U.G.C. SPONSORED
MINOR RESEARCH PROJECT

A STUDY ON HEALTH STATUS OF RURAL WOMEN OF BAJALI REVENUE CIRCLE

A Project Report of M. R. P. Submitted to

University Grants Commission

(No. F-5 – 12/2015-16(MRP/NERO)/356 Dated 03 MAR 2017)

KALYANI DEVI

PRINCIPAL INVESTIGATOR

DEPARTMENT OF POLITICAL SCIENCE

NIRMAL HALOI COLLEGE, PATACHARKUCHI

BARPETA (ASSAM), 781326

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विश्वविद्यालय अनुदान आयोग,
University Grants Commission,
(मानव संसाधन विकास मंत्रालय, भारत सरकार)
(Ministry of Human Resource Development, Govt. of India)
पूर्वोत्तर क्षेत्रीय कार्यालय/North Eastern Regional Office
हाउसफेड परिसर/Housefed Complex
बेलतला-बशिष्ठ रोड / Beltola- Bashistha Road
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FD Dairy No:
Dated:

No.F.5-12/2015-16(MRP/NERO)/356 Date: 03 MAR 2017

To
The Accounts Officer
University Grants Commission
North Eastern Regional Office, Guwahati – 781 006

Subject: Release of Grants to **Nirmal Haloi College, P.O. - Patacharkuchi – 781 326, Dist. - Barpeta, Assam** for the year **2016-17** under Plan in respect of **Minor Research Project** entitled **A study ..... Circle** awarded to **Kalyani Devi**, Department of **Political Science**

Sir/Madam,

I am directed to convey the sanction of the Commission for payment of grant of Rs. **1,20,000/-** (Rupees **One Lakh Twenty Thousand**) only as **1st Installment** for the year **2016-17** towards the scheme of **Minor Research Project** to the Principal **Nirmal Haloi College, P.O. - Patacharkuchi – 781 326, Dist. Barpeta, Assam** for the year **2016-17** (Plan / Non-Plan) expenditure to be incurred during **2016-17** as per details given below:

1.

Sl. No.	Name of the Item	Allocation (Rs.) W	BE/RE (Rs.)	already sanctioned (Rs.) X	Grant now being sanctioned (Rs.) Y	Unspent balance if any / adj. (Rs.)	Total Grant Z=(X+Y)	Balance grant (Rs.) (W-Z)
(A) Recurring (General 31)								
(i)	Chemical & Glass Work	-		Nil	50,000/-	-	50,000/-	50,000/-
(ii)	Travel/Fieldwork	60,000/-						
(iii)	Contingency	40,000/-						
(iv)	Any Other Item	-						
(B) Non-Recurring (Capital 35)								
(i)	Books & Journal	30,000/-		Nil	70,000/-	-	70,000/-	Nil
(ii)	Equipment	40,000/-						
(iii)	Any Other Item	-						
Total:		1,70,000/-		Nil	1,20,000/-	-	1,20,000/-	50,000/-

2. The sanctioned amount is debitable to Head of Account 3(D)50 [2552.00.131.02.01.31 & 35] and is valid for payment during the financial year 2016-17 only.

3. The amount of the grant shall be drawn by the Drawing and Disbursing Officer, University Grants Commission, NERO Guwahati on the Grant-in-Aid bill and shall be disbursed to and credited to grantee as above through Electronic mode as per the following details:

a.	Details (Name & Address) of Account Holder: Principal:	**Principal, Nirmal Haloi College, P.O. - Patacharkuchi – 781 326, Dist. - Barpeta, Assam**
b.	Account No:	**33552531314**
c.	Name & Address of Branch:	**State Bank of India, Patacharkuchi, Barpeta, Assam**
d.	MICR Code of Branch	**781002529**
e.	IFSC Code	**SBIN0013448**
f.	Type of Account: SB/Current/Cash Credit	**SB**

4. The grant is subject to the adjustment on the basis of Utilization Certificate in the prescribed Proforma submitted by the University / College / Institution.

5. The University / College shall maintain proper accounts of the expenditure out of the grant which shall be utilised only on approved items of expenditure.

6. The University / Institution may follow the General Financial Rules, 2005 and take necessary action to amend their manuals of financial procedures may adopt the provisions of GFRs, 2005 and thereafter have their own approved manuals on financial procedures may adopt the provisions of GFRs, 2005 and instructions / Guidelines there under from time to time.
7. The Utilisation Certificate to the effect that the grant has been utilised for the purpose for which it has been sanctioned shall be furnished to the University Grants Commission as early as Possible after the closing of the current financial year.
8. The assets acquired wholly or substantially out of the University Grants Commission's grant shall not be disposed or encumbered or utilised for the purpose other than those for which the grant was given, without proper sanction of the University Grants Commission.
9. A register of assets acquired, wholly or substantially out of the grant shall be maintained by the University / College in the prescribed Proforma.
10. The grantee institution shall ensure the utilization of grant-in-aid for which it is being sanctioned / paid. In case of non-utilization / part utilization, the simple interest @ 10% per annum as amended from time to time on unutilized amount from the date of drawal to the date of refund as per provisions contained in General Financial Rules of Govt. of India will be charged.
11. The University / College shall follow strictly the Government of India / UGC's guidelines regarding implementation of the reservation policy [both vertical (for SC, ST & OBC) and horizontal (for persons with disability etc.)] in teaching and non-teaching posts.
12. The University / College shall fully implement the Official Language Policy of the Union Govt. and comply with the Official Language Act, 1963 and Official Languages (used for official purposes of the Union) Rules, 1976 etc.
13. The sanction is issued in exercise of the delegation of power vide UGC Order No.(9)2014(F.No.10-1/12 (Assam)/A&E)} dated 26/03/2014.
14. The University / Institutions shall strictly follow the UGC Regulations on curbing the menace of Ragging in Higher Education Institutes, 2009 and amendments thereof.
15. **The University / Institutions shall take immediate action for its accreditation by National Assessment & Accreditation Council (NAAC).**
16. The accounts of the University / Institutions will be open for audit by the Controller & Auditor General of India in accordance with the provisions of General Financial Rules, 2005.
17. The annual accounts i.e. balance sheet, income and expenditure statement and receipts and payments are to be prepared strictly in accordance with the Uniform Format of Accounting prescribed by Government.
18. Funds to the extent of Rs. _____ are available under the scheme.
19. The grantee institution shall remit the unspent amount of grant-in-aid / or interest though e-mode (RTGS / NEFT / PFMS) directly UGC account indicating No. dated and amount of sanction letter under intimate to the concerned section and Finance Division (FD-II).
20. This issue with the approval of _____ vide Diary No. _____ dated _____

Yours sincerely

(Dr. Mohammad Arif)
Joint Secretary

Copy forwarded for information and necessary action to:

1. Kalyani Devi, Department of Political Science, Nirmal Haloi College, P.O. - Patacharkuchi – 781 326, Dist. - Barpeta, Assam
2. Principal / Teacher-in-Charge, Nirmal Haloi College, P.O. - Patacharkuchi – 781 326, Dist. - Barpeta, Assam
3. Director General of Audit, Central Revenue, AGCR Building, I. P. Estate, New Delhi
4. The Registrar, Gauhati University, GopinathBordoloi Nagar, Guwahati-781014, Assam, India
5. The Director, College Development Council, Gauhati University, GopinathBordoloi Nagar, Guwahati-781014, Assam, India
6. Accountant General, Govt of India (A&E), Assam, Maidamgaon, Beltola, Guwahati: 781028
7. The Director of Higher Education, Kahilipara, Guwahati 781019, Assam, India
8. Guard File.

5/1/17

(Naresh Pal Meena)
Education Officer

OFFICE OF THE PRINCIPAL

NIRMAL HALOI COLLEGE

NAAC Accredited

PATACHARKUCHI

P. O.- PATACHARKUCHI-781326 : DIST.- BARPETA (ASSAM)

Estd.-1979

Contact No.
03666 264650 (O)
99549 61242 (M)

Date : 11/01/2019

From :
Dr. Bhupesh Sarma, M. A., J. D., Ph. D.
Principal

Memo No: NHC/M.F.-92/2019/164

To Whom It May Concern

Certified that this thesis titled **"A STUDY ON HEALTH STATUS OF RURAL WOMEN OF BAJALI REVENUE CIRCLE"** is the bonafide work of **Mrs.Kalyani Devi,** Associate Professor to the department of Political Science, N. H. College, Patacharkuchi completed under the MRP Grant from UGC. The work reported herein does not form part of any other thesis or dissertation on the basis of which a degree or award has been conferred on an earlier occasion to the candidate herself or any other else to the best of my knowledge and belief.

Principal
N. H. College, Patacharkuchi

Principal
Nirmal Haloi College
Patacharkuchi

Kalyani Devi, Associate Professor,

Department of Political Science, Nirmal Haloi College, Patacharkuchi.

Certified that this thesis titled **"A STUDY ON HEALTH STATUS OF RURAL WOMEN OF BAJALI REVENUE CIRCLE"** is bonafide work which has carried out by me, **Mrs. Kalyani Devi,** Department Political Science, Nirmal Haloi College, Pattacharkuchi, Barpeta, Assam. Certified further, the work reported herein does not form part of any other thesis or dissertation on the basis of which a degree or award was conferred on an earlier occasion of thesis of any other candidate.

Date : 05/02/2019

Kalyani Devi

(Kalyani Devi)

PRINCIPAL INVESTIGATOR

Content

Preface and Acknowledgement

"A STUDY ON HEALTH STATUS OF RURAL WOMEN OF BAJALI REVENUE CIRCLE" is an attempt to see the socio-economic and health status of women of the Bajali Revenue Circle of Bajali Sub-division, Barpeta district of Assam. Here empirical, institutional and questionnaire methods of research was used. A few case study is also made regarding the issue. In the patriarchal society woman is deprived of every corner of her life whether it be social, economic or political. So in the changing circumstances of the politics of local level in the expansion of the participation of women after the reservation of seats, it become imperative to see the level of socio-economic and psychological changes of women. Health is also an inseparable task when we undertake any study on women.

To make the research work systematic I divided it into five principal chapters. The health of Indian women is intrinsically linked to their status in society. The health of families and communities is tied to the health of women- the illness and death of woman has serious and far reaching consequences for the health of her children, family, community. Poor health has repercussion not only for women but also their families. Woman in poor health are more likely to give birth to low weight infants. They are unable to provide food and adequate care for their children. Women in poor health will be less productive in the labor force. Women

are more vulnerable as they bear the risk of reproductive, child rearing and house-hold work. The reproductive role of women is very important in determining their health standard which is often associated with the health risk. Moreover, the social culture, religious practices and economic factors have a direct impact on women's health which determines the status of women in society. All these aspects are seen in the **Chapter I.**

Chapter II contains a general profile of Assam and Barpeta district. A profile of Bajali Revenue Circle in particular is also added to this. Assam is situated in North-East corner of India, bordering seven states, viz. Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Tripura and West Bengal and two countries viz. Bangladesh and Bhutan. Assam may be divided broadly into two river valleys: they are the Brahmaputra valley and Barak valley. The Brahmaputra valley covers 24 districts in which four districts under the Bodoland Territorial Council (BTC) areas: they are Kokrajhar, Baksa, Chirang and Udalguri. On the other hand the Barak valley covers three districts.

