CHAPTER-V

SUMMARY AND CONCLUSION
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5.1. INTRODUCTION

'Reproductive health' is defined as: "A state of complete physical, mental and social well-being and...not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore 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 are the right of men and women to be informed [about] and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of birth control 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." (ICPD-1995)

Within the framework the WHO's definition of health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health, or sexual health/hygiene, addresses the reproductive processes, functions and system at all stages of life. Reproductive health problems remain the leading cause of ill health and death for women of childbearing age worldwide. Everyone has the right to enjoy reproductive health, which is a basis for having healthy children, intimate relationships and happy families. Reproductive health encompasses that every child is wanted; every birth is safe, every young person is free of HIV and every woman is treated with dignity and respect. The most important period in the life span of women is the reproductive period, which extends from menarche to menopause; the intervening periods are marriage, pregnancy, childbirth and contraception. However, these conditions are determined by socioeconomic and cultural factors and available health care facilities. A broader approach to reproductive health means that women have the ability to reproduce and to regulate their fertility, that is, they are able to go through pregnancy and child
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health safely, that the outcome of pregnancy is successful in terms of maternal and infant survival and wellbeing.

Reproductive health is a universal concern, but is of special importance for women particularly during the reproductive years. Although most reproductive health problems arise during the reproductive years, in old age general health continues to reflect earlier reproductive life events. The last decade has witnessed momentous and multi-dimensional changes in the sexual and reproductive health situation in India. The policy and programme environment has undergone a significant shift from a narrow target-oriented family planning approach to a broader orientation that stresses sexual and reproductive health and the exercise of reproductive rights more comprehensively. Over the same period, there have also been major changes in the context of sexual and reproductive health. Health services in India are available through the public sector, the private sector and the not-for-profit voluntary sector. The government is the primary source of preventive services such as immunisation and family planning while the private sector is largely involved in the delivery of curative care. As is known, the small family norm is widely accepted (the mean ideal family size reported by young people currently is 2.5 children) and general awareness of contraception is universal (99 per cent of currently married women in the reproductive age group were aware of a contraceptive method). However, awareness of reversible (modern or natural) methods is relatively limited among women. Other trends are extremely disturbing, such as stagnating levels of maternal mortality, the spread of sexually transmitted infections (STIs) notably HIV, the persistence of wide gender imbalances and limited exercise of reproductive rights by large segments of the population, particularly women. There are many religions in India. Different religious people are following their own ways of practices, taboos and norms.

As such the present study entitled “Reproductive health concerns of young adult women belong to Hindu and Muslim community” is a modest attempt in this direction.
5.2. OBJECTIVES OF THE STUDY

The main objectives of the study were:

- To find out the demographic and socio-economic characteristics of the households between Hindu and Muslim women.
- To examine the Reproductive Health Profile of women belonging to Hindu and Muslim.
- To explore the information on fertility levels, differentials and trends of women belonging to Hindu and Muslim.
- To examine the use of safe motherhood services provided by the public and privates of women belonging to Hindu and Muslim.
- To assess the fertility impact of contraception in Hindu and Muslim women.
- To know the utilization of Health Care services of women belonging to Hindu and Muslim.
- To assess the knowledge on HIV / AIDS of women belonging to Hindu and Muslim.

5.3. HYPOTHESES

A hypothesis is an assumption about the possible outcome of the study. Based on the aforesaid objectives, the following hypotheses were formulated:

- There is no variation in demographic and socio-economic characteristics of the Hindu and Muslim women.
- There is no significant variation in the reproductive health profiles of Hindu and Muslim women.
- There is no significant difference in fertility levels and trends between Hindu and Muslim women.
There is no significant difference in fertility impact of contraception between Hindu and Muslim women.

There is no significant variation in utilization of safe motherhood services by the public and private sectors by Hindu and Muslim women.

There is no significant difference in the utilization of health care services between Hindu and Muslim women.

There is no significant difference in knowledge of HIV/AIDS between Hindu and Muslim women.

5.4. RESEARCH DESIGN

Ex-post-facto research design was utilised to study the determinants of Reproductive health: Concerns of Young Adult Women.

5.5. LOCALE OF THE STUDY

The study was carried out in Rayalaseema region of Andhra Pradesh in order to make the findings applicable for a Rayalaseema region. Since, it is difficult to cover the entire state due to paucity of time and funds, one mandal from each districts viz., Chandragiri mandal from Chittoor and Rajampeta mandal from Kadapa district were selected at random for the study.

5.6. SELECTION OF THE RESPONDENTS

For the present Study, young adult women in the age group of 15 to 35 years belonging to Hindu and Muslim religions, with at least one live birth was considered as sample of the study for an analysis of maternal health practices viz., ante-natal care, delivery and post partum care, pregnancy wastage, utilization of health care services, and knowledge of contraceptive methods and acceptance of modern spacing methods. All the villages in each of the selected mandals were listed based on the information collected from the mandal office. Out of these, four villages from Chandragiri mandal viz., Kongravaripalli, Kotala, Ithepalli and Chandragiri and four villages namely Ram Nagar, Usman Nagar, Mannuru, and Boinapalli from Rajampeta mandal were selected randomly from the list provided by Mandal Officer.
for the present study. From each mandal a sample of 200 young adult women belonging to Hindu (100) and Muslim (100) communities were selected randomly. 200 young women each adhering to the sampled criterion were selected in the districts of Kadapa and Chittoor, using Stratified Random Sampling Technique, totaling a sample of 400.

