

Chapter-5

Status of Reproductive Health of the Respondents

After studying the status of the socio economic background and the status of health awareness with particular reference to reproductive health of the respondents, the focus can now shift to the core of the study which deals with the knowledge of the status of the reproductive health of the respondents. In this chapter to understand the status of reproductive health of the respondents, particular focus is given to the 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. These reproductive health indicators summarize data which have been collected to answer questions that are relevant to the planning and management of Reproductive health programs. The indicators provide a useful tool to assess needs, and monitor and evaluate program implementation and impact.

Age at menarche

Menarche symbolized the attainment of physical maturity and ability to bear children. *Thagi khongkap lakpa* (coming of monthly period) or *mangba* (polluted) are the local terms used for menstruation and are justified by its occurrence once a month and segregation of women during this period. Flowery terms like *lei lakpa* (coming of flower) are also used as metaphor for menstruation.

Age at menarche of the respondents are categorized into seven categories viz : 1) 10 years, 2) 11 years, 3) 12 years, 4) 13 years, 5) 14 years, 6) 15 years, 7) 16 years. The distribution of the respondents into these categories is shown in Table-5.1

Table-5.1: Age at menarche of the respondents

Age	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
10 years	5	3.3	4	2.7	9	3.0
11 years	42	28	32	21.3	74	24.7
12 years	74	49.3	47	31.3	121	40.3
13 years	25	16.7	49	32.7	74	24.7
14 years	4	2.7	11	7.3	15	5.0
15 years	0	0	4	2.7	4	1.3
16 years	0	0	3	2.0	3	1.0
Total	150	100	150	100	300	100

Source: Field Data

The data reveals that majority (89.3 percent) of the respondent menstruation started at the age of 11-13 years, and there is hardly any rural urban difference that can be observed in this category.

Menstruation circle

The average menstrual cycle is 28 days long from the first day of one menstrual period to the first of the next. A normal menstrual cycle in adult women is between 21 and 35 days. In adolescents, there is wider variation, and cycles are normally between 21 and 45 days.

Menstruation circle of the respondents are categorized into two categories: 1) Regular, and 2) Irregular. The distribution of the respondents into these categories is shown in table no Table no-5.2

Table-5.2: Menstruation circle of the respondents

Circle	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
Regular	105	70	124	82.7	229	76.3
Irregular	45	30	26	17.3	71	23.7
Total	150	100	150	100	300	100

Source: Field Data

The data reveals that majority of the respondents' menstruation circle is regular, and the same can be observed in both the settings.

Amount of the menstruation blood

The average volume of menstrual fluid during a monthly period is 35 milliliters (2.4 tablespoons) of menstrual fluid) with 10-80 milliliters (1-6 tablespoon of menstrual fluid) considered typical. Menstrual fluid is the correct name for the flow, although many people prefer to refer to it as menstrual blood.

The amounts of menstruation blood of the respondents are categorized into three categories: 1) Scanty, 2) Moderate, and 3) Excessive. The distribution of the respondents into these categories is shown in table no Table-5.3

Table-5.3: Amount of the menstruation blood of the respondents

Amount	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
Scanty	54	36	36	24.0	90	30.0
Moderate	72	48	85	56.7	157	52.3
Excessive	24	16.0	29	19.3	53	17.7
Total	150	100	150	100	300	100

Source: Field Data

The data establish that more than half (52.3 percent) of the respondent amount of menstruation blood is moderate, followed by 30 percent of the respondents who reported to have scanty amount of menstruation blood and the remaining 17.7 percent of the respondents have reported to have the problem of excessive menstruation. Even in this category too it can hardly be observe any visible rural urban difference.

Duration of menstruation

Regular menstruation (also called amenorrhea) lasts for a few days, usually 3 to 5 days, but anywhere from 2 to 7 days is considered as normal. The duration of menstruation of the respondents are categorized into four categories: 1) three days, and 2) four days, 3) five days, 4) more than five days. The distribution of the respondents into these categories is shown in table no Table-5.

Table-5.4: Duration of menstruation of the respondents

Duration	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
3 days	13	8.7	73	48.7	86	28.7
4 days	75	50	33	22	108	36
5 days	47	31.3	22	14.7	69	23
More than 5 days	15	10	22	14.7	37	12.3
Total	150	100	150	100	300	100

Source: Field Data

The data shows that 36 percent of the respondent menstruation lasted for four days, 28.7 percent of the respondent duration of menstruation is three days, 23 percent of the respondent duration of menstruation is lasted up to five days and 12.3 percent of the respondent duration of menstruation is lasted more than five days. There is hardly rural urban difference that can be observed in this category too.

