlization opertion but due to her poor health she was not able to get that and her husband was reluctant to undergo that and thus suggested her to take measures. So she started taking oral-pills. She stopped taking pills it as she had complications like irregular periods, vomitting after taking pills. Thus, she conceived due to household work could not go early for the abortion, it is only after 2 months she went to a city practitioner for the abortion who refused to do so as it was risk for her life. She also consulted staff nurse at PHC and ANM. But all of them suggested her to bear the child. She wa very much worried and somehow wanted to get rid of the child for that she used to come to PHC to consult ANM.

This revealed the conditions of helplessness in which a poor women who has to live and carry the burden of their lives. As they have desired to limit their family size in accordance to their socio-economic

conditions but poverty and lack of adequate family planning measures prevent them from doing so. Moreover, cultural factors like subordination to the husbands prevent their assertion. They have to bear and rear the children".

Satisfaction with Family Planning Measures

Among rich category, more percentage of women were not satisified with these family planning measures i.e. 26.3% as compared to the 21.1% women who reported to be satisfied. More other caste women were happy with adoption of family planning measures while backward caste woamen were unhappy with these measures. Educated or literate women reported to be happy with these measures as compared to the illiterate women.

Among not so rich category, only few women i.e. 2.7% reported to be satisfied with family planning measures as comapred to 22.6% reported to be dissatified. More backward caste women of not so rich category were satisfied with family planning measures as compared to other caste. More percentage of housewives reported dissatisfction as compared to farm workers those who was satisfied. Only illiterate women of this category reported to be happy with family planning measures. Thus, housewives, backward ward caste and illiterate women reported their satisfaction with family planning measures.

Among poor socio-economic status category, very less percentage of women reported to be satisfied i.e. 10.4% as

compared to the 31.3% women reported their dissatisfaction. Only backward caste women reported to be satisified while no other caste or schedule caste women reported so. More housewives and wage labourer women reported to be dissatisfied with these measures. More educated women reported to be satisfied as well as dissatisfied as compared to the illiterate with family planning measures. Backward caste women and few educated women reported to be satisfied with these services.

Among very poor more percentage i.e. 26.1% women reported to be dissatisfied with family planning measures as compared to 21.7% reported to be satisfied. Schedule caste women reported to be more satisfied with these services as compared to the backward caste and other caste women. More percentage of backward caste women reported to be dissatisfied. More percentage of wage labourer women reported their satisfaction as well as dissatisfaction with family planning services while houswives reported their dissatisfaction. More percentage of educated women reported to be satisfied as compared to the illiterate women. Thus, educated, wage labourer, schedule caste women reported their satisfaction with family planning services of very poor socio-economic category.

Case Study

"Urmila a women of 35 yrs and mother of three children belonging to poor socio-economic conditions. Researcher happend to meet her as she was one of the sample women's sister-in-law and silently sitting in the corner she was listening to the conversation. She looked very weak and untidy. During informal talks with her, researcher came to know that she has been suffering from continuous watery discharge since long time and also had infections after using copper-t along with that she had problem, as her vargina was not at its normal position but come out after the delivery of her third child. She revealed that only once she consulted ANM and shown her conditions but she could not get any medicine and then she consulted a quack in the village from whom what ever medicine she got she had that but could not continue her treatment due to lack of money to pay for medicines. She herself told that she felt shy as watery discharge lead to foul smell due to which other women do not want to talk to her. She was a deserted by her husband. This shows, ill women living in helpness conditions due to poverty and proper health services".

Perception and Problems of Reproductive Health

The detailed data which has been presented earlier in this chapter has projected the following salient findings -

The perception regarding the reproductive health of the women was found in a state of confusion, misperception and wrong understanding. It was clearly found that the women belonging to the poor and very poor section, mostly associating reproductive health problems with their general health problem and were not taking preventive, promotive and creative measures because of their day-to-day work load in the family and outside. They were not able to find time to consult a qualified practitioner, nor they were able to get

access to the insufficient services of the PHC. Moreove, the PHC could not make available the antenatal or post natal services to the women of these two poorer section. But it was very evident from the data, inspite of their economic misery and social status they had apaproached practitioner in the crisis or having complications after mustering their little resources which they had.

It was found that most of the women in general in the village complaint of weakness, body ache, backache and fatigue. After discussion with medical officer of PHC it was known that most of the girls and women coming to the health centre or otherwise in the village were anemic. So these have all these complaints for which medical staff give iron tablets or other things which were not sufficient to meet the need of these women of poverty and burden of work were the main two reasons behind that. Apart from the general weakness they have also perceived reproductive health problems at larger extent. Most of them suffered from irregular periods, abdominal pain during periods or non onset of menstruation. For these problems generally treatment is not sought and if taken then from ANM, infact precautions were taken related to food to prevent these illnesses. Many women specially after sterlization complaint of irregular periods. Only few cases consulted PHC doctors in this regard.

There are lots of cases of abortion in the village and many women were not able to conceive. While some wanted family planning measures to restrict their family size, and to get ride of unwanted pregnancies. No abortion faciliity was there at PHC level and also not being allowed to ANM to do so. So most of these women got aborted either by taking traditional medicine or very few those who could afford go to the city quack or private practitioner and civil hospital for the same. Thus these conditions adversely affect their health. Many of them complaint of bleeding during pregnancy but they hardly took treatment for that as not able to afford it and lack of time for the same among poor. Thus, take precautions like not lifting weight or avoid taking some kinds of food etc. or they consult to the traditional practitioner. Many women reported neonatal deaths and pre-term babies. Most of the women considered their own weakness as responsible for that. After birth problems or infections are hardly dealt or taken care due to the same reasons. Many of the women also complaint of irritation or infections as gynae-problems. They had watery discharge or infections but they rarely took treatment for the same and sometimes got cure themselves.

It was found that women are very much aware of their periods, pregnancy, child-birth and child-rearing problems. But due to poverty, lack of time and lack of money they

hardly took treatment. Moreover, govt. has not provided adequate services at village level for these women. All these make women's conditions miserable and resulted into poor reproductive health.