District Kamrup with headquerters at Guwahati was formally established in 1834. Barpeta was the only outlying Subdivision. Later, Nalbari Sub-division was created in 1967. Barpeta as a district was found on 1st July 1983. The district has at present two Sub-divisions- Barpeta (Sadar) and Bajali along the headquerters at Barpeta and Madan Rauta Nagar (Dumuria).

Bajali is a historically important place in Assam. It is situated in the extreme north of Barpeta district of the state of Assam. The length of the north east side is 50km while east west side is 12.4 km. the borders are surrounded as accordingly i.e. on the north there is Baksa district on the east Nalbari district while on the south there is Paka mouza and on the west is Gobardhana mouza. According to the 2011 census report the numbers of villages in Bajali Revenue Circle is 70. During the British rule in the year 1931, the Bajali- revenue circle was curved out of Barnagar circle of the erstwhile Kamrup district with eight mouzas namely Pub-Bajali, Uttra Bajali, Dakhin Bajali, Manikpur,Chapaguri, Koklabari, Bijni, and Hastinapur mouza taking Patacharkuchi is the head quarter of the Bajali circle.

In **Chapter III** the general health care scenario of India and Assam in general and Bajali area in particular is discussed.

Chapter IV is divided into two sections, viz., section A comprised of Social Profile. In this chapter I want to depict Socio-Economic background of the respondents and their household and also from which social group the respondents come from. Section 'B' studies the health issues of rural women in the sample. Thus, this chapter can be termed as the heart of this research project.

In **chapter V** overall findings of the study along with some related and valuable suggestions are included.

To make this attempt more meaningful and valuable I add appendixes and annexure in the last part of this thesis. At the same time relevant tables, maps are added in the concerned places. I try my level best to make this thesis error free as far as practicable but err is human so, I sought pardon from all concerned for such unconscious mistakes.

If I do not mention the helps and suggestions provided by my Principal Sir, Dr. Bhupesh Sarma who himself is a library of experiences and expertise in the research field, the valuable suggestions provided by other members of the research committee of N.H. College and my colleague friends, my task will not be completed. I always feel their contributions in the fulfillment of this project. The Programme Manager of Nityananda Block P.H.C., Mr. Dwipen Talukdar helps me a lot. The respondents women and some of my students also help me a lot. I am grateful to all of them. At the same time, my family members, specially my husband, Mr. Manmath Goswami, who always inspire and actively encouraged me, my two daughters Mridusmita and Nabanita and only son Madhurjya always took pain when I asked. I remain thankful them all.

Kalyani Devi

Associate Professor,

Department of Political Science

Nirmal Haloi College, Patacharkuchi.

Abbreviation

A

A.S.H.A. : Accredited Social Health Activists

B

B.P.H.C. : Block public Health Centre

BTC : Bodoland Territorial Council.

C

CDC : Community Development Centre.

CSWB : Central Social Welfare Board.

D

D H : District Hospital.

DWCD : Development of Women and Child Development.

F

F.R.U. : First Refferal Unit

G

G.O.I. : Government of India

I

I.M.R. : Infant mortality Rate

I.P.H.S. : Indian Public Health Standards

J

J.S.S.K. : Janani Sishu Surkhya karikram

J.S.Y. : Janani Surksha Yojana

M

M.M.R. : Maternal Mortality Rate

N

N.B.P.H.C : Nityananda Block Public Health Centre

N.R.H.M. : National Rural Health Mission

N.H.M. : National Health Mission

O

O.B.C. : Other Backward Classes.

P

P.H.C. : Public Health Centre

R

R.C.H. : Reproductive Child Health

S

S.C. : Sub –Centre

S.C. : Scheduled Cast

S.T. : Scheduled Tribe

S.D.H. : Sub-Divisional-Hospital

S.D.C.H. : Sub-Divisional –Civil-Hospital

U

U.N.: United Nations.

W

W.H.O.: World Health Organization.

CHAPTER - 1

INTRODUCTION

Happiness, happiness, happiness

It may be of different origin on this earth

But the happiness of being healthy

Is the real happiness.

Dashdorjin Natragdorj

Good health is a prerequisite to human productivity and "development" process. For the economic and technological development good health is very essential. There is a saying, "Where there is a sound health there is sound mind". A healthy community is the infrastructure upon which to build an economically viable society. Basically the development of a society greatly depends on the quality of its people. Health is man's greatest possession, for it lays a solid foundation for his happiness. Charaka, the renowned Ayurvedic Physicians is known to have said, "Health was vital for ethical, artistic, material and spiritual development of human being."[1]

The constitution of India declared that Indian women will get the equal right with men. The constitution provides right to equality (Art

14), no discrimination by the state(Art 15(1)),equality of opportunity(Art16)and equal pay for equal work (Art 39(d)).Parliament has enacted laws giving equal rights to women in marriage, divorce, inheritance, etc. In spite of the constitutional provisions and legislations the women are not getting equal right with man. Indian women are deprived of all rights education, employment, economic independence and mainly "Health"[2]

Even after 71th years of independence health remains a major concern for rural people: Health is not only a matter of doctors, social service and hospitals. It is an issue of social justice. Health care is regarded as a human right. Right to health is one of the developmental rights mentioned in the United Nations Declaration on the Right to Development" 1986 which reflects the notion of justice.[3]

According to the World Health Organization (WHO) women's health is an issue to be looked into sincerely. The world body is of the view that health is "a state of complete physical, mental, social well-being and not merely the absence of disease and infirmity". Looking at the health status of Indian women from this perspective we have a

dismal picture. This is because of the society's continued apathy and unchanged attitude towards women. Good health remains a far cry.

Women have the unique natural qualities like motherhood, kindness, patience, tolerance, and sacrifice. Women are a powerful instrument in the process of creating a dynamic, civilized and cultured society. She is the creator, and protector of a family. Woman gives birth to generations takes care of them and thus forms a society. She is a Devi, a mother, a caring nurse, an embodiment of perfect knowledge and untrained but efficient manager of household and what not. Despite being an epitome of many qualities woman is not getting the love and respect due to her. The condition of women in rural areas is incalculably pathetic. For women, especially those living in the countryside and ever dependent on their male counterparts, life seems a living hell. Rural women have to face a number of problems which do not allow them to develop. Problems of poverty, ill-health, social customs keen her busy. She can never imagine moving forward. Poor sanitation, unhygienic surroundings, difficulty in procuring, safe drinking water is some of the factors that affect the general health of women. Every second one woman in India suffers from some degree of anemia.[4]

The health of Indian women is essentially linked to their status in society. The health of families and communities is related to the health of women- the illness and death of woman has serious and far reaching consequences for the health of her children, family, community. Poor health has repercussion not only for women but also their families. Woman in poor health are more likely to give birth to low weight infants. They are unable to provide food and adequate care for their children. Women in poor health will be less productive in the labor force. Women are more vulnerable as they bear the risk of reproductive, child rearing and house-hold work. The reproductive role of women is very important in determining their health standard which is often associated with the health risk. Moreover, the social culture, religious practices and economic factors have a direct impact on women's health which determines the status of women in society.[5] The health status of women in rural areas is incalculably pathetic. Gender differences in health status are significant. Though women enjoy a higher status of life expectancy than men but the class of life they lead is poor in conditions. Women's health complication and problems are existed during all phases of life since childhood to old age. But the reproductive health complication or problems are most

important and required urgent attention. This issue was raised in the Copenhagen Conference.

This has been a sensitive and widely discussed issue for quite some time. So to effect some positive changes in the health status of rural women the issue under discussion has been taken into account.

With the growing consciousness in society about subjugation, subservience and exploitation of women in every sphere of life countless seminars, workshops, and conferences have been organized to improve the status of women but no such research work relating to health status of women has been undertaken in this particular area so far to find some long term solution.

1.1 : Significance of the study

For the present study, the area Bajali- Revenue- Circle has been selected which is under Barpeta District of Assam.

Barpeta become a District in 1983 headed by the Deputy Commissioner. The District has two sub-divisions namely Barpeta and Bajali. The sub-division forms a large part of Barpeta District. The Bajali sub-divisional office (civil) is the civil head of Bajali sub-division. There is total number of revenue circles in Barpeta District

and three of them constitute the Bajali sub- division. The revenue circles that constitute Bajali sub-division are – Bajali, Sarupeta and Jalah.

The total land area of Bajali revenue circle is 164.79 sq. Km. which is divided into 3 Mouzas viz.Sariha, Uttar Bajali & Pub Bajali. The number of villages in the Bajali revenue circle is 70 and the no of Lots is 21.Patacharkuchi is the head quarter of the circle.

In the east of Bajali circle there is Nalbari district and a part of Baska. Barpeta sub-division and Sarupeta revenue circle in the west. Jalah revenue circle and a part of Baska district in the north and Barpeta Sub- division in the south. According to 2001 census report the total population is 1 lakh. There is a mixed kind of locality in this area. It is mostly rural but with two semis- urban set –ups. Most of the people are dependent on agriculture and the other people of the area are service holders, business men, entrepreneurs and laborers. People belonging to all categories viz. general, O.B.C., SC, and ST constitute the population of the area.[6]

The area selected for investigation assumes great significance as it deals with a sociological issue. Exploitation of women has not

only caused harmed to the women population, it has also caused serious harm to the population as a whole. The neglect meted out to women has pushed the society backed. It has also contributed to the slow economic progress. Such an issue is quite absurd in the present era of globalization. But it is shameful on the part of humanity to take up this issue for investigation at this present juncture. In view of what is stated above present study bears great significance.

1.2 : Objectives of the Study

The present study is concerned with achieving the following main aims and objectives. It seeks:

The study aims at understanding the health conditions of women in rural areas.

- It investigates the general as well as reproductive health problems among women in rural areas.
- To analyse the health infrastructure and health care facilities available especially for the women.
- To explore the reason for the poor health status of women in rural areas.

- To look into the socio-economic aspects reflecting the poor health status of women.
- To study the somewhat consciousness of the male population of the female health status
- To device ways in which women's poor health status can be improved.

1.3: Hypothesis

On the basis of the above stated objectives the following hypothesizes have been outlined:-

Health infrastructure and health care facilities especially for women are not sufficient in rural areas of Bajali Revenue Circle.

The health status of women in Bajali Revenue Circle is not well and it varies due to different heterogeneous nature.

Family is not affected due to the health problems of the women family members.