Some general health problems

Apart from studying typical reproductive health problems of women, other general health problems like anemia, blood pressure also have an impact in their status of reproductive health. Hence the table deals with the status of other general health problems which also impact the overall status of reproductive health. The distribution of the respondents into these categories is shown in table no Table-5.5

Table-5.5: Some general health problems of the respondents

Problem		Rural (Heinoubok)		Urban (Nagamapal)		Total	
		f	%	f	%	f	%
Anemia	No	142	94.7	144	96	286	95.3
	Yes	8	5.3	6	4	14	4.7
Low BP	No	139	92.7	124	82.7	263	87.7
	Yes	11	7.3	26	17.3	37	12.3
High BP	No	142	94.7	138	92	280	93.3
	Yes	8	5.3	12	8	20	6.7

Source: Field Data

The data reveals that 4.7 percent of the respondents are reported of facing the problem of Anemia, 12.3 percent of the respondents are reported of suffering the problem of low BP and 6.7 percent of the respondents are reported of facing the problem of high blood pressure.

Among the rural respondents, 5.3 percent of the respondent and 4 percent among the urban respondent are reported of suffering the problem of anemia, 7.3 percent of the rural respondent and 17.3 percent of the urban respondents are reported of suffering the problem of low BP and 5.3 percent of the rural respondents and 8 percent of the urban respondents are reported of suffering the problem of high BP.

Little more percent of the problem are reported by urban respondents. It can be said that there is no much disparity among the two different setting regarding the reporting of anemia, low BP and High BP

Problem related to Reproductive tract infections RTIs

Reproductive tract infections (RTI's) are endemic in developing countries and entail a heavy toll on women. If untreated, RTI's can lead to adverse health outcomes such as infertility, ectopic pregnancy and increased vulnerability to transmission of the human immunodeficiency virus. Respondents have reported some RTIs related problems such as white discharge, burning urination, rash & soil near public region and arms, itching during menses, backache, and abdominal pain. The distribution of the respondents into these categories is shown in table no Table-5.6

Table-5.6: Problem related to RTIs among the respondents

Problems		Rural (Heinoubok)		Urban (Nagamapal)		Total	
		f	%	f	%	f	%
White discharge	No	123	82	129	86	252	84
	Yes	27	18	21	14	48	16
Burning urination	No	141	94	134	89.3	275	91.7
	Yes	9	6	16	10.7	25	8.3
Rash & soil near public region and arms	No	145	96.7	143	95.3	288	96
	Yes	5	3.3	7	4.7	12	4
Itching during menses	No	107	71.3	117	78	224	74.7
	Yes	43	28.7	33	22	76	25.3
Backache	No	45	30	71	47.3	116	38.7
	Yes	105	70	79	52.7	184	61.3
Abdominal pain	No	80	53.3	72	48	152	50.7
	Yes	70	46.7	78	52	148	49.3

Source: Field Data

The data reveals that backache followed by abdominal pain, itching during menses and the problems of white discharge are reported most by the respondents in the study area.

After segregating the respondents into rural and urban setting, it can observe that the problems as backache, white discharge and itching during menses is reported more by the rural respondents and problems as abdominal pain, burning urination and rash and soil near public region & arms is reported more by the urban respondents.

To add to it in almost all the problems are reported more by the rural respondents. The gap between the rural and urban respondents is visibly much more than the problems that the urban respondents are reporting more.

Reproductive health related problems among the married respondents

Married respondents have reported two types of reproductive tract infections such as painful intercourse and infertility. The distribution of the respondents into these categories is shown in table no Table-5.7.

Table-5.7: Reproductive related health problems among the married respondents

Problem		Rural(Heinoubok)		Urban (Nagamapal)		Total	
		f	%	f	%	f	%
Painful intercourse	No	71	94.7	72	96	143	95.3
	Yes	4	5.3	3	4	7	4.7
Infertility	No	72	96	74	58.7	146	97.3
	Yes	3	4	1	1.3	4	2.7

Source: Field Data

The data shows that very few respondents in both the setting have reported of suffering from the problem of painful intercourse and infertility. Moreover it can hardly observe any significant rural urban difference in the category.

Treatment

In India, women are reluctant to seek medical treatment because of lack of privacy, lack of a female doctor at the health facility centre, the cost of treatment and their subordinate social status. This reluctance is exacerbated when symptoms are embarrassing, as they are with RTIs. A "culture of silence" shrouds gynecologic morbidity throughout India and elsewhere. Furthermore, women, more so than men, tend to regard RTI symptoms as normal discomfort and therefore often do not seek treatment.

Therefore the following table deals with the respondents' response on whether they go for any treatment for those problems, which will reveal their awareness and seriousness of these health problems.

Table-5.8: Treatment for health problems of the respondents

Received treatment	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
No	141	94	103	68.7	244	81.3
Yes	9	6	47	31.3	56	18.7
Total	150	100	150	100	300	100

Source: Field Data

For the above mentioned problems, only 18.7 percent of the respondents have received some treatment. It can be observe that only 6 percent of the rural respondents and 31.3 percent of the urban respondents have received some treatment for the above reproductive health problems. Even after receiving so much of education and mass media exposure particularly in the urban setting, it can still observe 68.7 percent of the respondents who have not opted for any treatment for the above reproductive health problems.

Cured after treatment

In order to understand the affectivity of the treatment, it needs to find out the number of patients who are actually cured from the problem by using the treatment. Therefore, the following table -5.9 shows the distribution of the respondents into two categories, viz 1) No and 2) Yes.

