Health is an important aspect for the survival of human. The concepts, knowledge, skills and infrastructure for healthcare have been evolved through the evolution of human civilization in various societies. However, due to gender bias the health priorities for men and women have been different in different traditions and different societies.

Health is a very broad concept. It is the general condition of a person’s mind and body usually meaning to be free from illness, injury or pains. The World Health Organization (WHO) has defined health in 1946 as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Provision of health should be considered a fundamental human right. This definition was accepted by all the signatories to the Alma-Ata Declaration on health adopted by the 31st World Health Assembly (WHA) in 1978. This declaration accepted that Primary Health Care was a key to attaining this goal.

Health systems are too often being devised outside the mainstream of social and economic development. These systems frequently restrict themselves to medical care, although industrialization and deliberate alteration of the environment are creating health problems whose proper control lies far beyond the scope of medical care. Health is thus not only about disease and medical care system but also about the environment around us, which influences the mental and physical state of a person. It is multidimensional phenomenon. World Development Report 1993 considers good health as an input for increasing productivity, leading to economic growth. The National Council of Applied Economic Research considers health status as “an important indicator of the level of economic development” and it includes mainly mortality and morbidity (NCAR: 1992).
Women’s health has long been a concern for WHO but today it has become an urgent priority. It involves their emotional, social and physical well being and is determined by the social, political and economic context of their lives as well as by biology. It also refers to health issues specific to female anatomy which often relate to structures such as female genitalia and breasts or to conditions caused by hormones specific to females. Women’s health is made complex by the fact that, apart from the general health needs, women have special health needs related to their role in child bearing and rearing. It is thus imperative that one looks at women’s health comprehensively, historically and culturally. Women have an inherent biological advantage over men which makes their life expectancy 5-7% longer than that of men. However this biological advantage is negated by the discriminatory treatment towards girls and women and the health risks associated with their reproductive health.

Women’s reproductive health is an indispensable ingredient of health and crucial component of a woman’s general health. It refers to the diseases, disorders and conditions that affect the functioning of the female reproductive systems during all stages of life. Within the framework of WHO's definition of health, the ICPD Cairo in 1994 has defined the term reproductive health. It outlines the sexual and reproductive health (SRH) is not merely about reproduction. It must be viewed as three interconnected domains that include universal rights, women’s empowerment and health service provision. These three concepts must work in unison in order for individuals to achieve healthy reproductive and sexual lives.

Rural women’s health is compromised as a result of a web of interrelated factors operating at different levels. The most common problems with the women are lack of basic amenities such as food, water, fuel, fodder and health facilities. Poverty among rural Indian populations has a devastating impact on rural women’s health. It can cause delays in seeking appropriate health services until a condition reaches its most critical stage.
Culture and society play a significant role in rural women’s health status and access to services. Rural communities adhere more rigorously to customary laws and norms of social stratification that may result in being treated with contempt, humiliated, violated and discriminated against which leads to their lowered self-esteem and feelings of fear and loneliness.

Rural women in India are among the most disadvantaged people in the world in terms of their health status particularly when SRH is concerned. As a host of social, cultural, political and economic factors increase rural women’s vulnerabilities to early marriage, early pregnancy and childbirth related deaths and disabilities, unsafe abortion, HIV/AIDS and reproductive cancers. Early marriage is more common in rural areas and unfortunately this can negatively impact their health and well-being. Pregnancy often follows soon after marriage, which carries a higher risk of complications for adolescences as their reproductive systems are not fully developed. Women who marry at a young age, who often drop out of school, also have less of an opportunity to learn about their sexual and reproductive health and rights and how to access related services. With minimal education and limited access to reproductive health services, they are left on their own to manage their fertility and sexual and reproductive health and well-being.

1.1 BACKGROUND OF THE STUDY:

The concept of healthy mother and healthy baby is an important aspect of Reproductive and Child Health (RCH) programme. A healthy mother can produce a healthy child. It is a common saying that “when mother is developed, the child is better developed”. Hence, women's health in general and reproductive health in particular is currently receiving considerable attention during recent past.