1.4: Methodology

Since a sociological issue requires a total involvement of the investigator, primary research methodology or case study method needs to be employed. It is a useful and reliable method of data

collection. The basic unit of a case study is a case a particular one of its kind. It may be one individual, a nation, a race, or an epoch in history. In respect of the topic under reference, cases are mostly individual person. The research work is based on both primary and secondary data collected through direct interview. For primary data collection a self prepared questionnaire is used. The sources of data collection include - Circle office, PHC, MPHC, SC, and NBPHC of Bajali-circle in Bapeta District. The major tools of research fall into the following categories;

(A) Questionnaire

(B) Interview

(C) Field-study

1.5 : Need of the Study

As an inhabitant of Greater Bajali area the investigator has been observing the health status of women. Women are regarded as a proved and noble symbol of creation and regeneration.

It is a known factor that women are always subjugated in different ways. The neglect of women health means the neglect of the whole society. Women's role is so important that society can achieve its ultimate evolutionary goals so women should given equal status

with men. It is a need for the time to give importance on women's health. Understanding the importance on women's health the proposed dissertation will be a humble attempt to find out the problems of health care of rural women and find out some solutions.

1.6 : Women's Health

The women are "neglected half" in India. The slogan "Healthy Women Healthy World" embodies the fact that as custodian of family health women play a critical role in maintaining the health and well-being of their communities.

Health is a personal and social static of balance and well being in which a woman feels strong, active, creative, wise and worth-while, where her own body's power of healing is intact, where all her diverse capacities and rhythms are valued, where she may make choices, express herself and move about freely. Several women's activists who were consulted found the concept of "Women's Health" more meaningful than the concept of "Reproductive Health". Other Women's groups, researchers and activists felt an artificial dichotomy was being created between "Reproductive Health" versus "Women's Health". These actors understood reproductive health as a legitimate

question of women's health rights; need and empowerment. Gender differences in health status are significant.[7]

1.7 : Women's Malnutrition

Poor nutrition among rural women begins infancy and continues throughout their life time. Women and girls are typically the last to eat in a family, if there is not enough food they are the ones to suffer. The Recharger when go to contact the rural women specially in Bajali- Revenue Circle ,they said that they do not get quality food, mainly due to poor economic situation. When a family is unable to buy enough quantities of required food the women's access to quality food becomes more difficult as the children and men get priority. This leads to weakness which in turn may give rise to several other health problems.

Generally in rural area, women are the one who eat last and least in the whole family. So they eat whatever is left after men folk are satiated. As a result most of the times their food intake does not contain the nutritional value required in maintaining the healthy body. Their nutritional deficiency has two major consequences for women first they become anemic and second they never achieve their full

growth which leads to an unending cycle of undergrowth as malnourished women cannot give birth to a healthy baby.[8]

1.8 : Maternal Health

Maternal health refers to the health of women during pregnancy, child-birth, and the postpartum period. While motherhood as often a positive and fulfilling experience, for too many women it is associated with suffering, ill health and even death.

Maternal mortality and morbidity are the two health concerns that are related to higher levels of fertility. India has a high maternal mortality ratio- approximately 112 deaths per 100,000 live births on 2017.7 According to WHO, one of the widest health disparities between rich and poor is in maternal mortality? There are more maternal deaths in India in the space of one week than there are in all of Europe in a whole year.[9]

The major direct causes of maternal morbidity and mortality include hemorrhage, infection, high blood pressure, unsafe –abortion and obstructed labor. Globally about 800 women die every day of preventable causes related to pregnancy and childbirth, 20% of these women are from India. Annually it is estimated that 44,000 women

die due to preventable pregnancy related causes in India. Most of these new mothers succumb to heavy blood loss (post – partum hemorrhage).[10]

Pre-Natal –Care (Also known as antenatal care) – Pre-Natal care means regular medical and nursing care of women during pregnancy. Pre-natal-care is important because it is one type of preventive care. During pregnancy women need regular check-ups to prevent potential health problems for promoting healthy life styles for the benefit both mother and child. During check-ups, women will receive medical information over maternal physiological changes in pregnancy, biological changes and pre-natal nutrition including prenatal vitamins. Healthy lifestyles are possible through regular check-ups during pregnancy. The availability of routine prenatal care has played a part in reducing maternal death rates and miscarriages as well as birth defects, low birth weight, and other preventable health problems.[11]

1.9: Anemia and Pregnancy

One of the most common nutritional deficiency disorders of pregnant women are anemia. It is one of the major health problems

that affect 25-50% of the population of the world and approximately 50% of pregnant women. According to WHO in a developed country the prevalence of anaemia in pregnant women's 14% while 51% in developing countries and 65-75% in India. India contributes to about 80% of the maternal death due to anaemia in South Asia.

Mild anemia is common for many women during pregnancy. But it can become a serious problem that requires treatment. There are more than 400 kinds of anemia.

Iron deficiency is the most common cause of anemia in pregnant women. When pregnant women should consume double the amount of iron as non- pregnant women, about 30mg, total, in order to adequately provide for themselves and their growing fetuses. This is not only to account for the higher volume of blood during delivery. Women's health reports that about half of pregnant women take in too little iron. These women face a greater risk of premature delivery.

Folate- deficiency anemia is another common kind of anemia during pregnancy. Women need higher levels of foliate in pregnancy. Vitamin- B-12 is also used by the body in the production of red – blood cells. Less serious is that anemia in pregnant women can cause

weakness, increased fatigue, shortness of breath, heart palpitations, pale complication and excessive stress. Anemic women are more prone to illness; as well women should be tested for anemia at the first pre-natal visit and take iron supplements while pregnant.[12]

Poor health status of women in India will be studied with reference to various data like the sex-wise mortality rate, sanitation, which includes pre and post-natal stage, expectation of life, importance in society etc. It is an immensely difficult task to obtain accurate information regarding these factors. But from the information and feed- back provided to me by the women in the ten villages in Bajali- Revenue circle bring out the alarming health status of women. As for birth and fertility factors, the health of the mother is always in a declining state. With every subsequent birth, her health deteriorates. The husband or mother-in -law is least worried about it. The candid and moving revelations of the women I approach are a living testimony to the deteriorating health of women. They told me that they were not aware of the care and nurturing needed during pre and post natal stage. One woman (named not disclose) made the shocking revelation that she had to help her mother -in -law in rice processing and just then her baby was born. She was shy and scared of

her mother-in –law and kept the entire fact a secret. Not to speak of regular health check up, nutritious food, rest and care. The another woman reveal to me that she had to go to crop field to help her husband just five days after giving birth to her baby. These are only few instances of the society's apathetic attitude towards women in matters of health. There will be countless such cases if we go into the remotest villages which will bring out the gravity of the situation.

As for the high increase in female death in the age group of 15-29 for both rural areas and the nation as a whole our investigation has unfolded tremendous result which also indicates the poor health status of women. Further, it also shows the high death-rate for the child bearing women or higher maternal mortality rates.

1.10 : Limitations of the Study

This study was conducted in Bajali- Revenue circle, which consists of 70 villages. Out of 70 villages the Researcher selected 10 villages randomly. From each village the researcher selected 15 respondents out of large population. The 10 villages are-, Barsahan, Chaibari, Barnalikuchi, Bamunkuchi, Nizsathisamukha, Dharamtola, Patasatra, Patacharkuchi, Sarihchakla, Barbhala. From these 10

villages the researcher selected 150 respondents as sample for the study.

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CHAPTER - 2

Demographic Profile of the Study Area

2.1 : Socio-Economic Profile of Assam

Assam is situated in North-East corner of India, bordering seven states, viz. Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Tripura and West Bengal and two countries viz. Bangladesh and Bhutan. Assam may be divided broadly into two river valleys: they are the Brahmaputra valley and Barak valley. The Brahmaputra valley covers 24 districts in which four districts under the Bodoland Territorial Council (BTC) areas: they are Kokrajhar, Baksa, Chirang and Udalguri. On the other hand the Barak valley covers three districts.

2.2 : Location

Assam is bounded by latitudes 24°08′10″ N and 27″58″15″ N and longitudes 89″42′05″E (Approx).[1]

2.3 : Area

The total geographical area of Assam is 78,438 sq. k.m.s, i.e., about 2.4 percent of the country's total geographical area.[2]

2.4 : Population

The total population of Assam as per 2011 census of India is 3,11,69,272 of which 1,59,54,927 are males and 1,52,14,345 are females. The decadal growth of the state's population workout to

16.93 percent during the decade 2001-2011 which was 340 in 2001 census. The density of the population of India is 382 in 2011 census[3]. The following table shows the trend of population in Assam and India.

2.5 : Employment of Women in Organized Sector

The employment of women in organized sector of the state was 366.7 thousand during 2010 which is 32.9 percent of the total employment. In the year 2009 the number of women employee was 360.3 thousand showing a share of around 32.7 percent of the total employment.

Table: 2.1

Employment of Women in Organized Sector

Year	In Thousand No.s			
	Public Sector Women	Private Sector Women	Public +Private Sector women	Percentage
2003	77.4	241.1	318.5	30.0
2004	77.3	255.6	332.2	30.0
2005	81.5	268.4	349.9	30.7

2006	81.8	299.0	380.7	34.0
2007	84.9	310.8	395.7	33.9
2008	85.6	266.5	352.1	32.5
2009	87.3	273.0	360.3	32.7
2010	87.0	279.7	366.7	32.9

Source: Directorate of Employment and Craftsmen Training, Assam.[4]

2.6 : Education

Education is the key input for the development of individual as well as the society. It is accepted as the crucial inputs for nation building. The vision 2020, concerned with the sector of Elementary Education, is focused on the accomplishing of the constitutional obligation of providing free and compulsory education for every child within the age group of 6-14 years. The State Government equally put emphasis on to providing qualitative technical education to build technical skills to cater the needs of the economy. Keeping in view the importance of education in the socio-economic development the State-Government has been implementing various educational programmes.

Literacy rate of Assam is 63.25 percent, as per 2001 census, which is behind the national average of 64.8 percent.[5] On the other

hand, as per census 2011, the literacy rate of Assam is 73.18 percent, which is behind the national average of 74.04 percent.[6]

2.7 : Health Service

In the health sector, the state has continued to strengthen the curative health services while at the same time ensuring the basic health care facilities so that people living in the remote and inaccessible areas get proper health care.

The present health infrastructure in Assam has been presented in the following table-

Table No.: 2.2

Health Infrastructure in the State

(Figure in number)

Public Health Facility	Number
Medical Colleges Hospitals	06
State Level Hospital	01 (MMC, Guwahati)
District Hospital (DH)	22
Sub-Divisional State Hospital	13
Primary Health Centre	844
Community Health Centre	103

Block PHC	149
State Dispensary (SD)	261
Subsidiary Health Centre (SHC)	71
Mini PHC	453
Sub- Centre	4592
B.Sc. Nursing College	01
G.N.M. Training Centre	15
A.N.M. Training Centre	18
Private Health Facility	
Private Sector Hospital (Nursing Home)	191
GNM Training Centre	12
B.Sc. Nursing College	01
ANM Training Centre	04

Source: Department of Health Services, Assam.[7]

2.8 : Socio-Economic Profile of Barpeta District

When Assam was formed a separate Province under the Chief Commissioner in February, 1874, the following ten districts were included viz. Goalpara, Kamrup, Darrang, Nagaon, Sibsagar,

Lakhimpur, Cacher, the Garo Hills, the Khasi and Jayantia Hills and the Naga Hills.[8]

District Kamrup with headquerters at Guwahati was formally established in 1834. Barpeta was the only outlying Subdivision. Later, Nalbari Sub-division was created in 1967.