Table-5.9: Problem cured after the treatment

Cured	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
No	4	44.4	31	66	35	62.5
Yes	5	55.6	16	34	21	37.5
Total	9	100	47	100	56	100

Source: Field Data

Out of 18.7 percent respondents who have received treatment, 37.5 percent of the respondents are cured from their problems, and for the rest 65.5 percent respondents the treatment did not worked as problem persisted. It can observe that in the urban setting where it found more number of treatment seekers for the above stated reproductive health problems, they are also mostly (66 percent) not benefitted from

the treatment, the rural setting has almost equal numbers of both cured (44.4 percent) and not cured (55.6 percent) patients.

Age at marriage

Age at marriage of the respondents are categorized into nine categories: 1) before 18 years, 2) 18-20 years, 3) 21-23 years, 4) 24-26 years, 5) 27-29 years, 6) 30-32 years, 7) 33-35 years, 8) 36-38 years, 9) 39 and above 39 years. The distribution of the respondents into these categories is shown in table no-5.10

Table-5.10: Age at marriage of the married respondents

Age at marriage	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
Before 18	4	5.3	0	0	4	2.7
18-20	21	28	9	12	30	20
21-23	15	20	22	29.3	37	24.7
24-26	6	8	20	26.7	26	17.3
27-29	8	10.7	16	21.3	24	16
30-32	19	25.3	3	4	22	14.7
33-35	2	2.7	3	4	5	3.3
36-38	0	0	1	1.3	1	0.7
39 and Above	0	0	1	1.3	1	0.7
Total	75	100	75	100	150	100

Source: Field Data

The data reveals that 2.7 percent of the respondents are married before the legal marriage age, 20 percent of the respondents are married at an early age of 16-18 years, and 24.7 percent of the respondents are married at the age of 19-21 years, 2 percent of the respondents are married at the age of 31-33 years.

The segregation of the data into rural urban setting reveals one visible difference that is 2.7 percent of the rural respondents got married before the legal age of marriage i.e 18 years.

Number of living child

Here an attempt is made to look at the total number of children that the respondents are having without focusing on any age group. The distribution of the respondents into these categories is shown in table no-5.11

Table-5.11: Number of living child of the respondents

Number of living child	Rural (Heinoubok)		Urban(Nagamapal)		Total	
	f	%	f	%	f	%
1-2 child	34	45	38	51	72	48
3-4 child	22	29	32	42	54	36
5-6 child	11	15	4	5	15	10
7-8 child	1	1	0	0	1	1
No child	7	9	1	1	8	5
Total	75	100	75	100	150	100

Source: Field Data

The data shows that almost half of the respondents have small family (48 percent) with 1-2 children, 36 percent of the respondents have 3-4 children, and 10 percent of the respondents have 5-6 children and 1 percent of the respondents have 7-8 children.

In both the setting most of the respondents (rural- 45 percent, urban- 51 percent) have 1-2 child, but when it look at the respondents having 5-6 child, the rural setting has much more representation (15 percent) in this category than their urban counterparts (5 percent). Moreover the only respondent who has reported to have highest number of children i.e 7-8 child is also from the rural setting. Hence it can see dearth of the practice of family planning in the rural setting in comparison to the urban setting.

Children under 0 to 14 years

To know the status of immunization of the children, the mother respondents are asked whether they have children of 0 to 14 years. The distribution of the respondents into these categories is shown in Table no-5.12.

Table-5.12: Respondents who have children (0 to 14 years)

Any child	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
No	18	24	16	21	34	23
Yes	57	76	59	79	116	77
Total	75	100	75	100	150	100

Source: Field Data

The data shows that majority (77 percent) of the married respondents have one or more child up to fourteen years.

Little more than three-fourth (76 percent) of the rural respondents and 79 percent of the urban respondents have one or more child of the age group.

Sex of the child

Sex of the child are divided into two groups ie. male child and female child. The distribution of the child into these categories is shown in Table no-5.13

Table-5.13: Sex of the child of the respondents

Sex	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
Male	20	35	21	36	41	35
Female	17	30	23	39	40	34
Both	20	35	15	25	35	30
Total	57	100	59	100	116	100

Source: Field Data

The data indicates that male, female and child of both the sex is almost equally distributed among the respondents, with 35 percent of the respondents have only male child, 34 percent of the married respondents have only female child and 30 percent of the respondents have both male and female child, and almost same can be observe in both the setting too

Spouse reaction regarding the sex of the child

In patriarchal society, the preference for a son is an established fact. But the development in the spheres of educations has help to narrow the impact of these values. Hence the following table is an attempt to know the status of girl child by looking at the preferences of gender (if any) of the child by their father.

Table-5.14: Respondents spouse reaction regarding the sex of the child

Husband reaction	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
Happy	60	88	66	89	126	89
Unhappy	8	12	8	11	16	11
Total	68	100	74	100	142	100

Source: Field Data

The data shows that majority (89 percent) of the married respondent's spouse are happy after knowing the sex of the child born whereas 11 percent of the married respondents' spouse are not happy with the sex of the child. Almost equal numbers of fathers from both the setting are not happy with the sex of their child.

