Chapter-1
INTRODUCTION

Good health is a precondition for human productivity and for the progress. The development of society depends largely on the quality of the life of its citizens. Health is an significant feature in the achievement of status, and is also an indicator of social status, mainly for women, whose physical condition, to a great extent, by social attitudes and values. These social values and attitudes also influence the condition and use of preventive and remedial health care, including maternal care. The health care facilities offered by a community in the form of medical, particularly maternity services for women, is a significant indicator of the emphasis that a community places on the health of its women.

Maternal health indicates status of health of women during pregnancy and child birth. It is directly related to the state of women’s health which, in turn, is related to their status not only in the family but in the entire community, and also to their development. Woman’s health during infancy, childhood and adolescence has a bearing on her health as a mother which, in turn, influences the health of the child also.

1.1. REPRODUCTIVE HEALTH

The health of a woman in her childbearing years is something that concerns every country throughout the world, but it is of special concern for women. It has therefore now become the focus of attention as it directly affects the general health of women, of their children, their family members and has a great influence on the socioeconomic development of the society. Throughout the world the state of reproductive health of women in a country decides the content of population programmes in that country. In a developing
country like India the reproductive health position of women needs urgent attention.

The various components of reproductive health include various aspects of a woman’s health such as abortion, childbirth, sexuality, contraception, and maternal morality. It is the woman who suffers the risks arising from complications of pregnancy and childbirth, prevention of unwanted pregnancy, and the consequences of unsafe abortions. They bear the brunt of conception and are more vulnerable to complications arising from reproductive tract infections, particularly STDs (sexually transmitted diseases) including HIV/AIDS.

1.2. DEFINITION OF REPRODUCTIVE HEALTH

The WHO defines “health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. (Kamalam et al., 2005) Reproductive health, and functions and systems at all stage of life fall within the purview of the term ‘health’. The health of women in the maternity phase has been a topic of nationwide concern in India since independence. Maternity health includes reproductive health, and functions and systems at different stages of life. According to International Conference on Population and Development Programme of Action: “reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods 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". (www.un.org)[2]

A more inclusive approach to reproductive health would mean that (i) women have the ability to reproduce and regulate their fertility; (ii) they are able to go through the period of pregnancy safely and also take care of the health of the child; (iii) in terms of the survival of the mother and of the infant the outcome of the pregnancy is positive; and (iv) couples are capable to have sexual relationships without the fear of pregnancy or of contracting STD.

1.3. **THE COMPONENTS OF REPRODUCTIVE HEALTH CARE**

1.3.1 **Family Planning and Abortion:**

Family planning means to plan a family in such a fashion so as to keep up the family needs and resources in balance which leads to a happy, healthy and better life. Family planning is defined as “planned regulation by a married couple of the pregnancies which are liable to result from their conjugal union, through the adoption of precautions”. Family planning empowers individuals and couples to plan the number of kids they wish to have and the difference of age among them through the use of contraceptives or sterilization. Induced abortion is one of the oldest and most widely practised methods of avoiding an unwanted birth. When women are determined not to have a child and if other means of preventing birth are not available or have failed, they do resort to abortion, regardless of the risks.

1.3.2 **Menstruation and Menopause:**

Menstruation is the monthly procedure of releasing blood and other matter from the womb that occurs between puberty and menopause in women and female primates who are not expectant. It is a natural process occurring in all adult women who are
healthy and have not reached menopause. It is understood as a lengthy period of transition known as the ‘change’ of life.

1.3.3 **HIV/AIDS:**

AIDS is the acronym for Acquired Immune Deficiency Syndrome. It is a syndrome of a condition, not a disease proper. In this condition the body loses the resistance to fight disease-producing organism, because the virus destroys the very foundation of the defence mechanism of the body. AIDS mostly attacks the productive age group between 15-45 years, since it is usually acquired due to sexual behavior. AIDS is caused by a virus called HIV (Human Immune Virus). It is not a single virus, but a family of many viruses called retroviruses.

1.3.4 **Nutrition during Pregnancy and Lactation:**

Another life-threatening problem faced by Indian women is that of malnutrition. It endangers not only their lives but also threatens the survival of their children. The problem is further complicated by poverty which forces them to do hard manual labour. Childbearing requires special nutrition if the health of the mother and the child is to be ensured. Similarly, the mother needs special diet in the lactation period. Thus poor nutrition is a potent cause of sickness and high fatality in the pre and postnatal phases.