Both Barpeta and Nalbari Sub-divisions have been upgraded as Districts in 1983 and 1985 respectively. The new Barpeta District has one outlying Subdivision, Bajali set up in 1989.[9]

Barpeta as a district was found on 1st July 1983. The district has at present two Sub-divisions- Barpeta (Sadar) and Bajali along the headquarters at Barpeta and Madan Rauta Nagar (Dumuria).[10]

Table: 2.3

Area, Sub-divisions, Towns, Villages, Blocks and Gaon Panchayats in Barpeta District, 2011

Area in Sq. Km.	2677.33
Sub-division	2
Towns	9
No. of Villages	835
CD Blocks	12
Gaon Panchayats	129

Source: Statistical Hand Book, Government of Assam; p.1.[11]

Table: 2.4

Distribution of Population in Barpeta District, 2011

Person	1693190
Male	867891
Female	825299
Rural	1545901
Urban	147289

Source: Statistical Hand Book, Government of Assam; p.3.[12]

Table: 2.5

Population and Literacy rate in different towns in Barpeta district, 2011

Town	Population		% Decadal Growth	Literacy Rate		
	Total	Male		Total	Male	Female
Barpeta Road (MB)	35489	18434	-0.66	88.09	92.60	83.20
Sarbhog	8105	4069	5.44	88.55	92.61	84.48
Uttar Athiabari (CT)	6095	3180	-----	82.97	86.99	78.52

Khaira Bari (CT)	10212	5333	------	72.51	77.71	66.88
Bohari (CT)	8267	4245	2.24	79.92	86.56	72.93
Barpeta (MB)	42663	21257	3.96	91.73	95.95	87.55
Howly (TC)	18312	9395	9.46	80.26	85.23	74.96
Sarthebari (TC)	6909	3466	-9.43	92.57	96.93	88.15
Pathsala (TC)	11237	5817	12.66	94.08	96.42	91.56

Source: Statistical Hand Book, Government of Assam; pp.8-9.[13]

Table: 2.6

Literacy Rate by Sex in Barpeta District, 2001 and 2011

Person		Male		Female	
2001	2011	2001	2011	2001	2011
56.00	65.03	64.23	70.72	47.16	59.04

Source: Statistical Hand Book, Government of Assam; p.18.[14]

2.9 : History Bajali

Bajali is a historically important place in Assam. It is situated in the extreme north of Barpeta district of the state of Assam. The length of the north east side is 50km while east west side is 12.4 km. the borders are surrounded as accordingly i.e. on the north there is Baksa

district on the east Nalbari district while on the south there is Paka mouza and on the west is Gobardhana mouza. According to the 2011 census report the numbers of villages in Bajali Revenue Circle is 70. During the British rule in the year 1931, the Bajali- revenue circle was curved out of Barnagar circle of the erstwhile kamrup district with eight mouzas namely Pub- Bajali, Uttra Bajali, Dakhin Bajali, Manikpur, Chapaguri, Koklabari, Bijni, and Hastinapur mouza taking Patacharkuchi is the head quarter of the Bajali circle. A well known citizen of Pattacharkuchi late Chandranath Dev Choudhury donated ten bighas of land for construction of the office building. The office started functioning from first April of 1932 and late Chandra Mohan Goswami was the first sub- deputy collector. In 1971, Bijni and Hastinapur mouza were taken out of this circle to create Sarupeta Revenue Circle and in 1981, Koklabari, Chapaguri and Manikpur mouza were also taken out to create Jalah Revenue Circle. At present there are 70 villages with a geographical area of 169,79 sq. k.m. in Bajali revenue circle. Geographical area-164.79 sq km.

No of mouza-3 (Sariha, Uttar Bajali & Pub- Bajali)

No of villages- 70

No of lots- 21

The present study is confined to the Bajali Revenue Circle of Barpeta District in Assam. Bajali is situated in the extreme North-East of Barpeta District (1983, 15th August) extent between 26.15^0 and 26.45^0 North latitudes and 91.5^0 and 91.30^0 East longitudes. In the length of North-South side is 50 K.M. and East West side only 12.4 K.M. It is bordering on the North of Baska and Nalbari District. On the East and South Paka Mouza and of Bhabanipur and Gobardhana Mouza is situated on the West. It covers the areas of 210.59 miles. The total population of this area is 2,20,321 (2011 census) out of which 1,19,740 are male and 100581 are female SC and ST population are 16,423 and 11,124 respectively. The total numbers of Goan Panchayat are 27. The total numbers of revenue Village are 70 and the total numbers of Anchlik Panchyat are 02.

Bajali revenue circle, with population of about 2,20,321 (2011 Census) is Barpeta District's the 2nd least populous sub-District, located in Barpeta District of the state of Assam in India. There are 70 villages among them Barbang is the most populous village with population of 5685 and Bangra Bari is the least populous village with

population of 20. Bhotanta Mohitara is the biggest village with an area of 10 K.M. and Doloi Goan is the smallest with 0 K.M.

There is only one city in the sub- District that comes under the sub- District administration which is Pathsala Town Committee.

2.10 : Demographics

The sub-District is home about 1 lakh people, among them about 51 thousand (50%) are male and about 51 thousand (50%) are female. 88% of the whole population is from general caste, 8% are from Schedule Caste and 4% are Schedule tribes. Child (aged under 06 years) population of Bajali (pt) circle is 10% among them 51% are boys and 49% are girls. There are about 23 thousand households in the circle and an average 4 persons live in every family.

The majority of population nearly 89% (91 thousand) lives in Bajali Sub-District rural part and 11% (about 11 thousand) population live in the urban part. 15

The study area constitutes of seventy villages in which the Researcher selected only 10 villages randomly. These villages have historical importance.

2.10.1 : Patacharkuchi :

Patacharkuchi is a historical importance place of Assam. It is situated in the south-East of East Bajali Tehsil. In a broader sense Patacharkuchi is a place surrounded by Gobindapur and Kuwarain the North, Bhaluki in the South, Barsahan and Balihajri in the east and Barbhala, Marka, Bamunkuchi in the west. It is an administrative centre of Bajali Circle. It is the centre of Bajali. It is also a name of Assam Legislative Assembly Constituency.

There was not any place called Patacharkuchi before the English had reigned Kamrup. Towards the reign of 17th century two Sages from Jagra Satra came and one of them set-up Satra at Bejkuchi and the other at the western side of the Kaldia river. During the first Commissioner of undivided Kamrup Majar Fracis Jenkins Tehsil and Revenue villages were created for the collection of taxes. The village which was constituted after the Sages of Patasatra had left the land of Royal Patta was known as Pattacharkochi. In course of time it was change to Patacharkuchi.

There is another story of the origin of Patacharkuchi. Once there was a hermitage of the Sage Parasar on the west side of Kaldia

River. The old and holy name Kaldia is Kalindi Ganga.On the bank of Kalindi Ganga the sage meditated. With the name of that Sage it was named as Parasarkuchi. In course of time it has changed to Patacharkuchi.

2.10.2 : Sariah Chakla

Sariah Chakla is an adjacent village of the Patacharkuchi revenue village. During the reign of Koch King Narnarayana, Bajali was constituted as an administrative unit in the name of Chakla. The meaning of Chakla is divided State.

There are many neighborhoods in the village of Sariah Chakla-Kanagaon, Pamelipara, Sripur. The name of Kanagaon originated from Kanafut, an adjoining area.

2.10.3 : Barnalikuchi

Barnalikuchi is a revenue village adjacent to Patacharkuchi. The different neighbourhoods like Bargha, Tangarkur, Bakapara, Ballattri, Kapla, of Sariah Satra are included in this village. In ancient time there were dense forests on both the banks of the Kaldia. Having cleared this forest there set-up a village Barnalikuchi by name.

2.10.4 : Bamunkuchi

Bamunkuchi is situated in the south west side of Patacharkuchi. During the reign of Ahom King Narnarayan destroyed the Hindu Temples. He also invaded the Kamakhya temple. The inhabited Brahmins there fled away in fear of Kalapahar and settled here in Bamunkuchi.

2.10.5 : Gobindapur

Gobindapur is a name given by Damodardev. Guru Damodardev set-up the Satra Gobindapur after the clearance of the dense forest. The Satra was built again when the Kaldia river change of its course.

2.10.6 : Dharamtala :

The name Dharamtala originates from the devout ideas of religion. During the 17th century, a Satra was set-up there. At that time a religious centre was set-up to spread the Satriya Culture.

2.10.7 : Barsahan

The people living here were very brave and wealthy; hence it was named as Barsahan.

2.10.8 : Barbhala

Barbhala is situated in the west of Patacharkuchi. Once there were many big Holas (drains).Hence, it was named as Barbhala.

2.10.9 : Patasatra

It is situated on the eastern side of Patacharkuchi. Earlier it was at Kuwara. After the establishment of the Police Station and the Bangalow, the Temple of the Satra was established on the eastern side of Kaldiya.Since there was established the modern Satra, it was named Patasatra.

2.10.10 : Chaibari : Chaibari is a historically important place. It is an indigenous name. The chai means Bamboo chilling. The Takoi tree is available there. The people of that area built the roof of the houses, Cow houses, etc. from the leaf of that particular tree. Therefore, the place was named by Chaibari.[16]

Table 2.7 : Statistics of Bajali Revenue Circle

Total HH	T-P	T-M	T-F	P-SC	M-SC	F-SC	P-ST	M-ST	F-ST	P-LIT	M-LIT	F-LIT	P-ILL	M-ILL	F-ILL
20217	91183	45336	45847	8019	3991	4028	4097	2026	2071	7222	37975	34237	18071	7361	11610

Source: Census, 2011, Govt. of India.[17]

Table : 2.8

Statistics of Various villages of Bajali Revenue Circle (Houhold, Population, S/C, S/T Population, Literacy Rate Male-Female)

Name of the villages	Total Household	Total Population	Total Male	Total Female	Population SC	M-SC	F-SC	Population ST	M-ST	F-ST	P-LIT	M-LIT	F-LIT	P-ILL	M-ILL	F-ILL
Barsahan	192	927	471	456	152	79	73	01	01	0	750	410	340	177	61	116
Barnalikuchi	387	1759	893	866	34	24	10	01	0	1	1497	781	716	262	112	150
Patacharkuchi	352	1530	776	754	47	23	24	43	26	17	1265	662	603	265	114	151
Brabhala	214	966	462	504	45	23	22	0	0	0	814	404	410	152	58	94
Nizsathisamukha	106	474	224	250	155	77	78	150	65	85	338	166	172	136	58	78
Bamunkichi	339	1572	770	802	159	85	74	O	0	0	1327	683	644	245	87	158
Gobindapur	424	1963	952	1011	0	0	0	0	0	0	1539	789	750	424	163	261
Sarih Chakla	473	2135	1088	1047	6	6	0	2	2	0	1768	931	837	367	157	210
Nitya	378	1708	831	877	310	164	146	6	2	4	1461	733	728	247	98	149
Chaibari	333	1516	748	768	0	0	0	0	0	0	1231	640	591	285	108	177

Source : Census, 2011, Govt. of India.[18]

2.11 : Growth of Population

In the last ten years the population of this area has increased by 2.9% According to 2001 census reports there were about 1lakh population. The growth rate of female population is 5.2% which is 4.5% higher than male population growth rate of 0.7%.According to the 2011 census the general caste population has increased by 3.5%,Schedule caste population has increased by 18.5%, Schedule Tribe population has decreased by 25% and child population has decreased by 8.2%.