5.7. TOOLS FOR COLLECTION OF DATA

The questionnaire Standardized by International Institute for Population Sciences, Mumbai for NFHS-II (National Family Health Survey – II), was adopted for collection of data for the present research study.

5.8. STATISTICAL TESTS AND PROCEDURES FOLLOWED

The schedules were numerically coded in order to suit the computer analysis. Suitable statistical techniques viz., frequencies, percentages, means and chi-square were employed to know whether independent variables could influence significantly the reproductive health concerns of young adult women.

5.9. MAJOR FINDINGS OF THE STUDY

5.9.1 Socio-economic and demographic profile

- **Age**- Majority of Hindu respondent (38.5%) were in the age group of 25-29 years whereas Muslim respondents were more in the age group of 20-24 years of (42.5%). District-wise comparison showed that, there were little difference among different age levels of respondents in the two religious groups in the districts of Kadapa and Chittoor.

- **Ages at marriage**- Majority of the respondents were married between 18 to 20 years among Hindus (50.5%) and as also from Muslims (48.5%). Among Hindus, a comparatively higher proportion of respondents from Kadapa (55) district were married in the age group of 18 to 20 years than from Chittoor (46). Similar pattern was observed among Muslims in the two districts i.e. 51 from Kadapa and 46 from Chittoor.
Size of the family - A higher proportion of respondents in both the religions had 1 to 4 family members i.e. 80.5% in Hindus and 72.0% in Muslims.

Cohabiting with spouse- A large proportion (94.5%, 92.5%) of the respondents from Hindus and Muslims were cohabiting with their spouse. District wise comparison shows that higher number of respondent’s from Chittoor (97 from Hindus and 95 from Muslims) than Kadapa (92 from Hindu and 90 from Muslims) respondents were cohabiting with their spouse.

Type of family-Comparatively higher percentage of Hindus (83.5%) than Muslims (74.5%) belonged to nuclear families. A higher number of respondents from Chittoor (86 in Hindus and 78 from Muslims) than from Kadapa (81 from Hindus and 78 from Muslims) belonged to nuclear families.

Educational status - Nearly two fifth of the respondents spouses in Hindus had completed their high school level of education. More than one third of respondent’s spouses in Muslims were educated up to primary level. District-wise comparison among Hindus shows that, slightly higher number of respondent’s spouses in Kadapa district (40) had completed their high school level of education than in Chittoor district (36). Among the Muslims a little variation was observed in education status of the respondent’s spouses in both districts i.e. Kadapa (30) and Chittoor (31).

Occupational Status- Nearly double the percentage of respondents in Muslims (86.5%) were homemakers than Hindu (46.0%). A higher proportion of Hindus were engaged in gainful employment as against Muslims. District-wise information revealed that a little more number of respondents from Kadapa district (15) were homemakers than from Chittoor district (10). Among Muslims, slightly higher numbers of respondents from Kadapa district (88) were homemakers than from Chittoor district (85). Remaining number of respondents were engaged in gainful employment, Higher number from Chittoor district were engaged in gainful employment than from Kadapa district.
Spouse's occupational status - Fifty percent of respondent's spouses from Muslims had own business, but only 35.5% from Hindus depended on it. Among Hindus, the occupation of slightly higher number of respondent's spouses in Chittoor district (37) than in Kadapa district (34) was business. In case of Muslims, nearly an equal number of respondent's spouses were engaged in own business in both the districts i.e. 51 from Kadapa and 49 from Chittoor.

Housing characteristics - Irrespective of religion the entire respondent's houses had electricity supply. Slightly higher proportion of respondents from Hindus (82.5%) used tap water for drinking purpose when compared to Muslims (79.5%). Regarding purification of drinking water, comparatively higher proportion of Muslims (49.5%) than Hindus (42.5%) did not use purified water. More than two fifth of respondents were using flush toilets in their houses in both the religions. Comparatively higher percentage of Muslims (68.5%) used LPG as fuel for cooking than from Hindus (51.5%). Slightly higher proportionate of respondents from Hindus (48.5%) than Muslims (43.5%) were living in pucca houses.

District-wise comparison of Hindus revealed, there was no variation observed in case of electricity usage, source of drinking water, purification of water and sanitation facilities etc. Almost an equal number of households were using LPG as fuel for cooking from Kadapa (51) and from Chittoor (52). Regarding type housing, a higher number of respondents from Chittoor district (52) than from Kadapa district (45) had pucca houses.

