INTRODUCTION

In the light of the paradigmatic shift in the way population is understood in the post-Cairo era, it is necessary to integrate new areas of concern. Some of which include family life, gender equity, adolescent reproductive health, sustainable development.

In this context it is pertinent to mention that in July 1993, the government of India set up a committee under the Chairmanship of Dr. Swaminathan to review the National Family Welfare Programme and draft a new national population policy. The Swaminathan Committee submitted a draft Population Policy in May 1994, four months before the ICPD in Cairo. The report contained far-reaching recommendations, amongst them one important recommendation being shifting the programme emphasis from achieving national demographic targets to helping couples achieve their reproductive goals. Many of the recommendations were consistent with the ICPD plan of action.

India is seriously implementing a major paradigm shift in its family welfare programme. This choice represents a shift from the aim of achieving purely demographic goals to the adoption of comprehensive national development plan which incorporates the goals of the Cairo and Beijing international conferences on population, women and development. The ICPD has helped in accelerating this process. As the first step, the method-specific family planning target approach has been
replaced by a reproductive and child health (RCH) programme, which “aims to provide need-based, client-centered, demand-driven, high quality and integrated RCH services” (GOI, 1997).

**Reproductive and Child Health (RCH) Programme**

The withdrawal of the target approach was the first step and almost an essential requirement for introducing the Reproductive and Child Health (RCH) Programme in India. The RCH programme was formally launched by the Ministry of Health & Family Welfare in October 1997. Essential components of the programme strategy included community participation in planning for servers, multi-sector approach in implementing and monitoring services, a client-centred, gender-sensitive approach to service provision, upgraded facilities and improved training, emphasis on quality of care, and the absence of contraceptive targets and incentives.

Operationally, the RCH Programme is an alternative integrated approach to the vertical programmes aimed at improving the health status of young women and children, which have been operating during the past decade. It incorporates all the components covered under the Child Survival and Safe Motherhood programme (CSSM) and includes two additional components, one relating to sexually transmitted disease (STD) and another relating to other reproductive tract infection (RTI). Further, it emphasizes the provision of services in manner which is
client-centered, demand driven, high quality and based on the needs of the community arrived at through decentralized participatory planning without target (GOI, 1997). Thus RCH programme seeks the efficiency of the earlier programmes, bring about a holistic approach to programme implementation and to produce a paradigm shift in implementation based upon client’s needs.

**Concept of Reproductive Health**

“Reproductive Health is a state of complete physical, mental and social wellbeing and not merely absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes. Reproductive Health therefore, implies that people are able to have a satisfying and safe sex life and they have capability to reproduce and have freedom to decide if, when, and how often to do so. Implicit in this last condition are the rights of men and women to be informed and have access to safe, effective, affordable and acceptable method of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. It also includes sexual health, the purpose of which is enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases” (ICPD Programme of Action).
Reproductive Health focus provides a means for addressing health and population issues with an emphasis on needs of women and men. Specific reproductive events, notably pregnancy and child bearing have an impact on women’s health as well as on traditionally emphasized demographic trends. However, Reproductive Health presents a life long process inextricable linked to the status and role of women in their homes and societies and is not just related to the biological events of conception and birth.

Reproductive health is defined as ‘the ability of women to live through the reproductive years and beyond, with reproductive choice, dignity and successful child bearing, and to be free from gynaecological diseases and risks’. Within the framework of WHO's definition of health as “a state of complete physical, mental and social well being and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and systems at all stages of life.

Reproductive health implies that people are able to have a responsible, satisfying and safe sex life, and that they have the capacity to reproduce and the freedom to decide if, when and how often, to do so. Implicit in this last condition are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable method of fertility regulation, of their choice, and the right of access to appropriate health services, that will enable women to go safely
through their pregnancy and child birth and to provide couples with the best chance of having a healthy infant (WHO, 1994).

One cannot fail to notice that the concept of reproductive health has also been explained by a term reproductive morbidity. Various conceptualizations of reproductive health consider reproductive morbidity as inclusive of conditions of physical ill-health relating to ‘successful child bearing and freedom from gynecological diseases and risks”. WHO defines reproductive morbidity as “any morbidity due to dysfunction of reproductive tract which is a consequence of reproductive behaviour including pregnancy, abortion, child birth or sexual behaviour, arising due to physical, social and mental problems, or are aggravated by these functions”. Zurayk et al (1993) also defined reproductive morbidity to include obstetric morbidity and gynecological morbidity, which include conditions during pregnancy, delivery and post partum period, as well as conditions of reproductive tract related infections, cervical cell changes, infertility and such other conditions respectively.

The complexity of the concept of reproductive health may seem overwhelming, particularly when translating it into action. The concept of reproductive health represents a new approach to existing programmes rather than a set of new programmes. It involves adapting what is already in place, revitalizing and modifying the same rather than starting from the scratch. An important aspect of the concept of reproductive health is the focus on meeting individual and community needs as the
foremost priority. Also, this approach involves empowering women to take decisions regarding their reproductive lives; involving young people in the development and implementation of programmes and services; making greater efforts to reach the poorest of the poor, the marginalized and the excluded; and invoking men to assume greater responsibility for reproductive health.

Reproductive Health care is defined as the constellation of methods, techniques and services that contribute to the reproductive health and well-being by preventing and solving reproductive health problems. The essential components of reproductive health programmes include the following.

**Components of Reproductive Health**

Reproductive health approach links demographic concerns, including fertility reduction with a range of objectives for improving the health and socio-economic status of women. It also proposes to address the needs of special target groups such as adolescents, and to increase the involvement of men, and their responsibility, for sexual reproductive behaviour. Adopting this approach implies going beyond the domain of family planning to encompass additional aspects of human sexuality and reproductive health needs throughout the various states of the life cycle.
Prevention of unintended pregnancy through the provision of accessible and high quality family planning service which are based on reproductive needs of couples.

- Provision of safe abortion and post abortion care services;
- Provision of safe motherhood services to improve maternal morbidity and mortality, including services to improve prenatal and neonatal mortality and post-neonatal mortality;
- Prevention and treatment of reproductive tract infections and sexually transmitted infections and HIV/AIDS transmission;
- Provision of reproductive health services to adolescents;
- Improving maternal and infant nutrition including promotion of breast feeding programmes;
- Screening and managing specific gynecological problems such as:
  - reproductive tract cancers, including breast cancer;
  - infertility;

The concept of Reproductive Health brings a new dimension to safe motherhood, family planning and STD programmes. Integrating them so that they are not delivered in isolation enables communities to deal in a more comprehensive manner in order to overcome the issue of territoriality.
Review of Literature

Review of literature is essential for the research to have a strong base and to support the study with the help of the literature in all dimensions. The main function of the review of literature was to determine the theoretical and empirical work done previously and assist in the delineation of the problem area. It provides insight into the methods and procedures and suggests operational definitions of major concepts. Review of literature provides a basis for interpretation of the findings.

Reproductive Health means more than bio-medical interventions. Reproductive Health affects, and is affected by, the broader context of people’s lives – their economic circumstances, education, employment, living conditions, family environment, social and gender relationship, and the traditional and legal structures within which they live. It involves a greater awareness of health by individuals so that they can promote and protect their own reproductive health. It implies the involvement of other sectors, notably in education, finance and planning.