2.12 : Sex Ratio- Female per 1000 Male

According to the 2011 census there are 1002 females per 1000 male in this area. Sex ratio in general caste is 1001,in schedule caste is 1003 and in schedule tribe is 1030. There are 966 girls under 6 years of age per 1000 boys of the same age. Overall sex ratio has increased by 43 females per 1000 male during the years from 2001-2011. Child sex ratio here has decreased by 0 girls per 1000 boys during the same time.

Table : 2.9

Villages and Cities with highest sex ratio

Name of the villages	Bangnabari	Kochdiga	Kukua Batabari	Niz-Sathi Samukha	Bilpar	Bangaon	Rupdiga	Balipara	Barbhala	Garemari
Sex Ratio	1222	1200	1174	1116	1114	1107	1097	1092	1091	1084
City	Pathsala									
Sex Ratio	930									

Source : Census, 2011, Govt. of India.[19]

2.13 : Literacy

The literacy rate of the area is 88%. The total literate people in this area is 82 thousand, among them about 43 thousand are male and about 39 thousand are female. Literacy rate (children under 6 are excluded) of Bajali (Pt) is 88%. 93% of male and 83% of female population are literate here. Overall literacy rate in this area has increased by 3%. Male literacy has gone down by 1% and female literacy rate has gone up by 6%.

2.14 : Climate

The Bajali Revenue area which is a part of Assam state in the north eastern part of India lies within the zone of monsoon climate of sub- tropical belt. Climate of this area is characterized by heavy summer rainfall, with high relative humidity (80%+), winter drought and relatively low temperature during a year. As per Metrological Department of India the area received 2000mm, mean annual rainfall and falls within the zone of 23 C to 25 C mean annual temperature.

Table : 2.10

Biggest Villages and Cities in Bajali (Pt)

Nameof villeges	Bhotanta Mohitara	Barbang	Doloi Gaon	Maripur Anandapur	Borsaderi	Barsaderi	Bar Bamakhata	Titkataje	Sarih Chakla	Khara Dhara
Area(Km2)	10.4	5.9	5	4.5	4.3	4.2	3.9	3.7	3.6	3.5
Name of Cities	Pathsala									
Area(Km2)	2.7									

Source : Census, 2011, Govt. of India. [20]

2.15 : Satra Institutions

The word satra is a corrupt form of the Sanskrit word satra. In Sanskrit literature the word has been used in two senses; firstly, in the sense of an alms house and secondly, in the sense of a sacrifice lasting from a few days to a year or more.

2.16 : Principal Sartras in the area

Sidhapur Satra, Rajadiya Deka Satra, Sathiya Satra, Niz-Sariha Satra, Bhaluki Satra, Pata Satra, Kochdiya Satra, Paka Satra, Belana Satra, etc.

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CHAPTER - 3

HEALTH SCENARIO IN ASSAM WITH SPECIAL REFERENCE TO BAJALI REVENUE CIRCLE

3.1 : Health care system in India

The most fundamental aspect of human life is health which unfortunately can not be given or distributed. It is to be actively acquired or won. It forms an integral component of overall socio-economic development of any nation.[1] The health status of a state depends to a great extent on the availability of health related infrastructure. In rural India, Govt. health infrastructure and facilities are not adequate to meet the challenges for the common people. Due to the insufficient facilities, the expenditure on health is increasing day by day for the rural people. The Government has responsibility to provide health care to all people in equal proportions in both urban and rural areas of the state. The Government have been launched various health schemes and programmes to improve the health status of people of the country, especially for those living in rural areas since Independence. The idea to construct of primary Health centers (P H Cs) began in the early 1950's. By the 1970s one PHC per community development block (living a population of 60,000 on an average) had been achieved in accordance with the Bhore Committee's recommendation. Since the average population of a block had increased significantly, the concept of sub- centre (SC) came into

force. The structure of health care service in rural areas provide a network of sub- centre (SC) and primary health centres (PHCs), hospitals and dispensaries in Government as well as private health sectors. The Sub- Centre (SC) is the first point of contact between the community and the health care system. Primary health centres (PHCs) is a referral unit for six SCs with 4-6 beds. Community Health Centre (CHCs) is a 30 bedded Hospital/Referral Unit for four PHCs with specialized services. As per the Indian Public Health Standards (IPHS) norms prescribed by GOI the requirement of SC, PHC and CHC is based on population as below.

Table : 3.1

Category of Health Centre	Population norms	
	General areas	Tribal/ Hilly/ Desert areas
SC	5,000	3,000
PHC	30,000	20,000
CHC	1,20,000	80,000

Source : Rural Health Statistics-2012 p-13.[2]

The National Rural Health Mission (NRHM) now (NHM) is an Indian health program for improving health care delivery across rural

India. On 12th April, 2005 the Government of India launched the National Rural Health Mission. The aim of the NRHM is to improve the health status of people of the country, especially for those living in rural areas. NRHM specially focuses on states, which have poor health outcomes and inadequate public health infrastructure and workers. The primary focus of the mission is to improve access to health care for rural people, especially women and children. The main goal of NRHM is to reduce infant mortality rate (IMR) and Maternal mortality ratio (MMR) by promoting newborn care immunization, ante natal care, institutional delivery and post partum care. The NRHM foundation built on community involvement in drawing a village health plan under the auspices of village health and sanitation committee (VHSC). This would enable rural primary health care services accountable to the community and giving authority to the district health Mission for implementation of inter-sectoral District health plan including drinking water, sanitation, hygiene and nutrition. The interface between the community and the public health system at the village level is entrusted to a woman. Accredited social health Activist (ASHA) a health Volunteer, receiving performance based compensation for promotion of universal immunization, referral and

escort services for reproductive and child health (RCH), construction of household toilets, and other health care delivery programmes. To promote institutional delivery, cash incentive programme under Janani Suraksha Yojana (JSY) is made an integral component of NRHM. Although NRHM aims to cover all the states of the country, special focus given to 18 states-Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh.[3]

Since the present research work is purely relay on rural health care system, it will be appropriate to give a glance of rural health care system, in India before going on further description. The health care system infrastructure in area of rural places has been created as a three tier system and is depend on the population. The sub- centre is the most marginal and first contacting point between the primary health care system and the community of the area. Each sub- centre is required to employed by one Auxiliary Nurse Mid wife (ANM) in consist of Female health employer and one Male health employer. Primary health Care (PHC) is the first contact point between village community and the Medical officer supported by about 14

paramedical and other supporting staff. Under National Rural Health Mission (NRHM) there is a provision for two additional staff nurses at PHCs on contract or temporary basis. It acts as a referral unit for six sub- centres and minimum consists of 4 to 6 beds for patients. Community Health Centre (CHC) serves as a referral centre for 4 PHCs and also provides facilities for obstetric care and specialist consultations. A chc is required to be manned by four Medical specialist's i.e. Surgeon, Physician, Gynecologist and pediatrician supported by 21 paramedical and other staff. It has 30 indoor beds with one OT, X-RAY, labour room, and laboratory facilities.

3.2 : Health Care

The dictionary meaning of health care is the prevention, treatment, and management of illness and preservation of mental and physical well-being through the services offered by the medical and allied health profession. The World Health Organization (WHO) defines health care in terms of primary health care that the main goals of primary health care is better health should be provided for all. WHO has identified five key elements to achieving that goal:

- Reducing exclusion and social diparities in health (Universal coverage reforms)
- Organizing health services around people's needs and expectations (Service delivery reforms)
- Integrating health into all sectors (Public policy reforms)
- Persuing collaborative models of policy dialogue (Leadership reforms)
- Increasing stakeholder's participation. [4]

3.3 : Public Health Care system in Assam

The poor patients depend heavily on public health service because the cost of treatment of illness is higher in private health care centres. It is found that women are suffering from different types of health problems for which proper health care facilities are not available in the health centres of rural areas. Moreover the Government has undertaken many health policies and schemes for the rural people but due to their illiteracy, negligence, and awareness problem, negligence behaviour of health providers, the services are not properly utilized. In this section the availability of health infrastructure facilities are discussed.

According to the Economic Survey –Assam 2015-16 , the total fertility rate of the state is 2.7. The birth rate (per thousand) is 22.4 (2014) and death rate (per thousand is 7.2 (2014) The infant mortality rate (per thousand) is 49 (2014) and maternal mortality ratio (2014) death per lakh live birth is 112 on 2017.[5]

3.4 : Infrastructural Facilities in Assam

Infrastructural facilities in Assam comprise of 25 district hospitals (DH), 151 – Community Health Centres (CHC), 1014 PHCs and 4621 SCs. There are 103 health facilities functioning in 24into 7 basis and only 60 are functioning as first referral units (FRU). The 62 FRUs comprise 25 DHs, sub- divisional hospitals (SDH) and 36 CHCs.

Table : 3.2

Health Infrastructure in Assam 2015

Health Institutions	Number
Medical Colleges	06 (2013)
District Hospitals	25
Ayurvedic Hospital	01

MBBS Doctors (Govt.&NHM)	2581 (2014)
Homeopathic Hospitals	03
Specialist Doctors (Govt.&NHM)	1133
State level Hospitals	01
Sub- Divisional Hospitals	13
CHC	151 (2015)
PHCs	1014 (2015)
State Dispensaries (SD)	261
Subsidiary Health centre (SHC)	71
Sub- Centre	4621 (2015)
B.SC Nursing College	01
24into 7 Health facilities	103
F R U	62 (2015)

Source : Rural Health Care System in India,2015& NHR, 2008 Assam.[6]

Table : 3.3

Physical Health Infrastructure of Rural Assam & Barpeta District

		SC since 2015		PHC since 2015		CHC since 2015	
Sl no		No.	Population Served	No	Population Served	No	Population Served

01	Assam	4621	5801	1014	26437	151	177530
02	Barpeta	264	5857	51	30319	06	357711

Source: Rural Health Care System in India, 2015&NHR, 2008, Assam.[7]

Table : 3.4

Availability of Health centres against requirement and shortfall in Assam

Category of health centre	No of required as per population as on 31st March 2016	No of available as on 31st March 2016	Shortfall (%)
SC	6,817	4,621	2,196 (32.21)
PHC	1,112	1,014	98 (8.81)
CHC	278	151	127 (45.68)

Source : https://cag.govt.in.[8]

3.5 : Private Health Facility in Assam

Private hospitals in Assam are health care institution providing treatment with specialized doctors. In Assam the private hospital typically contains health care facility in its region, with large numbers of bed for all intensive care and long-term care of patient. The specialized private hospitals of Assam include trauma centres,

hospitals of rehabilitation, children's hospitals which are dealing with specific medical needs of the patient such as psychiatric problems. These hospitals in Assam have the range of departments such as Surgery care unit, cardiology, emergency care, ICU, Chronic treatment Unit, radiology, Pathology, etc.[9]

Today private hospitals in Assam are largely staffed by professional doctors like the Physician, Surgeons and nurses.