To add to it almost all these fathers apart from one from both the setting wanted to have male child. Though the number is small which is a good indicator, but it can still see the preference of male child and the alarming factor is that even people from the urban areas with all their mass media exposure and education still fall into the prey to this social ill.

Miscarriage

Poverty, illiteracy and lack of gainful employment and pro-natal cultural norms contribute to higher fertility rates in several regions. Frequent childbearing often endangers health of women in turn also leads to higher incidence of miscarriages. Several empirical studies indicate that under reporting of miscarriages and abortions are a common phenomenon. Nevertheless, information on miscarriages elicited from the respondents is given below in Table-5.15.

Table-5.15: Miscarriage

Miscarriage	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
No	65	87	61	81	126	84
Yes	10	13	14	19	24	16
Total	75	100	75	100	150	100

Source: Field Data

The data reveals that 16 percent of the respondents have reported of miscarriages.

When the sample size is segregate into rural and urban setting, it can observe that 19 percent of miscarriages are reported by the urban respondents and 13 percent of miscarriages are reported by the rural respondents. Hence it can be observed here that the urban area with all their health care facilities, awareness and exposure are doing worst than the rural counterparts.

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

Reason for miscarriage

To get more specific reason behind the miscarriage of women in the area, the respondents are categorized into four categories of reasons. The distribution of the respondents into these categories is shown in Table-5.16

Table-5.16: Reasons for miscarriage among the respondents

Reason	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
Bleeding	7	70	10	71.4	17	71
Accident	1	10	3	21.4	4	17
Lifting heavy weight	2	20	0	0	2	8
Exertion	0	0	1	7.1	1	4
Total	10	100	14	100	24	100

Source: Field Data

The data reveals that in majority of the cases in both the setting, bleeding (71percent) is the prime reason of the problem, but accidents (17 percent) are more reported in the urban area (21.4 percent) than in the rural setting (10 percent), and lifting heavy weight is the reason that led to miscarriages only in the rural setting (20 percent), and only one case of exertion is reported in the urban setting.

Abortion

Abortion is the termination of pregnancy by the removal or expulsion from the uterus or a foetus or embryo before viability. The World Health Organisation (WHO) published an estimate that in 2003 approximately 42 million pregnancies are voluntarily terminated, of which 20 million are unsafe. The WHO reports that in developed regions, nearly all abortions (92%) are safe, whereas in developing countries, more than half (55%) are unsafe.

Table-5.17: Abortion among the respondents

Abortion	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
No	59	79	64	85	123	82
Yes	16	21	11	15	27	18
Total	75	100	75	100	150	100

Source: Field Data

The data indicates that 18 percent of the married respondents have undergone abortion. It can see that 21 percent of the rural respondents and 15 percent of the urban respondents have undergone abortion.

Reason for Abortion

As well as the respondents decided to have an abortion then there may be some reasons for choosing this method.

The study reveals that all the respondents in both setting who have gone through abortion reported, the main reason for abortion is due to unplanned pregnancy

Prenatal care

Prenatal care (also known as antenatal care) refers to the regular medical and nursing care recommended for women during pregnancy. Prenatal care is a type of preventative care with the goal of providing regular check-ups that allow doctors or midwives to treat and prevent potential health problems throughout the course of the pregnancy while promoting healthy lifestyles that benefit both mother and child. During check-ups, women will receive medical information over maternal physiological changes in pregnancy, biological changes, and prenatal nutrition including prenatal vitamins. Recommendations on management and healthy lifestyles changes are also made during regular check-ups. The availability of routine prenatal care has played a part in reducing maternal death rates and miscarriages as well as birth defects, low birth weight, and other preventable health problems.

The data reveals that majority (96 percent) of the respondents have received antenatal check-ups during pregnancy. At the rural urban difference 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.

Number of ante-natal check-up

It is important for a pregnant woman to have regular check-ups with a midwife or doctor. These check-ups are called antenatal care or antenatal visits. Prenatal care generally consists of: monthly visits during the first two trimesters (from week 1–28), fortnightly visits from 28th week to 36th week of pregnancy and weekly visits after 36th week until delivery (delivery at week 38–42). To know how often the respondents go for antenatal checkups, the respondents are classified into three categories. The distribution of the respondents into these categories is shown in Table-5.18

Table-5.18: Number of ante-natal check-up by the respondents

No. of check-up	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
2-3 times	5	8	4	5	9	7
4-5 times	43	68	11	15	54	39
More than 5 times	15	24	59	80	74	54
Total	63	100	74	100	137	100

Source: Field Data

The data indicates that little more than half (54 percent) of the respondents have received more than 5 times antenatal check-ups, 39 percent of the respondents have received 4-5 times antenatal check-ups and only 7 percent of the respondents have received 2-3 times antenatal check-up.

