Abstract

It is well recognized that in patriarchal settings such as in India, hierarchical gender relations and unequal gender norms impact women's sexual and reproductive health and choice and act as significant obstacles to access of services and facilities. Equally, the achievement of good sexual and reproductive health may be inhibited by structural factors such as poverty and malnutrition, early marriage and inadequate educational and health systems. Gender roles have significant implications for sexual and reproductive health and choice. Gender norms condone early onset of sexual activity, pre-marital and extra-marital casual sexual relations and sex worker contacts among young males while severely prescribing even the hint of sexual misconduct among young females, as lack of awareness, lack of spousal intimacy and communication on sexual matters, and widespread gender-based violence compound women's inability to negotiate safe sex, seek appropriate health care or experience a healthy pregnancy. Finally, gender roles that perpetuate the 'culture of silence' inhibit women from communicating a health problem or seeking prompt treatment unless it inhibits them from carrying out their daily chores. This 'culture of silence' is even more exaggerated for gynecological and reproductive morbidity that are so closely linked with sexuality.

Hence the proposed study is aimed to unearth the patterns of reproductive health emerging under impact of education, economy, decision making among women. It is of prime interest to discover the actual reasons behind the backwardness of women's health in one of the most backward part of the country, what we call the north east region and particularly Manipur as there is dearth of serious research work on this issue.

The study was organized into seven chapters each dealing with a particular aspect of the research undertaken.

The first chapter is comprised of the introduction, statement of the problem, theoretical framework and review of literature, objectives, methodology, and significance of the study. To conduct the study four objectives have been set out. The first objective is to explore the perception and awareness level of the respondents about the women reproductive health. The second objective is to inquire about the use of contraceptive

methods, husband-wife communication on reproduction. The third objective is to inquire about the status of women's reproductive health. Forth objective is to find out the relationship between socio-economic background and reproductive health of women.

The study is conducted on Meitei women of Nagamapal area under Lamphel subdivision of Imphal west district and Heinoubok village under Nambol subdivision of Bishnupur district of Manipur. The study follows descriptive and analytical research design. It is based on both primary and secondary data. Secondary data are collected from books, journals periodicals and census and primary data are collected through field study. . It is focused on 300 meitei women respondents which are further sub-divided into three age groups viz, a) 16-25, b) 26-35, c) 36-45. The respondents are selected by stratified random sampling. The total 300 respondents are also categories into married and unmarried group.

The tools of data collection are interview schedule, field notes, camera and voice recorder. And the data is collected with the help of a structured interview schedule covering particularly their status of socio-economic, health, education, nutrition, decision making, cultural factors, their perception and awareness about the health care services. For analyzing the data from the possible angles software name statistical packages for social sciences (SPSS) is used.

The second chapter deals particularly with the study areas. Profile of the state, health Indicators and health infrastructures in the state are highlighted in the chapter. The study finds that there has been considerable progress numerically in the establishment of health institutions in the State. Although the department has been able to establish the required number of health institutions, wide infrastructural gaps still exist in the area of building, equipment and manpower.

The third Chapter provided information regarding socio economic background of the respondents, which is here measured in term of their age-group, marital status, religion, type of family, number of family members, language known, educational qualification of the respondents and the father/spouse of the respondents, occupation of the respondents and the father/spouse of the respondents, type of house, household consumption pattern, cultivated land, quantity of land, type of land ownership, monthly household income.

After going through the socio-economic background of the respondents in both the study areas it finds that majority of the respondents are practicing Hinduism followed by the local religion (Sanamahi). As far as the preference of family is concerned, though nuclear family is preferred more in both the settings, but the numbers of nuclear families are more in urban setting and the numbers of joint families are found more in rural setting as the concept of traditional family is still more popular in rural setting.

Hence, the study reveals that existence of more number of large families in rural setting than in urban setting. The educational background of the respondents and their father/spouse of the respondents reveal that a huge majority of the respondents and their father/spouse are literate, but the urban setting is accomplishing better than the rural setting as far as the educational qualification of the respondents and their father/spouse of the of the respondents' is concerned.

When it comes to the languages known by the respondents, it can see that in urban setting most of the respondents are multilingual who know Manipuri, Hindi and English and most of the rural respondents know only their mother tongue

The occupation of the respondents reveals that, as many as about 39 percent of the respondents are employed in different sectors which give a glimpse of their empowerment status in their family. But the rural urban difference reveals that apart from students or homemakers who are majority in both the settings but a considerable proportion of the rural setting's respondents are skilled and unskilled worker and in urban setting business are preferred as occupation by a significant proportion of the respondents. Moreover, it can also see that in rural setting as many as 9.3 percent of the

respondents are unemployed, whereas in urban setting only 4 percent are in this category.