On enquiring about their satisfaction with these services most of them wanted to have a big hospital in the village to deal with their and children's problems and lady doctors should also be there to whom them could approach and get treatment for their problems.

Poverty and cultural factors like not discussing their problems with mother-in-law or husband as they were not suppose to expose or express their problems and get care for minor porblems like infections, abdominal pain during periods, irregular periods etc. So it is only on the seriousness and acuteness of their problems they consult village quack or ANM and consult PHC but could not get proper treatment and many times could not afford the long treatment for their illnesses. In case of infections they again and again suffered from these problem.

It was also further found that women of this village could not relate the cause of their reproductive illnesses to the wider issues like poverty, lower social status, illiteracy, malnutrition and traditions and customs. Very few educated women could relate to such problems which were responsible for their ill-health for reproductive role in

family. Since the women were not able to relate the larger issues to the reproductive health problems they were seeking solutions in a narrow medicines and doctors. A very few educated women could see the implication of their low social status, illiteracy and customs responsible for miserable reproductive health.

CHAPTER-IV

DISCUSSION

The status of women in a society is a significant reflection of the level of social justice extended to the women in that society, and this process is involved in a complex set of interrelated factors. Women's status is often described in terms of her level of income, employment, education, health and fertility, as well as the roles she plays within the family, community and society. It also involves society's perception of these roles and the value it places upon them. Women's work participation in agriculture or industry; their contribution to the family income, household maintenance, community organisation and development; and their role in the family and the bearing and rearing of children, not only affects their health but is also affected by it.

The significance of women's reproductive and nurturing roles for health and development as a whole is undeniable. The biological and social realities of their maternal role are closely linked to their health status and are major factors in the problems they face in health, employment, education and many other areas. Considering that the value society attaches to the women's maternal role is one of the crucial factors influencing the status of women, How can we say that a high value is attributed to a women if she dies needlessly in child birth ? If her child is born too small

to survive the first weak because her nutrition was so poor and her worked load was so great during pregnancy ? if she is unable to breast-feed because she cannot devote enough time or leave her job ? if she is not given access to effective, safe and acceptable methods to regulate her fertility ? if she is by passed by education and technological advances and isolated from the mainstream of community action while she is trying to prepare her children for healthy, productive lives in the community ? in short how do we assess the social value accorded to reproduction and nurturing if women are denied the support needed to carry out these roles ? With the above perspectives on the status of women the reproductive health of the women was studied in Dhurala village.

The village Dhurala represents a typical Haryana village and very similar to a typical North-Indian village. Though Haryana is developing state in the country, its rural area is also under going lots of change. But still the change is very slow. In this aspect the village is neither very developed nor underdeveloped, Being not very close or far away from the town the change in the village is also gradual and it is preceding towards the modernization like other north Indian village. The village also has caste variations and has various castes people. The overll life process of the people in this village is found more or less

similar to the other parts of the state.

Village was found to be having distinct four class groups, the people living with the background of different socio-economic conditions were thus categorized into four groups. Such as rich, not-so-rich, poor and very poor.

The people belonging to the rich and not-so-rich categories had resources and lead an life similar to city people with modern gadgets. While people belonging to poor and very poor categories had to take a lot of strenous efforts and hardships to meet their both ends. Thus, the life style was the outcome of their socio-economic conditions. This village has maximum percentage of backward caste households. While schedule caste and other caste were low in number. Still the power structure of the village was dominated by high caste who are supported by backward caste. So these high caste controls all decision making process at the village level and thus plays a important role in the its developmental activities by affecting its policy making and also at the time of programme implementations and also getting maximum benefits at the cost of poor sections of this village.

So far the women's social status is concerned conditions of the women was found to be not good. Women

have no important place in the socio-cultural mileu of the village. They are not at all considered at par with males but have very low status in comparison to that of males. Inspite of their hard work inside and outside their homes and an important role as family supporter, they are still least recognized by their families and do not get support and care from them. Traditions like Purdah-system prevails, which plays an important role in discouraging their education or employment outside or inside the village. Practices like wife-beating are common in the village and women's opinion in their families is not considered. They are rarely asked to give their opinions.

Women also plays a negligible role in the village politics. Thus not able to influence the policy or decisions in favour of them. They are suppose to show submissive behaviour in their own as well as in-law's home. They themselves could not take care of their own problems. As they work hard throughout the day and thus found to be malnourished because of non-availability of food and nutrition. They hardly get treatment for their minor and sometimes major illnesses. No govt. programmes are there in the village to uplift the living conditions of these poor women. Except few women belonging to rich socio-economic households, other women had very miserably poor status in the village.

Reproductive health of women largely affected by the life - style in which women lives. The reproductive health of the women of Dhurala has been studied after categorising the women into four distinct socio-economic groups. The overal life process and health status has been studied in detail to analyse the sociological dimensions of reproductive health.

The women belonging to rich group was found to be having less problems, difficulties in reproductive health in comparison to other three groups. This was because, the women were from higher caste, literate as well as had access to better health services in the village as well as in the nearby town.

Among not-so-rich category. 22.7% women had prior information on one or other aspects of reproductive problems. Schedule caste women in this category had no such informations, whereas 28.5% backward caste and 21.3% other caste women had such information and knowledge. Thus more backward caste of not-so-rich category had information on these aspects. Housewives of this socio-economic category had more information as compared to the farm worker women. Within this socio-economic category illiterate women reported to have more prior knowledge i.e. 24.9% as compared

to 21.1% educated women.

Among women from poor socio-economic group 32.9% had prior information on one or the other aspect of reproduction. Castewise maximum percentage of other caste women i.e. 50% had prior information as compared to schedule caste i.e. 41.1% and 31% backward caste. Students of this category had no such prior knowledge, while student cum house job doer i.e. 50% had more such information than, housewives i.e. 40% and lastly among wage labours women more educated women of poor socio-economic status category had information on future reproductive role as compare to illiterate women.