In urban setting majority of the respondents (80 percent) have received more than 5 times antenatal check-ups in comparison to mere 24 percent respondents of the rural setting who have received the same amount of antenatal check-ups, to add to it majority of the respondents (68 percent) of the rural setting have received only 4-5 times antenatal check-ups in comparison to mere 15 percent respondents' representation in the urban setting in this category. Hence it can be observed that in rural setting though antenatal check-ups are given but most of them have not taken all the 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.

Place of antenatal check-up (ANC)

During pregnancy, women received antenatal check-ups from Government health facility and private health facility. The distribution of the respondents into these categories is shown in Table-5.19

Table-5.19: Place of ANC check-up

Place	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
Sub-centre	62	98	7	9	69	50
Govt. hospital	0	0	34	46	34	25
Private hospital	1	2	33	45	34	25
Total	63	100	74	100	137	100

Source: Field Data

The data reveals that half (50 percent) of the respondents have received antenatal check-ups at the sub-centre, and 25 percent each of the respondents have received antenatal check-ups in government hospital and private hospitals respectively.

The rural urban difference reflects that the local sub-centre is clearly more preferred (98 percent) by the respondents in the rural setting, and government hospitals (46 percent) together with private hospitals (45 percent) are more preferred by the respondents in the urban setting. It is to be noted that the distance from the government and private hospitals have handicapped the respondents from taking the opportunity to get the antenatal check-ups there.

The data shows that among the respondents who received ante natal check-ups, 100 percent of the respondents have measured their blood pressure, weight and tested their urine, 95 percent of the respondents have taken TT injection, 93 percent of the respondents have taken test for anemia and 88 percent of the respondents have taken iron tablets during pregnancy.

Age at first delivery

The ideal age to give birth to a child is from 20-30 years, hence giving birth before and after the age limit is generally found to be engaged with health complexities which encourages many other health problems. Therefore the following table is an attempt to find out the age of the married respondents during their first birth to a child. The distribution of the respondents into twelve categories of age groups in which they have reported to have given birth to their first child is shown in Table- 5.20

Table-5.20: Age at first delivery of the respondents

Age	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	Freq	%	Freq	%	Freq	%
Before 18 years	3	2	0	0	3	1
18-19 years	21	14	3	2	24	8
20-21 years	11	7.3	6	4	17	5.7
22-23 years	7	4.7	19	12.7	26	8.7
24-25 years	7	4.7	10	6.7	17	5.7
26-27 years	14	9.3	22	14.7	36	12
28-29 years	5	3.3	9	6	14	4.7
30-31 years	0	0	4	2.7	4	1.3
36-37 years	0	0	1	0.7	1	0.3
No child	7	4.7	1	0.7	8	2.7
Total	150	100	150	100	300	100

Source: Field Data

The data cannot point out any particular age group when majority of the respondents are giving the first birth 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 (14 percent) whereas the highest no of first birth giving mothers in the urban setting are from 25-26 (14.7 percent). 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.

Delivery nature

The knowledge of nature of delivery of a child is an attempt to get more specific information on not only the number of deliveries but rather how the delivery was done, if it is a normal one or it is a result of caesarean operation. The distribution of the respondents into these categories is shown in Table-5.21

Table-5.21: Nature of delivery of the respondents

Delivery nature	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
Normal	61	90	52	70	113	80
Caesarean	1	1	12	16	13	9
Both	6	9	10	14	16	11
Total	68	100	74	100	142	100

Source: Field Data

The data shows that 80 percent of the respondent delivery is normal, 11 percent of the respondents had the experience of both normal and caesarean and 9 percent of the respondent's nature of delivery is caesarean.

In the rural setting the number of respondents with normal delivery (90 percent) is more than their urban counter parts (70 percent) whereas the number of respondents with caesarean delivery (13 percent) is more in the urban setting than their rural counter parts (1 percent). 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.

Place of delivery

One of the important targets of the Reproductive and Child Health Program is to encourage deliveries under proper hygienic conditions under the supervision of trained health professional. The provision of delivery services in the government health institutions is one of the components of the RCH program.

Table-5.22: Place of delivery of the respondents

Place	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
Govt. Hospital	16	24	31	42	47	33
Home	44	65	1	1	45	32
Private hospital	1	1	36	49	37	26
Home and hospital	7	10	6	8	13	9
Total	68	100	74	100	142	100

Source: Field Data

The data shows that 33 percent of the respondents' delivery are conducted at Government hospital, 32 percent of the respondents delivery are conducted at home, little more than one-fourth (26 percent) of the respondents delivery are conducted at private hospital and 9 percent of the respondents delivery are conducted at both home and Government hospital. It shows that 59 percent of institutional delivery among the respondents.

When the sample size is divide into rural and urban setting, it can spot the inequality as in the urban setting majority of the respondents prefer private (49 percent) and government hospitals (42 percent), whereas in the rural setting home delivery is clearly preferred more (65 percent) by the respondents. Therefore as far as the institutional delivery is concerned we can see that the government rural health services with all its attractive plans and projects still fails to reach to the people.

Reason for home delivery

To get more specific reason for opting home delivery in the area, the respondents are categorized into three categories and the distribution of the respondents into these categories is shown in Table-5.23.