1.3.5 **Nutrition during Adolescence:**

Adolescence is the period from puberty to adulthood in human beings. The adolescent phase of life witnesses accelerated physical, biochemical and emotional development. Faster growth demands more energy which in turn requires greater intake of proteins, minerals, vitamins and other nutrition. Girls, specially, need adequate intake of iron as they lose 0.5 mg/day of iron by method of menstruation. If this lost iron is not replaced, it predisposes women to iron deficiency anemia.
1.3.6 Nutrition for Expectant Mothers:

Maternal health is a complex problem, affected by different heritable, social and economic factors, infections and ecological conditions, many of which may influence the foetal growth. Nutrition requirement of the expectant mothers increases because of the additional nutrients required for the growth and physical activity of the foetus and growth of placenta. (Mathu, 2006)³

1.4 MATERNAL MORTALITY IN INDIA

According to WHO, “maternal mortality is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes”. (www.cahr.info, 2008)⁴

There are numerous signs to point out that the ignorant of health needs of women especially that of the expectant women, teenager girls and girl-child are responsible for the present high infant mortality rate (IMR), child mortality rate (CMR), and maternal mortality rate (MMR). The MMR is the number of maternal deaths per 1,00,000 live births in one year. “Every minute of every day, somewhere in the world and most often in a developing country, a woman dies from complications related to pregnancy or childbirth. According to WHO, UNICEF, UNFPA and the World Bank, there were about 358,000 maternal deaths throughout the world during 2008”. (WHO, 2010)⁵ Of the total estimated maternal deaths, developing countries accounted for 99% maternal deaths and with 63,000 cases in the year 2008, India has the largest number of maternal deaths in the world. (WHO, 2007)⁶ Though the maternal mortality rate declined in India from 254 per lakh in 2004–2006 to 178 in 2010-12 it is still far from the United Nations-mandated Millennium Development Goal (MDG) of 103.
Figure 1.1. shows “the MMR in major Indian States namely Punjab, Haryana, Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Orissa, Assam, West Bengal, Maharashtra, Gujarat, Andhra Pradesh, Karnataka, Tamil Nadu, and Kerala. It is heartening that the MMR has declined most significantly in Empowered Action Group (EAG) States and Assam from 375 to 308. Among the Southern States, the decline has been from 149 to 127 and in other states from 174 to 149”. (SRS, 2011)

Figure 1.1: State Wise Maternal Mortality Ratio

Source: Sample Registration System June, 2011

1.5 **MATERNAL MORTALITY: CAUSES**

Any death resulting due to problems of pregnancy, delivery or the postpartum stage, including problems of abortion, is known as ‘direct obstetric death’. On the other hand, an ‘indirect obstetric death’ is a death resulting from some existing medical condition that has been aggravated by pregnancy or delivery. The leading reasons of maternal deaths according to the Registrar General of India are haemorrhage (37%), sepsis (11%), complications of abortion (8%), obstructed labour (5%), hypertensive disorders (5%), and other disorders (34%) as indicated in figure 1.2. (Registrar General of India, 2006)
Haemorrhage is the most common cause of maternal death. Haemorrhage often occurs without warning and may cause death before two hours of the start of bleeding. Women suffering from constant malnutrition are more susceptible to obstructed labour.

The specific involvements that can decrease the high risk of sickness and death due to complications before, during and after birth are antenatal care, trained attendance at birth, emergency obstetric care, postpartum care, contraception and family planning delivered across a continuum of care.

1.6 **FACTORS AFFECTING OF REPRODUCTIVE HEALTH**

Though medical science undoubtedly plays a central role in ensuring good health but good health also depends on a combination of several factors such as biological, genetic, environmental and socio-economic. It is even truer in the case of women because they naturally have to bear the greatest burden of problems related to reproduction. In their case social, economic and cultural influences play a vital role as far as health is concerned.

Economic conditions, employment and education, standard of living and family environment, gender relationships, and the authorized structure in which they live affects the reproductive
health of women. On these factors depend access of health care, nutrition and the number of pregnancies a woman undergoes in her reproductive years. Complex biological, cultural and psychosocial patterns govern the sexual and reproductive behaviour of people; biological factors alone cannot explain the disparities women suffer from. The social, economic and political disadvantages to which they are subjected have a detrimental impact on their reproductive health.