In urban setting most of the father/spouse of the respondents are engaged in government jobs and in business, but in rural setting most of them are unskilled and skilled workers, which also reveals the economic status of the respondents in both the settings. Here the role of higher educational qualification is reflected in the quality of jobs that the father/spouse of the respondents' are engaged in.

The living condition of the respondents can be reflected from the pattern of houses they live in which shows that overall more than half of the respondents live in a kutcha houses. But a noticeable variation in the living condition of the respondents in rural and urban setting, as majority of the respondents (45.3 percent) are living in pucca houses in urban setting, whereas in rural setting almost all of them (90.7 percent) are living in kutcha houses. Hence it reflects the disparity of economic status in both the settings.

Moreover the household consumption patterns of the respondents also provides a glimpse of the economic state of the respondents and here the real picture of the status of the respondents' consumption pattern is revealed only when the sample size is segregate into rural and urban setting. As in urban setting the major concentration of the respondents is in high and very high consumption pattern and in rural setting it is shared by average, low and very low consumption pattern. The poor economic condition together with lack of awareness and lack of facilities is reflected in the poor consumption pattern of the rural setting's respondents.

The status of the possession of cultivated land is also an important indicator of the socio-economic status of the respondents, which states that little more than half of the respondents' family has cultivated land. Very expectedly in urban setting most of the respondents family don't have (72.7 percent) cultivated land unlike in rural setting where most of the respondents have (70.7 percent) cultivated land. The availability of land in the rural areas can be looked as the reason behind the difference of possession of the land in both the setting.

One of the significant indicators of the economic condition of the family is their monthly income and here the data reveals that the urban setting is earning much more than the

rural setting. The educational qualification together with technical education, job opportunities and superior infrastructure can be looked at the major rationale behind the difference of income between the rural and urban setting.

Hence in almost all the sectors stating from education of the respondents and their father/spouse of the family, occupational background of their father/spouse, living condition, consumption pattern and monthly household income, urban setting's respondents are performing much better than their rural counterparts, only in the possession of cultivated land, the rural setting's respondents are doing better. Therefore it will be of prime interest to see the overall reproductive health status of the respondents from these two completely diverse infrastructural and socio-economic backgrounds.

The fourth Chapter studied the status of health awareness of the respondents with particular reference to reproductive health.

After studying the status of health awareness of the respondents with particular reference to reproductive health, finds that there is a visible difference in almost all the indicators studied between rural and urban respondents. Education, poor economic condition together with dismal infrastructure can be seen as the key rationale behind the disparity in the overall status of awareness in both the setting.

Indexes as purification of drinking water and use of sanitary toilets reveals that the respondents from the rural setting are performing inadequately in comparison to their urban counterparts.

The exposure to mass media also reveals the same story. Though in case of watching television there is no diversity between rural and urban respondents but most of the rural respondents watch television only occasionally. It is worth mentioning here that the role of poor electricity supply in the rural areas of Manipur, particularly in Heinoubok is a major reason behind the asymmetrical statistics**.** Moreover in case of newspapers there is a noticeable inconsistency in both reading and the frequency of reading newspapers by the respondents in rural and urban settings. As most of the rural respondents believe that they don't need to spend money on newspapers as they can get the necessary information from other sources like radio, T.V. and peer groups. Surprisingly though radio as medium of communication is losing its popularity in most part of the country,

but in the study area a significant proportion of the respondents listen to radio regularly and most of them are from rural background (90.7 %). Hence apart from listening radio the rural respondents' mass media awareness is indigent in comparison to urban respondents.

Though the attendance of the rural respondents is healthier in the health awareness programs than their urban counterparts which is a good sign, but it also signify that the respondents in the rural setting with lesser education and poor infrastructural facilities considers themselves more the need to attend these programs.

In case of medicine preferred by the respondents, the rural respondents are found to be still loyal to their folk medicine though they are also using allopathic medicines whereas majority of the urban respondents are favoring only allopathic medicines. Hence the rural respondents are still attached to their natural way of treating diseases. The venue for treating the first health problem also reveals the status of health awareness of the respondents, the respondents from the rural setting clearly prefer (95.3 percent) the nearest pharmacy for treating the first health problem they had and the respondents from the urban setting visibly prefer (75.3 percent) the private doctors for the purpose. The economic condition of the households together with lack of facilities can be looked as the reason behind the preference in both the setting.