Housing characteristics among Muslims showed that cent percent of households had electricity in both districts. Majority of respondents were getting drinking water from taps (78 from Kadapa and 81 from Chittoor). Comparatively higher number of respondents from Kadapa (52) than from Chittoor (46) did not use any method for purification of drinking water. Majority of respondents used LPG as fuel for cooking (65 from Kadapa and 72 from Chittoor). Slightly more number from Kadapa (43) than from Chittoor (39) had pucca houses.
Ownership of durable goods - A large proportion of Hindus and Muslim households had mattress (99% and 97%), clock, watch (93.0% and 91.5%), electric fan (85.5% and 90.0%) and chairs (81.5% and 85.0%) pressure cooker. More than fifty percentages of Hindus (52.0%) and Muslims (50.5%) had telephones.

District-wise comparison of Hindus showed that, cent percent in both districts of had mattress. Small variation was observed in possession of durable goods like pressure cooker, cot/bed, table, and other goods between districts (Kadapa and Chittoor).

In case of respondents from Muslims, a large number of respondents possessed the following durable goods viz., mattresses (99 and 96), cot/bed (89 and 81) in Kadapa and Chittoor districts respectively.

Land and livestock - Comparatively higher percentage of respondents from Muslims (57.0%) than from Hindus (35.5%) did not own any agricultural land. A higher number of Hindus possessed livestock (like cow’s 36.0% and buffaloes 16.5%) than Muslims. District-wise comparison in Hindus showed that, 29 number of respondents from Kadapa and 33 from Chittoor households owned less than one acre of irrigated land. The proportion of livestock i.e. cows owned households from Chittoor (42) were more than from Kadapa (31). Among Muslims, higher number of households from Chittoor district (68) relative than to Kadapa didn’t own any agricultural land. In case of livestock, 13 and 16 in Kadapa and Chittoor respectively had cows in their households.

Life style indicator - Majority of Muslim women (10.0%) than Hindu’s women (6.5%) had the habit of chewing paan masala. Among Hindus slightly higher number of respondents from Kadapa (8) than from Chittoor (5) had the habit of chewing paan masala. Among Muslims slightly more number in Kadapa than in Chittoor respondents had the habit of chewing paan masala. None of the women reported the habit of drinking alcohol.
Exposure to mass media - Majority of respondents were exposed television regularly in both the religion i.e. 81.5% from Hindus and 82.5% from Muslims. Among the Hindus, television was the most important mass media, but it was higher in Chittoor (85) than in Kadapa district (73). In case of Muslims slightly higher number from Chittoor (84) than from Kadapa (81) watched television regularly.

5.9.2 Contraception

Knowledge of family planning methods- All the respondents from both religions were aware of female sterilization. Percentage of knowledge on spacing methods was lower than knowledge of permanent methods in both religions among Hindus, there were only minimal differences observed in the knowledge of female sterilization in both the districts (Kadapa and Chittoor). In case of Muslims, comparatively more number of respondents from Chittoor than from Kadapa did not have knowledge of the modern methods of contraception like pill.

Current use of contraceptive methods – More percentage of respondents from Hindus (73.5%) were adopting contraception relative to Muslims (67.5%). District-wise comparison among Hindus revealed that a minimal difference was observed in the usage of modern as well as traditional methods of contraception in Kadapa and Chittoor districts. In case of Muslims, usage of female sterilization was higher than other contraceptive method in both the districts.

Source of discussion about family planning - More than one fifth (23.00% from Hindus and 21.00% from Muslims) in both religion’s discussed with their spouses. District-wise comparison of Hindus showed, little variation observed in both the districts in discussion of family planning methods. Similar to Hindus, among Muslims also little difference was seen in both districts in discussion of family planning methods.

Source of information about family planning messages- Major source was television (27.0% from Hindus and 26.0% from Muslims) and Radio (21.0%
from Hindus and 26.0% from Muslims). In case of Hindus nearly one third (29) from Chittoor and one quarter (25) from Kadapa respondents were seen family planning messages on television. Among the Muslims, one quarter number of respondents from Kadapa (25) and more than one quarter from Chittoor (27) said that they had obtained family planning messages from television.

- Usage of spacing methods before sterilization - Comparatively higher percentage of Muslims (57.14%) than Hindus (48.20%) never used any spacing methods before sterilization. Among Hindus, slightly more number of women from Chittoor (22) than from Kadapa (18) had never used any spacing methods before sterilization.

- Acceptance of permanent contraceptive methods- Comparatively higher percent of respondents from Hindus (70.5%) than from Muslims (58.0%) was accepted permanent contraceptive methods. District-wise comparison of Hindus showed 73 from Kadapa and 68 from Chittoor has accepted permanent methods of contraception. Among Muslims, nearly two third from each district were accepted permanent methods of contraception i.e 58 in each district.

- Reasons for not currently using contraceptive methods - Majority of respondents from Hindus (28.34%) were worried about side effects and more than one third (35.40%) of Muslims wanted more children. Among Hindus, 7 members from Kadapa and 8 from Chittoor were worried about side effects for usage of contraception. In case of Muslims also, 7 members from Kadapa and 6 from Chittoor were worried about side effects for usage of contraception.