Reproductive health in India is largely influenced by poverty-related and socio-culture factors on the one hand, and programme interventions on the other. Socio-cultural factors which impinge reproductive health include women’s lack of awareness of health practices, strong seclusion norms which inhibit health-seeking,
adolescent marriage, large family size norms which encourage frequent and closely spaced pregnancies, and a general devaluation of women which makes them the last to obtain food or health care and which requires of them long periods of physical activity.

Therefore, a brief review of literature relating to different aspects of reproductive health is presented in this chapter. More specifically the review is concerned with such aspects as age at marriage, age at birth, delivery practices, maternal health care, access and utilization of maternal health care services.

Studies conducted by scholars from other disciplines such as, anthropology, medicine, and demography, on women communities with respect to their health and Reproductive Health, mainly reported descriptive statistical information obtained from cross sectional surveys and field observations. These studies have focused on Reproductive Health of Women at micro and macro level. This chapter reviews the literatures on Reproductive Health and attempts to generalize the reported findings and observations. The literature review includes peer reviewed articles, relevant books and book chapters, and articles from recognized news sources.

This review has been categorized and presented under the following headings
• Studies Related to Socio, Cultural and Economic Status of women
• Studies Related to Reproductive Health
• Studies Related To Nutritional Status and Morbidity
• Studies Related to Literature in Fertility Behavior and Contraceptives

Lal Suresh and Padma (2005) have analyzed the problem of empowerment of women of Andhra Pradesh this study makes use of census data on women population, literacy rates in Andhra Pradesh, the women in Andhra Pradesh were found well at dry land agriculture. Women are facing the problems in health and nutrition such as malnutrition is common among the women, higher infant mortality rate in compared to national average, and the average protein calorie intake was found to be low among women.

The national anemia prophylaxis programme of iron and folic acid distribution, in which pregnant women are provided with 100 iron and folic acid tablets during pregnancy, was initiated as early as the 1950s. However, both service statistics and sample surveys confirm that this programme has not been very successful. From service statistics, were find that no more than an estimated one-third of all pregnant and lactating women (as estimated from population and birth rate figures for 1988 089) have received iron and folic acid supplementation (Ministry of
Welfare, Dept. of Women and Child Development, 1991; Jain and Agarwal, 1986). Even more discouraging are the results of the few sample surveys (Khan et al., 1988). A micro-level evaluation by the Indian Council of Medical Research has shown that the programme has had little effect on the prevalence of anemia among pregnant women (UNICEF, 1991).

While antenatal care undoubtedly improves maternal and infant well-being, this service reaches few pregnant women.

On the national level, it is estimated that no more than 40-50 per cent of all regnant women in India receive any antenatal care at all (Singh and Paul 1988; Stars and Measham 1990; Acsadi and Johnos-Acsadi 1990).

And fewer women are actually registered for antenatal care: only 21 per cent of all pregnant women in the rural sector and 47 per cent in the urban (UNICEF 1991 quoting NSS 1986-87). Local level sample surveys give a more disturbing picture of ANC service utilization and programme awareness (see also Gopalan 1989; Mathai 1989; Kanitkar and Sinha 1989; Khan and Prasad 1983; Mehta et al. 1983; Khan et al. 1988) and Punjab (Bhatinda district, Singh et al. 1988). Where visits do occur, they occur infrequently and their content is unclear (Jain and Agarwal 1986; Murthy et al. 1990). (Whereas at least five antenatal check-ups are considered ideal, pregnant women who received antenatal
care have rarely had more than one or two contacts and that too only when halfway through the pregnancy (Gopalan, 1989). The reasons for this poor utilization of services are cultural and socio-economic condition on one hand and a result of poor quality of services on the other (Kanitakr and Sinha, 1989).

Six per cent of home deliveries to women who did not have any antenatal check-ups were attended by health professionals compared with 24 per cent of home deliveries to women who had four more antenatal checkups. About 11 per cent home deliveries that were normal were attended by a health professional.

About 13 per cent of home deliveries attended by a health professional with availability of health facility in the village compared to 9 per cent non-availability of health facility in the village.

The review of literature suggests that access to services has bearing on maternal health care and on reproductive health of women. For instance, Greene (2005) points out that currently there is much evidence to suggest that although access may be increasing at a national level in some countries, access is not equal across different social groups. Poverty is a key factor excluding many from accessing services. For example, studies have found that access to a skilled birth attendant at delivery is over three times higher for women in the richest quintile than those in the poorest in sub-Saharan Africa, and eight times higher
in South Asia (Greene, 2005). Hemminki (1997) also noted that access to care and the experience of treatment are also difficult among women in the lower socioeconomic status (Hemminki, 1997). Similarly, Molesworth, K. (2005) observed that poor communications and transport infrastructure can be important in preventing access to services in rural areas, especially in maternal health care where transport to referral services is an essential component of dealing with emergencies and preventing mortality (Molesworth, 2005).

The low social status of women also limits their access to care when it is needed. In some cases, exclusion or because decision-making is the responsibility of other family members, women may not seek care for certain illnesses (Pang Ruyan, 2001). As a result there is poor quality health care, lack of access to health care, work and environment neglect and hazards, and inefficiency of health care.

The lack of social support is often a hindrance for women seeking health care (Pitmann, 1999). Most women expressed distress over not being recognized as ill and cared for accordingly by family members, lack of companionship among friends and neighbors. Men on the other hand are encouraged by their wife and children to seek health care.

Access to care and the experience of treatment are also difficult among women in the lower socio-economic status (Hemminki, 1997).
Many studies have documented how traditional practices and beliefs also affect access to services. For example, in many countries it is standard practice to seek the services of traditional healers over public health service providers, in particular for SRH issues; a study in India found that many pregnant women preferred services of a lay attendant to those of a midwife (Matthews, 2005).

While poor quality of care can inhibit women from seeking health care, women’s lack of autonomy in decision-making or movement is also an important constraint on women’s health seeking. Women are, by and large, taught self-denial and modesty from an early age and are hence unlikely to acknowledge a health problem, and particularly a gynecological problem, unless it is very advance (SEWA-Rural, 1994). For example, large number of women experience white discharges but considers it as part of their lives and rarely seeks medical care for such a problem. Lack of decision-making, freedom of movement and time can restrict visits to health centres, even where a health problem has been recognized. Moreover, pelvic examinations are strongly resisted by women. And even if a problem has been diagnosed, treatment of it frequently not followed through because it is seen as an unnecessary expense or too demanding.

Mohammad A waisTosibAlamMohd (2009). This study focus on status of women in present society is a significant reflection of the level of social justice in that. Women’s empowerment is often described in terms
of their level of income, employment, education, health and fertility as well as their roles within the family, the community and society. And they also taking considered women in Agriculture. Over 80% of work in the primary sector against 53% of the general population. About 45% are cultivators against 32.5% of the general population. Women in Education play an extensive role in the economic development for the sustained growth of a developing society. And it is largely responsible for the reduce the disgraceful trouble of the women mistreatment. Healthcare is a major problem in far flung isolated areas. Lack of food security, sanitation, and safe drinking water, poor nutrition and high poverty levels aggravate their poor health status. Till recently, an abundance of fruits, tubers, roots and leaves in forests in the one hand and indigenous health indicators of OC, BC, Tribals, SCs and others are given below to establish their poor state of health. Women play a major role in the management of their natural, social, economic resources and agricultural development including crop production, livestock production, horticulture and post harvest operations but they remain backward due to traditional values, illiteracy, superstitions, and dominant roles in decision making, social evils and many other cultural factors.