Data related to the reproductive health beliefs also highlights the poor status of the rural respondents. In case of Sanitary napkins which are clearly preferred more (43.3 percent) by the urban respondents than the rural ones (9.3 percent). The rationale for these diverse stats is the dissimilar economic condition, and awareness level of the respondents. More than 70 percent of the respondents (both in rural and urban) were not taking bath during the menstrual period by complying the traditional myth. In rural area this rate is high (89.3percent) than urban area (56.7 percent), moreover the engagement of the majority of the respondents of the urban setting in occupations as business, government and private jobs also necessitates them to take regular

The study clearly detect disparity in both the setting in both the consumption of nutritional food and practice of giving enough rest during pregnancy, which draw dearth of awareness particularly in the rural area regarding the importance of both nutritional

food during pregnancy and rest during pregnancy; moreover the poor economic condition is also responsible for this.

Moreover the share of rural respondents is more than their urban counterparts who had experienced sex without consent during their pregnancy and after delivery which also highlights the status of women particularly in rural area and it also points towards the potent existence of patriarchal values in the area. The habit of taking alcohol drinks by the rural respondents' spouse can also be seen as one of the prime rationale behind the problem. The consumption of alcoholic drinks by the spouse or father is generally found as the reason for unwanted happenings in the house and mostly in such cases women or the child are the victims. In the present study it is found that most of the respondents' either spouse or father in both the setting consumes alcoholic drinks. But surprisingly most of the alcoholics in the urban setting, targets their wife whereas in the rural setting they generally do not target any particular family member. This because in urban setting people are more isolated so they have no one but their family to throw their frustrations, whereas in rural setting they are more connected with their peer groups which help them to share their distresses.

In order to assess the overall status of health of women, one of the prime indicators can be the number of time they take meal and amount of water consumed in a day. In the present study the data reveals that most of the respondents take meal twice a day and in case of consumption of water most of the respondents consumes much below par i.e. below 2 liters. In the present study the data reveals that more than half (53.7 percent) of the respondents reported to have some kinds of addiction like chewing pan, tobacco, smoking etc. The share of rural respondents (60.7 percent) in this category is more than their urban counterparts (46.7 percent). Hence the respondents in the urban setting are addicted to a food habit (jarda pan) that is more injurious to their health. Hence the overall food habit in terms of amount of drinking water, number of meal and addictions, it can be concluded that respondents from both the setting are following an unhealthy food habits.

The fifth Chapter focused on the status of reproductive health of the respondents with particular reference to menarche, prenatal and postnatal health behavior, quality family planning services, safe motherhood: prenatal, safe delivery and post natal care, status of prevention and treatment of infertility, status of abortion, status of reproductive tract infections, including sexually transmitted infections and status of harmful social practices related to sexuality and reproduction

The study reveals that in many of the indicators of reproductive health of women, there is hardly any difference among the rural and urban respondents. In case of age at menarche of most of the respondents it started at the age of 11-13 years. Most of the respondents reported that their menstruation circle is regular. Similarly, more than half of the respondents' amount of menstruation blood is moderate. Likewise, majority of the respondents reported that the duration of their menstruation lasted for three to five days which is treated to be normal in medical field. Even in case of general health problems most of the respondents are suffering from anemia and blood pressure in both the settings. Hence the data related to menarche and general health problems of the respondents reveals that as it is more a biological developments, it is not affected by the respondents' locality, consequently the data in both the settings reveals similar findings.

The data related to RTI reveals that most of the respondents are suffering from problems as abdominal pain, backache, itching during menses and white discharge in both the setting but all these problems are reported more by the rural respondents except the problem of burning urination which is more reported by the urban respondents. One of the most startling findings of the study is that though quite a few of the respondents have reported about the problems related to RTI, very negligible part of the respondents actually opted for any treatment to cure these health problems, though the share of these respondents is more in the rural setting but surprisingly a significant portion of the urban respondents with all their education, mass media exposure and health infrastructure are also not opting for any treatment to cure these problems. Hence it confirms the fact that though the rural respondents are more vulnerable to these problems and more attention is obligatory towards rural women particularly in case of RTI, but there is still dearth of awareness even among the urban respondents particularly about RTI.

The data related to the age at marriage of the respondents indicates that in the rural setting respondents either get married at an early age i.e. before 23 years or as late as 32-35 years, whereas in urban setting most of the respondents get married from 21-29 years of age.

In case of miscarriages the data reveals that as many as 16 percent of the respondents have reported of miscarriages. But astonishingly the respondents in the urban area with all their health care facilities, awareness and exposure are doing worst than their rural counterparts in this category.