Table-5.23: Reasons for home delivery by the respondents

Reasons for home delivery	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
Lack of money/cost too much	32	63	0	0	32	55
Did not feel necessary	16	31	7	100	23	40
Husband/ in-laws decision	3	6	0	0	3	5
Total	51	100	7	100	58	100

Source: Field Data

The data of reasons for opting home delivery reveals that more than half (55 percent) of the respondent stated lack of money or in other words institutional delivery would cost them too much money which they don't have, 40 percent of the respondents did not felt that it is necessary to go for the institutional delivery and 5 percent of the respondent reason for not opting for institutional delivery is because their spouse/ in-laws decided to do so.

Now home delivery which is clearly preferred by the respondents of the rural setting have also mostly held (63 percent) lack of money or 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 centre's is free of cost rather the mother and the child are given money from the NRHM's project viz. Janani Suraksha Yojna and others 31 percent of the rural and all the urban respondents did not felt the necessity of institutional delivery also reflects their lack of awareness about the need of the proper hygienic environment and trained doctors to undertake their delivery.

In traditional home delivery, the mother use to sleep in a mattress made of straw and a hearth is kept near the mother to keep her warm.

Y. Ibetombi Devi (local dais) said “sleeping in a mattress made of straw helps in the blood circulation and reduces the chances of body ache after the delivery. The warmth of the fire helps to keep the delivery mother warm and discourages the growth of viruses. The warmth of the fire also keeps the body of the mother free from aches”.

Assistance during delivery

One of the most important requirements for an idle child birth is that every pregnant woman has to be attended by a trained doctor in a well equipped hospital. Through in various studies it is found that the share of institutional deliveries particularly in rural areas is less than their urban counterparts. Hence, the Government of India has introduced many programs as ICDS (Integrated Child Development Service), JSY (Janani Suraksha Yojana).

Table-5.24: Assistance during delivery of the respondents

Assistance by	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
Doctor	17	25	70	94.6	87	61.3
Relatives+ dais	44	64.7	2	2.7	46	32.4
Health worker + dais	7	10.3	2	2.7	9	6.3
Total	68	100	74	100	142	100

Source: Field Data

The data indicates that most of the delivery (61.3 percent) is attended by the doctors, followed by the relatives and dais (32.4 percent) and finally the health worker and dais (6.3 percent).

But the real disparity can be observed only when it split up the sample size into rural and urban setting, which reveals that majority of the respondents (94.6 percent) in the urban setting are attended by doctors during their delivery whereas majority of the respondents in the rural setting (64.7 percent) are attended by either their relatives or the local dais during their delivery. Doctors are only preferred for attending delivery by mere 25 percent of the rural respondents. Hence it can observe that the people of the rural area are clearly in need of awareness of proper trained hands particularly in serious time as delivery of child.

Health problems after delivery

It is often observed that post delivery patients often complain about different health problems, which can be for different reasons. The following table-5.25 is an attempt to find out if women had experience any post-delivery health problems.

Table-5.25: Faced health problems by the mother respondents after delivery

Problem after delivery	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
No	33	48.6	40	54	73	51.4
Yes	35	51.4	34	46	69	48.6
Total	68	100	74	100	142	100

Source: Field Data

The data reveals that little more than half (51.4 percent) of the respondents have faced some health problems after delivery.

The respondents in the rural setting who reported to have faced health problems after their delivery of child are little more (51.4 percent) than their urban counterparts (46 percent).

Type of health problems after delivery

To get a more specific idea about the kind of problem that the mother faced after delivery, the respondents are categorized into four categories reported by the respondents. The distribution of the respondents into these categories is shown in Table-5.26.

Table-5.26: Type of health problems faced by the mother respondents after delivery

Problem	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	F	%	f	%	f	%
High fever with foul discharge	0	0	3	8.8	3	4.3
Paleness/convulsion/fit	1	2.8	2	5.8	3	4.3
Excessive bleeding	2	5.7	5	14.7	7	10.1
Pain in abdomen	32	91.4	24	70.5	56	81.1
Total	35	100	34	100	69	100

Source: Field Data

The data shows that majority (81.1 percent) of the respondents have faced the problem of pain in abdomen area after delivery, 10.1 percent of the respondents faced the problem of excessive bleeding, and 4.3 percent each of the respondents have gone through the problem of high fever with foul discharge and paleness/ convulsion/fit after delivery.

Pain in the abdomen area is the problem faced by bulk of the respondents of both the settings (rural- 91.4 percent, urban- 70.5 percent), followed by the problem of excessive bleeding (rural- 14.7 percent, urban- 5.7 percent).

Breast feeding

Infant feeding practices and child nutrition have significant effects on child survival, child health, infant mortality and fertility. WHO, working group on infant feeding recommended that infants should be given only breast milk until 4-6 months. Rather no other food or liquids are needed during this period. The breastfeeding not only improves the nutritional status of infants but also reduces morbidity and mortality through protection against certain infections. Indirectly breastfeeding helps in reducing fertility such as prolonged breastfeeding increases post partum amenorrhea

during which mothers are saved from the risk of pregnancy. To judge the status of child health the respondents are asked whether their child is given proper breast feeding. The distribution of the respondents into whether they give their child breast feeding or not is shown in Table--5.27

Table-5.27: Breast feeding by the respondents

Breast feed	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
No	2	3	4	5	6	4
Yes	66	97	70	95	136	96
Total	68	100	74	100	142	100

Source: Field Data

The data shows that majority (96 percent) of the respondents are breast feed their baby and 4 percent of the respondents are not breast feed their baby.