5.9.3 Safe Motherhood

- Problems during pregnancy - A large proportion of respondents in both religions reported experience of various problems. More than half of the respondents in both religion cited anemia as one of the major problem experienced during pregnancy. This was followed by excessive fatigue and edema (swelling of legs/body/face). These problems were reported by Hindus and Muslims in Kadapa and Chittoor districts.
- **Ante natal checkup** - Majority of respondents among Hindus and Muslims reported Government doctor/Private doctor as health professional whom they have consulted for ante natal care. A higher proportion of Hindus (95.5%) as well as Muslims (94.5%) women receiving the ante-natal care.

- **Reasons for not taking ante natal care** - A major proportion of Hindu's stated that it was due to lack of knowledge and awareness. Relative to this a quarter of the Muslims stated that it was not customary to received ante natal care while another quarter stated that their family did not allow them to go for ante natal care. Among Hindus a high number of respondents from Kadapa have undergone tests like weight (90%) and Height (45%) measurement, Blood (48%) and Urine test (67%) than their counterparts in Chittoor district (85%, 36%, 43 and 61% respectively). District-wise comparison showed that, a higher number of Muslim respondents from Chittoor than Kadapa had received the following components of ante-natal check-ups done i.e., weight (93 and 61), height (44 and 41), urine test (67 and 61) and abdomen examinations (77 and 73) respectively.

- **Iron and Folic acid tablets** - Large proportion (96.5% in Hindus and 94% in Muslims) had received iron and Folic acid tablets. There is considerable gap between receiving and consumption of tablets. The trend prevails in both the districts, more so among the Muslim women.

- **Tetanus toxoid injection** - Majority of respondents had two tetanus toxoid injections in both religions. Higher proportion of Muslims (72.5%) than Hindus (70.5%) had two TT injections. District-wise comparison among Hindus revealed that 72 in Kadapa and 69 in Chittoor had received two doses of TT injections. Among Muslims, nearly three quarter (74%) of respondents in Kadapa and 71% in Chittoor had two doses of TT injections.

- **Health assistance of delivery** - More than fifty percent (56.5% in Hindus and 53% in Muslims) of women seek assistance from private doctors for their deliveries. Among Hindus higher proportion of women in Kadapa (61) than Chittoor (52) had undergone deliveries under the supervision of a private doctor. In Muslims, more than half of women had sought the assistance of private doctor for their deliveries in both the districts.
Place of birth- more than fifty (56.5% in Hindus and 53.5% in Muslims) percent of respondent’s deliveries took place in Private Institutions. 33% Hindu and 37% Muslims Women had deliveries in public medical facilities. In Hindus, higher proportion of women in Kadapa (61) had consulted private medical Institutions for deliveries than in Chittoor (52). Among Muslims, more than half of women had attended private medical institutions for their deliveries in both districts (Kadapa 55 and Chittoor 51).

Birth weight of babies- 56% in Hindus and 66% in Muslims babies were born with more than 2.5 Kg. of birth weight.

Type of delivery - Majority of respondents had normal delivery (58.5% of women in Hindus and 60% of women in Muslims). Among Hindus, majority (62%) of women had normal deliveries in Chittoor than in Kadapa (55%). In case of Muslims, more than half of women had attended private medical institutions for their deliveries in both districts (Kadapa 55 and Chittoor 51).

Birth weight of babies- 56% in Hindus and 66% in Muslims babies were born with more than 2.5 Kg. of birth weight.

Postpartum checkups - 32% in Hindus and 29% in Muslims have not received any postpartum checkups after delivery. Majority of women received postpartum checkups 2 weeks after delivery in both religions (62.23% in Hindus and 68.30% in Muslims). A higher proportion of women in Muslims (28.17%) had received postpartum checkups within days than in Hindus (21.48%). In Hindus a higher proportion of women in Kadapa (49) than in Chittoor (35) had received postpartum checkups 2 weeks after their delivery. In case of Muslims, nearly an equal number of women received postpartum care within 2 weeks in Kadapa (50) and in Chittoor (47).

Safe motherhood indicators - Regarding safe motherhood indicators revealed that more than 50 per cent of respondents received all recommended types of ante-natal care. Very small proportion of respondents received postpartum check-ups after delivery in both the religions. District-wise comparison indicated that among Hindus nearly an equal number of respondent received all recommended types of ante-natal care. In case of Muslims, the slightly higher percentage of respondents in Chittoor than in Kadapa received all recommended types of ante-natal care.

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5.9.4 Reproductive Health Profile

- **Age at menarche** - The mean age of menarche for majority of respondents was 12.4 years in both the religions in the two districts.

- **Perception of menstruation** - More than fifty percent of respondents in Hindus (57.5%) and as well as in Muslims (55.0%) also expressed that menstrual process was natural. District-wise comparison revealed that, there were similar views expressed regarding perception of menstruation in both the districts of respondents in Hindus. A higher number in Chittoor (59) than in Kadapa (51) perceived that menstruation was a natural process by Muslims.