The Cairo International Conference on Population and Development (ICPD) in 1994 formulized a growing international consensus for improving reproductive health including family planning for human welfare and development. The decennial ICPD at Cairo stressed the importance of
women's health and particularly their reproductive health to overall economic development. The definition of reproductive health of ICPD Cairo in 1994 is being utilized as a functional definition for the present study.

The proponents of reproductive health framework believe that reproductive health is inextricably linked to the subject of reproductive rights and freedom. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and help to attain the highest possible standard of SRH. They also include their right to make decisions concerning reproduction free of discrimination, coercion and violence. So the present study is also an attempt to understand the women’s reproductive rights and how these will be going to improve women’s reproductive health and are important means of women’s empowerment.

Feminism celebrates women’s different sexualities which involve critics in countering operative political assumptions such as in the assertion of radical and class differences in giving women control over reproduction by ensuring the access to contraception and well women health care. Most of the radical feminists have viewed that women’s biology especially on reproduction and mothering is also a choice of the women. Women's health is an issue which has been taken up by many feminists, especially where reproductive health is concerned such as right to legal and safe abortion, right to readily available contraception.

The subject of reproductive health can be studied from reproductive mortality and morbidity rate. More than 99% of the estimated 5,36,000 maternal deaths occur in the world and out of them 1,00,000 deaths occur in India (NFHS 1992-93). When maternal morbidity is often overlooked; the little evidence is available on women’s health. For every maternal death, it is estimated that 15-20 mothers suffer from impaired health during the

1. N.K. Behura & R.P. Mohanty: Family Welfare in India – A Cross Cultural Study; Published by Discovery House, New Delhi, 2005; Page 66-77
antenatal, natal and post natal period. A significant proportion of maternal deaths and illness among women are the combined effects of poor health, poor nutrition, prolonged and closely spaced period of fertility stretching from adolescence to menopause. It is not only early marriages and early pregnancies but also lack of health education, inadequate maternity services and the poor quality of health care received during pregnancy which is responsible for both high levels of neonatal and maternal morbidities and mortalities. This might be one of the reasons why reproductive health could not be successful in India.

In rural areas, the government delivers reproductive and other health services through its network of Primary Health Centers (PHC’s), Sub Centers (SC’s) and other health facilities. In addition, the non-governmental organizations (NGO’s) such as private hospitals, maternity homes, dispensaries also play an important role in providing the services. Even though the health care is a public good, it is not equally available to all individuals. The existing health services being provided either do not reach or remain unutilized by women especially in rural areas. This may be because of lack of care and rights of health takers or negligence of health care providers.

In order to obtain a complete picture of women’s reproductive health it is necessary to ascertain the problems that they experience during reproductive age. Since family planning is one of the crucial determinants of ensuring sound reproductive health hence the study of contraceptive behavior is also necessary. The proponents of reproductive health are inextricably linked to reproductive rights which decide individuals reproductive health hence there is need to study of reproductive rights behavior. Since socio-economic and socio-demographic characters, health care patterns and its utilization are also influence reproductive health so the study of these factors is also important.

Women of rural Bijapur are silent sufferers of ill-health throughout their life course mainly because of their low self esteem, low perception and negligence of their own health and rights. Researchers in social sciences relate ill-health status of women to their deprived socio-economic and cultural conditions. They suffer from many health problems during their life time and many of which are very often specific only to their reproductive processes. Even today maternal mortality in rural areas continues to be the major cause of death among women of reproductive age.

In these circumstances, the present study is most relevant as it will help to identify many obstacles such as the social, cultural, economical, health and its care and utilization, decision making power etc that hinder women from improving their maternal health. The obstacles faced by rural women in terms of limited access to education, health and its care, decision making power etc prevent them from better reproductive health and well being.

1.2. NEED FOR THE STUDY:

The importance of understanding the reproductive health has advanced significantly in the last decade. Reproductive health is an indispensable ingredient of health and crucial component of a woman’s general health. Though it is universal concern both men and women but special importance for women particularly during the reproductive years as it affects their lives directly before, during and beyond child bearing age.