S. Thaddeus and D. Maine (1994) have referred to three factors as crucial in determining maternal morbidity and mortality. These are

(i) socioeconomic and cultural factors that determine women’s status in the family and society and their education;
(ii) accessibility to medical facility, i.e. distance, transportation, etc.; and
(iii) quality of care available including accessibility of human resources and equipment in health facility centres.

1.7 **CHILD HEALTH**

In the area of child survival and health also India faces a great challenge. India has the highest under-five child death ratio in the world. Of the 10.8 million deaths that occur every year in this category India’s share is a shocking 2.4 million. (www.Planningcommission.nic.in)\textsuperscript{10} Approximately 27 million infants that are born every year, 1.2 million die within complete the first four weeks of life and 1.5 million die within complete the first year. (www.unicef.org ,2009)\textsuperscript{11} The new born and child health burden in India is larger than in any other country which is 55 per 1000 live births for children under five, 42 per 1000 live births for infants, and 31 per 1000 live births for neo-natal deaths. The greatest
dangers to a child’s life are low weight at the time of birth and malnutrition.

Child health is a vital part, which cannot be ignored. India’s National Population Policy lays stress on the need to bring down IMR and reduce the risk to the life of the mother and child as far as possible. Throughout the world nearly two hundred million children under five years of age are denied the basic minimum health care. Evidently it is the poorest children who suffer the most. In our own country a staggering fifty-three percent of children (about 67,127,000) go without the primary health care, and a poor man’s child is almost three times more probable to die than a wealthy man’s. A poor child is more exposed to the dangers of unsafe drinking water, lack of sanitation, indoor pollution and poor housing conditions. (Westport, USA, 2008)\textsuperscript{12} In addition, they are more likely to be underweight and malnourished at the time of birth. According to WHO, any baby born with a weight of less than 2500 grams is underweight. In our country, 8.3 million children are born every year with a birth weight of less than 2500 grams. Considering the fact that throughout the developing world 19 million infants are born with a birth weight of less than 2500, India’s position is rather untenable. (www.savethechildren.in, 2009)\textsuperscript{13}

Factors contributing to malnutrition among infants include low adoption of exclusive breastfeeding due to cultural inhibitions, poor understanding of complementary feeding, lack of awareness about nutritional needs, inadequate purchasing power leading to insufficient access to food, unfair and unequal distribution of available food, and improper and poor food habits. Lack of employment, inadequate health care services, lack of potable water, poor hygiene, and all-round poverty, are other key, indirect causes of malnutrition among babies.
According to a study in Westport, Massachusetts, USA, parents who are poor often display lack of awareness about healthy exercises and availability of life-saving services. The study also concluded that staffing pattern in poor, hilly areas is improper, supervision inadequate and supplies difficult to reach in such remote areas. According to the NFHS, Indian children are among the most malnourished in the world. Considering the desirability of decrease in child mortality, the United Nations has integrated it in its Millennium Development Goals (MDGs). Its major aim is to reduce child death by at least two-thirds during 1990–2015. However, its current information indicates that the death rate of under-five children remains insufficiently high and about 29,000 children under the age of five die every day; in other words about 21 children die every minute. (Panday, 2009)

1.8 **INDICATORS OF CHILD DEATH IN INDIA**

Child mortality is generally considered using three indicators: NMR, IMR, and U5MR.

<table>
<thead>
<tr>
<th>Table 1.1: Child Mortality Indicators</th>
</tr>
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<tbody>
<tr>
<td><strong>Neo-Natal Mortality</strong></td>
</tr>
<tr>
<td><strong>Infant mortality</strong></td>
</tr>
<tr>
<td><strong>Under five mortality (U5)</strong></td>
</tr>
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**Neo-Natal Mortality Rate** has declined by 6 point from 37 per thousand in 2006 to 31 per 1000 live births in 2011. **IMR** in India has registered on 13-point decline from 57 per thousand in 2006 to 44 per thousand live births in 2010. IMR in 2012 came down to 42 per thousand live births. Still, one out of every twenty children dies within one year of birth (against 1 in 37 under MDG). Every sixth death in the country pertains to an infant.