Among women from the very poor category, 13.0% women had information on one or other aspect of reproduction. 14.3% schedule caste. Women had information on periods as compared to 13.4% backward caste, while no other caste women had such information. Very less labourer women had such information as compared to housewives of this socio-economic category, and 14.3% illiterate women had knowledge on one or other aspects of reproductive role.

It has been seen that backward caste and illiterate women among not-so-rich category were more aware of the future reproductive role, In the poor SES category schedule caste women as compared to backward caste and schedule caste and illiterate women among laborer reported to have more

information. This shows that information regarding the future reproductive role among low caste and illiterate women is more in this very poor category.

The trend broadly can be seen across the class, caste, occupation and education in general. As maximum no. of women had information on various aspects were there in rich socio-economic status category, then among poor socio-economic, after that among not-so-rich and lastly very poor women. Caste wise, other caste women had more information i.e. 39.5% as compared to backward caste and schedule caste i.e. 28.1% and 29.6% respectively. Occupation wise more information was found on various aspects of reproductive role among house wives. More educated women had knowledge on these as compared to illiterate. Thus it can be said that rich socio-economic status women, high caste, housewives and educated women have more information on various aspects related to the reproduction. While within the various socio-economic categories it was found that high caste women and housewives as well as educated women had more information and it decreases with lowering of caste, occupational status and education.

Regarding, practices of various traditions and customes in reproductive health, across class, caste, occupation and education among women also these type of variations was seen. As maximum high caste women observed such practices

and it reduces with lowering of caste. Thus high caste women observed more such practices as compared to backward and schedule caste, women of rich socio-economic status also observed these traditions more than that of not-so-rich, poor and very poor women. This may be because these women could afford to observe such traditions in comparison to other women. These traditions and customs could not be observed because of this poor socio-economic conditions and they were compelled to work outside their houses as well as they themselves had to perform all their housejobs. This life process made it impossible for them to observe such traditions. More over they did not have sufficient food, thus, had no choice for observing food related traditions. High caste women mostly belonging to rich and not-so-rich categories were able to afford such practices. More students, and housewives observed such traditions while labourer women could not afford to observe food and work related taboos during menstruations. Education wise also more literate women can afford these practices i.e. 28.1, as compared to 17.1% illiterate women, who have to work hard in their daily lives. Education has not played any role in observance of these traditions. As these have been observed in the families from the old times and thus posed pressure on younger generation to observe these. These are generally related to food and involved not taking sour food during the

menstruation in order to avoid abdominal pain and other problems related to menstruation. The women who could not observe these traditions and practices did not have any complicatins. So according to them these traditions and customs were meant for rich women who could afford to follow these.

Difficulties faced by women during menstruation also varies from different socio-economic, caste, occupation and education categories.

Across socio-economic categories maximum percentage of problem as reported was abdominal pain which was reported maximum by women of poor socio-economic status. The next maximum reported problem was irregularity of periods and maximum percentage of very poor women had such problems. Thus maximum percentage of poor and very poor socio-economic status women reported problems like abdominal pain during periods and its irregularity respectively. Thus more problems related to the menstruation found among poor women. Schedule caste and backward caste women reported abdominal pain as the main problems during menstruation, while other caste women reported irregularity of periods as the main problem related to menstruation. Occupation wise also students maximum reported abdominal pain during menstruation, housewives and wage labourer women also

reported irregular periods. Thus it was seen that most of the women belonging to poor socio-economic category more reported such problems, whereas housewives and students more reported such problems as compared to labourer women.

Treatment taken from the different sources for the reproductive health problems affected by various factors in the life of a women.

Across classes it was seen as in table no. 31, that maximum percentage of women belonging to very poor socio-economic category and after that not so rich and lastly poor SES did not take treatment. Maximum percentage of rich and poor socio-economic status group women consulted ANM. Maximum percentage of women of rich and not-so-rich category observed precautions. Thus, it can be said that poor women generally did not take treatment and not even take precautions and only rich women avail specialist services and few poor women also take the help of ANM in this matter while not-so-rich women were able to afford the precautions related to food and other matters in contrast to very poor women.

It was found that more schedule caste women did not take treatment as compared to the backward and other caste, more backward caste women take treatment from ANM, as compared to other caste who rely on different sources as well take specialist treatment. Thus, among higher the caste

more women took precautions and consult specialist, while among low caste less women took the treatment.

Occupation wise also, more housewives and student seek treatment in comparison to labourers who rarely took treatment. Most of the housewives and wage labourers also took precautions only. Thus this showed that labourer women were not able to afford health services. This was also seen as pointed by table no.32, more educated women seek treatment for menstruation related problems from ANM and from other sources like traditional practitioner and village RMP or quack as compared to the few illiterate women.

Thus, it was found that rich, educated and women who work as housewives were more able to take treatment from ANM or from specialist as compared to poor or very poor SES women who could not afford such services due to lock of money time and thus generally could not take treatment.

It was found that women observed traditions or practices related to the pregnancy depending upon their socio-economics, educational or cultural background.

Across socio-economic categories, it was found that more women belonging to the rich socio-economic category observed such practices while it was least observed by very poor socio-economic status women as shown in table no. 33. Due to poverty these poor women did not have any choice

except doing hard jobs and eat what ever little they get. Thus they could not afford to observe food or work related practices ever during pregnancy. It was also found that more high caste women observed such practices as compared to backward or schedule caste as in table no.34. These high caste women had these traditions moreover due to better living conditions they could afford to observe these practices as they mostly belonging to the rich and not so rich socio-economic status category. More wage earner women did not observe such practices as compared to housewives who mostly observed such practices. As wage labourer women had to work hard so they could afford not to lift weight or take rest and observer food related practices as some housewives could do so. It was also found that more educated women were observing such traditions as compared to the illiterate. As they mostly remained at houses and worker as housewives as compared to illiterate women who work as wage labourers. Because of this hard work and lifting of heavy weight more abortions and preterm babies were reported by the poor and very poor women.