One of the major reasons for more reporting of miscarriage by the urban respondents is that the rural women are more used to hard physical exercise even during pregnancy hence they can overcome many of these health problems, whereas the urban women are more pampered and at times take too much precautions which hardly help them to face these health problems that can lead to even miscarriages. In case of abortion opted by the respondents the data shows that 18 percent of the respondents have opted for this option and the share is more in the rural setting than the urban setting. Moreover most of them irrespective of all setting held unplanned child the reason behind opting for the choice. Hence though the number of abortion may not be very high but the respondents particularly in the rural setting are found as more vulnerable to control birth, which is more because of their unawareness and inconsistent use of family planning methods.

The number of living child which reveals the size of the family shows that though most of the respondents in both the setting have small family with 1-2 child, but most of the large families with 5-6 child are also from the rural setting. This also indicates ineffective use of family planning methods particularly in the rural area.

Out of the number of living child more than three fourth of the respondents have one or more child up to fourteen years, and almost same number is shared between rural and urban respondents in this category. When the data is further segregated to know the sex of the child, it shows that male, female and child of both the sex is almost equally distributed among the respondents, and the same picture can be seen in both the setting. Now though most of the mothers of these children have received antenatal check-ups during pregnancy, but all the respondents who have not received any antenatal check-

ups during their pregnancy are from rural background. Hence it can see that though the number is small but there is still want of awareness about the importance of antenatal check-ups during pregnancy particularly in the rural area. Moreover, in the rural setting though antenatal check-ups are given but most of them have not received the entire check- ups. Therefore there is room for much more improvement particularly in elevating the awareness about completing the entire course of the antenatal check-ups in the rural setting.

The age at first child birth of the respondents says that any particular age group cannot be pointed out as majority of the respondents as it is almost equally distributed in age group from 15 to 30 years.

In the rural setting the highest no of first birth giving mothers are from 17-18 whereas the highest no of first birth giving mothers in the urban setting are from 25-26. Therefore it can trace more mothers of less age in the rural setting than in the urban setting which also reflect their status of awareness about the knowledge of the minimum ideal age for a woman to give birth to a child. Most of these deliveries in the study area are found to be normal, but in the rural setting the number of respondents with normal delivery is more than their urban counter parts, whereas the number of respondents with caesarean delivery is more in the urban setting than their rural counter parts. One of the reasons for the high percentages of normal deliveries in the rural setting can be the lack of private hospitals which encourages caesarean delivery more than the normal delivery. Hence majority of the respondents in the urban setting favor private and government hospitals for their child's delivery as it will be attended by doctors, whereas in the rural setting home delivery which is attended by either relatives or local dais is clearly preferred more by the respondents. Therefore as far as the institutional delivery is concerned it can see that the government rural health services with all its attractive plans and projects still fails to reach to the people. Now home delivery which is clearly preferred by the respondents of the rural setting have also mostly held too much cost for the system of delivery as the prime reason for not opting it, which reflects their lack of awareness as the institutional delivery which is available in all the sub centres is free of cost rather the mother and the child are given money from the NRHM's project viz. Janani Suraksha Yojna. Moreover it also reflects their lack of awareness about the need of the proper

hygienic environment and trained doctors to undertake their delivery. The lack of institutional deliveries in the area also keep the mother vulnerable to post delivery health problems, and the data also confirms that more than half of the respondents have reported about post delivery health problems as pain in the abdomen and the problem of excessive bleeding, and very expectedly the share is more among the rural respondents than their urban counterparts.

In case of immunization the data shows that 99.2 percent of the respondents have given immunization to their children. Moreover, The data also confirms that all the children of both the setting are given all the doses of immunization, which reveals the fact that the parents of both the setting have taken care of immunization of their children seriously and health workers particularly in the rural setting have successfully elevated the awareness level of the parents about the importance of total immunization of their child. Hence overall it can be said that the mission of immunization of the children is almost successfully reached the people in both the setting.

Looking at the status of children who are ill in the study area shows that nearly half of the respondent's child have suffered from health problems as fever, diarrhea and both diarrhea and vomiting during the last six months, and the share of the rural respondents is little more than their urban counterparts. But the startling finding comes up when the data reveals that all the ill children in the urban setting are given some kind of treatment whereas as many as 24.3 percent of the rural respondent's ill child are not given any kind of treatment. Hence the poor economic condition together with lack of awareness can easily be traced from the above data, as they are not consulting their health problems in its initial stage with experts.

The study of the status of Family Planning in the study area shows that more than half of the respondents from both the setting reported to have not using any family planning methods. Moreover, the data also reveals that a vast majority of the respondents themselves are using family planning method such as copper-T, pills and tubectomy. Therefore it can trace both the need of the awareness of the importance of family planning together with the continuation of patriarchal values in the practice of family planning where only women are more encouraged to practice family planning measures.