**Under Five Mortality Rate (U5MR)** in India has gone down in the last ten years from 74 per thousand during the period (NFHS III-2005–06) to 69 every thousand in 2008. As per the SRS 2011, the under five-death rate is 55 per thousand live births as shown in table 1.2.
Table 1.2: Child Death Statistics

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009(^{16})</th>
<th>2010(^{17})</th>
<th>2011(^{18})</th>
<th>2012(^{19})</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMR</td>
<td>37</td>
<td>36</td>
<td>35</td>
<td>34</td>
<td>33</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>IMR</td>
<td>57</td>
<td>55</td>
<td>53</td>
<td>50</td>
<td>47</td>
<td>44</td>
<td>42</td>
</tr>
<tr>
<td>U5MR</td>
<td>N.A</td>
<td>N.A</td>
<td>69</td>
<td>64</td>
<td>59</td>
<td>55</td>
<td></td>
</tr>
</tbody>
</table>

Lists of the major states in India, which have extremely high NMR, IMR, and U5MR is given in table 1.3.

Table 1.3: States with NMR, IMR, U5MR

<table>
<thead>
<tr>
<th>Name of State</th>
<th>NMR (2011)(^{18})</th>
<th>IMR (2012)(^{19})</th>
<th>U5MR (2011)(^{18})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Madhya Pradesh</td>
<td>41</td>
<td>56</td>
<td>77</td>
</tr>
<tr>
<td>Odisha</td>
<td>40</td>
<td>53</td>
<td>72</td>
</tr>
<tr>
<td>Uttar Pradesh</td>
<td>40</td>
<td>53</td>
<td>73</td>
</tr>
<tr>
<td>Assam</td>
<td>30</td>
<td>55</td>
<td>78</td>
</tr>
<tr>
<td>Meghalaya</td>
<td>-</td>
<td>49</td>
<td>-</td>
</tr>
<tr>
<td>Rajasthan</td>
<td>37</td>
<td>49</td>
<td>64</td>
</tr>
<tr>
<td>Chhattisgarh</td>
<td>34</td>
<td>47</td>
<td>57</td>
</tr>
<tr>
<td>Bihar</td>
<td>29</td>
<td>43</td>
<td>59</td>
</tr>
<tr>
<td>Haryana</td>
<td>28</td>
<td>42</td>
<td>51</td>
</tr>
<tr>
<td>Andhra Pradesh</td>
<td>28</td>
<td>41</td>
<td>45</td>
</tr>
<tr>
<td>Gujarat</td>
<td>30</td>
<td>38</td>
<td>52</td>
</tr>
<tr>
<td>Jammu &amp; Kashmir</td>
<td>32</td>
<td>39</td>
<td>45</td>
</tr>
<tr>
<td>Jharkhand</td>
<td>29</td>
<td>38</td>
<td>54</td>
</tr>
<tr>
<td>Himachal Pradesh</td>
<td>28</td>
<td>36</td>
<td>46</td>
</tr>
<tr>
<td>Mizoram</td>
<td>-</td>
<td>35</td>
<td>-</td>
</tr>
<tr>
<td>Arunachal Pradesh</td>
<td>-</td>
<td>33</td>
<td>-</td>
</tr>
<tr>
<td>D &amp; N Haveli</td>
<td>-</td>
<td>33</td>
<td>-</td>
</tr>
<tr>
<td>Karnataka</td>
<td>24</td>
<td>32</td>
<td>40</td>
</tr>
<tr>
<td>West Bengal</td>
<td>22</td>
<td>32</td>
<td>38</td>
</tr>
<tr>
<td>Punjab</td>
<td>24</td>
<td>28</td>
<td>38</td>
</tr>
<tr>
<td>Tripura</td>
<td>-</td>
<td>28</td>
<td>-</td>
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</tbody>
</table>

1.9 **CAUSES OF CHILD MORTALITY**

About 55% of the deaths in children before five years of age occur in the neonatal period. Graph 1.3 shows that “infections 19% (including sepsis (7%), pneumonia (9%), diarrhoea (2%), and tetanus (1%), prematurity (13%), and birth asphyxia (10%), congenital abnormalities (2%) and other (11%)) are the causes of death in this period”. The remaining 45% of the deaths in this age group are because of pneumonia (11%), diarrhoea (11%), pertussis or whooping cough (5%), measles (4%), other non-communicable
diseases (4%), injuries (3%), malaria and HIV AIDS (1%) and other infections (6%).