Difficulties faced by women during pregnancy vary with their living condition.

Across the socio-economic status category, it was found that maximum percentage of women having bleeding during pregnancy as being reported by very poor socio-economic

status category as depicted by table no.37, maximum women complaining of abdominal pain belong to the poor socio-economic status category. Thus maximum percentage of women among poor and very poor socio-economic status category suffered from pregnancy related problems. Caste wise it can be seen that maximum schedule caste and high caste women reported abortion while maximum percentage of backward caste women reported bleeding and other problems like vomitting etc. Educated women reported a greater range of complaints while more illiterate women had bleedings problems and abnormal foctal position and abortion. Thus it can be said that more poor women belonging to law socio-economic conditions affected by pregnancy related problems for example bleeding, abdominal pain ache while rich women more reported abortion as their problem. More educated women could elaborately described their problem.

It was found that steps taken by the women to deal with pregnancy related problems also depends on their socio-economic and cultural background.

Across different socio-economic status category it was found that no women among very poor socio-economic status category was able to avail the specialist on private practitioner's services and this percentage is also very low for women belonging to poor socio-economic status category

as shown by table no.47, while more women belonging to not so rich and rich socio-economic status category were able to avail the services of private practitioner. It was also found that women availing the services of dai wes also maximum in percentage among poor and very poor socio-economic status category. Maximum poor women reported to consult ANM apart from that women of not so rich and very poor categories. Thus poor women were not able to avail the specialist services or taking treatment as compared to the rich women.

Caste wise it was found that more other caste or high caste women took treatment from specialist or trained private practitioner as compared to the backward or schedule caste women. While more schedule caste women took no treatment for pregnancy related problems. Thus more high caste women took specialist treatment as compared to the backward and schedule caste who could hardly take treatment for pregnancy related problems as depicted by table no. 49. Occupation wise more housewives took treatment from trained city practitioner as compared to the wage labourer women who mostly relied on dai. Thus the housewives were able to avail specialist treatment as compared to the wage labourers who due to poverty not in a position to do so. It was also found that more educated women took treatment from trained city practitioner and from other specialist, from ANM, civil

hospital etc. While more illiterate women rely on dai for taking treatment. Thus it can be seen that women those who belong to rich or not so rich, high caste and doing housejobs were able to avail health services from different sources along with from the specialist also. While poor like very poor and illiterate and belonging to low socio-economic status had to rely on dai or village quack very few of them were able to get specialist treatment.

Traditions or practices in relation to the child-birth included work related practices could be seen among women across and within class category.

Across socio-economic status category as in table no.58, it could be predicted that more very poor women started working early or few days after delivery as compared to the rich and not so rich socio-economic status category women. Who generally start doing work after one month or more after delivery. As women belonging to the very poor socio-economic category could not afford to take rest for long time. Women belonging to high or other caste are more able to take rest for long period i.e. one month or more as comparison to the schedule caste and backward caste. More housewives as compared to the wage earner women took rest for long time i.e. one month or more so after delivery and observed more practices like not to lift weight etc. More educated women took rest for a long period as compared to

the illiterate women. Thus more high caste, housewives and educated women were able to take rest for long time after delivery and more high caste women were able to observe such practices.

Across socio-economic status categories, only 6% poor socio-economic status category and 4.3% very poor women reported to have difficulties related to the child-birth or delivery. While no women belonging to rich and not-so-rich SES category reported to have any such problems as shown in table no. 59 . More schedule caste women i.e. 7.4% and backward caste i.e. 4% reported to have such problems while none from other caste or high caste. More housewives reported to have such problems i.e. 4.1% compared to the wage labourers i.e. 2.7%. More illiterate women i.e. 4.8% reported of having such problems as compared to the educated women i.e. 1.8%. Thus more poor women as belonging to low and wage-earner socio-economic status category, schedule caste and backward caste, housewives as well as wage labourers, illiterate women reported to have such problems.

Treatment for the problems related to child-birth also was the outcome of various factors affecting overall lives of the women.

Across socio-economic status category, it has been seen that most of the women belonging to the poor and very poor

socio-economic status category took help of dai, while women of rich, very rich category depended on ANM as well as dai for child-birth problems and also more take specialist or gynecologist treatment. It was found more schedule caste women relied on dai than backward and other caste women. While more other caste women took services of ANM and dai as compared to the backward caste and schedule caste women. Thus high caste women took more specialist assistance at the time of delivery as compared to the backward and schedule caste women as shown in table no.61. More wage labourer who mostly depend on ANM as well as dai. More illiterate women consulted dai, as compared to the literate women who more rely on specialist treatment. Thus it was seen that poor women belonging to lower and wage earner SES category were not able to get ANM's or specialist assistance as compared to the rich women as well as high caste and educated women belonging to privilege class were able to do so.

Gynecological problems faced by women also varied with their socio-economic, cultural background as it was seen, among women belonging to the rich socio-economic status category, few of them reported of having gynecological problems, only high caste women of this socio-economic category reported to have such problems while no backward caste women reported. 31.3% housewives reported to have such problems while service doing women had no such problems.

More illiterate women reported such problems as compared to the educated women. Thus more high caste, housewives and illiterate women reported to have such problems among rich socio-economic status category.

Among not-so-rich socio-economic status category 35.5% women reported to have gynaecological problems, it was reported by all caste women and also with more or less similar percentage 36.7% housewives reported to have such problems, more educated women as compared to the illiterate women also reported to have such problems. Thus equal percentage of all the caste women, housewives and educated women reported to have such problems while less illiterate women reported such problems.

Among poor 32.8% women reported to have such problems maximum percentage of other caste women reported to have such problems after that backward caste and lastly schedule caste women reported so. Housewives as well as wage labourer women also reported to have such problems. Both educated and illiterate women reported also to have such problems while more educated women reported such problems.