Puttaraja and Haggadic (2012) women in a society play a vital role in their social, cultural, economic and religious ways of life and are considered as an economic asset in their society. But they are as still lagging far behind in the various walks of life like education,
employment, good health and economic empowerment etc. Empowering may be understood as enabling weaker sections like poor women, especially women to acquire and to possess power and resources. The purpose of this study is exploring factors facilitating of discouraging economic empowerment of women, such studies are attempted by Banerji, Sen., Krishna raj, Augural, Kelkar and Hugged. These Indian scholars have explored the economic opportunities like employment, education, access to healthcare services, improvements in human resources development, property rights and inclusive grown process for women as important determinants of economic empowerment of women. Some other studies reveals the similar results, according to Lesmke (2003) study has analyzed, how very high levels of domestic violence and rape have caused women disempowerment and thus has become a source of economic poverty, Budlender (2000: 133) state “proper women are often rapped in abusive relationship due to their dependence on partner for food, shelter and money. 

Awais et al. (2009) point out that women face problems and challenges in getting a sustainable livelihood and a decent life due to the environmental degradation and the interference of the outsiders. However, there are wide variations across regions in terms of work participation, sex ration, economic productivity, and social life.

Awais et al. (2009:2) further pointed out that without any healthy and productive women, the societies cannot have productive settled
agriculture. That means women contribute immensely to the agriculture. However in modern India, the natural resources and natural habitat of the used for commercial purposes and their ecological sustainability is damaged. This has the potential to damage the life sustenance of goods from the forest and its water bodies. This study suffers from primary data about women participation by different state sponsored employment and welfare programmes in regions.

Kantidas (2012) has made out a strong case for the socio-economic empowerment of the women in India. This study identifies many social, political, economic, technological and physiological constraints in the way of women empowerment. Kantidas has attempted an analysis of constraints in women empowerment of Assam state. This research has found that, the cognitive and infrastructural constraints are major development as well as empowerment. In particular, Kantidas has pointed out that the main reason for the poor empowerment of women was noted as lack of Knowledge about new technology and information.

D. PullaRao (2013) in his study “The socioeconomic status in Visakhapatnam District of Andhra Pradesh State (India). In the sample, the majority of the households is the tribe of Konda Dora. The majority of the sample households in the study area are Hindu and more than 70 percent of the sample population were illiterate. There is a need to put more attention on educational aspects of Scheduled Tribes and Back Ward classes, where this only can motivate them for future life.
Pandey (2001) in his study on “Socio-Cultural Reproductive Health Practices of Primitive Tribes of Madhya Pradesh: Some Observations” have attempted to describe the socio cultural beliefs and practices of three primitive tribes-Bharias, Hill Korwas and Kamaras of Madhya Pradesh. Majority of the Tribal women suffered from domestic violence. About 62 percent of women were physically beaten by their husbands at least once a month and 83 percent of females reported verbal abuse by their husbands, in laws and other family members at least once a week. The violence among women was higher among the labour. The wives of non-worker, alcoholic and smoker husband’s suffered 45 percent more form of domestic violence in comparison to the wives of working husbands. The position of literacy of Rajasthan was extremely poor, and more so in the case of female literacy. More than half of mothers had 3 and more live births. Women produced average 4.31 children during her reproductive life bit they want only 2.7 children. The traditional health care system and treatment were based on their deep observation and understanding of nature. About 86 percent deliveries performed at their home and three fourth of deliveries conducted by dais and other untrained persons. About 74 percent of the mothers squeezed first milk from breast. Female sterilization was more popular among castes. About 29 percent of the women were using any method of birth control.

Rich Chandraker et al., (2009) A study of “Reproductive and Child Health among the Community of Mahasamund District, Chhattisgarh,
India”. This cross-sectional study was conducted to understand the pregnancy related issue, women’s Reproductive Health, infant and child morality and also to assess the nutritional status of mother and under five children among community of Mahasamund district of Chhattisgarh, India. 174 ever married women and 68 under five children were selected for the present study. Pre-structured schedule was used to collect socio-economic, demographic, Reproductive health including ante-natal care, delivery practices etc. Weight of under five children and height and weight of mother were measured by standard techniques. Weight for age was calculated for assessing child nutritional status using NCHS standard, body mass index (BMI) was used to assess for mother nutritional status. Results revealed that high percentages of mother had not taken ante-natal checkup (51.72%), tetanus injection (41.38%) and iron and folic acid tablets (56.32%) during pregnancies. 94.83 percent deliveries performed at home and 57.47 percent births were done mainly by untrained dai (traditional birth attendant’s). infant and child mortality rate was 5.92 and 4.28 per 100 live births respectively. 47.12 percent of mothers were undernourished (BM1< 18.5 kg/m2) and all the children suffered from malnutrition. Grades II and III malnutrition were higher among girls compared to boys. Poor health status during child bearing period, low ante-natal care, high deliveries at home along with high prevalence of under nutrition of under five children and mothers were
mainly due to low socio-economic conditions, high illiteracy and lack of awareness among Community.

Narahari et al. (2009) in his study “The Porja; A study on pediatric practices recorded the feeding practices of 260 ever married women, who have at least a child in their reproductive span, belonging to the porja, a primitive group of Visakhapatnam District, Andhra Pradesh, the sample hails from 18 villages of munchagiputru and pedabayalumandals. The results show that almost all the mother started breast feeding to their new born immediately, About 71 percent of the respondents squeezed out the colostrums, milk ere to start the feeding the baby, thereby depriving of their babies from, colostrums, a thick yellow liquid rich factors that provide natural immunity. This may be due to illiteracy and lack of awareness. About the nutritive and immunity.value of the colostrums. The duration of lactation was noticed mostly for 2 years (42 per cent) followed by 3 years (38 percent ) and 4 years (17 percent) . very few mothers (3 percent ) lactate babies below the age of 1 year due to conditions of ill health the practices of supplementary feeding starts 6 months on wards which is grater during 8-12 months (60 percent ) the predominant type of supplementary feedings is ambali a liquidfrom of rice or chodi (87 percent) and a few of them are fed with rice in mashed solid form. The result are discussed in the light of available information on other local
women besides focusing the relevance of illiteracy, status of awareness etc. on pediatrics health care practices.

Nalinsinghneet al (2010) evaluated a study on "Antenatal care among women: A study of Chhattisgarh and Jharkhand," The study examines the influences of socio-economic and demographic variables influence (age, social class, religion, marital duration surviving children etc.) on the utilization of Antenatal care (ANC) services from public or other health professionals among Tribal’s and non-Tribal. It also examines the effects of availability and accessibility of Reproductive and child health (RCH) services on utilization of ANC service. The data from District level Household Survey under Reproductive and child health project (DLHS-RCH-II) has been used for analysis. This survey collected data from 8860 currently – married rural women of Chhattisgarh and 10,569 currently – married rural women of Jharkhand during 2002-04. The discussion clearly reveals that in each socio-economic and demographic parameter, the women are lagging behind others in both the states. Distance to the nearest public health facility is not a satisfactory predictor for utilization of public health services because distance to the nearest public health facility does not indicate the relative accessibility of that health facility when there are a number of alternative places to go for the same services. Accessibility is a matter not only distance but also of the quality of service provided.
Stoop et al... (2010) evaluated a study on the intentions and attitudes toward oocyte cry preservation for on-medicals reasons among women of reproductive age. The aim of the present study was to investigate attitudes concerning social oocyte freezing among women of reproductive age in Belgium. The electronic questionnaire was completed by 1049 women giving a response rate of 55%, and 25 were excluded as they were incomplete/inconsistent. Our results demonstrate that 31.5% of respondents consider themselves as potential social oocyte freezers, of which 3.1% would definitely consider the procedure. Just over half of the women (51.8%) would not consider the procedure while 16.7% indicated they had no opinion. Potential oocyte freezers are characterized by a higher number of desired children and more openness to oocyte donation. The decision to actually embark on such treatment would primarily depend on conditions, such as the procedure not affecting their natural fertility and the health of future children. They conclude that a significant proportion of young women would consider safeguarding their reproductive potential or least open to the idea of social oocyte freezing.