The reproductive period is the most important period in the women’s life. It extends from menarche to menopause and the intervening periods are marriage, pregnancy, childbirth and contraception. The pregnant women have been widely recognized as a vulnerable group from the health point of view. They need more care for the proper nourishment of the growing foetus. The healthy reproductive status of women is extremely important to give a healthy baby as well as her healthy life. However poor reproductive health becomes a significant cause of disease and death. Hence it is in need to understand the concept of Women’s Reproductive Health.
According to the World Bank, about one third of the total disease burden among women aged 15 to 44 years in the developing countries and is associated with pregnancy, childbirth, abortion, HIV and reproductive tract infections. The high mortality rates among sepsis, anemia, toxemia, hemorrhage, abortion, STIs including STDs etc indicate that women’s health in general and reproductive health in particular remains low.  

Health status of women in rural outset is being infinitely a broad topic. India, as a country with more than 70% of its population residing in rural areas, it is worthwhile to know the health condition of women in villages. The 2/3rd of the population in the country consists of women of child bearing age and children under the age of fifteen years. In India women of the reproductive age between 15-49 years and children below five years of age comprise 62% of the total population.  

In a developing country like India, the reproductive health status of women in rural area is low and has been largely and sadly neglected. The reproductive health status of rural women presents a sobering picture. The maternal mortality ratio ranges from of 448 and 397 per 100,000 births in rural and urban areas respectively, in 1992-93. It is also estimated that 4,00,000 maternal deaths occur every year in the world and out of these 1,00,000 deaths occur in India. Community based assessments have addressed all three natal periods indicate 41% of maternal morbidity in Karnataka.

Bijapur is one of the largest, densely populated and backward states of Karnataka. A closer look at the micro level often reveals Sample Registration System (SRS) of 2004 to 2005 shows the maternal mortality rate of Bijapur district as 50.80%. Though the State’s Health Department does not maintain district-wise statistics on MMR, it has classified districts

6. K.P.Neeraja:”Rural Women”; Published by Discovery Publication House; 2003, PP-1
of Yadgiri, Gulbarga, Bidar, Raichur, Koppal, Bijapur and Bagalkot under ‘C’ category as the maternal mortality rate is bad here based on the education and health indicators.

When it come to the reproductive health scenario of Bijapur women, especially in rural areas, it can see that their poverty-related and socio-cultural factors influence their perception of health and their health seeking behaviour to a great extent. Socio-cultural factors which impinge on reproductive health include women’s lack of awareness of health matters, strong seclusion norms which inhibit health-seeking of adolescent girls, family norms and indifference towards family planning, encouraging frequent and closely spaced pregnancies which frequently result in maternal mortality, morbidity and delivery complications.

Above all, gender bias operates at several levels from womb to tomb and restricts their availability and timely utilization of health services. Women are doubly disadvantaged with regard to their accessibility to health care. Culturally they are not predisposed towards caring for their own selves and socially they are hampered by various taboos and obstacles that prevent them from accessing health care even when it is available.

To understand the real pictures a micro level studies are in need. This study analyzed the reproductive health status of women in selected rural villages of the Bijapur taluka. There is no remarkable study available on reproductive health for understanding the concern of women. Hence, the present study is an attempt to understand the reproductive health status of women in rural Bijapur.

1.3. OBJECTIVES OF THE STUDY:

The broad objective of the study is to evaluate the reproductive health status of women in selected rural areas of Bijapur taluk. The specific objectives are:
1. To understand the concept of women's reproductive health and rights.
2. To study the socio-economic and socio-demographic profiles.
3. To study the pattern of health services and its utilization.
4. To study the reproductive health status.
5. To analyze the factors influencing reproductive health.
6. To recommend appropriate strategies for improvement of reproductive health status of women in rural areas.

1.4. REVIEW OF THE STUDY:

Available literature on reproductive health is vast and multifarious primarily due to inter-disciplinary focus of the subject. It is not possible to address all perspectives within the confines of the present study. So in this chapter, the efforts have been made to review thoroughly the literature pertinent to the research topic and research setting. It can give insight into analysis and help in establishing a meaningful rational for the present study. The present chapter reviews the previous studies in chronological order.