The popular reasons given by respondents from both the setting for not using these methods are that that they prefer to control themselves than using family control measures, the desire of additional child, held their husbands' lack of cooperation to use it. Hence the reflections from both the setting reveals the poor picture of awareness as far as the use, need and the knowledge of the safety level of using family planning measures is concerned.

The sixth chapter highlights the correlation between socio economic background and reproductive health of the respondents

Place of consultation for the first health problem is an important variable as it reveals the awareness of the respondents regarding the choice they make. Now these choices may be inspired by other sociological variables as monthly income, educational qualification and occupation, hence it generates a quest to know the status of other sociological variables of the respondents who are making these particular choices. When the monthly income of the respondents who is making these choices as place of consultation for the first health problem is seen, the data shows that consulting private doctors which encumbers expenses is a choice of the higher income group women, whereas the nearest pharmacy is preferred by women of almost all income groups as these problems are generally perceived as trivial health issues which can be cured by taking popular medicine from the pharmacy or consulting the pharmacist. Analysis of data shows that as the educational level of the respondents raises their preference for the place of consulting their first health problem shifts from the nearest pharmacy to the private doctors. It also shows that women who are doing private jobs and those who are in business are preferring the services of the private doctors for consulting their first health problem, whereas women who are unskilled workers, skilled workers and unemployed are clearly preferring to visit the nearest pharmacy for their first health problem. Homemakers and students are consulting both the private doctors and pharmacist in the nearest pharmacy for their first health problem. .

The relation between belief of not taking bath during menarche and the occupational background of the respondents shows that the profession as business, government jobs and private jobs which demands women to look neat and tidy are actually not following this belief. Moreover, the relation between respondent qualification and take bath daily

during menstruation confirms that with the rise in educational qualification respondents tend not to practice the ritual of not taking bath daily during menstruation. When the relationship between another belief of keeping shunned during menstruation and surprisingly there is hardly any relation between educational qualification and belief of treating women as shunned during menstruation. Similarly, when the relation between general reproductive health problems and age groups is seen the data shows that the respondents of almost all the age groups in the study area are mostly suffering from reproductive health problems such as abdominal pain, backache, itching during menses and white discharge. Now the relation between reproductive health problems particularly those suffered by the married women and age groups confirms that the problem of painful intercourse is reported more by the young respondents whereas though the number is few but the cases of infertility is found only in case of the comparatively older age group. A very clear relation between reproductive health problem and marital status cannot be established as the problem of abdominal pain and backache is a common among the respondents of both the marital statuses.

Opting for treatment to these reproductive health problems is a very imperative choice that the respondents make; hence there is always a quest to know the other socio economic background i.e. educational qualification, occupation and monthly household income of the respondents who are making these choices. The data related to relationship between respondent qualification and received treatment indicates a positive relationship between educational qualification and opting for treatment for reproductive health problems is established because as the educational qualification of the respondents mounts more of them opt for treating the health problems. Likewise the relation between respondent occupation and received treatment reveals that most of the respondents who are engaged in business (53.3 percent) and private jobs (31.6 percent) and government jobs have opted for treating their reproductive health problem, whereas respondents who are skilled and unskilled workers don't prefer to treat their reproductive health problem is in the expected lines considering their poor economic and educational background.

Now the respondents' choice of a particular form of medicine can be influenced by other sociological variables as monthly household income and education. Therefore the data

regarding the relation between respondents' monthly household income and medicine preferred indicates that as the income ascends the trust of the respondents' shifts from folk medicine to allopath for treating their illness. Moreover the data related to the relation between respondents' qualification and medicine preferred clearly indicates that as the educational qualification of the respondents go up the reliance of the respondents' shifts from folk medicine to allopath for treating their illness.

When the data associated with the link between respondents' qualification and health awareness program attended is studied it shows that the respondents who have lesser educational qualification considers more that they need to attend more health awareness programs. Moreover the data also confirms the fact that the respondents who are engaged as skilled and unskilled workers believe that they need to attend more health awareness programs.

The number of children of respondents can be directly linked to either their educational qualification or monthly household income. Though the data reveals that the respondents who have any educational qualification generally have 1-2 children, but surprisingly there is hardly any relation between number of children and monthly income of the respondents, as the increase or decrease in income is not affecting in the rise or fall in the number of the children of the respondents.

Similarly the place of antenatal check up can also be directly linked to either their educational qualification or monthly household income. Hence the data related to their relation to monthly household income reveals that the poor respondents prefer to visit the sub centre for ante-natal checkups as it is both close to their house and cost them less and as their income rises their choice shift to both government and private hospitals. In case of their relation with educational qualification the data shows that as the educational qualification of the respondents go up their preference shifts from sub centre to government and private hospitals for ante-natal checkups.