Caserta et al. (2010) Environment and Women Reproductive Health this study summarized and classified as fertility and fecundity, pregnancy outcomes, trans generational exposure and effects. Epidemiological studies on EDCS are not always consistent, in part due to limitations imposed by practical constraints in order to make progress in this field,
we recommend taking advantage of bio monitoring and biobanks, including the development of appropriate biomarkers, and taking into greater consideration modulating factors such as genetic polymorphisms and dietary habits. Further human studies are warranted with particular focus on impaired fertility. Fecundity associated with currently widespread ED (e.g. biphenyl A, phthalates and polybrominated flame retardants). A detailed appraisal of compounds specifically related to adverse reproductive outcomes is very important for prevention and risk–communication strategies. Besides research needs, the current evidence is sufficient to prompt precautionary action to protect women’s reproductive health.

Ndidi et al. (2010) A cross-sectional questionnaire-based survey conducted to determine the reasons for late booking among women presenting at the antenatal clinic of major tertiary hospital in the Niger Delta, Nigeria. Findings revealed that the majority of respondents were aged 20-39 years (97.1%) quarters were primigravida and 25% of the women belonged to the upper socio-economic class. Seventy-three percent booked in the second trimester and 26.45 in the third trimester. Of the women who had given birth before, 80% had booked late in at least one previous pregnancy. More than three-fifths of the women (65.5%) booked late due to ignorance or misconceptions of the purpose of and right time to commence antenatal care, their study suggest that most women book late because of a belief there no
advantages in booking for antenatal care in the first three months of pregnancy.

Susan Hally (2011) Nutrition in reproductive health “This article reviews nutrition’s related issues affecting women and their reproductive health. Health care providers must be able to perform a basic nutritional assessment to identify risk factors and develop a plan of care to reduce those risk factors and improve health guidelines are provided to assist in performing a nutritional status assessment. Nutritional assessment of women of reproductive age should identify factors that may affect fertility, periconceptional health, and pregnancy outcome recommendations are provided to assist the health care provider in counseling women regarding the relationship of food choices and exercise to health, fitness and optimal bodily function. Controversies surrounding the effects of micro-nutrient deficits and excesses on reproduction and correction for these imbalances are discussed. Women should be encouraged to initiate dietary and other lifestyle changes to allow for optimal reproductive outcomes.

Monali Go Swami et al. (2011) conducted an intensive explorative study Traditional method of reproductive health care practices and fertility control among the Bohemia of Baleswar, Orissa. To collect data in the Tribal (BHUMIJA DOMINATED VILLAGES) of Baleswar District, five villages of Remuna Block namely, Phulkiary, Jodabari, Ghatghrsahi, Jambani and Gudgudia and three villages of Niagara Block
namely, Chaturkhanta, Chandipur and Makhapada of the District were covered. The study reveals that the Bhumijas have vast knowledge about ethno–medicinal uses of plants growing in their vicinity. It has been well revealed in this study that the Bohemia community has been changing at a certain pace along with their health seeking behavior. The Tribal inherit a rich traditional knowledge about the flora investigated and apply this knowledge for making crude herbal medicines to cure different diseases. But it is observed that the traditional knowledge which formed the basis for the origin of alternative medicine also paved way to evolution of modern medicine. Now such indigenous knowledge is facing slow and natural decline. However the study certainly points out that the traditional Reproductive Health care system still finds its meaning of survival in the Tribal domain in this study, it is also found that though the Bhumijas are in favour of taking the modern medical facilities, the older generation still has inclination towards traditional medicine. Presently, very few elders in the community practice traditional medicine. If this trend continues, a few years from now, there will not be a single elder member in the community who speak on the traditional medicine. The growing disinterest in the use of traditional medicine for Reproductive Health problems among the younger generation will lead to disappearance of this practice. Therefore, greater efforts are required to documents the rich traditional knowledge of the local people so as to prepare a comprehensive account of it. Wild
plants and other and other natural resources used as traditional medicine unfortunately are being eroded due to the loss and degradation of their natural habitat or over harvesting for commercial purpose. Therefore, there is an immediate need to execute a revitalization strategy for protecting the indigenous knowledge from complete desertion.

Sativasusuman (2012) in his study “Correlates of Antenatal and postnatal care among Women in India” an attempt is made in this paper to rate the socio-economic and demographic characteristics of the currently married women in eight districts of Chhattisgarh with factors associated with antenatal and postnatal care. Data for this study were taken from District Level Household survey on Reproductive and child Health (DLHSRCH 2002), a representative sample of 1569 OC, BC, SC,ST Community currently married women aged 15-44, residing in eight districts of Chhattisgarh. Adjusted effects (odds ratios) analysis has been used to find out the effects of antenatal and post-natal care on institutional delivery in Chhattisgarh. It is observed that majority of the women, about 84 percent, have a low standard of living. Also, 74 per cent of the women are illiterate. The finding of the adjusted effects (odds ratio) shows that giving birth in the medical institution for the women who received full antenatal check-up is 2.5 times higher than those women who did not receive any antenatal check-up. It suggests that majority of the currently married women have low standard of living there is a need
to improve their economic standard so that they can fulfill their basic needs.

Krishna Kumari (2014) investigates the issues and challenges among the Tribal women in comparison to the non-Tribal women in the newly states by drawing upon data from the National family health in terms of standard of living, education and other socio-demographic indicators. There is a need for proper understanding of the different health aspects of women and their specific health needs so that relevant health measures can be prepared and implemented, More particularly, there is a need for undertaking a region specific study of the health of the women, which will make planning for their welfare more successful. In this investigates the maternal health care practices, health condition, education and unemployment among the women in comparison to the women. Education as a means of advancement of capacity, wellbeing and opportunity is uncontested and more so among communities on the periphery. Low literacy rates in communities continue to indicate a need for overarching support that tactless issues from health, education and unemployment.

Prenatal multiple micronutrient supplements provided no added advantage over iron and fioate in reducing outcomes such as low birth weight and probably non survival benefit. Data were also suggestive that adding zinc may negate the beneficial effect of iron and folic acid on birth
weight. Research was needed to further understanding of nutrient-interactions.

Upper et al.,(2006)conducted a study on Health care seeking behavior among men in an “urban slum for reproductive morbidity”. A total of 268 males residing in an urban slum of Delhi were interviewed to study their socio-demographic characteristic, perceived reproductive morbidity and sources of health care facilities utilized by them for reproductive morbidity during the last 6 months preceding the study. The study revealed that majority of the sample respondents were in the age-group of 20-29 years and 154 were married. Out of 268 males, 64(23.9%)had some kind of perceived reproductive morbidity, of which, 25 (39.1%)did not seek any treatment from any health care facility. Of those who sought any treatment more than half (56.5%)preferred informal sources, the study revealed. So the authors feel the necessary for making people aware of the availability of formal health care services for male reproductive morbidity.