A study by Srinivasan (1984) argues that health care is one of the most important of all human endeavors to improve the quality of life of the people. It implies the provision of conditions for normal physical and mental development and functioning of human being individually and the group. It provides a wide spectrum of service, including primary care integration of preventive and curative services, health education, the protection of mothers and children, family welfare and control of environmental hazards and communicable diseases.

437 women out of every 1, 000, 00 women die every year due to pregnancy and its related causes (NHFS: 1992-93). It also estimated that
about 4, 00,000 maternal deaths occur every year in the world and out of these 1, 00,000 lakh deaths occur in India. The major causes of maternal death are bleeding, severe anemia of various origins, puerperal sepsis and obstructed labour and toxemia of pregnancy. Early marriage, early pregnancy and short-spaced pregnancies are also some of the factors underlying such high rates of maternal deaths. Low knowledge of nutrition health education, lack of adequate maternity services and under utilization of the existing has aggravated the problem. Therefore, safety of the life of women in her reproductive age depend on a number of factors, such as, number of pregnancy, number of miscarriage / abortions, and still births etc and also antenatal, natal and postnatal care she receives during her pregnancy and child birth (NFHS: 1992-93).

**Bhatia (1993)** has reported that 78 % of maternal death can be avoided by specific timely actions. Prenatal care is often prescribed as a preventive measure and evidence from routine statistics and special studies suggests that women who receive prenatal care experience have lower rates of maternal mortality.

**Ravindran (1993)** argued women’s poor health status through various intervening variables affects their reproductive choice. Poor health leads to a high incidence of wasted pregnancies and secondary infertility. This is an important reason why women do not want to voluntarily limit their family size. Also poor living conditions and other factors increase infant mortality rate (IMR). **Patel and Khan (1994)** found new approach needs to be gender sensitive, dealing with all aspects of human sexuality with a life-cycle approach to address reproductive health (RH) needs of men and women. It addresses role for the Reproductive Health. It analyses that what role is played by ANMs in treating women’s reproductive health problems and what are the levels of gynecological morbidities. The rural areas of Agra district have been used in community survey; in-depth interviews find that 77 % ever-married eligible women have reproductive health problem. Only 28 % of them had taken treatment or consulted a health providers or medical practitioners. Majority of the ANMs reported
that women contact them with problems of white discharge, menstrual cycle, infertility, prolapsed, abortion and problems infertility prolapsed (PID).

Rathnaiah, Raju and Reddy (1995) found that the health status of women is low and the demographic status is adversely affecting social and economic development. The female age at marriage is very low, the MMR is highest. The infant mortality rate is higher for female than for male and life expectancy at birth for females is lower than males. 80% of the babies are born in poor conditions which are pathetically unhygienic and one-third of them have low birth weight, which clearly indicators the poor health status of the mother. Women in India suffer more from diseases than men, and the mortality rate was also higher among women than men. Lack of proper health care and medical facilities, absence of basic nutrition from childhood, continuous sacrifice for the service of family due to prevailing socio-cultural values takes a heavy toll on the lives of the rural women.

Singh and Jayaswal (1996) in their study reported that in backward tribal district in central part of India, 92% of the women suffered from gynecological diseases, ten village females are trained for disseminating Reproductive and Child Health Education (RCHE) covering the themes of fertility regulation, Safe Motherhood, STDS, HIV and AIDS.

Bhatia et al (1996) found that there is sufficient evidence to indicate that considerable proportions of Indian women may have a RTI (Reproductive Tract Infection). The evidence is based on women’s self reporting of symptoms and clinical laboratory examinations from several community studies from four sites (urban slum of Bombay and Baroda, rural areas of West Bengal and Gujarat) found that women reported symptoms indicative of RTIs such as excessive discharge (22 to 57 %) lower backache (5 to 39 %) and lower abdominal pain (9 to 20 %). Virginities (10-15 %) and pelvic inflammatory disease (1 to 17 %) are the prominent morbidities. Similarly clinical and laboratory examination of rural women in Karnataka revealed that 70 % had virginities, civilities or PID (Bhatia et al, 1996). In terms of the specific infection, the laboratory
assessment indicates bacterial vaginosis (18.2 %), trichomeniasis (7.5 %), and Chlamydia (1.5 %) gonorrhea (0.8 %), syphilis (1.5 %) urinary tract infections (6.5 %). Apart from the community studies, clinical and microbiological studies have also confirmed the wide prevalence of RTIs among Indian women (Luthra et al: 1992).