3.6 : Human Resources in Assam

Number of Medical & Paramedical Staffs in Assam, 2015

Table : 3.5

Post	Position		
	Govt.	NHM	Total
1	2	3	4
MBBS Doctors	2264	608	2872
Specialist Doctor	896	191	1087
AYURBEDIC Doctor	358	443	801

Dental Surgeon	63	174	237
Homeopathic Doctor	75	247	322
MBBS Doctor for 1 year rural posting	0	402	402
ANM	5934	4875	10809
GNM	3100	2960	6060
Pharmacists	1368	684	2052
Laboratory Technicians	860	776	1636
Radiographer	91	46	137
Rural Health Practitioner	0	562	562

Source: Statistical Hand Book Assam- 2016 .[10]

3.7 : Caseload

Caseload is the number of cases handled (as by a court or clinic) usually in a particular period. Now a day caseload it is to see that caseload has improved significantly. Number of institutional deliveries has increased (NRHM-2007-08). Introduction of Rural Health Practitioner (RHP) Under NRHM has been innovative idea and

is going to make a huge difference in delivery of health services at PHC levels in Assam. Improvement in use of human resources has facilitated evening OPDs in Assam and is expected to bring effective utilization of existing physical health infrastructure in Assam.

3.8 : Outreach of the Health Services

With the introduction of ASHAs and AYUSHs health reach has spread to the interiors of the state. ASHA acts as a link between the health centres and the villages. At present there are 30,508 ASHA workers, are in the state looking after child and women health services.

AYUSH implies Ayurveda, Yoga, Naturopathy, Unani, Sidha and Homoeopathy. NRHM aims at improving and correcting the deficiencies in the health care delivery system with a focus on integrating all the available health care facilities like AYUSH along with ongoing programmes.[11]

3.8 : Various Maternal and Child Health Scheme sponsored under NRHM

3.8.1 : Janani Suraksha Yojana-

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Rural Health Mission (NRHM) being implemented with the objective of reducing maternal and neo- natal mortality by promoting institutional delivery among the poor pregnant women. Under the scheme 37.63 lakh women have got benefited in the state till 2015-16 Year wise break -up of Janani SurakshaYojana (JSY) beneficiaries in Assam

Table : 3.6

Year	Beneficiaries
2011-12 (April-January)	3,28,926
2010-11 (April-January)	3,91,675
2009-10	3,66,596
2008-09	3,27,894
2007-08	3,04741
2006-07	1,82,873
2005-06	17,523

Source : Economic survey, Assam[12]

3.8.2 : Janani Sishu Suraksha Karyakram

Janani Sishu Suraksha Karyakaram (JSSK) implemented from Feb, 2012.It is a national initiative of JSSK is to provide free and

cashless services to pregnant women including normal deliveries and caesarean operations and sick new born (up to 30 days after birth) in Government health institutions, accredited private hospitals and sub-centre in both rural and urban areas where in the delivery is conducted. Entitlements for pregnant women under the schemes are free and cashless delivery, free caesarean section, free drugs and consumables, free diagnostics ((up to 3 days for normal delivery and 7 days for caesarean sections) free nutritional supplement such as Horlicks to the mothers, free ultra sonography and free tests required including for seeking hospital care up to 6 weeks post delivery for post natal complications. Exemption for new born till 30 days after birth are free at the public health institutions, drug and consumables, diagnostics such as blood test, urine examination and other user charges.

3.8.3 : Mamata

The scheme Mamata seeks to reduce IMR and MMR by insisting on a post delivery Hospital stay of 48 hours of the mother and new born. During discharge from hospital a gift hamper called "Mamata Kit" is given. It contains materials for the new born.

3.8.4 : Mamani

Under the scheme cash assistance to pregnant women for nutritional support of Rs. 1000.00 in two installments is provided to the beneficiaries. It is a state Government sponsored scheme that encourages pregnant women to undergo at least three ante- natal check-up which identify danger signs during pregnancy and offer proper medical care.

3.8.5 : Majoni

Social assistance to all girl children born in the family up to second order is given a fixed deposit of rupees 5,000.00for 18 years. On the 18th birth day, the girl will be able to encase the fixed deposit. In case she is married before attaining 18th years of age, the fixed deposit will be forfeited. The scheme is applicable to families who are limiting themselves to two children.

3.8.6 : Morom

The "Morom" scheme will provide financial support to indoor patients of Government Health Institutions for supplementary nutrition and compensation for weight loss during hospitalization and post hospital expenses. Indoor patients admitted to a hospital receives

Rs.75/- per day for Medical College, Rs 50/- per day for District Hospital and Rs 30/- per day for SDCH/CHC/PHC/.[13]

3.9 : Health Care Facilities in Bajali Revenue Circle

One of the Bajali- sub –Divisional Block office of health Department is situated at Nityananda under which there are one sub – Divisional Civil Hospital, two state dispensary and eleven mini-primary health –centre. All total there are 14 big or small hospitals, centre led by this Block. Besides, there are 41 sub centres. These are all listed below:

1* Sub-Divisional Civil-Hospital (SDCH)

(a) Pathsala SDCH

2* State Dispensary (SD)

(a) Helona SD

(b) Sadery SD

3*Mini-Primary Health Centre (MPHC):

(a) Patacharkuchi MPHC

(b) Baramsary MPHC

(c) Akaya MPHC

(d) Dhemsa MPHC (Near AnandaBajar)

(e) Gomura MPHC (NEAR Sarupeta)

(f) Sarupeta MPHC

(g) Puthimary MPHC

(h) Cheky MPHC

(I) Barbang MPHC

(J) Baghmara CHC (Community Health Centre)

k) Nityananda MPHC

Various facilities are provided by this Block office to the 14 Hospitals. The 24x 7 facilities are provided to 13 Hospital. This facility is not available in Chiky Hospitals. Pathsala SDCH and Baghmara CHC has the IPT (indoor Patient) facility. All others including Nityananda MPHC has only OPT (Out door patient)facility. The Block office maintain a link between the Government (Health Department) and the 14 hospitals and sub- Centres which are under its control by medicine distribution, financial package distribution, training program me and it also assist in infrastructural development. By its two field NGO, Pacca Grammonnayan Parisad and Pithadi Welfare Society it facilitate the society and also collect report. These

two field NGO is controlled by District level mother NGO. The Barpeta District mother NGO is known as RUWA, which is responsible for rural upliftment of women activities. It also organizes awareness meeting and controls the field NGOS. Under the jurisdiction of Nityananda Block office the two field NGO helps the Department in field level survey, awareness meeting ,distribution of materials like-banner, oral-pil, condom, pregnancy test instrument etc. Another jurisdiction of Nityananda Block Office is distribution of Aasha kits and Sub-Centre kits which contain medicine for common disease like fever, diaria disease, pregnancy test items, family planning items. Besides Pathsala SDCH, in all hospitals under Nityananda Block Office has only the provision of normal delivery. For community development there the provision of VHND (Village Health and Nutrition Day). In that programme the pregnant mothers, mother –in –law, village grand –mother, members of self-help-group, infants, teachers of the community, mother's group present there. It is a program me arrange in every Wednesday for health awareness.

According to the programme Manager there is also some deficiency in health Dept. and particularly in Nityananda Block Office. The infrastructural development is poor and also there the

deficiency of proper store room, conference Hall, for conducting meeting and training. The boundary facility is not proper, which threat the security of the nurses reside in quarter.

ASHA plays an important role in the communication of health related information by maintain a link with the society. In every 1000 population there should be one ASHA. By their periodical house to house field survey with the ANM, the ASHA collect records from the society. They categories the population like-0-1 years, 0-5 years old etc and the listed it accordingly. In the end of the March they submit the report to the Department. They are the primary care holder for both maternal lady and infant. The ASHA motivates the maternal lady at their stage for going to Hospital and provide the knowledge about medical help and their periodical check –up. The first duty of the ASHA is to register the maternal lady in the nearest Hospital and ask to open an account in the nearest bank for collecting financial assistance given by Government. She assist the lady in delivery period and remain wither. After the delivery period the ASHA care for the health condition of both mother and infant. They have also the duty for full immunization of the infant. The four check-up of maternal lady held in 3 months, 5 months, 8 months, 9 months. In every check

–up weight of the lady should be increased. After delivery the lady should remain in the Hospital at least for 48 hours. These are the normal activities of a pregnant women till to her delivery that should have very cautiously maintained.

There is an inter-sect oral convergence among health Department, Public health Department and social welfare Department. Treatment duty is remain with the Medical Department. But the cleanliness duty is performed by public health Department. Social welfare Department helps the Medical Department in immunization by the Anganbadi centre. In sanitation programme the health Department gives 300 Rs and Public health Department gives 2700 Rs.

The Health Department now increasingly becomes conscious for various schemes and its financial and material assistance. By the Janani Suraksha Yogona, the village maternal lady find 14 00 / and the town maternal lady find 1000/ for blood transfuse. Also free conveyance from home to health institution, between health institutions in case of referral and free drop back home after delivery under "Aadarani Scheme" Exemption from all kinds of user charges,

Table : 3.7

Reproductive Health Care facilities under NBPHC (2017-18)

Variables	Total	Percent
Mother who receive any anti-natal check-up	2,983	92.69
Mother who receive full anti-natal check-up	2,297	71.37
Mother who receive anti-natal care from Govt. source	2,297	71.37
Institutional Delivery	3,781	117.49
Delivery at Govt. Hospital	2,883	89.58

Table : 3.8

Details of New born Baby weight under NBPHC

Year	<1kg	<1.79kg	Between1.8-1.99kg	More than 2.5kg
2014-15	0	28	427	2590
2015-16	06	13	304	2521
2017-18	07	28	73	3,275

Table : 3.9

Family Planning performed under NBPHC

Family planning	2014-15	2015-16	2017-18
L/S	299	47	02
PPS	40	38	263
IUCD	258	205	312
PPIUCD	42	40	201
Post abortion IUCD		01	41
Oral pill	17,220	12,175	19,925
Condom	40,903	24,795	49,723
Emergency tap	0	0	25
Pregnancy test kit	846	503	1,011

Table : 3.10

Child Immunization: No of infants- 0 to 11 months who received the following (Under NBPHC)

Year	BCG	DPT-3	OPV-3	Hepatitis B-3	MLS (Ist Dose 9-12 months
2014-15	2354	2957	2759	2847	3004
2415-16	1827	245	1691	222	2097

Source : Nityananda Block PHC[14]

Though Government has taken some schemes and policies for health care in general and women's health in particular in the last couple of years,Assam has not been able to achieve the desired health outcomes including the study area. The health status among the rural

population is not at all satisfactory. It is the need of the time to take appropriate step to develop the health status of rural people by providing quality health care services. The State Government has to take necessary step to improve the health care infrastructure.