KiranVani (2000)in the study on knowledge and adoption of selected health and nutritional practices by rural women in Belgaum District, Karnataka with a total of one hundred and fifty(150) respondents found that while studying nutritional practices of children majority reported that colostrums should be given to new born baby (53%), breast feeding for infants was must (100%) introducing solid foods like kichri/ rice/dal/soaked chapattis has to be given to seven month old
child (63%), daily consumption of combination of rice, dal and vegetables was beneficial for growing children (55%), introducing small quantities of soups, juices, cheers etc. to baby’s diet at three months stage was good for child health (42%), introducing milk products, egg and its products was good for growing child (87%) and the knowledge about the nutritional practices of adults revealed that green leafy vegetables must be included in the diet (58%), supported pulses were more nutritious (46%), including cereal-pulse combination (dal chapatti, dal –rice) in regular diet was nutritious for the body (63%), consumption of milk and curd strengthen bones (56 %), using the jiggery often in the diet reduces iron deficiency (38%), fruits provide and mineral (78%), drinking of 2 litres of water would makes the person hygiene (42%), Mixing soya bean with jowar and wheat during grinding makes food more nutritious (60%). The remaining percent of each statement showed that the respondents did not have the knowledge about nutritional practices.

Krishna ray et al.,(2008) in his conducted a cross-sectional study carried out on women attending the peripheral government clinics of Delhi. The study was healthcare centers, both rural and urban, overall self-reporting of morbidity was 65.0%. this study highlighted the wide variation between self-reporting of morbidity and syndromes’ and etiology-based diagnosis in women from both rural and urban setting.

Shine et al.,(2008) in his conducted a study on “evaluating completeness of maternal mortality reporting in a rural health and social
affairs unit in Vellore, India”, 2004. This study identified under-reported and misclassified maternal deaths among women of reproductive age between 1999 and 2004 in rural services unit in Vellore, India. In-depth interviews, semi-interviews and structured questionnaires were used to identify maternal deaths known to health care providers and community leaders who regularly come in contact with pregnant women. Eighteen under-reported and misclassified cases –or 50% of maternal deaths—were reported. These included 29% of abortion-related and 7% of domestic violence related deaths. Based on this study’s fieldwork, the existing deaths surveillance system detected 100% of the maternal deaths reported by community workers. However, it missed most likely than deaths reported by hospital workers to result from abortion and family violence. The existing surveillance system should be augmented with a community-based death surveillance system. This comprehensive approach identified twice as many maternal deaths than previously recorded and could be applied in other settings. Appropriate public health interventions should be initiated to prevent maternal deaths in this community.

Miguel angel et al., (2009) conducted A cross-sectional study “differences in the reproductive pattern and low birth weight by maternal country of origin in Spain, 1996-2006.” Designed study objectives maternal age on the date of giving birth, birth multiplicity, birth weight and the mothers country of origin. The maternal country of origin
variable comprised of 21 categories. LBW was associated with a combination of older maternal age and multiple pregnancies in the case of women who had been born in Europe (EU15). However, this association was not found in women who originated from outside the EU15, mostly from countries who have shown significant emigration to Spain during the last decade. LBW was present among all age groups, in both singleton and multiple births, and in particular Romanian mothers showed the highest or 2.34 (95% CI 1.20-4.80). This study confirms differences in the reproductive pattern and LBW depending on maternal country of origin. These results allow a better understanding of the reproductive pattern and the implications of mothers country of origin in LBW. Thus, helping health decisions makers to plan future health interventions aimed at reducing the LBW prevalence in Spain.

Raginiulkarni et al., (2009) was evaluated a study on Maharashtra component of a large multicentre task force study on the cause of deaths among reproductive age group women were presented along with the factors contributing to these deaths. House-to-house surveys of a representative population from rural and urban areas in six Districts of Maharashtra were undertaken by probability of proportion to size sampling. Their study found communicable diseases, injury and poisoning and cancers were the major among reproductive age group women. Several factors responsible for accidents and suicides also contributed substantially to the mortality load among these women.
Majority of the maternal deaths were seen in rural areas indicating the need to strengthen the maternal health care.

Mitheskumar et al., (2010) “Untreated reproductive morbidities among ever married women of slums of Rajkot city, Gujarat: the role of class, distance, provider attitudes and perceived morbidities and to study factors affecting treatment seeking behavior among ever married women of urban slums. they selected 1,046 women the reproductive age group (15-49years) using two-stage cluster sampling for a community based cross-sectional study. From this sample, 593 responses reporting reproductive morbidity were analyzed for treatment seeking behavior and its correlates. Information was collected on demographics, socioeconomic status; self-reported reproductive morbidity and treatment-seeking patterns along with reasons for not utilizing available health services, all using a pre tested structured interview schedule. Univariate and multivariative analyses were done in SPSS 15.0 in the there sample 57% of women had at least one reproductive scheduled castes/scheduled tribes caste group(OR=3.92,95% CI 1.44-10.64), at a distance of more than 2 km from a health facility (OR=2.67,95%CI 1.28-5.58), and whose duration of illness was more than 1 year (OR=14.44,95%CI 3.66-56.87)accessed fewer reproductive health services compared to their counterparts. The present study found that a lower sense of needed the cost of care and societal barriers were the reasons for not seeking care. Provides poor attitudes, poor quality of services, and long waiting times
were found to be the reasons for not utilizing health facilities. The determinates for accessing reproductive health care were resources available at the household level, social factors the availability of services and behaviors related to health. Government facilities remained underutilized.

Prabha Chauhan et al., (2012) in his study on maternal mortality as per gravidity among women at a tertiary level of care in bester, Chhattisgarh, India. Materials and methods: this was a hospital based retrospective reproductive-age mortality study of women of bastar region, Chhattisgarh, that were admitted and managed in obstetrics and gynecology department govt. medical college, jagdalpur, bastar, Chhattisgarh, between July 2007 and October 2011. There were total 120 cases result: results of the present study showed that among 120 deceased women highest maternal mortality 65 cases (54.166%) was noted in primigravida (nullipara GIPO), second highest maternal mortality 44 cases (38.33%) was noted in 2nd to 4th gravid 10 cases (8.33%) ceptivewere in 6th and 7th grand muktigravida and (65.7%). Number of living children at the time of first contraceptive use was found to be more than two in 74.4 percent of the cases. Socio-economic status (SES) of the family was seen significantly with the use of contraceptive method. The reasons for non-acceptance were either for an expectation of a male child (44%) or fear of side effects (29%). Despite their knowledge on different methods, one-third of the women was found not
using any contraception because it was not available free of cost. The above findings indicated married women in the study population seemed to possess a reasonable Knowledge about contraceptives as five percent only expressed having not heard of any contraceptive method at all.

Jagdish Prasad et al.,(2007) examine a study on “Trends and Forecasting the Estimation of Different Contraceptive Needs in the Districts of Rajasthan. This research paper made an attempt to find out the trends and forecasting the estimation of different contraceptive needs in the Districts of Rajasthan. Secondary data were used for and study. The result showed that some districts of Rajasthan have a significant increment in accepting the family planning methods. Three methods of spacing, i.e., intrauterine devices (IUDS), Condom contraceptives (CCS) and oral pills (Ops) performance are forecasted up to the year 2010-11 by using the method of least square. Forecasted values for different methods of family planning may be useful for government and social workers while formulating family planning policies. This also helps in finding users trend of different family planning methods and actions can be taken accordingly. It also useful for manufacture for inventory purpose of all family planning accessories in advance.