When the respondents spouse' reaction regarding the sex of the child is studied it also generates a quest to know the educational background of the spouse as it is expected to make a difference in the decision. But surprisingly the data shows that there is no clear relationship between the spouses' negative reaction on the sex of the child and their

educational background, as the spouses who have reacted negatively on the sex of the child are from different educational background.

The relation between educational qualification of the respondent spouse and abortion shows that as the educational qualification of the respondent's spouse go up the number of abortion cases falls, which shows that the educated respondents' spouse must have practiced the preventive measures that can avoid abortion of the child. Likewise the relation between respondent qualification and abortion indicates that the rise in the educational qualification of the respondent leads to the fall in the number of abortion cases, which shows that the educated respondents must have practiced the preventive measures that can avoid abortion of the child.

Similarly the relation between respondent qualification and consumption of nutritious food during pregnancy shows as the educational qualification of the respondents go up they prefer more to take nutritious food. Hence expectedly the educational qualification of the respondents and their preference for nutritious food is positively related. Moreover the relation between monthly income and consumption of nutritious food during pregnancy also shows that they are positively related. Therefore nutritious which demands more money is preferred more by the respondents who can more easily afford it.

There is hardly any relation between consumption of nutritious food and family type indicates that as in both the type of families' majority of the respondents take nutritious food. Similarly, in both the type of families' majority of the respondents takes enough rest during pregnancy. The relation with monthly household income suggests that with the rise in the monthly income of the respondents' family their practice of taking enough rest also increases. Hence the respondents whose monthly income is more can afford to take enough rest during pregnancy.

The relation between monthly income and nature of delivery reveals that with the climb in the monthly income of the respondents' family their preference of kind of delivery shifts from normal to caesarean. Hence the respondents whose monthly income is more can afford to go for caesarean delivery.

Relation between respondent qualification and place of delivery shows that the educated respondents preferred delivery at hospital rises, followed by the MCH centre and nursing homes. But home is the preference for majority of the respondents for delivery who are either illiterate or have less educational qualification. Moreover, when its relation with monthly income is considered the data indicates that respondents who are economically backward preferred more home for the delivery of their child, whereas those whose monthly income is healthier favored hospitals followed by nursing homes for the delivery of their child.

Likewise, the relation between respondent qualification and person attended delivery shows that the educated respondents preferred delivery under the supervision of the doctors. But relatives or *dais* are the preference for majority of the respondents for conducting delivery who are either illiterate or have less educational qualification. Its relation with monthly household income suggests that respondents who are economically backward preferred the services of their relatives or *dais* for conducting the delivery of their child, whereas those whose monthly income is more favored delivery of their child under the supervision of the doctors.

The data related to the relation between respondent qualification and duration of rest after delivery shows that educated respondents who are more aware of the importance of physical rest after delivery, prefer to take more rest (up to three months) compared to their less educated counterparts whose economic condition only allows them to take rest up to forty days. In case of relation between family type and duration of rest after delivery the data indicates that in joint families more respondents take rest up to three months after delivery as there is more human resource in the families and in nuclear families comparatively less respondents can afford to take rest up to three months after delivery, and here many factors are playing their role as economic condition of the family which is not allowing them to take enough rest together with their deep rootedness with their culture which discourage them to take more rest. Similarly, the relation between monthly income and duration of rest after delivery a child shows that the economically poor respondents prefer to take less rest after their delivery of child compare to their affluent counterparts.

As far as the relation of family planning methods used and monthly household income of the respondents is concerned, the data shows that though the use of family planning measures may not ask for much economic affluence, but the economically poor respondents who are also less educated could only be motivated by the ASHA workers, and the economically stable respondents who are generally also more educated avoid it as they prefer to have natural sex and practice the tradition of self control to control birth. Moreover when the monthly household income of the different family planning method users are studied that data shows that copper-T is visibly preferred largely by the respondents in the study area but the share of the respondents who prefer this method of family planning is much more in the least three income groups. The higher income groups are favoring pills and tubectomy more.