**Graph 1.3:**
*Causes of Mortality Under 5 Years of Children in India (2008)*

1.10 **VARIOUS FACTORS AFFECTING CHILD HEALTH**

The health of children in any community is affected by various environmental factors. The chief factors that impact adversely child-health in India are:

a) Factors related to Motherhood or Maternal Factors: These include young maternal age, mother suffering from malnutrition and sickness, frequent pregnancies with short spacing between births, etc.

b) Socio-economic Factors: In this we may include female illiteracy, poor economic condition, urbanization, illegitimate pregnancies, large family size, gender discrimination, etc.

c) Factors relating to Culture: This includes early marriage, poor feeding practices, e.g. top feeding, childcare customs that are dangerous and harmful for the infant, taboos, etc.

d) Factors relating to Environment: Overpopulation, unclean water, improper disposal of excreta, lack of personal hygiene, broken
families leading to stressful domestic environment often resulting in child bashing, etc. are extremely hazardous for the infant and are life threatening.

e) Factors Relating to Healthcare include improper care in the antenatal period, delivery by untrained personnel, inadequate immunization, and poor access to health care services, especially in the villages. (www.childpack.com)²¹

1.11 NEED OF THE STUDY

Uttar Pradesh has an unimpressive record as far as mother and child health is concerned as compared to the rest of India. The common parameters of reproductive health, like maternal mortality ratio, maternal morbidity, unmet need for family planning, abortion, HIV prevalence, low birth weight babies, and the nutritional status of the mother and children warrant a discussion in the present context. Uttar Pradesh has been ranked 16th on the basis of various socio-economic parameters. (PHD Research Bureau, 2011)²² The IMR was 53 in U.P whereas it was 42 at the India level, U5MR was 73 in U.P as compared to 55 in India, MMR was 359 for U.P and 212 for India, and the TFR in U.P was 3.4 while it was 2.4 for India as a whole.

Most of the health problems experienced by women in the reproductive age group are mainly due to their nutritional status and to some extent they are because of physiological reasons. Nutritional status of women is influenced by their socio-economic backgrounds, while certain demographic factors influence the physiological problems. Therefore a set, of such variables has been considered and problems during pregnancy have been analyzed against these variables for a better understanding. The present study entitled ‘Reproductive and Child Health Care: A Sociological Study’ (With Special Reference to Etawah District of U.P.) has been undertaken against this backdrop.
1.12 **OBJECTIVES OF THE PRESENT STUDY**

The primary objective of this research project is to examine the gaps in various socio-economic groups regarding the basic reproductive and child health indicators in India together with Etawah which is one of the backward districts of U.P. To make the present study systematic and scientific, the researcher has set the following objectives:

- To understand the concept of reproductive and child health (RCH).
- To study the RCH status in Etawah district.
- To study the effectiveness of major RCH health programmes and policies in Etawah district.
- To study the differential in access and utilization among women of different socio-economic status.
- To study the effects of demographic and socio-economic characteristics on RCH at the district level.
- To suggest an action plan for improving the RCH care.

1.13 **RESEARCH METHODOLOGY**

Research methodology is a method to systematically explain a research problem. Research problem in general, refers to some difficulty which a researcher experiences in the perspective of either a theoretical or practical solution or wants to obtain a solution for the same. Research methodology may be defined as a method of learning how research is completed scientifically. In it we study the variety of steps that are commonly taken by a researcher in studying a research difficulty along with the logic behind it.

Research methodology may be defined as the procedure used to gather information and data for the purpose of doing research
scientifically. The methodology may include publication research, interviews, surveys and other research techniques and could include both present and historical information.

a) THE RESEARCH AREA

District Etawah lies between the parallels of 26°21'-27°01' North latitude, and 78°45'-79°45' East longitude. The area of the district is about 2,311 sq. km. It is situated in the south-west of the Kanpur Division. It is surrounded on the north by the districts of Mainpuri and Farrukhabad, on the east by Auraiya and on the south partly by Jalaun and partly by district Bhind of the State of Madhya Pradesh, which also forms its western boundary to a certain distance, while the small area of western border connect Tehsil Bah of the Agra district. The district comprises 5 tehsils, 8 blocks, 75 nyaya panchayats, 3 Nagar Paika, 3 Nagar Panchayat, 420 gram sabhas, 686 inhabited villages, and 3 town areas. (www.dcmsme.gov.in) The total population of Etawah district is 15,81,810 out of which 3,66,299 people live in urban and 12,15,511 in rural areas. With regards to Sex Ratio in Etawah, it stood at 870 per 1000 male and child sex ratio is 875 girls per 1000 boys. (www.census2011.co.in)