Notes and References

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2. Rural Health Statistics-2012 p-13

3. Shekhar,B.K. "Natonal Rural Health Mission in India"-pp. 64-68

4. OGI.N.Shashikala "Health Status of Rural Women", A Study on Hydarabad and Karnataka Region" p. 120.

5. Statistical Hand book of Assam-p. 324.

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7. Ibid:p-212-13.

8. https://cag.govt.in.

9. https://www.hospitalkhoj.com/hospitals/private/assam.

9. Statistical Hand Book Assam-2016p-322.

10. Ibid

11. Economic Survey,Assam-2015-16.

12. Ibid:pp258-260.

13. Nityananda Block PHC.

14. Ibid : p. 217.

Chapter 4

HEALTH STATUS OF RURAL WOMEN- EVIDENCES FROM THE FIELD

Chapter IV has sub-divided into two sections, viz., Section A, which consists the social profile of the study area and Section B, studies the health issues of rural women in the sample area.

A. SECTION-A

4. A : Social Profile

In this chapter we want to depict Socio-Economic background of the respondents and their household and also from which social group the respondents come from. An effort is made for the development of such background and contextual variables which could be used in the analysis and interpretation of the social implication and status of rural women. It helps with significant and relevant backdrop against which the findings of the present study could be brought to bear upon.

The following analysis along with the data given in the concern tables reveal the social profile of the respondents which include age, sex, caste, educational status, family occupation and so forth. It is also analysis the major health issues of rural women.

4. A.1: AGE OF THE RESPONDENTS

Age of the respondents is one of the most important variables for any social science research. Age is an independent variable, which could influence on the other attitudinal aspects of the respondents. The study is going on general and reproductive health status of rural women of Bajali- Revenue Circle it is important to collect data on the age of the respondents. As such the data on the age of the respondents is collected and is presented in the following table:

Table- 4.1

Age of the respondents (NO- 150)

Age	NO	Percentage
Between 20-25	14	9.34
Betwwen 26-30	20	13.34
Between31-35	28	18.67
Between 36-40	28	18.67
Above 41	60	40.00
Total	150	100.00

The data on the age group of the respondent's reveal that, an overwhelming majority of the respondents was belonging to age of

above 41 is 60 (40%). The number of women between the age group of 20-25 is 14 (9.34%).Interestingly the number of women between the age group of 31-35 and 36-40 are same. Most of the selected respondents are matured. Therefore they are free to express the problems related to reproductive health.

4. A.2 : Caste of the Respondents

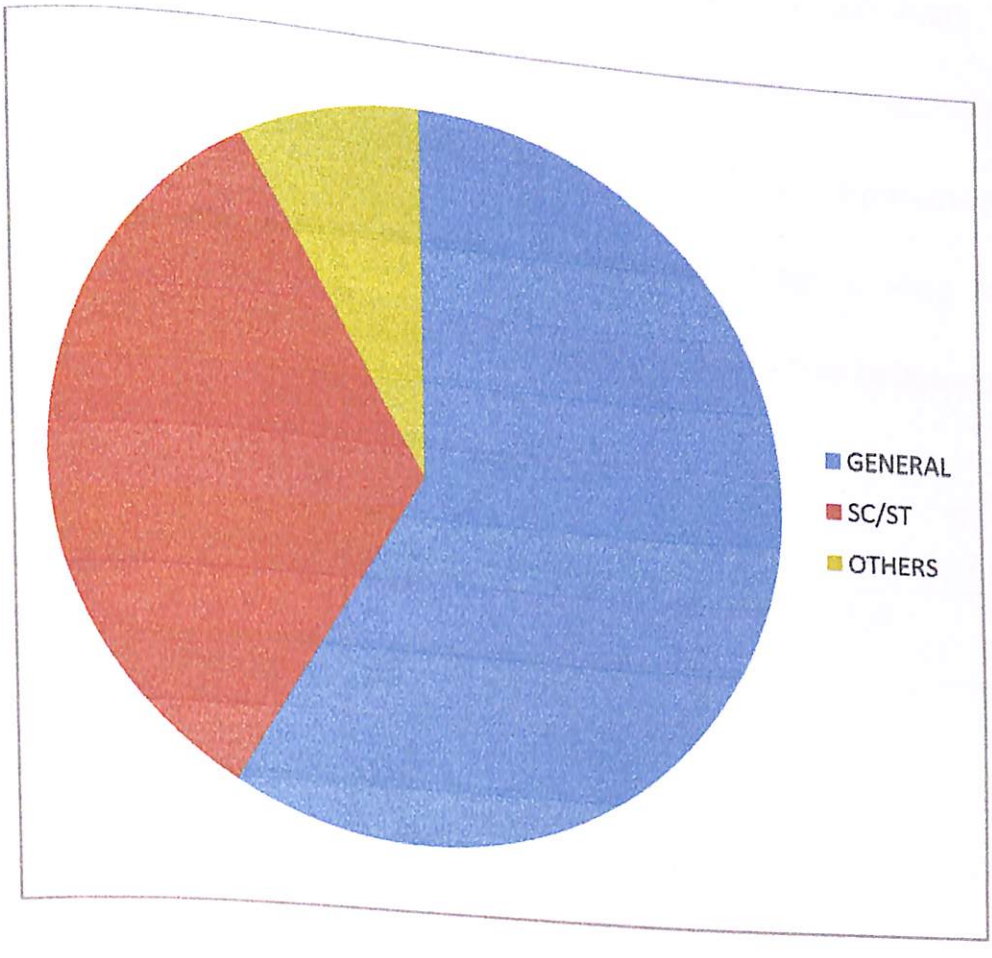
The word caste is used only for descent or hereditary. Caste is a hereditary endogamous group which decides the individual status in the social stratification and his profession. The caste system of India is unique- in the religious ritual which explains it in its complexity and in the degree to which the constituent groups are cohesive and self regulating. Henri Maine Defined caste as a natural division of occupational classes and eventually upon receiving the religious sanction, become solidified into the existing caste system.

Caste system is an integral part of Indian society. It is a system of social stratifications as a result of which the status and role of the individual member of the society determined. In India caste system is still an important factor in the rural society. In comparison to urban areas rural areas are more affected by caste based sociology. [1]

Table : 4.2

Caste	NO	Percentage
General	**88**	**58.67**
SC/ST	**50**	**33.34**
Others	**12**	**8.00**
Total	**150**	**100.00**

Chart :1



The table 4.2 shows that out of 150 respondents, 88(58.67%) belong to general caste, 50 (33.34%) Schedule Caste/tribe, where

as remain 12 (08 %) considered as others respectively. The present study shows that the studied area is dominated by general caste.

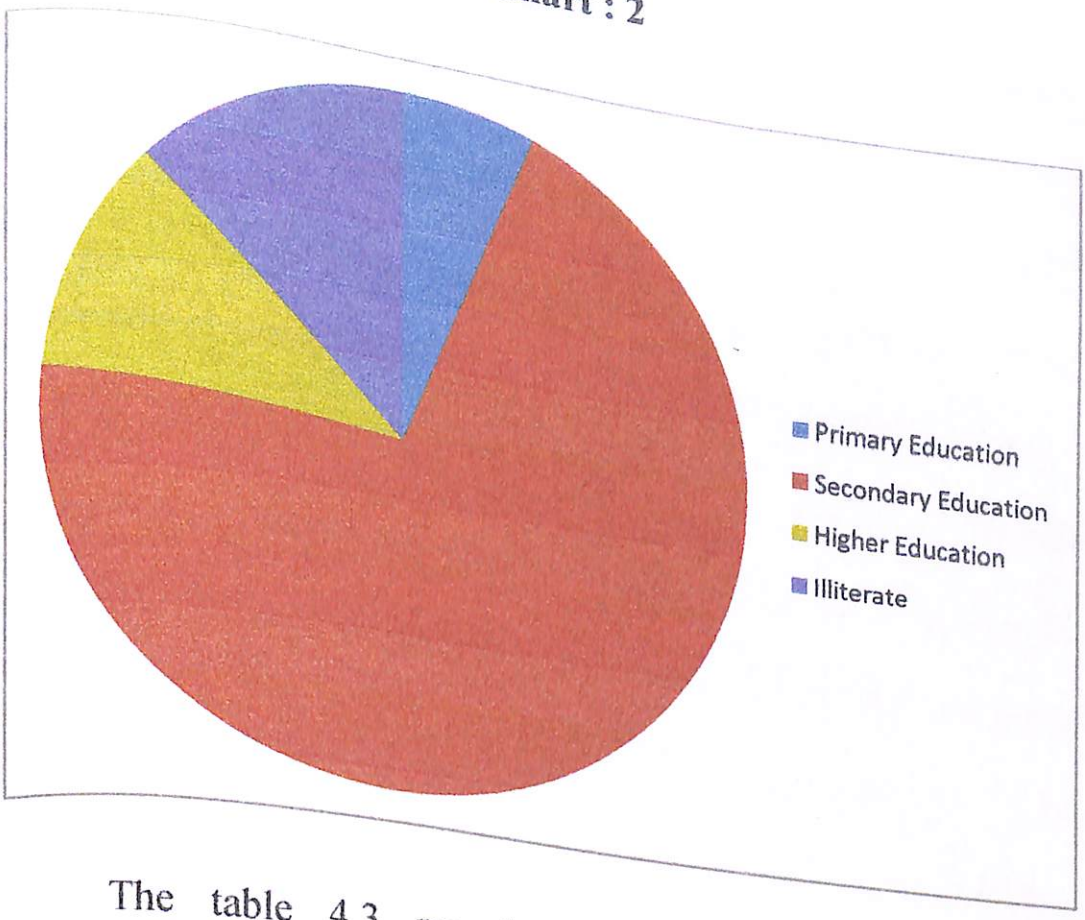
4. A. 3 : Education of the Respondents

Education is one of the important factors to shape up the personality of an individual. It also develops the social set-up of the community as a whole. Education is the milestone of women empowerment because it enables them to responds to the challenges, to confront their traditional role and change their life. Educated women can help in reduction of fertility and growth of population. Educated women can recognize the importance of health care and know to seek it .Education has a long been recognized as a crucial factor influencing reproductive behaviour.2

Table : 4.3

Education	No	Percentage
Primary Education	09	6.00
Secondary Education	106	70.67
Higher Education	16	10.67
Illiterate	19	12.67
Total	150	100.00

Chart : 2



The table 4.3 reveals the educational status of the respondents among 150 respondents about 12.67% of the women in the present study are illiterate and about 6% are educated up to primary level. Among the educators 70.67% are studied at level of secondary education, whereas 10.67%women are studied higher education.