The seventh chapter shows the major findings and conclusion of the study. Some of the findings on the basis of the study are as below:

1. The socio economic status of the respondents reveals that in almost all the sectors stating from education of the respondents and their father/spouse which is though over all good in both the setting, but it is not reflected in the occupational background of their father/spouse, living condition, household consumption pattern and monthly household income. Consequently, the urban setting's respondents are performing much better than their rural counterparts in all these indicators, only in the possession of cultivated land; the rural setting's respondents are doing better.
2. Indexes as purification of drinking water and use of sanitary toilets, mass media exposure, status of empowerment of women reveals that the respondents from the rural setting are performing inadequately in comparison to their urban counterparts. Moreover the overall food habit in terms of amount of drinking water, number of meal and addictions, validates that respondents from both the setting are following an unhealthy food habits.
3. The status of health awareness of the respondents with particular reference to reproductive health, which tells that there is a visible difference in almost all the indicators studied between rural and urban respondents. Education, poor economic condition together with dismal infrastructure can be seen as the key rationale behind the disparity in the overall status of awareness in both the setting.

4. Only in case of the attendance of the rural respondents in the health awareness programs is healthier than their urban counterparts which is a good sign, but it also signify that the respondents in the rural setting with lesser education and poor infrastructural facilities considers themselves more the need to attend these programs.

5. In case of medicine preferred by the respondents, the rural respondents are found to be still loyal to their folk medicine though they are also using allopathic medicines whereas majority of the urban respondents are favouring only allopathic medicines. The place for treating the first health problem also reveals that the respondents from the rural setting clearly prefer (95.3 percent) the nearest pharmacy and the respondents from the urban setting visibly prefer (75.3 percent) the private doctors for the purpose. The economic condition of the households together with lack of facilities can be looked as the reason behind the preference in both the setting.

6. To add to it though most of the respondents in both the setting have small family with 1-2 child, but most of the large families with 5-6 child are also from the rural setting. This also indicates ineffective use of family planning methods particularly in the rural area.

7. The study finds the existence of communication between husband and wife in the decisions regarding the size of the family, the impact of which can be seen in the number of children (1-2 child (48%) and 3-4 child (36%) in the family. But in case of sex during pregnancy and after delivery, considerable numbers of husbands don't take the consent of their wives in the study area. Hence, the communication between husband and wife is finding positive impact in case of decision regarding the size of the family but, in case of sex during pregnancy and after delivery, the study also highlighted lack of communication between couples in the study area.

8. The status of antenatal check up confirms that though the number is small but there is still want of awareness about the importance of antenatal check-ups during pregnancy particularly in the rural area. Moreover, in the rural setting though antenatal check-ups are given but they have not received the entire check- ups.

9. The study also traces more mothers of less age in the rural setting than in the urban setting which also reflect their status of awareness about the knowledge of the minimum ideal age for a woman to give birth to a child, moreover, in the rural setting

the number of respondents with normal delivery is more than their urban counter parts, whereas the number of respondents with caesarean delivery is more in the urban setting than their rural counter parts. One of the reasons for the high percentages of normal deliveries in the rural setting is the lack of private hospitals which encourages caesarean delivery more than the normal delivery. Hence majority of the respondents in the urban setting favour private and government hospitals for their child's delivery as it will be attended by doctors, whereas in the rural setting home delivery which is attended by either relatives or local dais is clearly preferred more by the respondents.

10. In case of immunization of the children overall it can be said that the mission is almost successfully reached the people in both the setting as 99.2 percent of the respondents have given immunization to their children.

11. The startling finding shows that all the ill children in the urban setting are given some kind of treatment whereas as many as 24.3 percent of the rural respondent's ill child are not given any kind of treatment. Hence the poor economic condition together with lack of awareness regarding attending any health problem in its initial stage rather than in its matured stage particularly in case of children can easily be traced from the above data.

12. Besides the reflections from both the setting also reveals the poor picture of awareness as far as the use, need and the knowledge of the safety level of using family planning measures is concerned. Moreover a huge majority of the women in the rural setting (97.1 percent) and a significant part (71 percent) of the them in the urban setting are encouraged more to practice family planning measures either copper-T or tubectomy, which reflect the continuation of patriarchal values in the area.

13. The status of reproductive health of women, which states that in many of the indicators of reproductive health of women. In case of age at menarche, most of the respondents it started at the age of 11-13 years. . Majority (76.3) of the respondents reported that their menstruation circle is regular. Among the respondents who reported irregular menstrual are found more among the rural respondents (30 percent) than the urban respondents (17.3 percent). Little more than half of the respondents' amount of menstruation blood is moderate and nearly half (47.7 percent) of the respondents are reported of having scanty or excessive menstruation, when the sample size is split into

rural and urban it founds that rural respondents (52 percent) are reported more than the urban respondents (43.3 percent). Likewise, majority of the respondents reported that the duration of their menstruation lasted for three to five days which is treated to be normal in medical field.

14. In case of the problem of RTI though data revels that the rural respondents are more vulnerable to these problems and more attention is obligatory towards rural women, but there is still dearth of awareness even among the urban respondents particularly about RTI. In case of miscarriages astonishingly the respondents in the urban area with all their health care facilities, awareness and exposure are doing worst than their rural counterparts in this category.