Mensch et al., (1998) contend that lack of education not only decreases an adolescent woman's ability to use contraception but it also inhibits her decision making power pertaining to contraceptive choice and thus results in her having fewer alternatives to motherhood. As the reproductive behaviour of a woman is usually determined by her husband, husband's education also plays a significant role in influencing the utilization of reproductive health services by wife.

Even if women want to use the services, the RCH services are not easily accessible to women, especially in the villages. Women have to travel long distances to avail the services. In a study of family welfare program in Madhya Pradesh, Talwar (1988) noted that 38% of respondents reported that government services were far off and it takes a very long time to reach there. He found that a large number of women had no knowledge of the advantages of the antenatal care, had no strong motivation and found facility far off.

Shane, Barbara and Ellsberg (2002) illustrates that millions of girls and women suffer from violence and its consequence because of their sex and their unequal status in society. Violence against women (after called gender based violence) is a serious violence of women’s human rights. Yet little attention has been paid to the serious health consequences of abuse and the health needs of abused women and girls. This article focuses on the reproductive health consequences of violence against women. It explores how the health sector can take an active role in the prevention and treatment of violence against women.

Mandal (2003) conducted a study in Bardhman district of West Bengal which explains the social aspects and behavioral pattern during pregnancy in terms of nutrition, health and treatment seeking. The study
reveals that due to lack of education, low income, lack of medical facilities, preference for the traditional wags and inaccessibility are the main reasons for under utilization facilities during pregnancy and delivery of child.

Rani (2005) examines some of the factors related to SRH and its effects on adulterants and young married girls. These include socio-economic conditions, demographic aspects like menarche and marriage related issues, nutrition, anthropometry, prenatal, natal and post-natal care and various customs prevailing in the community.

Ram and Singh (2005) have found that ante-natal care is a strong predictor of safe delivery in rural areas. Women bear their health problems in a “culture of silence' and do not seek timely health care. They often cannot travel beyond the areas of their normal activities to obtain services.

1.5. METHODOLOGY OF THE STUDY:

Research methodology is a strategy to systematically solve the research problem. According to Black and Champion (1976), “The research methodology is the blueprint for researcher activity and specifies how the investigator intends to test hypothesis, study the people, or describing social settings”. It may be understood as a science of studying how research is done scientifically.

The present study is based on survey method. It has been undertaken with the broader methodological framework of women for her reproductive health which involves both primary and secondary data.

SOURCE OF THE STUDY:

The Primary Data has been collected through field work which involved face-to-face interviews with respondents at home with research proforma. The proforma has been framed mainly in relation to the independent variables such as socio-demographic, socio-economic, socio-ecological and pattern of health services; dependent variables like reproductive life, gynecological and obstetric health condition, contraceptive status and reproductive rights status.
The **Secondary Data** has collected mainly through literature which includes books, magazines, journals, articles, newspaper etc; National Family Health Survey (NFHS-I, II and III); WHO, UNFPA, UNDP, World Bank Reports, Other periodicals and Internet.

### AREA OF THE STUDY:

Bijapur district is located in the northern part of Karnataka state. It falls in the northern maidan region, between 150 50’- 170 28’ north latitudes and 740 59’-760 28’ east longitudes and lies between two major rivers namely the Krishna and the Bhima. The district is bounded on the north by Sholapur district of Maharastra State, on the west by Belgaum district, on the east by Gulbarga district and on the south by Bagalkot district of Karnataka. Bijapur district is land locked district and is accessible both by rail and road. The broad gauge line of Railway connecting Hubli-Sholapur passes through the district. The NH-13 Bangalore to Sholapur and NH-213 of Hubli-Sholapur pass through the district. Bijapur district is connected with other district headquarters through state highways.