- **Restrictions after menarche** - Comparatively higher percentage of respondents from Muslims (41.5%) were allowed to certain places but higher percentages of respondents from Hindus (38.5%) were allowed if anybody accompanied. Among Hindus, in both the districts majority of the respondents were expressed that they were allowed to go out, if someone accompanied them. In case of Muslim women a higher from Kadapa district (35) than Chittoor district (30) were allowed to go to certain places.

- **Restrictions during menstruation** - Majority of (68% Hindus and 73% Muslims) respondents expressed that they were not allowed to enter the Pooja room or Namaj room during menstruation time. District-wise comparison in Hindus showed that, slightly higher numbers from Kadapa (71) than from Chittoor district (65) were not allowed to enter the pooja room. In case of Muslims, much variation was not observed in two districts regarding restrictions during menstrual periods.

- **Duration of menstruation** - Comparatively higher percentage of women from Muslims (47.5%) than from Hindus (34.5%) had periods of 1-3 days. District-wise comparison revealed that, irrespective of religion higher number of women in Kadapa district than in Chittoor districts experienced 1-3 days of menstrual periods.

- **Frequency of menstrual cycle** - Majority of respondents had regular menstrual periods in both religions (85.0% in Hindus and 80.5% in Muslims). Little
variation was observed in the two districts among Hindus as well as among Muslims also regarding frequency of menstrual cycle.

- **Experience of blood clots during menstruation** was higher among Muslims (29.0%) than Hindus (24.55). Among the Hindus, a higher number of women from Kadapa (27) than from Chittoor (20) experienced it. In case of Muslims, slightly higher number of women from Kadapa (31) than from Chittoor (27) had experienced blood clots during menstruation.

- **Feelings before menstruation** - Comparatively higher percentage of women from Hindus (19.0%) than from Muslims (13.0) felt uncomfortable. Among Hindus, a higher number of women from Kadapa (19) than from Chittoor (12) experienced fullness of breast, abdomen, face & feet before menstruation. In case of Muslims, there was slightly higher number of women from Chittoor (15) than from Kadapa (11) had who were uncomfortable before menstruation.

- **Feelings during menstruation** - Nearly fifty percentage of respondents in both the religions (49% from Hindus and 48% from Muslims) experienced calf muscle pain. Among Hindus, nearly fifty members from Kadapa (53) experienced calf muscle pain as also their counterparts in Chittoor (45). In Muslims also more than half of the women from Kadapa (51) and more than two fifth from Chittoor (44) experienced calf muscle pain during menstruation.

- **Feelings after menstruation** - Relatively a higher percentage of women from Muslims (45%) than Hindus (38%) felt normal and comfortable after menstruation. Among Hindus, women who felt normal and comfortable were higher from Chittoor (41) than from Kadapa (35) after menstrual periods. Similarly among Muslims also higher number of women from Chittoor (48) than from Kadapa (42) was felt normal and comfortable.

- **Problems of vaginal discharge** - In both the religions, a large proportion of women (87.0% from Hindus and 85.0% from Muslims) didn't experience any vaginal discharge problem. District-wise comparison among Hindus, disclosed that a little variation was observed in those experiencing the problems of vaginal discharge in both the districts (i.e. 14 from Chittoor and 12 from Kadapa). In
case of Muslims, slightly higher number of women from Kadapa (17) than from Chittoor (13) had experienced vaginal discharge problems.

- **Nature of vaginal discharge** - Among those who experienced white discharge 8 members in each religion experienced mucoid non-foul smelling and small in amount. District-wise comparison in Hindus showed that 5 members from Kadapa and 3 from Chittoor experienced mucoid non-foul smelling and small in amount. Among Muslim women, a higher number from Chittoor (7) than from Kadapa (1) experienced mucoid non-foul smelling and small in amount.

- **Reproductive health problems** - Higher number of women in Hindus (8) than of Muslim (3) women had experienced pain during intercourse. Among Hindu women, those who experienced reproductive health problems were slightly more in number from Kadapa (12) than from Chittoor (9), they experienced burning sensation, pain or difficulty while urination. In case of Muslim women, 11 in Kadapa and 15 in Chittoor had reported symptom of burning sensation, pain or difficulty while urination.

- **Outcome of pregnancy** - Large percentage of women had live births in both the religions and slightly more number of women from Muslims (11) than from Hindus (8) had still births. District-wise comparison among Hindus indicated that, slightly higher mean pregnancies were in Chittoor (2.30) than in Kadapa (2.24) and comparatively double the number of women from Kadapa (4) than from Chittoor (2) had experienced spontaneous abortions. In case of Muslims, slightly higher mean number of pregnancies was observed in Chittoor (2.46) than in Kadapa (2.40) and in case of spontaneous abortions, slightly more in Kadapa (5) than in Chittoor (4).