The research has been conducted in the Etawah district of U.P. The reason behind the selection of this district is that it has been on the fast track of development after the rule of Mulayam Government. Huge changes have been taken place in the area of health care such as the establishment of a medical college and para-medical college. Nine Integrated Counselling and Testing Centre (ICTC), an Anti Retroviral Therapy (ART) Centre has also been established in the district. 108 Emergency Medical Transportation Service (EMTS) and 102 Ambulance service have been provided by U.P. government recently. All the 4 Primary
Health Centres (PHC) have been upgraded to Community Health Centres (CHC). A large number of Accredited Social Health Activists (ASHA) have been appointed and trained for the purpose. Twenty-seven New PHCs have been established in the district. National Rural Health Mission (NRHM) is now under the control of the District Program Manager (DPM). Formerly it was headed By Chief Medical Officer (CMO).

b) RESEARCH DESIGN

The following research design and methodology has been used in the present research work:

This research work is basically descriptive and comparative in nature and based on primary and secondary data. The aim of this research is to understand the reproductive health care of 15–49 years age group of women in the district of Etawah, U.P. The socio-economic and culture factors which influence the health care practices of women have been to be taken into consideration. All the primary information has been collected from the respondents by self-need based interview schedule. The secondary data has been collected from reliable secondary sources such as annual reports, websites, books and journals.

c) INTERVIEW SCHEDULE

Self-need based interview schedule is designed to collect information from 15–49 years age group of women who are the generally inhabitants of the sample household. The women interview schedule covered the following segment:

Section I: Background Characteristics

In this section, the information collected on religion, caste, educational and occupational status, type of family, present and
age at the time of marriage, and present status of the living children.

**Section II: Housing Characteristics**

In this section, the information collected about the facility of electricity, supply of drinking water, toilet facility, and availability of cooking fuel, type of house, durable goods in use, and the standard of living as measured through the annual income of the family.

**Section III: Availability of Health Facilities and Services**

In this section, the questions were targeted to measure the health services availed by various health facilities. The information was also collected about the distance of health facility from home, type of transportation for the respondent to go to the health centre, and facilities of antenatal checkups and ASHA.

**Section IV: Antenatal Care**

In this section, through interview schedule, I have collected information only from women having children below six years of age. I concerning information women receiving antenatal check-ups (ANCs), place of ANC, health personnel who provide ANC, number and time of ANCs have been collected. Data regarding women receiving TT and IFA, complications arising through pregnancy, and reasons for not seeking any antenatal checkups were also collected.

**Section V: Delivery care**

In this section, information about place of delivery, who attended the delivery, type of delivery, the nature of complications during and after delivery have been collected.
**Section VI: Use of Contraceptive**

This section gives information on the awareness and exercise of specific family planning methods. Questions were included about the source of contraceptive method, reasons for non-use of contraceptive, and health problems arising due to the use of a certain contraceptive method.

**Section VII: Awareness about RTI/STI and HIV/AIDS**

In this section, the information was gathered about women’s knowledge of RTI or STI and the source of their knowledge; and their awareness about HIV or AIDS. I also canvassed awareness of the mode of transmission of such infections.

**Section VIII: Immunization and Childcare**

This section provides information about breastfeeding practices, time of breastfeeding, vaccination coverage, sources of vaccination, and reasons for lack of immunization of children.

d) **VARIABLES OF THE RESEARCH**

Following variables were identified in this research for analyzing the effectiveness of the reproductive and child health care.

(i) **Independent Variable:**

Independent variable included various socioeconomic variables like *place of residence of the woman, her age, caste, educational level, religion and the standard of living* of the household.