Saini et al., (2007) evaluated a study on “study of unmet need for family planning in a resettlement colony of east Delhi”. The prevalence of unmet need for family planning in an urban resettlement east Delhi the and the factors associated with it are investigated in this study using a
sample size of 1051 married females aged 15-49 years who and were fecund and sexually active. The findings reveal that (i). Among the subjects, 562 (53.5%) were currently using contraceptives, 130 (12.4%) were pregnant and 359 (34.1%) were not using any contraception; (ii). The overall unmet need for family planning was 25.4 percent of 6.7 percent had need for spacing and 18.7 per cent had need for limiting the family; (iii). Unmet need was the highest among the illiterate group, followed by women with per capita income of less than rs.500 per month and women having three of more children; and (iv). It was lower in women who discussed family planning with their husbands as compared to those who did not.

Hariharsahoo (2007) was studied “Determinates of contraceptive use in Orissa; an analysis from national family health survey lii”. This of the paper attempts to study the determinants by using data from national family health survey III, conducted during 2005-06 for Orissa. Also, data have been drawn from family welfare year book 2001. Both bi-variate and multivariate analysis have been used in the present study. The various predictor variables used in the analysis were caste, religion, women’s educational level, place of residence, wealth index of the household, work status of women, number of living sons, age at marriage marital duration, whether experienced infant death and exposure to mass media. The findings revealed that, only one-third of the women with one child use contraception in Orissa. Such proportion goes to 60 per cent for
women with two, three and more than three living children respectively. The analysis indicated that spacing is not very common but most of the contraceptive’s uses are for limiting family size. Educational of women, sex preference, marital duration, infant death and exposure to mass media have a significant effect on the use of contraption. Therefore, these aspects may be given due attention while framing family planning program and efforts should be made to make people aware of the benefit of small family norm.

Hong He et al., (2009) found in their study “Reproductive and family planning history, Knowledge, and needs: A community survey of low-income women in Beijing, China”. The purpose of this study is to broadly assess reproductive and family planning history, Knowledge and health needs among low income urban women with ANM to informing health services interventions. Subjects of the study 1642 low-income women age 18-49 from haidian district, Beijing were selected. All were interviewed via a standardized questionnaire in 2006. Most women reported at least one pregnancy and delivery 97.7%, 98.3%). Deliveries in hospitals (97.3%) by medical personnel (98.5%) were commonplace, as was receipt of antenatal care 86.0%). Nearly half had at least one abortion, with most (56.0%) performed in district hospitals, by physicians (95.6%), and paid for out-of-pocket (64.4%). Almost all (97.4%) used contraception, typically IUDs or condoms. Reproductive Knowledge was limited. Health needs emphasized by the participants
included popularizing Reproductive Health information, being able to discuss their Reproductive Health concerns, free Reproductive Health insurance, examination and treatment. Among poor urban women in Beijing, antenatal care and contraceptive use were common. However, abortions were also common. Knowledge about Reproductive Health was limited. There is a need for better Reproductive Health education, free medical care and social support.

Ebro Gabalci et al., (2010) Descriptive study was carried out to determine the effects of contraceptive methods on the sex lives of women. The study was conducted at the family planning center and Gynaecology Clinics of Obstetrics and Gynaecology and children’s Hospital. The sampling comprised of 366 women who had applied to these centers. Data collection forms generated based on the literature and the Arizona Sexual Experience Scale (ASEX) was used as data collection tools. The average ASEX scores were similar for women using the withdrawal method as a traditional method (:13.75), RIA as a modern method (:13.93), condoms (:13.30), and oral contraceptives (:13.37), were found to be similar (p ≤ 0.05). Since the average scores of ASEX were higher than 11, problems in sexual life were determined at high levels. The difference between ASEX average scores and duration of family planning, problems due to the method, duration of marriage, number of pregnancies and living infants, frequency of sexual perception; was statistically significant (p < 0.05). The study found higher than normal
average ASEX score and we therefore suggest counselling services, provided by healthcare staff, on sexual health and family planning that include information on FP methods and their effects on sex life.

Emily M Godfrey et al. (2011) conducted a study “contraceptive methods and use by women aged 35 and over: A qualitative study of perspectives”. Semi-structured, in-depth interviews were conducted with 17 women. They were all 35 to 49 years old, regularly menstruating, sexually active, not sterilized, not desiring a pregnancy in the near future, and at least 3 months postpartum. The study purposely ordained through home interviews, and focused on socio-demographics, Knowledge, attitudes and behaviors sexuality, HIV/AIDS and other STDs. The study revealed that only 22% of adults had even heard of AIDS, and 18% knew how it is transmitted. In addition, only 5% knew that STDs and AIDS were related to each other. AIDS awareness among women was lower compared to men (14% vs. 30%). Regarding sexual practices, 35% of the respondents reported having. Lack of awareness, permissiveness of societies for premarital or extra-marital sexual relationships, and sexual mixing patterns predispose these communities to HIV/AIDS and STD infections. There is a dire need for targeted interventions in order to curtail the increasing threat of HIV and other STDs among these vulnerable populations.

Olanrewaju et al., (2007) evaluates a study on “HIV Voluntary Counselling and Testing of pregnant women in primary Health care
Centers In Ilesa, Nigeria. This study was carried to determine the prevalence of HIV and the acceptability of HIV voluntary counselling and testing (VCT) in pregnancy as a strategy for the prevention of mother to child transmission (PMTCT). Methods: group and individual pre and post-test counselling were performed by trained field workers. Screening for HIV infection was based on two sequential rapid HIV tests. Focus group discussion was also held among HIV positive pregnant women. Result: 587 (80.6%) pregnant women underwent the test after pre-test counselling. Sixty-nine women (9.5%) had a positive result. The women were counselled on the need for prevention of mother to child transmission of HIV infection. Thirteen (18.8%) of the women accepted to utilize PMTCT FACILITIES. Reason cited for no utilization of PMTCT facilities mainly bordered on the belief that they could not transmit HIV to their unborn children. Significant associations were found between HIV positivity and marital status, low educational status, low social class and high parity of the study subjects. Conclusion: the study suggests that a successful integration of VCT into the existing primary health care services is feasible in developing countries like Nigeria, though; there is a need to create more awareness on the effectiveness of PMTCT.

Sri Devi et al., (2007) presented a study on “prevalence of RTI/STI among Reproductive Age women (15-49) years in urban Slums of Tirupati Town, Andhra Pradesh”. Prevalence of RTI/STI in the present study was 35.6 per cent based on the symptoms and (26.9 per cent based on per-
speculum examination. Prevalence of RTI was maximum in 15-29 years age group. The most commonly observed symptoms were vaginal discharge (21.3 per cent) and lower abdominal pain (4.9 per cent). Prevalence of vaginal discharge decreased with an increase in age, education and per capital monthly income. Prevalence was observed higher in scheduled castes and tribes, married of women, worker, IUCD acceptors and those with unhygienic men rural practices, history of abortions and non – institutional deliveries. Based on laboratory finding, highest positive results were seen in candidacies (88.9 per cent) followed by trichomoniasis (50.0 per cent). 80.0 per cent of women completed the course of treatment and 57.2 per cent of women got complete relief.