Among very poor, 39.1% women reported gynecological problems. More backward caste reported of having gynaecological problems as compared to the schedule caste and other caste. More housewives reported of gynae problems as compared to the wage labourer women 42.9%, illiterate

women only reported to have such problems. Thus among very poor more backward caste, housewives and illiterate women reported to have such problems. Thus among different socio-economic status category women of different socio-cultural background all reported of having such problems.

Across socio-economic status category, it was found that maximum percentage of women reported of having gynaecological problems belong to the very poor socio-economic status category and least reported by women belonging to the rich category. Maximum percentage of high or other caste women reported of having such problems after that backward caste and lastly by schedule caste. Thus more high caste women reported such problems. Both housewives and wage earner women equal percentage reported such problems and the same was true for educated and illiterate women. Thus the more women reported such problems belonging to very poor category.

This proved that various gynaecological problems were associated directly with poor socio-economic and hard life of malnourished women.

Treatment sought for the gynaecological problems depends on the socio-cultural and economic background of women. As women belonging to rich category mainly took treatment from gynecologist or specialist, after that, few from ANM, village quack, dai etc. High caste or other caste

women mainly consulted specialist for the treatment of gynaecological problems. Maximum percentage of housewives also consulted trained gynecologist or private specialist, after that to the ANM, then to the dai, village quack etc. More educated women reported to consult ANM, gynecologist, dai, village quack and specialist. While illiterate women more reported to consult village quack and also few to gynaecologist. Thus illiterate women took more treatment from village quack than ANM in the village. Thus high caste, housewives and educated women took treatment from gynecologists while illiterate women took treatment from village quack inspite of ANM. Thus education also play an important role in influencing treatment seeking behaviour of women for the gynaecological related problems.

Among women belonging to the not-so-rich category, most of them consulted ANM, and maximum percentage of women did not take treatment, few from specialist, ANM, Dai, village quack, PHC etc. More other caste women took treatment for gynaecological related problems and also more from gynecologist as compared to the backward caste. While maximum women consulted specialist those belonging to the schedule caste category least percentage of backward caste women took treatment for gynae related problems. Most of the housewives reported not taking treatment as well as farm worker women. Maximum percentage of housewives women

consulted ANM after that to the city private specialist, village quack, civil hospital, ANM, dai etc. More housewives took treatment for gynae related problems. More educated women took treatment for gynae related problems as compared to the alliterate women. Thus, it can be said that most of the women belonging to, not so rich category did not take treatment for gynae related problems while maximum schedule caste, housewives and educated women took treatment for gynae related problems. While other other caste, backward caste, illiterate women hardly took treatment for these problems. As mostly women could not seek treatment for socio-cultural reasons as well as due to lack of proper health services available at the village levels.

Among women belonging to the poor socio-economic status category maximum percentage of women did not take any treatment at the initial stage for gynae problems very few consulted traditional practitioner, dai, village quack, specialist. More other caste women did not take treatment while maximum percentage of high caste women consulted specialist after that, backward caste who took treatment from ANM, village quack, lastly schedule caste women who consulted ANM, dai and traditional practitioner. As higher the caste more percentage of women did not take treatment for gynaecological related problems and at the some time few of them who took treatment, consulted specialist. Thus high

caste women were able to get specialist treatment as compared to the backward caste and schedule caste. More percentage of housewives did not take treatment as compared to the wage-labourers while more housewives took treatment from ANM and trained city practitioner or specialist. More educated women did not take treatment for gynae problems and those who took from ANM or specialist while illiterate women more took treatment and more rely on traditional practitioner. Thus high caste, educated women, and housewives did not take treatment. This might be due to various socio-cultural factors. Because of these women felt shy in getting treatment while poor women were not getting treatment because of heavy household burden.

Few very poor women reported to take treatment and those who took mainly relied on traditional practitioner or dai, also specialist and village quack. Schedule caste women and other caste women mostly did not take treatment as compared to the backward caste who took treatment from ANM, village quack, specialist, traditional practitioner, dai, more housewives took treatment as compared to the wage - earner women and also consulted more to the ANM city quack and tradition practitioner as compared to the wage labourer women. More percentage of educated women took treatment and that too from specialist.

Across socio-economic status category, it was found

that maximum percentage of women not taking any treatment in the initial or primary stage of gynaecological problem belonging to the very poor socio-economic category while maximum percentage of women belonging to the rich socio-economic category took treatment from specialist like gynecologists, as depicted by table no. 69. As rich women could afford so they availed specialist services but minimum due to socio-cultural factors because of which women even belonging to rich category felt inhibited to take treatment for gynae related problems. Maximum percentage of high caste women took treatment i.e. 31.9% while minimum percentage of schedule caste women did so. Moreover more percentage of other caste women took specialist treatment as compared to low caste. More wage labourer women did not take treatment for gynae problems as compared to the housewives, more housewives take treatment from ANM and specialist as compared to the wage earner women. More illiterate women did not take treatment as compared to the literate women. Most of the illiterate women relied on the traditional practitioner. Thus only those women who were rich could afford the specialist services as compared to the poor wage earner women who hardly took treatment and if taken mainly relied on traditional practitioner.

Among rich socio-economic status category, maximum percentage i.e. 42.1% took family planning measures by themselves while very few i.e. 5.3% adopted these with ANM's suggestion and many did not even take treatment i.e. 31.6%. Maximum percentage of other caste women took family planning measures by themselves, while maximum backward caste women were taken these measures with ANM's suggestion and also less percentage of these women took these measures as compared to the other caste. Thus more high caste women took these measures and also themselves as compared to the backward caste who took these with ANM's suggestion, as depicted by table no. 70. Maximum percentage of women who were housewives took family planning measures by themselves as well as one service doing women. Very few of them did not take any family planning measures, as depicted by table no. 71. More literate women had taken these measures themselves as compared to the illiterate women who less taken these measures and also taken with ANM's suggestion as well as self in the equal percentage. Thus high caste, educated and housewives took these measures themselves as compared to the backward caste, illiterate women of rich category. As these were not able to took these by their own but only with ANM's suggestion. High caste, educated women were able to took their own decisions among high rich category.