- **Causes of induced abortion** - Women who experienced abortions, 3 out of 4 from Hindus and 2 out of 3 from Muslims were due to intra-uterine death of fetus. Among Hindus, 2 women from Chittoor and only one from Kadapa reported that the cause of induced abortion was intra-uterine death of fetus. In case of Muslims, one woman from each district had induced abortion due to intra-uterine death of fetus.
Complications after abortion - 3 out of 4 from Hindus and 1 out of 3 from Muslims had experienced hemorrhage after abortion.

Source of health seeking behavior for reproductive health problem - More than one fifth of women from Hindus wanted to seek help from private medical doctors while Muslim women sought from traditional healer. Among Hindu women, one quarter from Kadapa and more than one fifth in Chittoor wanted to go to private medical doctors. Among Muslims, more than one fifth of women from each district wanted treatment from traditional healer’s i.e. 21 from Kadapa and 22 from Chittoor.

5.9.5 Fertility and fertility preference

Number of living children - The total and mean number of living children was higher among Muslims (2.43) than Hindus (2.02). Majority of respondents in Hindus had their children between the age of 25 to 35 years whereas the Muslims had their children between 20 to 29 years of age. District-wise comparison among Hindus revealed minimal difference among those who preferred two children in their family in both the districts (78 from Kadapa and 80 from Chittoor). Among Muslims, comparatively a higher number of respondents from Kadapa (69) than from Chittoor (63) preferred to have two children in their family.

Fertility planning - Comparatively a higher percentage of respondents from Hindus (73.5%) than from Muslims (67.5%) wanted to have fertility planning (child) immediately. Regarding Hindus, slightly higher number of respondents in Kadapa (75) than in Chittoor (72) reported their fertility planning was wanted then. Similar to Hindus, slightly a higher number of Muslims in Kadapa (69) than in Chittoor (66) stated that fertility planning was desired by them.

Desire for an additional child - Comparatively higher percentage of respondents in Hindus (73.5%) than in Muslims (67.5%) reported that they did not want to have an additional child because they have undergone sterilization. District-wise comparison in Hindus showed that majority of respondents reported that they didn’t have any desire for an additional child because they underwent sterilization in both districts (75 in Kadapa and 72 in Chittoor).
case of Muslims, slightly higher number of respondents in Kadapa (69) than in Chittoor (66) expressed that they had no aspiration to have an additional child because of sterilization.

- **Preferred sex of an additional child** - Comparatively higher percentage of respondents in Muslims (50.77%) than in Hindus (41.50%) reported that they wanted a boy as an additional child. District-wise comparison among Hindus revealed that there were minimal differences in preference of sex of an additional child in both the districts. Among Muslims, slightly higher number of respondents in Kadapa (18) than in Chittoor (15) preferred a boy.

5.9.6. Utilization of Health Care Service

- **Utilization of health care services** - More than fifty percent of respondents used private medical sectors in both religions. Similar trend was observed in two districts in Hindus as well as in Muslims.

- **Quality of home visits by health worker** - Comparatively a higher percentage of respondents in Hindus than Muslims were satisfied with time spent by health worker for family planning and health care services. A higher percentage of women in both religious said that the health worker talked to them about family planning and also other health care services.

- **Quality of services** - Private sector was rated higher than public sector by the respondents including other indicators such as time spent, way of talk, regarding privacy, cleanliness of facilities. But median waiting time for treatment was higher in private sector than in public sector in both the religions. There was no difference was observed in two districts of both religions.

- **Topics of discussion with the health workers during visit to health facilities** - Majority of respondents discussed about treatment of health problems, disease prevention and immunization etc with the health worker. Compared with Hindus, majority of Muslims expressed that health workers discussed about family planning with them. A small percentage of respondents in both religions reported that post-partum care was discussed with health workers.
5.9.7. Family Life Education

- Essentiality of family life education - Two thirds of Hindus and more than two thirds (61.5%) of Muslim respondents opinioned that family life education was not essential before marriage. Among Hindus, more than two thirds (64) in Kadapa and more than fifty (56) in Chittoor said that family life education was not essential. Majority of respondents expressed that there was no necessity to have family life education for good reproductive health in both districts i.e., Kadapa (57) and Chittoor (66).

- Opinion on right age marriage - Comparatively higher proportion of respondents in Muslims (65.5%) than from Hindus (58.0%) opined that the right age at marriage was 18 years. In Hindus, majority (58 from each districts, Kadapa and Chittoor) opined that right age of marriage for girls was 18 years.

- Opinion on between marriage and conception - Comparatively, a higher percentage of respondents in Muslims (71.0%) than Hindus (64.5%) expressed their opinion that there should be at least one year gap after marriage for having children. Among Hindus more than two thirds (62 and 67) of respondents said that minimum one year after marriage was good for conception. Majority (70% and 72%) of Muslims respondents in Kadapa and Chittoor expressed that minimum one year was enough to conceive after marriage.