Time of first breast feeding

It is generally prescribed by doctors that a child should be given breast feeding within two hours of birth, but many studies has revealed that there are beliefs in many parts of the country particularly in rural areas which do not find this a healthy practice. Therefore it is necessary to know when did the respondents actually started breast feeding their child. The distributions of the respondents into these categories are divided into 2 categories accordingly to their response viz 1) Same day within 2 hours of birth and 2) Same day after 2 hours. The distribution of the respondents into these categories is given below in Table-5.28

Table-5.28: Time of breast feeding of the new born child by the respondents

Time	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	F	%	f	%	f	%
Same day within 2 hours of birth	11	17	41	59	52	38
Same day after 2 hours	55	83	29	41	84	62
Total	66	100	70	100	136	100

Source: Field Data

The data reveals that little more than three-fifth (62 percent) of the respondents starts breast feed their baby same day after two hours of delivery and 38 percent of the respondents starts breast feed their baby same day within two hours of birth.

First feed

If the respondents do not opt for breast feeding, what did they first give to the new born? The following table is an attempt to find answer to the question. The distribution of the respondents into four things they gave to the child is shown in Table-5.29.

Table-5.29: First feed of the new born child by the respondents

First feed	Rural(Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
Pure milk	0	0	7	10	7	5
Glucose	1	1	7	10	8	6
Honey	42	64	3	4	45	33
Breast milk/wet nurse	23	35	53	76	76	56
Total	66	100	70	100	136	100

Source: Field Data

The data indicates that more than half (56 percent) of the respondents are first feed their child by breast milk / wet nurse, 33 percent of the respondents are first feed their child by honey, 6 percent of the respondents are first feed their child by glucose and 5 percent of the respondents are first feed their child by pure milk.

Immunization

The immunization of children against six serious but preventable diseases namely, tuberculosis, diphtheria, pertusis, poliomyelitis and measles is the main component of the child survival program. As part of the National Health Policy, the National Immunization Program is being implemented on a priority basis. The Government of India initiated the Expanded Program on Immunization (EPI) in 1978 with the objective of reducing morbidity, mortality and disabilities among children from six diseases.

The study found that 99.2 percent of the respondents have given immunization to their children. Only one case in the rural setting is reported where the child was not given immunization. Hence overall it can say that the mission of immunization of the children is almost successfully reached the people in both the setting.

Type of immunization

The study reveals 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.

Ill Child during last six months

Children are generally most vulnerable to health problems. The following table is an attempt to find out if the respondents have any child who is suffering from any health problems in the past six months.

Table-5.30: Ill child during last six months of the respondents

Ill child	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
No	31	45.5	44	59.4	75	53
Yes	37	54.4	30	40.6	67	47
Total	68	100	74	100	142	100

Source: Field Data

The data indicate that nearly half (47 percent) of the respondent child have suffered from some health problems during the last six months.

The rural urban difference says that as many as 54.4 percent of the rural respondents and 40.6 percent of the urban respondents have one or more child in their house who has suffered from some health problems during the last six months.

Type of Illness of the Children

To get a more specific knowledge about the type of health problem the respondents ill children are categorized into seven categories of health problems reported by the respondents which is shown in Table-5.3

Table-5.31: Illness type of the respondents children of the respondents

Illness type	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
Vomiting	1	2.7	0	0	1	1.4
Heart problem	1	2.7	0	0	1	1.4
Chicken pox	3	8	0	0	3	4.4
Fever + Vomiting	2	5.4	4	13.3	6	8.9
Diarrhoea	5	13	2	6.6	7	10.4
Vomit + diarrhoea	1	2.7	6	20	7	10.4
Fever	24	64.8	18	60	42	62.6
Total	37	100	30	100	67	100

Source: Field Data

The data indicates that majority (62.6 percent) of the respondent's child in both the settings suffered from fever in last six months, followed by diarrhea and both diarrhea and vomiting (10.4 percent).

Treatment given

If a child is suffering from any health problems, the next question that needs to be asked is whether he or she is given any treatment. The distribution of the respondents into whether their ill child is given any treatment is shown in Table--5.3

Table-5.32: Treatment given to the ill child of the respondents

Treatment	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
No	9	24.3	0	0	9	13.4
Yes	28	75.6	30	100	58	86.6
Total	37	100	30	100	67	100

Source: Field Data

The data establishes that majority (86.6 percent) of the respondents have given some treatment to their ill child.