(ii) **Dependent Variable:**

We have used five broad critical health care variables namely, *antenatal care, institutional delivery (medical assistance at deliveries), breastfeeding and immunization for children, contraceptive use, and knowledge of RTI/ STI and HIV/ AIDS*, as dependent variables.
e) **STATISTICAL ANALYSIS**

In order to analyse the collection of data, percentage method has been used in order to study the different views of various respondents.

f) **SAMPLE SIZE AND SAMPLE SELECTION**

The study was conducted in cities as well as villages. Multistage random sampling design was used in the study. In rural areas, one CHC from each region in the district, namely east, west, north, and south, was selected. Thus, Bharthana from east, Jaswant Nagar from west, Saifai from north and Udi from south were selected. Two villages from each CHC were selected randomly for the study. However, from urban areas, two towns situated far away and two towns near the district hospital were selected. Finally, a sample of 10% of the eligible women from the total population of reproductive women was chosen. A total number of 260 respondents (140 urban and 120 rural women) from households having children below 6 years of age were randomly selected. Households sample have been selected from Pulse Polio report.

| The Sampling Process for Primary Data Consists of Four Stages |
|-----------------|---------------------------------------------------------------|
| Selection of Town | 4 Towns—two far from and two near the district hospital       |
| Selection of CHCs | 4 out of 8 purposely selected (considering the regions from the headquarters, i.e. East, West, North, and South) |
| Selection of Villages | 2 villages from the selected CHCs—randomly picked              |
| Selection of Women | 10% women from those households with children under 6 years of age—randomly selected |
Table 1.4: The Matrix of Sampling Selection

<table>
<thead>
<tr>
<th>Urban Areas</th>
<th>Total Population of Reproductive Women</th>
<th>Sample Size 10% of Women Randomly Selected</th>
<th>Rural Areas Selected</th>
<th>Total Population of Reproductive Women</th>
<th>Sample Size 10% of Women Randomly Selected</th>
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Source: Pulse Polio Report, Department of WHO, Etawah

1.14 LIMITATIONS OF THE STUDY

* Merely those women who have children less than 6 years of age were involved in the study.

* The current study is limited only to 260 respondents in Etawah district. The results drawn, therefore, may not be appropriate at the macro level.

* Data regarding the socioeconomic profile of the respondents is for a period of three months (September to November 2012).

* The facts and figures given by the respondents may not be correct as most of the figures are based on memory.

* This study was limited within a selected area of Etawah district and it is particularly based on 10% of sample respondents from urban and rural areas. Therefore, the findings and suggestions are applicable only to the area of study.
1.15 **STRUCTURE OF THE THESIS**

**Chapter I: Introduction**

This thesis starts with introduction and elaborates the meaning of reproductive health and child health, its components, its causes, and the factors that can affect it; the purpose and aim of the study; the research methodology [research area, research design, sample size, statistical analysis, etc.] and finally the limitations of the study.

**Chapter II: Review of Literature**

The conclusion of various studies has been given in this chapter. The chapter has been divided mainly into four heads namely reproductive and child health status, factors affecting mother and child health, mortality causes of mother and child, and reproductive and child health care services.

**Chapter III: Programmes and Policies on Reproductive and Child Health: A Critical Analysis**

This chapter throws light upon the various programmes and policies like family welfare, reproductive and child health programmes, national population policy, NRHM run by the government are mentioned according to their objectives, their scope, problems and prospects.

**Chapter IV: Organizational Framework of Reproductive and Child Health Care System**

In this chapter, we have discussed the health care sector which is divided into three sectors comprising the public health sector, private health sector and private non-profit sector. The health care services in the country extend from the national to the village level. The chapter also deals with the health personnel situation in India and especially in Uttar Pradesh.

**Chapter V: Reproductive and Child Health Status in India – A District Level Analysis**
The chapter deals with the demographic profile and health status indicators in India and its States. The health seeking behavior of the women of Uttar Pradesh and its districts has been described with the help of graphs and tables.

Chapter VI: Socio-Economic and Demographic Factors Influencing Reproductive and Child Health - A District Level Analysis

This chapter presents analysis based upon independent variable include various socio-economic variables such as place of residence, age, religion, caste, education, standard of living, etc. We also use five broad critical health care variables like antenatal care, delivery care, contraceptive use, awareness of RTI/STI and HIV/AIDS, and breastfeeding and immunization, as dependent variable.

Chapter VII: Conclusion and Suggestions

In this chapter, we discuss the result and conclusion of the present study. Further scope of extension and replication of the research in some other areas and the limitations and future research extensions of the study are discussed.