5.9.8. Knowledge on HIV / AIDS

- Knowledge on HIV/AIDS - Majority of women from Hindus (86%) and Muslims (81%) have heard about HIV / AIDS. District-wise comparisons in Hindus revealed that majority of women have heard about HIV / AIDS in both the districts (87 from Kadapa and 85 from Chittoor). Among Muslims slightly higher numbers of women from Chittoor (83) than from Kadapa (79) were aware of HIV / AIDS.

- Source of information on HIV/AIDS - Television was the most important source of information on HIV / AIDS in both the religions (74.2% from Hindus and 76.5% from Muslims). Among the Hindus, slightly higher number of
respondents from Kadapa (76) than Chittoor (73) had information about HIV/AIDS through television. With regard to Muslim women, slightly higher number of respondents from Chittoor district (78) than from Kadapa district had information on HIV/AIDS through television.

- Knowledge about prevention of AIDS - A large percentage of respondents in both the religions (93.5% of Hindus and 91.5% of Muslims) said avoiding sex with commercial sex workers AIDS can be prevented. Among Hindus, comparatively a large number of respondents expressed that having only one sex partner can help to prevent transmission (92 from Kadapa and 95 from Chittoor) of AIDS infection. Abstinence from sex and using condoms in both the districts also helped to prevent AIDS. Similar trend was observed in case of Muslims also in Kadapa and Chittoor districts.

- Aware about AIDS was serious health hazard - More than eighty percentage of respondents from Hindus (86.5) as well as from Muslims (84.5%) were aware that AIDS was a serious health hazard to mankind. District-wise comparison in Hindus revealed that slightly more number of respondents from Chittoor (88) than from Kadapa (85) was aware that HIV/AIDS was a serious health hazard to mankind. With regard to women in Muslims, slightly more number of respondents from Chittoor (88) than from Kadapa (85) were aware that HIV/AIDS was a serious health hazard to mankind.

- Misconception about transmission of HIV/AIDS- Slightly higher percentage of respondents from Muslims (32.0%) than from Hindus (28.0%) expressed the kissing and shaking hands (27.0% from Hindus and 25.5% from Muslims) with an infected person can cause HIV/AIDS. District-wise comparison in Hindus revealed that, slightly higher number of women from Kadapa (30) than from Chittoor (26) stated that kissing an infected person can cause HIV/AIDS. Among Muslim women, comparatively higher number from Kadapa than from Chittoor stated that kissing (35 from Kadapa and 29 from Chittoor) and by shaking hands (27 from Kadapa and 24 from Chittoor) with infected persons may cause HIV/AIDS.

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Knowledge on Mode of transmission of HIV/AIDS - Comparatively higher percentage of women expressed that heterosexual intercourse (87.0% from Hindus and 86.0% from Muslim) was an important mode of transmission of HIV/AIDS than other factors in both the religions. Among women in Hindus a higher number of respondents from Chittoor than from Kadapa said mode of transmission of HIV/AIDS can be homosexual intercourse (77 and 70) and heterosexual intercourse (86 and 78). In case of Muslims, slightly higher number of respondents from Chittoor (88) than from Kadapa was the reasons for transmission.

Knowledge on HIV to as AIDS - Comparatively higher percentage of Hindus (74.5%) than Muslims (68.5%) had knowledge about development of AIDS from HIV virus. Among Hindus, a higher number of respondents in Chittoor (77) than from Kadapa (72) had knowledge that HIV virus develops as AIDS. With regards to Muslim women, lightly higher number from Chittoor (70) than from Kadapa (67) had knowledge on development of AIDS from HIV virus.

5.10. IMPLICATIONS OF THE STUDY

A policy implication is that maternal and child health programmes should identify those women who do not receive tetanus immunization during pregnancy and classify their children as a high-risk group. Public-health education programmes designed to persuade these women to be immunized against tetanus should make sure that they receive information about other health risks that also threaten infants and children. It might also be useful for health workers to identify any other health-seeking behaviours that tend to characterize women who are immunized against tetanus during pregnancy. Promotion of such behaviours might then be incorporated into health education programmes aimed at women who are not immunized.

The analysis of demand for temporary methods of contraception indicates that the government should make greater efforts to promote temporary methods of contraception, and should do so in part through private sector outlets. The finding that education is a key factor influencing contraceptive use indicates that the government should increase its efforts to achieve universal primary and secondary
education in the country. The finding that son preference has a negative impact on contraceptive use indicates that the government should increase its efforts to promote values of gender equality and to increase the status of women in society. The finding that religion influences contraceptive use independently of residence and education suggests that the government should take steps to make family planning services more attractive and acceptable to Muslims. For example, Muslim women may be more receptive to temporary methods that can be obtained with less violation of privacy and modesty than is the case with sterilization. The finding that exposure to the electronic mass media has substantial effects on contraceptive use, even after controlling for residence and education, suggests that the government should intensity its efforts at rural electrification as well as its efforts to propagate family planning messages through these electronic media. This is especially important in rural areas where a large majority of women are illiterate.

A policy implication is that the government can speed up the process by promoting the value of gender equality and by enhancing the status of women by increasing educational levels, media exposure, and opportunities to work outside the home for women.