But the startling finding comes up when the sample size is segregate into rural and urban setting which says that all the ill children in the urban setting were given some kind of treatment whereas as many as 24.3 percent of the rural respondent ill child were 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 particularly in case of children

Family planning method

Women’s ability to choose if and when to become pregnant has a direct impact on her health and well-being. Family planning allows spacing of pregnancies and can delay pregnancies in young women at increased risk of health problems and death from early childbearing, and can prevent pregnancies among older women who also faced increased risks. Family planning enables women who wish to limit the size of their families to do so. The distribution of the respondents into whether they use family planning method is shown in Table--5.33

Table-5.33: Currently using Family planning method by the respondents

Currently using family planning method	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
No	40	53.3	44	58.7	84	56
Yes	35	46.7	31	41.3	66	44
Total	75	100	75	100	150	100

Source: Field Data

The data indicates that more than half (56 percent) of the respondents reported to have not using any family planning methods.

In both the settings (rural- 53.3 percent, urban- 58.7 percent) it can see similar trends where family planning methods are not practiced by majority of the respondents. Hence surprisingly even in the urban area with all its advantages are not reflected in the use of family planning measures.

Spouse who follow the family planning method

Mere using family planning measures may give us the whole picture, therefore it also very important to know who is using the family planning method. The findings of many studies revealed that the use of family planning method as copper-T, pills, etc by women often led to many health problems that they had to suffer. Therefore the distribution of the married respondents into husband and wife, who uses the family planning method, is shown in Table-5.34

Table-5.34 Family planning method user among the couple

F.P. Method user	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
Wife	34	97.1	22	71	56	84.9
Husband	1	2.9	4	12.9	5	7.5
Both	0	0	5	16.1	5	7.5
Total	35	100	31	100	66	100

Source: Field Data

The data reveals that majority (84.9 percent) of the female partner themselves using family planning method, 7.5 percent of the respondents' husband are using family planning method and of same percent (7.5 percent) are used by both respondents and their husbands.

Though in both the setting majority of the respondents are themselves using the family planning measures, but their number is more in the rural setting (97.1 percent) than in the urban setting (71 percent), where husbands (12.9 percent) and both husband and wife (16.1 percent) are also using it. 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.

Method use

To get a more specific knowledge of the method of family planning that is used in the area, the respondents are categorized into six categories of methods which is shown in Table-5.35

Table-5.35: Type of family planning method use by the couple

Method use	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
Copper-T	30	85.7	9	19.3	39	59
Pills	4	11.4	9	19.3	13	19.6
Tubectomy	0	0	7	22.6	7	10.6
Condom	0	0	4	13	4	6
Condom + pills	0	0	2	6.4	2	3
Vasectomy	1	2.9	0	0	1	1.5
Total	35	100	31	100	66	100

Source: Field Data

The data indicates that about three-fifth (59 percent) of the respondents are using copper-T, nearly one-fifth (19.6 percent) of the respondents are using pills, 10.6 percent of the respondents are done tubectomy, 6 percent of the respondents husband are using condom, 3 percent of the respondents and their husband are using condom and pills and 1.5 percent of the respondents husband are gone through vasectomy as a method of family planning.

Reason for not using family planning method

When family planning measures are not used, there has to be some justification or reason behind this. On the basis of the different reasons that the respondents gave for not using family planning, the respondents are categorized in seven categories which is shown in Table-5.36

Table-5.36: Reasons for not using family planning method by the couple

Reasons	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
Self control	24	60	17	38.6	41	48.8
Desire for additional child	9	22.5	5	11.3	14	16.6
No cooperation of husband	1	2.5	11	25	12	14.2
Scared	1	2.5	6	13.6	7	8.3
Remove womb	5	12.5	1	2.2	6	7.1
Shyness to discuss	0	0	2	4.5	2	2.3
Illness	0	0	2	4.5	2	2.3
Total	40	100	44	100	84	100

Source: Field Data

The data shows the reason for not using family planning method by the respondents. Nearly half (48.8 percent) of the respondents stated that they prefer to control themselves than using family control measures, 16.6 percent of the respondents stated that the desire of additional child as the reason, 14.2 percent of the respondents held their husbands' lack of cooperation to use it as the reason, 8.3 percent of the respondents said that they are scared to use family planning method, 7.1 percent of the respondents believed that the use of family control measures remove womb, 2.3 percent of the respondents feel shy to discuss it with their partner and same percent (2.3 percent) of the respondents are not using it because of their some health problem.

Looking at the rural urban picture, in the rural setting as many as 60 percent of the respondents prefer to control themselves than using family control measures, followed by 22.5 percent of the respondents who are not using it as they have a desire for an additional child, and 12.5 percent of the respondents believed that the use of family control measures will confiscate their womb. In the urban setting again as many as 38.6 percent of the respondents prefer to control themselves than using family control measures, followed by 25 percent of the respondents who held their husbands lack of cooperation to use it as the reason, 13.6 percent of the respondents reported that they are scared of using it, 11.3 percent of the respondents are not using it as they have a desire for an additional child. 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.

Conclusion

The status of reproductive health of women is here understood by analysing different stages of reproductive health as menarche, the status of pre natal health, post natal health and family planning.

The data 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 cycle 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.