Bijapur town is the headquarters of the district. The district has a total geographical area of 10,541 sq kms. The district has been divided into five taluks for administrative convenience viz. Basavana Bagewadi, Bijapur, Indi, Muddebial and Sindagi taluks. The table 1 shows the population and density of the district as per the 2001 Census is 18,06,918 and 245 respectively. The district witnessed a growth rate of 23 % during the last decade.
Table – 1.1
Taluk-wise Area, Villages, Gram Panchayats, Hobalis & Population in Bijapur District (2001 Census)

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Taluk</th>
<th>Area (sq. km)</th>
<th>No. of villages</th>
<th>No of Gram Panchayats</th>
<th>No of Hobalis</th>
<th>Population (as per 2001 census)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Basavana Bagewadi</td>
<td>1979</td>
<td>121</td>
<td>4</td>
<td>38</td>
<td>3,03,290</td>
</tr>
<tr>
<td>2</td>
<td>Bijapur</td>
<td>2659</td>
<td>118</td>
<td>-</td>
<td>46</td>
<td>5,69,348</td>
</tr>
<tr>
<td>3</td>
<td>Indi</td>
<td>2225</td>
<td>129</td>
<td>4</td>
<td>44</td>
<td>3,53,987</td>
</tr>
<tr>
<td>4</td>
<td>Muddebial</td>
<td>1502</td>
<td>145</td>
<td>8</td>
<td>31</td>
<td>2,53,638</td>
</tr>
<tr>
<td>5</td>
<td>Sindagi</td>
<td>2176</td>
<td>147</td>
<td>1</td>
<td>40</td>
<td>3,26,655</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>10541</td>
<td>660</td>
<td>17</td>
<td>199</td>
<td>18,06,918</td>
</tr>
</tbody>
</table>

Figure 1.1
Map of the Karnataka State

Figure 1.2
Map of the Bijapur District
The Bijapur district of Karnataka state consists of five Talukas namely, Bijapur, Basavana-Bagewadi, Indi, Muddebihala and Sindagi. Among them Bijapur Taluk was selected for the study which was conducted during the year 2012-13.

**SAMPLING DESIGN:**

Sampling was selected in multi stages. A stratified random sampling method was adopted for the study. In the first stage the list of the villages which exist in Bijapur taluk were prepared. It has 118 villages in all and out of them 30 villages which surround the Bijapur city was selected randomly by lottery method. In the second stage from each selected village 20 women who are in the reproductive age group between 15-49 yrs and are having at least one living child prior to the survey were selected using random sampling method. Thus in total 600 women were selected for the
study. Table 2 suggests the name of villages and sample selection from each village in Bijapur Taluk of Bijapur District.

Table – 1.2
Name of Villages & Selection of the Sample from each village in Bijapur Taluk of Bijapur District

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Name of the Selected Village</th>
<th>Selected Sample</th>
<th>Sl. No</th>
<th>Name of the Selected Village</th>
<th>Selected Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Darga</td>
<td>20</td>
<td>16</td>
<td>Arjunagi</td>
<td>20</td>
</tr>
<tr>
<td>2</td>
<td>Ittangihal</td>
<td>20</td>
<td>17</td>
<td>Jambagi</td>
<td>20</td>
</tr>
<tr>
<td>3</td>
<td>Lohaganva</td>
<td>20</td>
<td>18</td>
<td>Allapur base</td>
<td>20</td>
</tr>
<tr>
<td>4</td>
<td>Jalageri</td>
<td>20</td>
<td>19</td>
<td>Mahala</td>
<td>20</td>
</tr>
<tr>
<td>5</td>
<td>Toravi</td>
<td>20</td>
<td>20</td>
<td>Inapur</td>
<td>20</td>
</tr>
<tr>
<td>6</td>
<td>Khatijapur</td>
<td>20</td>
<td>21</td>
<td>Burnapur</td>
<td>20</td>
</tr>
<tr>
<td>7</td>
<td>Sarawad</td>
<td>20</td>
<td>22</td>
<td>Butanala</td>
<td>20</td>
</tr>
<tr>
<td>8</td>
<td>Ukumnal</td>
<td>20</td>
<td>23</td>
<td>Arakeri</td>
<td>20</td>
</tr>
<tr>
<td>9</td>
<td>Khatakanahalli</td>
<td>20</td>
<td>24</td>
<td>Baratagi</td>
<td>20</td>
</tr>
<tr>
<td>10</td>
<td>Hegadihala</td>
<td>20</td>
<td>25</td>
<td>Siddapura</td>
<td>20</td>
</tr>
<tr>
<td>11</td>
<td>Yogapur</td>
<td>20</td>
<td>26</td>
<td>Minchinal</td>
<td>20</td>
</tr>
<tr>
<td>12</td>
<td>Aliyabada</td>
<td>20</td>
<td>27</td>
<td>Kesaral</td>
<td>20</td>
</tr>
<tr>
<td>13</td>
<td>Dyaberi</td>
<td>20</td>
<td>28</td>
<td>Jumanal</td>
<td>20</td>
</tr>
<tr>
<td>14</td>
<td>Donawadahatti</td>
<td>20</td>
<td>29</td>
<td>Hitnhalli</td>
<td>20</td>
</tr>
<tr>
<td>15</td>
<td>Aheri</td>
<td>20</td>
<td>30</td>
<td>Rambhapur</td>
<td>20</td>
</tr>
</tbody>
</table>