Krishna Ray et al., (2008) conducted a cross sectional study “comparative study of syndromes’ and etiological diagnosis of reproductive tract infections/sexually transmitted infections in women in Delhi” A cross-sectional study was carried out in women attending the peripheral government clinics of Delhi. The study was conducted over 26 month in 4090 women attending peripherals government healthcare centers, both rural and urban, in four zones of Delhi. Date were analyzed by applying statistical methods. However, the percentages of women with some STD-related syndrome was 71.4%. the rural women were observed to have significantly more STDSyndromes than their urban counterparts. The etiological diagnosis could be established in only 32.2% of cases. This has implications for the syndromes approach to STI case management.
These observations call for a review of the diagnostic policy for RTIs/STIs by national authorities in order to avoid the overuse of antimicrobials. The study also highlights the need for the introduction and/or strengthening of facilities for simple diagnostic tests for RTIs/STIs, especially at the peripheral healthcare level.

Llama Srivastava’s (2010) Study on “Reproductive Tract infections among Women of Rural Community in Mewat, India”. Mewat is a backward area of north India, dominated by Moe community following a mixture of Hindu and Islamic customs, practices and beliefs. Community based cross-sectional study was undertaken among married women (between 15 and 49 years) in Mewat. The objective of the study was to understand the socio demographic and socio-cultural factors that increase vulnerability to RTI among women. Both qualitative and quantitative data were collected. This article presents the findings of the study. 72.6 per cent of the respondents reported one or more symptoms of RTI. Only 31 per cent of the respondents were aware about RTI and 21 per cent about HIV/AIDS. Vicariate analysis indicated statistically significant association between educational level, age at marriage, place of delivery and awareness about RTI with presence of self-reported symptoms of RTI among the study population. Improving literacy and increasing awareness level among women about Reproductive Health is needed to reduce incidence of RTI in the study area.
Paul Sebo et al., (2011) examined an in-depth study of the “sexual and Reproductive Health Behaviors of Undocumented Migrants in Geneva: A Cross sectional study”. The aim of the present study was to describe sexual and Reproductive Health behaviors of undocumented migrants in Geneva. This descriptive cross sectional study included consecutive undocumented migrants presenting from November 2007 to February 2008 to health facility offering free access to health care to this population. Following informed consent, they completed a self-administered questionnaire about their socio demographic profile and sexual and Reproductive Health behaviors. Total of 384 participate were eligible for the study. 313 (82%) agreed to part pate of which 77% (241 patients) completed the survey. Participants were mainly young, Latino-American, single, well-educated and currently working women. They had multiple partners and reported frequently engaging in sexual intercourse. Use of contraceptive methods and strategies of prevention against sexually transmitted infections (STD) were rare. Nearly half of the women had at least one induced abortion and 40% had had planned pregnancy. The results of our study suggest that undocumented migrants engage in frequent and high risk sexual intercourse with insufficient use of contraceptives methods and suboptimal strategies of prevention against STI.

The review of literature on various life aspects of the reproductive women shows that there is further need for in depth research.
Thereasons for the existing inequities in the status of the women community. Very few comprehensive studies examining and assessing the socio-economic, cultural, reproductive and general health status have been undertaken. The review underlines the real need for specific sexual and reproductive educational programs targeting this hard to reach population. But region specific data is needed to formulate and implement policies and programmers’ to bring the marginalized population groups like BC, SC, ST women out of the groove of miserable situation.

Statement of the Problem

Gender, health and poverty are strongly interconnected and there is a strong dimension but according to WHO, the appropriate detailed studies and data collection of slums women's health circumstances have not been undertaken. Maternal health care and infant mortality statistics need to be collected and examined in relation to the level of infrastructural services present. Accessibility in respect of women's special health needs associated with their reproductive function needs to be undertaken: identification of the gender and household resource constraints, such as taboos and cultural customs, which prevent women accessing health facilities or place women in specific health danger in any particular location needs to be undertaken and a comprehensive data mapping of such patterns needs to be developed. As women have particular health needs examining the proportion of access to
reproductive health will provide an early indicator as to whether women have been adequately included or participate in health services.

To overcome in the area of health, India adopted the development approach. In the development approach, improvement in health status is viewed primarily as a product of socio-economic development. By definition, development implies improved nutrition, hygienic living and working conditions, greater awareness of health problems and wider accessibility to health care services which have a favorable effect on the health status of the people. Improvement in health status as well as health care are treated as integrated components of the development process, in which medical care is just one of the many inputs; the impact of state intervention on health status depends on its overall socio-economic policies.

India during the past few decades made a bold and impressive, determined and planned effort to empower health status of its populace. Over the years it has adopted a two faced strategy to usher social inclusion. On one hand it strived to achieve overall socio-economic development with equity to influence and enhance the health status; and on the other it has attempted to raise the health status independent of socio-economic development through state intervention by extending health care with equity. RCH was one such programme which was launched in the year 1997.
While poor quality of care can inhibit women from seeking health care, women’s lack of autonomy in decision-making or movement is also an important constraint on women’s health seeking. Women are, by and large, taught self-denial and modesty from and early age and are hence unlikely to acknowledge a health problem, and particular a gynaecology problem, unless it is very advance (SEWA- Rural 1994). For example, large number of women experience white discharge but considers it as part of their live and rarely seeks medical care for such problem.

Lack of decision-making, freedom of movement and time can restrict visits to health centres, even where a health problem has been recognized. Moreover, pelvic examinations are strongly resisted by women. And even if a problem has been diagnosed, treatment it frequently not followed through because it is seen as an unnecessary expense of too demanding.

The available literature is inadequate when it comes to assessing reproductive health and its underlying causes. Rigorous indirect estimates of maternal mortality, at the state and district level are essential. Micro-level analyses of the links between reproductive health outcomes and their socio-economic and cultural antecedents in different setting would go a long way in tailoring services in locally relevant way. On the impact of interventions designed to redress reproductive health deficiencies.
The present study is focused on women in slums of ATP and is understand in the context of selected indigenous communities. These selected communities are spread in slums of the remote and pockets of a backward District namely AnantapuramuMunicipal Corporation, Andhra Pradesh. The habitation is border to the Karnataka state.

**OBJECTIVES**

The present study aims at understand the “Reproductive Health care and hygiene practices of the women living in slums areas”

**The objectives of the study are as follow:**

1. To portray the socio-economic and demographic profile of respondents.
2. To study the psychological changes and cultural practices followed during puberty and menstruation among the women in slum areas.
3. To assess the antenatal, intra-natal and post-natal care availed by adolescent mothers in slum areas.
4. To study the social status of women in the slums in India.
5. To examine the reproductive health status of the respondents.
6. To analyze the reproductive health hygienic practices of the selected communities in the slums areas in Anantapuramu Municipal Corporation.
METHODOLOGY

A) Universe: The Universe of the study is Anantapuramu Municipal Corporation of Andhra Pradesh. Anantapuramu District is located in a rain shadow region and is a chronically drought-prone backward District. For the purpose of this study, a detailed interview schedule was administered separately for slum-dwellers and pavement dwellers covering various aspects such as socio-economic characteristics, sources of income, employment position, level of skills, level of aspirations of the urban poor, political socialisation and extent of utilisation of health and educational services provided to them. The household survey was conducted on census basis, covering each and every household in the selected slums. All the households were stratified into four groups as per their caste, viz. Scheduled Castes, Scheduled Tribes, Backward Castes and Others. The 'Others' category includes Muslims, Forward Castes among Hindus, and Christians. Besides these, slum profiles are prepared for the selected slums indicating the origin and growth of these slums as also the existing amenities available to them.