15. The status of abortion in the area shows that though the number of abortion may not be very high but the respondents particularly in the rural setting are found as more vulnerable to it, which is more because of their unawareness and inconsistent use of family planning methods.

16. When the relation between reproductive health status and socio economic background of the respondents is spotted, the data shows that very astonishingly education is not having any relation with the respondents' size of the family, the practice of ill social beliefs related to reproductive health of women as even educated respondents are following these rituals, moreover they are also not treating health problems as RTI. Similarly even educated respondents are also not following family planning methods. To add to it there is no clear relationship between the husbands' negative reaction on the sex of the child and their educational background, as the husbands who have reacted negatively on the sex of the child are even from higher educational background.

17. But poverty has emerged as one of the key rationale behind the poor reproductive health status of the respondents as it is playing a significant role in their preference for selecting the place for treating their first health problem, the place for delivery, place for antenatal checkups, form of medicine, nutritious food and enough rest during pregnancy.

18. The relation between reproductive health status and occupation of the respondents shows that the respondents working in occupations as private jobs,

government jobs and business which demands to look neat and tidy are not following their traditional beliefs related to reproductive health. Hence where even education has failed occupation is playing an important role.

19. The study found that the married respondents are mostly suffering from backache, abdominal pain and itching during menses, whereas abdominal pain and backache is mostly reported by the unmarried respondents. Hence abdominal pain and backache is a common problem among the respondents of both the marital statuses

20. Relation between reproductive health problem of married respondents and age groups shows that the problem of painful intercourse is reported more by women of 16-25 and 26-35 age groups. Only few cases of infertility are reported by women of 36-45 age groups. Hence the problem of painful intercourse is reported more by the young respondents whereas few cases of infertility is found only in case of the comparatively older age group

21. The data indicates that reproductive health problem is more reported by the women from 36-45 age groups. In 26-35 age group the problem of abdominal pain, backache, itching during menses and white discharge is reported more. Most of the respondents in the age group 16-25 are also suffering from abdominal pain, backache, itching during menses and white discharge. Hence the data shows that the respondents in the study area are mostly suffering from reproductive health problems such as abdominal pain, backache, itching during menses and white discharge.

Policy Suggestions

- Sensitization of women in the issues as both the purification and consumption of apt amount of drinking water, together with the importance of sanitary toilets.
- Implementing special awareness programs regarding women's popular reproductive health problems as RTIs and encourage them to visit trained doctors in the local health centre. Provide necessary infrastructural facilities that will attract women to visit these health centres.
- Poor utilization of public health in case of child delivery can easily be traced from the study particularly in rural setting. Hence more attractive and culturally

sensitive awareness programs are needed to be implemented to draw pregnant women to the public health centres for institutional delivery.

- Opportunities should be provided for unimpeded access to contraception, including condoms, consistent sexuality education, and widespread public education campaigns.
- Governments should also support massive, consistent, long-term public education campaigns utilizing the radio together with other channels mass media, pharmacies, and health care providers.
- A national desire to reduce the number of unwanted pregnancies and prevention of sexually transmitted infections should be the main aim.
- Designing and implementing programs to meet the special needs of women. Such programs include support mechanisms for the education and counselling of women in areas of gender relations and equality, responsible sexual behaviour, family life, reproductive health, prevention of RTIs, STIs, HIV, AIDS and violence against women.

Conclusion

Any understanding of reproductive and sexual rights can be gained better in the context of Human Rights in general. The perspective of rights presents a development over thinking of access to different resources as mere privileges or as charity. A resource in this context does not refer only to material or tangible goods but also information, communication and negotiation skills that enable in the well being of the person. The perspective draws attention to the fundamental nature of such access to individuals' well being which also has a legal basis. To ensure these rights, governments, NGOs, parents and other stakeholders of the community play a very important role. The major objective of this study is to identify the needs of women for focusing intervention strategies, which would serve as baseline to evaluate the impact of intervention in the future.

It can also be added that in regards to the overall sexual and reproductive health situation of the women in the area, there is no justification required to say that the vulnerability of the women particularly in the rural setting is more on account of lack of information, poverty, awareness, and emotional problems, social and cultural taboos and lack of medical facilities. In fact, there is a poor fit between existing programs and the

needs of the women. Thus, planners must build upon existing knowledge about women's needs, preferences, and health-seeking behaviours while taking resource constraints into consideration. There is a demand to consider the need for approaches that can help women to obtain information, skills-building opportunities, counselling, and clinical services in areas such as Nagamapal and Heinoubok.