Total Sample 600

DATA COLLECTION AND ANALYSIS:

The data is collected from the primary source. It is presented through direct tables and cross tables. The graphs have been used to make the presentation more clear and effective. The data is analyzed and interpreted for analysis in the study. Following figure describes the schematic representation of source, methods of data collection.

Figure 1.3
Schematic Representation of Data Collection
1.6. LIMITATIONS OF THE STUDY:

The present study is limited to:
1. only to 600 rural women of selected rural areas of Bijapur taluka. So, the entire findings of the study may not be applicable in case of other rural areas of Bijapur and even to other places.
2. primary data collected from the respondents of the said areas of Bijapur taluka.

3. verbal statements of rural women regarding independent and dependent variables have considered for analysis.

1.7. ORGANIZATION OF THE THESIS:

The study has been presented through the following broad chapters:

Chapter One introduces the study which includes a brief on concept of health, women and health, women reproductive health, rural health of women, background and need for the study, objectives, methodology, limitation and organization of the thesis.

Chapter Two comprises conceptual study pertinent to the research topic which is prepared on the basis of the secondary data. It gives insight into analysis and helps in establishing a meaningful rational for the present study. This chapter has been divided into three subsections.

First sub section focuses on concept of women’s reproductive health which includes introduction and definition, historical background, women’s reproductive system, sexual health and components of reproductive health. Second subsection deals with concept of women’s reproductive rights which contains definition, historical background and principles of reproductive rights, sexual rights. Third subsection describes the feminist perspectives of reproductive health and rights.

Chapter Three highlights in brief analysis of policies and programmes for development of reproductive health particular for women. It includes Government Health Facilities in Government Health Centers, National Policies and National Programmes related to reproductive health, National Health Schemes and Five Year Plans for development of women’s health.

Chapter Four deals the analysis and findings of the data of rural women of selected rural areas of Bijapur taluka. It has been divided into five subsections.
First sub section deals with the profile of the respondents as socio-economical and socio-demographic. Second sub section deals with pattern of health care services & their utilization. Third subsection deals with the reproductive health status of the respondents. Fourth subsection deals with contraceptive profile of the respondents. Fifth section deals with the reproductive rights profile of the respondents.

**Chapter Five** comprise the factors that influence reproductive health status. It also contains few case studies focusing on the central theme of the study.

**Chapter Six** shows the synthesis of the major findings of the study.

**Chapter Seven** recommends the strategy for improvement of the reproductive health.

**Chapter Eight** contains conclusions and recommendation for further research arising out of this study. This chapter is succeeded by bibliography, research proforma, photography and published articles of researcher.

One legitimate way of understanding a problem is acquiring indepth insight about an issue is reviewing the related literature. Review of literature is like a lamp which throws light on things which are unknown or known. In this study review of literature on some issues like concept of reproductive health, its components, issues, the policies and programmes for its improvements and strategy for its improvement has been made in the relevant chapters.