A concerted effort to reduce son preference and increase the status of women is essential. Such efforts would be admirable in their own right, but their potential demographic benefits provide a further rationale for placing relevant policies and programmes at the top of the government's agenda.

The finding that method-related problems and method failure are important reasons for discontinuing contraception and the finding that method-related problems and opposition to family planning are important reasons for not intending to use contraception in the future suggest that the quality of family planning services in India needs improvement. These findings also suggest the importance of education and motivation activities. Programmes should pay particular attention to women in those states and social categories in which the proportion mentioning method-related problems and opposition to family planning are especially high.

These findings had important implications for population policy makers in states where religious composition is a sensitive issue. They should realize that
religion or religious affiliation is an important characteristic in differentiating fertility, behaviour. At the same time, Muslims should not be 'accused' of having higher fertility, instead, the suitable intervention programme should be implemented to reduce the differences in the level of fertility and contraceptive use between these two communities. The religious differentials in fertility may be reduced, relatively slowly with overall improvement in the social and economic status. Failing which, may lead to considerable alterations in the religious composition over a long time. At the same, it should be also mentioned that the socio-economic variables which are not playing any significant role in affecting the Muslims fertility and current use of contraceptives, would not continue to be in effective in the future.

The study has brought out clearly that educational level of Muslim males in the households as well as among the respondents’ spouses are considerably lesser than that of Hindus. Therefore, it may be assumed that illiterates are less likely to adapt to the changes in the modern world and are more likely to stick to their age old traditional view of worldly affair. The household with illiterate or less educated male members would definitely prevent their women folk’s effort to limit family size or using contraception. It is also possible that majority of the Muslims end up in schools or Madarasas which are run by Muslim trusts or have been declared as minority institutions, established in their locality, which are less likely to provide quality education. Therefore, it is essential to improve the level of education among the males and also the quality of education provided for Muslims.

Muslims under the clutch of religious influence, such as lower middle economic class, illiterate and less educated Muslim males who are generally engaged in self employed business and transportation should be identified and with the help of progressive religious leaders they should be educated about the advantage of small family and the sanction of contraceptives in religious scriptures. The recommendation seems like simplistic, but it is the reality. For example, supportive role of the progressive Islamic religious leaders was one of main reason for the success of family planning programme in Bangladesh and Indonesia.

In short, the findings of the Research immediately call for a new programme perspective for family planning agencies. Up to now, the family planning
The programme has been developed in such a way that it focuses on the 'appropriate location of clinics', 'proper distribution of and counseling for contraception' or even sometimes 'door-to-door promotional efforts'. Advertising appeals are made to inform people about the options open to them and to promote a rational figure of family size for each couple. The findings open up a new perspective in that in addition to existing services, efforts can be made to make couples understand the importance of making decisions about family planning jointly, by planning their family after effective verbal communication between them.

The government need to mount a major public education campaign about HIV/AIDS and to intensively promote condom use among high-risk subgroups. The mass media need to become much more effective communicators about AIDS. The finding that teachers are rarely a source of HIV/AIDS information suggests that a comprehensive HIV/AIDS awareness program should include an expanded role for schools. Most important, effective ways to convey HIV/AIDS information to the rural majority and the illiterate must be developed— for example, through new uses of film, health workers, and community meetings.

Unlike traditional medical disciplines, HIV/AIDS is a key domain of medical and social research, currently being investigated on a war footing internationally. Hence, there is a flow of new information almost every day. It is important that the general public but especially HIV infected people, health providers and those responsible for health service management know about the developments taking place in medical and social research on HIV/AIDS. Governments and media must under take careful scrutiny of information before making interpretations and policy statements. HIV education packages must be a part of the health training for undergraduates at medical colleges and as an element of continuing professional development.

Blood transfusion is the second highest mode of HIV infection in India; the NACO (2001) estimates it at 5.52 per cent. Although blood transfusion accounts for only a small proportion of HIV infection in India the number of people infected through this is large. A report indicates that about 30 per cent of blood in India comes from commercial sources and only a portion of it is tested for HIV.
more, although the Supreme Court of India banned the use of blood from professional blood seller because they are considered high risk group for HIV, according to the blood transfusion safety division of the WHO, these professional blood sellers now claim to be family members of patients needing blood (Sharma : 2000: 1026). This makes the safety of blood transfusion more complicated in this context it is inevitable that blood test for HIV be made mandatory irrespective of the source, before it is transfused. Blood banks in India must be expanded with proper HIV testing facilities.

5.11. SUGGESTIONS FOR FURTHER RESEARCH

➢ A study may be undertaken to know the impact of Socio-economic status on of Reproductive behaviour of women.

➢ A comparative study of Reproductive Health among women in Scheduled Caste and Scheduled Tribes may be undertaken.

➢ A Comparative study of Reproductive Health among women in urban, rural and tribal may be undertaken.

➢ Comparative study of Reproductive Health among women between organized and un-organized sector may be planned.

➢ A study on male participation in women's Reproductive Health may be undertaken.