Among not-so-rich category, 19.4% women took family

planning measures with ANM's suggestion and very few i.e. 9.7% themselves. Schedule caste women of not-so-rich category had not reported to use those services. Backward caste used these with ANM's suggestion while high caste women used these themselves as well as with ANM's suggestion. More housewives women took these measures with ANM's suggestion, 20% took these by themselves. Only literate women of middle SES adopted these measures themselves in comparison to the illiterate who also adopted these with ANM's suggestion. Thus high caste, housewives and educated women of not-so-rich category adopt these measures themselves also.

Among poor SES category, women adopted family planning measures themselves as well as with ANM's suggestion and very few with other's advice. While other caste and schedule caste used these with ANM's suggestion. Maximum percentage of housewives took these measures themselves, while wage earner women did this with ANM's suggestion, literate women adopt these measures themselves as compared to the illiterate women who took these with ANM's suggestion.

Among very poor socio-economic category, maximum percentage of women adopted these measures with ANM's suggestion i.e. 39.1% while very few by themselves 4.3% and a greater percentage had not taken any measures i.e. 47.8%. Maximum percentage of schedule caste women had not taken

these measures i.e. 57.1%. Maximum percentage of women belonging to backward caste took these measures with ANM's suggestion i.e. 40% as well as by themselves i.e. 6.7% most of the housewives belonging to the wage earner socio-economic category adopted family planning measures with ANM's suggestion. More wage earner women had not taken these measures, in comparison to the housewives but most of them also adopted these with ANM's suggestion and very few themselves. Thus very poor women less adopted family planning measures as compared to the women of other socio-economic category. Most of the educated women of this category took family planning measures with ANM's suggestion while illiterate women also adopted these with ANM's suggestion and very few themselves. Thus backward caste, illiterate and wage labourer women reported to took these measures themselves. While most of the educated, high caste, schedule caste and housewives belonging to the very poor socio-economic category took these with ANM's suggestion.

Across socio-economic category, maximum percentage of rich women adopted F.P. measures themselves, and very poor category women with ANM's suggestion while not-so-rich SES category women very less used these measures. High caste women maximum adopted these measures, and also they adopted these by themselves in comparison to SC and Backward caste women. Wage labourer women more adopted these with ANM's

suggestion as compared to the housewives who maximum percentage took these measures themselves. More educated women reported to take these measures and also themselves as compared to the illiterate women.

It was found that most of the women first breast-fed the baby only after 2 or 3 days of their deliveries. While women belonging to rich section has started breast feeding early i.e. within the day of delivery and just after the child-birth. Thus these practices were undergoing changes. It was also found that immunization in case of children among poor and very poor categories was low as compared to the rich and not-so-rich. These were more depend on PHC and private practitioner for their child's immunization while poor had no time and money for the some. The reproductive health of various categories of women of this village is bound by several socio-economic, cultural and ecological factors and also in determined by the status a women enjoys in her family and society. It can be seen that most of the poor women suffered more from the reproductive health problems due to lack of money and time for their treatment. Suggestions can be made to see this social reality through more critical perspective as according to sociological criticism, there are always social constraints on the reproductive behaviour of the individuals it can not be free of these constraints and along with this a network of

social, economics, psychological pressures are there to perform the family roles within the perview of these factors. Under marxist critique it was described that theories and ideologies further affected by the capitalist set up and thus could not investigate the social realities.

Maxist alternative suggested that reproduction should be understood in structural rather than individual terms. It said that inspite of understanding reproduction as in individual behaviour based on market prices, choose to consume and produce children but through capitalist mode of production it is the complexed structured totality formed by the combination of the material and social element enter into this biological and social reproduction of human beings through historically specific relation of reproduction inducting relationship to the material and social condition of production and reproduction.

It was desired that Marxist analysis should define reproduction in real, concrete terms rather then formal terms. As the rationality of the capitalist class in based on the problem to maximize profits, the rationality of working class is on the problem of survival. Whose survival is ensured by compliance with the goals of capitalist class and thus working class rationality dependent, complementary, derivative upon the rationality of the capitalist class. At

the level of reproduction this rationality needed to be seen as affecting the reproduction behaviour of both the classes. Thus to define reproduction in real concrete terms mean to enquire into the conditions surrounding the reproduction of classes.

Another criteria is that it should analyze "taste" on an objective rather than subjective basis. According to the marxist analysis the number and extent of necessary wants are the products of historical development and thus no of children wanted can thus be viewed as an integral part of the historical and normal elements. Thus it has been stressed to see the need of children in this respect. In this way to see the social reality, the place of women in the capitalist system, either she belongs to the worker or capitalist section as a result of historical development of class relationship is need to seen. Apart from this, general issues also need to be considered.

CHAPTER-V

SUMMARY AND CONCLUSION

The reproductive health of the women has been analysed by several scholars in India and abroad from various dimensions. But very few studies so far been published on the reproductive health of the women from a holistic perspective giving emphasize on sociological dimensions. This study has been designed to address the sociological issues of the reproductive health of women in a village Dhurala in Kurukshetra district of Haryana.

Being a developed state Haryana has been selected for the study. Reproductive health of its rural women is also subject to be studied as to know their actual conditions in the state. Kurukshetra district has been selected as it is characterised by maximum female agricultural population in the state, being a PHC village and easily communicable, it was selected for the study.