B) The Sample: For the purpose of the study an attempt is made to elicit information with regard to women in slums area in Anantapuramu Municipal Corporation from different sources such as caste associations/bodies officials of the Municipal Corporation,
Revenue and Health Officials. Therefore, in the present study stratified random sampling technique was adopted to draw the study sample.

Thus the study sample comprises caste-wise distribution of respondents of 240 households: and represents OC’s (59), BC’s (104), SC’s (47) and ST’s (30) households.

**LOCATION OF SLUMS IN ANANTAPURAMU Municipal Corporation:**

The analysis of the location of slums in Anantapuramu Municipal Corporation clearly, show that transport and communication lines played a major role for the origin and establishment of slums. About one-fourth of slum such as Krishnadevarya nagar (19) Krupanandanagar and naiknagar , (18) Maruthinagar (14) Slum adjacent to judge bunglow , (17) Rahamathnagar (16) Ramanagar(13) Lakshminagar(12) Venkataredynagar (24) H.L.C colony road (3) and Mahatma Gandhinagar (28) are located along the railway line running from north to south.

Indiranagar (2) Judicial colony (4) Yuvaraj colony (5) Indiragandi Nagar (6) Tarakaram Nagar (7) Azadnagar (10) Nehru nagger (9) Medara colony (11) suples channel (20) Suryanagar(29) Municipal travelers bunglow slum (42) Tank road (43) banglor road slum (44) engineering college road slum (45) obuladevarnagar (23) Raninagar (35) Nagireddy colony (36) C D hospital slum (38) Chennakesava temple road slum
(39) and Munnanagar (40) slums are located by the side of important roads in the city.

A few slums such as Navodya colony (48) Buddappanagar (47) a slum along eastern side of Navodaya colony (49) Sivayamanyam hunts (31) Refuge quarters (33) Anjineyamanayam huts (34) and Maruti Nagar weaker section housing colony (15) are located in between major roads.

The sample frame for the study is the list of all household in the various slum distributed in Anantapuramu town. The different slum are divided into three categories. In the first have 400 to 300 household, the second category represent 300 to 200 household and third category was based on the number of 200 to 100 households.

**SELECTION OF RESPONDENTS:**

From the above categories two slums from each category was selected purposively for the selection of respondents. At the first instance, all the households in the selected slum of three categories were which represent the distribution of all castes. Subsequently the households in each selected slum are enumerated. From the survey of households the list of respondents numbering 240. One each household were selected by adopting proportionate stratified random sampling procedure. Thus the sample size is 240. Thus the study sample comprises 240 respondents, and represents OC’s (59), BC’s (104), SC’s (47) and ST’s (30) households.
## DISTRIBUTION OF SLUMS OF CATEGORIES IN ANANTAPURAMU

### MUNICIPAL CORPORATION

#### I Category

*(Households between 301 to 400)*

<table>
<thead>
<tr>
<th>Name of the slum</th>
<th>Number of the households</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Maruvkomma Colony</td>
<td>320</td>
</tr>
<tr>
<td>2. Sreenivasa Nagar</td>
<td>320</td>
</tr>
<tr>
<td>3. Vinayaka Nagar</td>
<td>323</td>
</tr>
<tr>
<td>4. Raninagar (C.D Hospital)</td>
<td>329</td>
</tr>
<tr>
<td>5. Rangaswamy Nagar</td>
<td>336</td>
</tr>
<tr>
<td>6. Ambedakar Nagar</td>
<td>358</td>
</tr>
<tr>
<td>7. Raninagar (2)</td>
<td>333</td>
</tr>
</tbody>
</table>

#### II Category

*(Households between 201 to 300)*

<table>
<thead>
<tr>
<th>Name of the slums</th>
<th>Number of the house holds</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Erukalavari Colony</td>
<td>201</td>
</tr>
<tr>
<td>2. Yuvajana Colony</td>
<td>244</td>
</tr>
<tr>
<td>3. Maruthi Nagar</td>
<td>244</td>
</tr>
<tr>
<td>4. Buddappa Nagar</td>
<td>253</td>
</tr>
<tr>
<td>Name of the slum</td>
<td>Number of the house holds</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>1. Khaja Nagar</td>
<td>101</td>
</tr>
<tr>
<td>2. Arunodaya Colony</td>
<td>111</td>
</tr>
<tr>
<td>3. Thirumalanagireddy Nagar</td>
<td>115</td>
</tr>
<tr>
<td>4. Ashok Nagar</td>
<td>130</td>
</tr>
<tr>
<td>5. Razaknagar</td>
<td>134</td>
</tr>
<tr>
<td>6. Tarakapuram</td>
<td>135</td>
</tr>
<tr>
<td>7. Naik Nagar</td>
<td>139</td>
</tr>
<tr>
<td>8. Neeruganti Street-1</td>
<td>148</td>
</tr>
<tr>
<td>9. Neeruganti Street-2</td>
<td>161</td>
</tr>
<tr>
<td>10. SreekrishnaDevaraya Nagar</td>
<td>167</td>
</tr>
<tr>
<td>11. Narapareddy Colony</td>
<td>175</td>
</tr>
<tr>
<td>12. NTR. Colony</td>
<td>181</td>
</tr>
<tr>
<td>13. RjakColony-2</td>
<td>183</td>
</tr>
<tr>
<td>I Category :</td>
<td>Name of the Slum</td>
</tr>
<tr>
<td>-------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>1</td>
<td>Ambedkar Nagar</td>
</tr>
<tr>
<td>2</td>
<td>Rani Nagar</td>
</tr>
</tbody>
</table>

| II Category : | |
|---------------||
| 1             | Buddappa Nagar       | 253             | 36     |
| 2             | Janashakti Nagar     | 253             | 36     |

| III Category : | |
|---------------||
| 1             | Naik Nagar           | 139             | 26     |
| 2             | Neeruganti Street    | 148             | 22     |

C) Tool: As a sizable proportion of the respondents are illiterates and ignorant, an Interview Schedule was prepared and administered for collecting detailed data pertaining to the situation the lead to slums in women health status. Further, a detailed analyses is made to know as to how the women reproductive health. After undertaking a pilot survey of sample cases, the schedule is perfected before data collection.

D) Data Collection: The data is collected both from primary and secondary sources. As far as the primary data is concerned, the respondents are interviewed with an independent structured schedule. The secondary data has been collected from books,
journals, reports, documents and newspapers to supplement the primary data and to add validity to the analysis.

E) Data Analysis: The data and information so gathered is checked and cross checked. The data then is codified through the computers for tabulation by using SPSS package. The analyzed data is presented in the form of simple tables. Simple statistical tools like percentages and averages are used in analyzing the data. The analysis and inferences are made based the data given by the select respondents.

**SCHEME OF PRESENTATION**

The Analysis of the study is documented in six chapters:

- **First** chapter provides introduction to the study, the review of literature, the issues under study and the method of study.
- **Second** chapter presents reproductive health status in India.
- **Third** chapter presents the profile of study area.
- **Fourth** chapter discusses on the socio economic and demographic profile of the respondents.
- **Fifth** chapter presents the analysis and discussion of the study.
- **Sixth** chapter presents the summary of findings and conclusion of the study.