Sample for the study was rural women of age group 15-45 years. After survey of the village, stratified random sampling was done and women of different age groups belonging to different socio-economic categories was selected. On the basis of pre-study and interview scheduled was prepared and tested in the field. Thus, information on the various aspects related to reproductive health was collected. Apart from this, techniques like observation, formal and informal discussions with women, health staff of

PHC, villagers, private practitioners, village level workers was done. A field dairy was also maintained to record the observation and people responses. After that, collected data was tabulated and put into computer for analysis. After the analysis, the salient findings of the study was found to be following :

In the village Dhurala, it was found that less desirability of a daughter than sons is prevalent. Pardah system is strong in a village as women and girls cover their heads infront of their relatives and also when going out of their houses. Girls are supposed to be submissive and not to express their will or feelings openly in any matter of their lives. Less consideration is given to their opinion by their families. Except few belonging to rich and not-so-rich socio-economic category. Most of the girls are not encouraged and get opportunity for studies and very less do higher studies and professional course. Most of the women were weak and malnourished as they eat very less. Their food includes one or two chapaties with very less or no vegetable, over burden with work, they mostly complaint of body ache and headache. Household work is considered as the main domain of the women and given not much importance.

In the restricted socio-cultural in the meliu of the village, girls do not get any information regarding their

future role. It is only through their friends, they come to know about the menstruation, marriage, child-bearing and rearing and also through observing others. It is considered undesirable and shameful to transfer such informations to girls as they should remain ignorant of all these matters. Unless, some severe problems faced by the girls and women related to their periods and pregnancy, they hardly discuss these with their parents and elders.

Generally, precautions related to food and work are observed to prevent these problems. On the acuteness of these problems some of them are shown to the quacks in the village but hardly get proper treatment for their problems. Due to poverty, the poor are not able to avail the specialist's treatment. Those who belong to rich and not-so-rich category consult ANM in the village, from whom they get temporarily relief but could not get properly treated. In this way, most of the women have learnt to live with their problems and difficulties. They also feel shy in approaching male doctors at PHC and hardly get medicine for their reproductive health problems from PHC. Thus, most of their problems like, abdominal pain during mensturation, irregular periods, excessive-bleeding during periods and pregnancy difficulties related to child-birth remained untreated.

As women's special health needs are primarily related

to their reproductive role. The process of gestation, birth, breast-feeding and child nurturing is in itself a healthy and normal process it is only when crucial elements in the environment are lacking or inadequate that this process becomes problematic and lack of care at the time have fatal effects. Appropriate care during pregnancy and child-birth is crucial to that of future generations. Failure to obtain such care among women in Dhurala village due to poverty and non-accessibility of health services has caused not only death of the child and women but also the debilitating conditions such as uterine prolapse and genital tract infections and that has added to the already burdened suffering and low quality of life of women for the rest of their lives. More over most of the deliveries are conducted by trained dai and also with the help of elder family members. While it is only among rich deliveries are conducted by ANM. Thus there is lack of accessibility of specialised services to the women. Malnutrition including anemia is a serious health problem, especially in women who have too many pregnancies too closely spaced while most of the women were found to be malnourished and weak in the village. As they hardly took food properly. Poor women are not able to afford while those who could afford also take less care of their own food and did not take vegetables along with dal (Pulses) and use of milk is also less by

them. Genital tract infections coupled with poor nutrition was also found and also adversely affected these women's health. More over the burden on their health due to many pregnancies and that too with less space has affected their health badly.

Occupational health hazards were found among women belonging to the poor and very poor socio-economic status. These women work outside their homes in the fields or at the constriction sites. Many complaint of swollen feet and hands problems after and during rice plantation and accidents like cutting finger and hand injury while harvest cutting or through thrasher and cutting grass for the animals. Incidence of snake and insect bites were also common for them. In these types of cases these women did not get proper medical aid or treatment. As the PHC timings are limited and they could not spare time & money to get treatment from ANM. Generally they approached village R.M.P or quack and in case of snake bites took treatment from traditional practitioner and very few took treatment from qualified practitioner at city at the time of accidents of for the swelling of feet or hands. Thus a lot of them had to bear these sufferings.

Traditional practices are being observed by village women since old times and also has rationale to prevent reproductive health problems like abdominal pain during periods, pregnancy related problems such as bleeding,

abdominal pain, child-birth problems. These traditions and practices are related to the food and work. But these could only observed by women of rich and not-so-rich category. While poor and very poor women could not afford to do so. These practices are being told by elders of the family to the younger generation and thus being observed.

Uncontrolled fertility among women in Dhurala village was found due to socio-cultural reasons which pose pressure on women to have atleast one or two sons and also in order to ensure the survival of few they have to bear many children more over due to inaccessibility of family planning, measures. This burden of high fertility also negatively affect their already poor health and lead to more morbidity among them. It also affects the health of younger children who may still be dependent on material feeding and care. Couple hardly plan timing, spacing and no. of children due to socio-economic, cultural reasons and due to lack of adequate health and family planning services.

Age at child-bearing was also found to be low as most of the girls in the village were married in their late teens or early twenties. Among poor and very poor women of age-group 17 to 20 were found to bear children an as result of early marriage. These also faced problems related to pregnancy e.g. bleeding and abdominal pain but could not get treatment due to poverty and sometimes not even get care

from their in-laws due to burden of work and lack of money and these problems are not considered as very serious.

Abortions both kinds i.e. induced and spontaneous were found widespread in the village Dhurala and also among women of all socio-economic categories. Due to non-accessibility of safe family planning measures. Cultural and economic reasons measures and lack of these services the cases of abortion were found to be high and these abortions through improper methods further lead to the complications and problems related to reproductive-health. The after affects of sterilization were also seen in the form of irregular periods, backache, irregular periods and excessive bleeding as reported by some women. It was found that there was more responsibility on women for family planning while men generally did not share this responsibility because the fear of after effects which could affect their health as they were the main breadwinner the family.

From the above data and salient findings of the study the following action for policy and programmes regarding reproductive health is suggested society should recognize women as an equal human beings and must provide special support to her for the performance & fulfillment of reproductive functions. The relation between health and sexuality should be understood and taken into consideration. Marriage should be taken as the union between equal partners

and both have right to enjoy sex without the obligation of reproduction and thus have mutual respect and shared obligations. There should be no sex discrimination by family, parents and health services. Health service should value a women as human being with no innate or social disadvantages in relation to men. Women should have right to chose her reproductive preference at any given time. Thus there should be appropriate social, psychological conditions for successful pregnancy delivery & child care and that interfere as little as possible with a women's other roles and personal satisfaction. Sharing of responsibility by the partner is a very important of this concept.

In order to realize these conditions in the society some steps in that direction can be taken. As sex education should be initiated early in life and encourage deep reflection on male and female roles in society to reduce discrimination against women. Education, information and access to the means for prevention of STDs's should be provided, starting from adolescence. Information, education and a full range of contraceptive choice for both sexes should be made available. These should be access to the clean and technically correct abortion of women of all ages. The synthesis of new drugs that induce menstruation in case of delay, and safe abortion services should be provided. For the women for whom pregnancy can be physical, social or

emotional disaster, approach to pregnancy and delivery care should include not only medical but also social and psychological support and it should take care and respond to women's multiple needs, taking into consideration the social environment and many obstacles to care that women's daily lives present. Adapting PHC hours to women's schedules, changing employment policies, and society to take proper responsibility for reproduction, day care centre near to women's work place. Progress towards a comprehensive reproductive health approach will be possible once society acknowledge that sexuality, reproduction and motherhood are not the exclusive domain of women, but a basic responsibility of society as a whole.

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APPENDIX I.

SOCIO-ECONOMIC AND DEMOGRAPHIC INFORMATION OF THE HOUSEHOLD

1. Village

2. House No.

3. Name of the head of the family - Male Female

4. Type of Family - Nuclear Joint

5. Religion (Specify)

6. Caste : SC ST Others (Specify)

7. Family Composition -

No. of Family members	Name	Sex	Age	Relation-ship with the head of the family	Education	Occu-pation	Income

8. Total Income of the family :

Primary Source	Secondary Source

9. Acquisition of land :

Landless Agricultural Labourer	Small Farmer (<5 acres land)	Middle Farmer (5 to 9 acres)	Rich Farmer (10 and more than 10 acres)

10. Acquisition of the Cattles :

Cows	Buffaloes	Goats	Camel	Horse

Pigs	Donkeys

11. Other Items : _____

12. Type of House :

Pucca Kaccha (Specify made of :)

13. Number of rooms in the house excluding kitchen :

14. Means of cooking :

Chullah Gobargas Plant LPG Gas

15. Electricity Facility in the House :

Yes : _____ No : _____

16. Type of Water supply : Tap

Well Handpump Pond Tubewell

17. Type of Toilet Facility :

Sewerage Septic Tank Dry Toilet Open Field

18. Type of Bathing Facility :

Bathroom No Bathroom Open Any other room in the House

19. Sanitary conditions of the House :

Clean Unclean

APPENDIX II.

SCHEDULE

1. House No.

2. Name of the respondent : Age :

3. Occupation : Housewife Housewife & Wage earner Student

4. Income :

5. Educated/Illiterate :

6. Are you a

   1) Adolescent girl
   2) Newly married woman
   3) Pregnant women
   4) Nursing mother
   5) Mother of one or more children

7. What are the health problems usually seen among women/girls ?

   a) Minor
   b) Major
   c) Chronic
   d) Accidents
   e) Problems due to Child-Birth

8. How do you try to solve these problem ?

   a) Minor illnesses –
   b) Major illnesses –
   c) Chronic –
   d) Accidents –
   e) Problems related to Child-Birth –

9. What are the ideas and knowledge have you developed regarding future reproductive role ?

10. What are the health problems caused due to menarche, pregnancy, child-birth and child-rearing ?

11. What do you do to parvent such problems ?

12. Do you have customs, taboos and practices related to

    a) Mensturation
    b) Pregnancy
    c) Child-birth
    d) Child-rearing

    and who practice more/less

13. What are the institutions available in your village provides you services to take care of the problems ?

    a) Mother-in-law/mother
    b) Neighbour/Indegenous medince man
    c) Dai
    d) ANM
    e) PHC/Hospital
    f) Qualified practitioner/RMP/Nursing home

14. Are you satisfied with their services. If yes why so ? If no - illaborate ?

15. Do you get attention from your family member during your sickness ?

    a) Mother/Mother-in-law/grand-parents
    b) Husband/Sister
    c) Relatives
    d) Any others

    If no - why so ?

16. How do you know that you are pregnant ?

17. After knowing pregnancy what do you do ?

18. Did you face any complications during your pregnancy ?

19. What did you do ? Did you take Antenatal Check-up from subcentre/PHC/ ANM. If not then why ? Please elabaorate.

20. a) Who conducted delivery and where delivery takes place/home delivery/institutional ?

b) What were the problems and complications ?

21. After child-birth do you do breast feeding, when the child was breast fed ? Besides breast-feeding what are the other feedings.

22. a) What are the practices for child-rearing, weaving practices and other problems ?

b) Who take care of the children when you do work ?

23. Any death of children in the family -

a) still birth
b) 0-1 month
c) 1 year
d) more than 5 yrs.

24. a) What are your daily routine, (Morning till bed)

b) Do you feel tired, if so why ?

25. Whether your opinion in the family recongised. If not why - If yes, why/how much ?

26. Being educated/uneducated do you find any difference from uneducated/educated women group ?

27. Have you accepted/practised the family planning methods. If so, Where/Who has advised/How you obtained ?

28. Are you happy with this ? What are the benefits ?

29. Have you immunized your all children ? From where you have received immunization ?

30. Do you have any gnaenecological problems ? If yes what do you do, whom you have approach ?

31. Do you avail government health services first or other non-government services. Why so ?

32. Do you face financial constraint for obtaining health services for you and for your children ?

33. What do you suggest to improve the health status of the women in the village ?

34. What do you think about the social status of yours and other women in the village ?

35. How many children do you want ?

a) Son : _____

b) Daughter : _____