The present study results clearly state the educational status of the respondents. The recent development in this area may be in further enhancing the higher educational percentage of backward people in general and women in particular.[2]

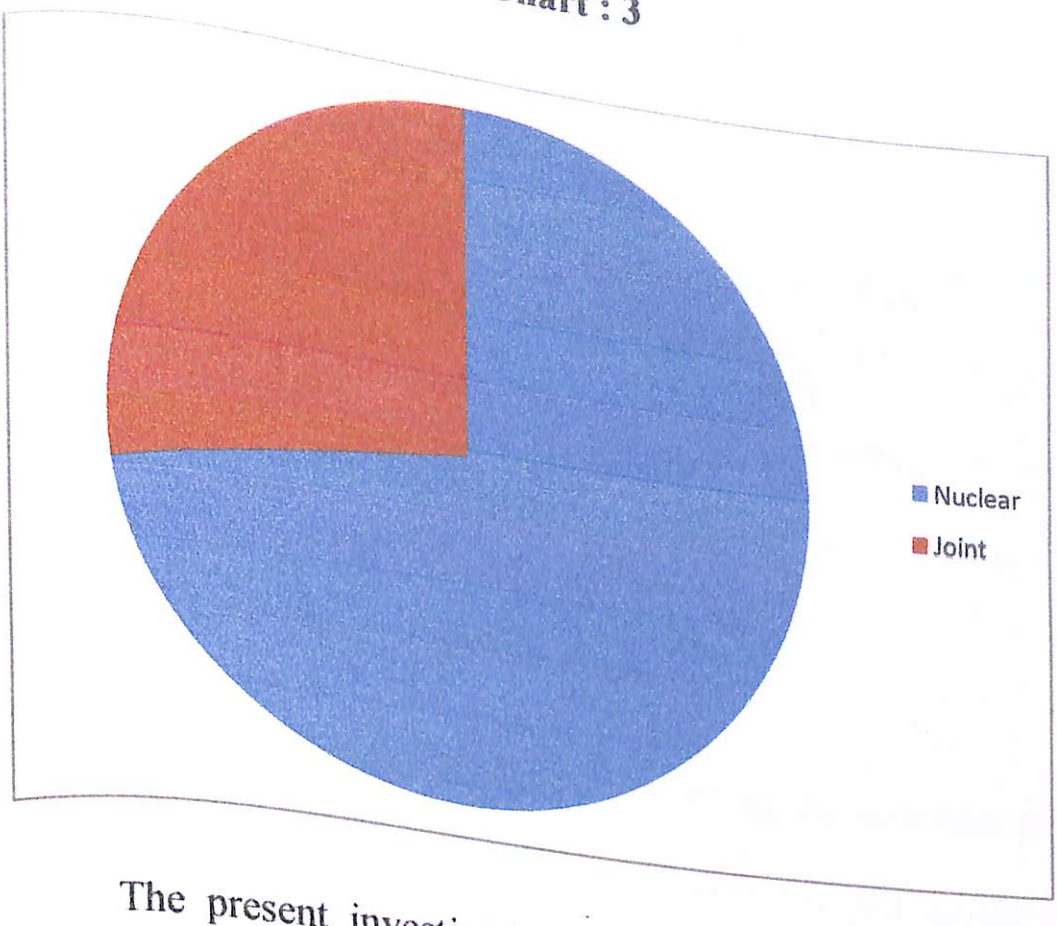
Nature of the Family- Family is the primary institution which controls various aspect of the society. Generally in rural areas joint family system prevail. Rural society is still dominated by joint family system. But due to the various reasons the concept of joint families in India has broken. The western values relating to modern science, rationalism, individualism, equality, free life, democracy, freedom of women etc. have exerted a tremendous influence on the joint family system. In rural areas also where joint families were predominant up to late 20th century, it has diminished and nuclear family concept has been adopted at large scale.[3]

Table-4.4

N (150)

Type of Family	NO	Percentage
Nuclear	109	72.67
Joint	41	27.34
Total	150	100.00

Chart : 3



The present investigation results, indicate that among the 150 respondents, only 41 (27.34%) have living in joint family, majority of the respondents they consists of 109 (72.67%) are living in nuclear families.

4. A. 4 : Marital status

Marriage is an important social institution. It is stable relationship in which a man and woman are socially permited to have children.The women in rural India are generally married at an early age. From the table 4.5 it is observed that among the respondents, all respondents about are married women.[4]

Marital Status of Respondents (N- 150)

Table : 4.5

Marriage Status	No.	Percentage
Married	150	100
Total	150	100

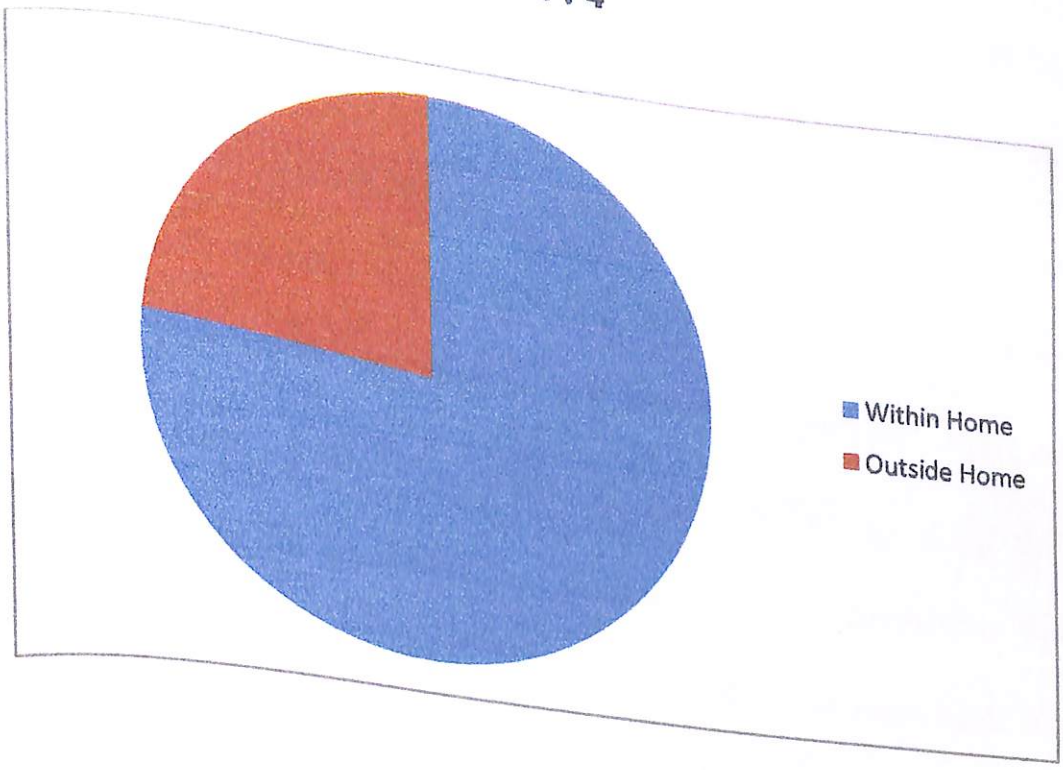
4. A. 5 : Work Place of Respondents

Occupation plays a vital role regarding the economic status of women in society. Occupation determines her knowledge, awareness level, decision making matters of reproductive health. Therefore it is one of the important factors to see occupation profile of the respondents.

Table : 4.6

Variable	No	Percentage
Within Home	132	88
Outside Home	18	12
Total	150	

Chart : 4



4.B : SECTION-B

This section studies the health issues of rural women in the sample. Healthy families make healthy people. The family is the primary unit of healthy care. "Health begins at Home" was the theme chosen for World Health Day(1973) of 25th anniversary of WHO in recognisation of the important role of the family in promoting and protecting the health of its members. Women occupy an important place in shaping the life of its family members. The mother is still the best teacher on life and health.[5] Despite being an epitome of many qualities, woman is not getting the love and respect due to her. The condition of woman in rural

areas is incalculably pathetic. She is deprived of all rights- Education, employment, economic independence, health and so on.

This very sensitive and widely discussed issue has been buzzing in my ears for quite some time, and with a view to gathering first hand information regarding the present status of women in rural areas; the researcher has decided to study this sensitive issue. To facilitate the investigation the researcher has adopted case study and questionnaire methods. The researcher has picked up 10 villages under Bajali Revenue Circle viz. Barsahan, Barnaikuchi, Nizsathisamukha, Barbhala, Nityananda, Bamunkuchi, Chaibari, Dharamtala, Patacharkuchi, Patasatra, Sariah Chakla. It is an immensely difficult task to obtain accurate information regarding these factors. But from the information and feed-bake provided to the researcher by the women in the 10 villages already mentioned bring out alarming health status of women. As for birth and fertility factors, the health of the mother is always in a declining state. With every subsequent birth, her health deteriorates. The husband and the mother-in law is least worried about it. The candid and moving revelations of the women the researcher approach are a living testimony to the deteriorating health of women. They told the researcher that they were not aware

of the care and nurturing needed during pre-natal and post-natal stage. One woman (name not disclose) made the shocking revelation that she had to help her mother-in-law in rice processing and just then her baby was born. She was shy and scared of her mother- in-law and kept the entire fact a secret. Not to speak of regular health check-up, nutritious food, rest and care. The another women reveal that she had to go to crop –field to help her husband just five days after giving birth to her baby. These are only are few instances of the society's apathetic attitude towards women in matter of health. There will be countless such cases if we go into the remotest villages which will bring out the gravity of the situation

The researcher has encountered lot of problems in eliciting information from the women respondents pertaining to their reproductive health. They hesitate and some of them were reluctant to respond when researcher approach them they asked that they will receive any financial help from Government. Some of the respondents even discouraged the researcher as not to ask such questions pertaining to their reproductive health because they thought it is a natural process. After two/ three visits and with the help of lady friends and Anganawadi workers researcher could

gather little information about their health. Women respondents were willing to answer about their general health conditions, but were not willing to disclose their reproductive health problem.[6]

4.B.1 : Abortion

Abortion is the ending of pregnancy due to removing an embryo or fetus before it can survive outside the uterus. An abortion that occurs spontaneously is also known as a miscarriage. When deliberate steps are taken to end a pregnancy, it is called an induced abortion, or less frequently an "induced miscarriage". [7]

Table : 4.7

Sl. No	Abortion	No.s	Percentage
1	Yes	30	20
2	No	120	80
3	Total	150	

In case of abortion the women were very hard to disclose their cases. It seems to be a deed of sin to abort a fetus. Therefore they do not disclose the fact. The researcher approached them again and again to focus the real fact but failed.

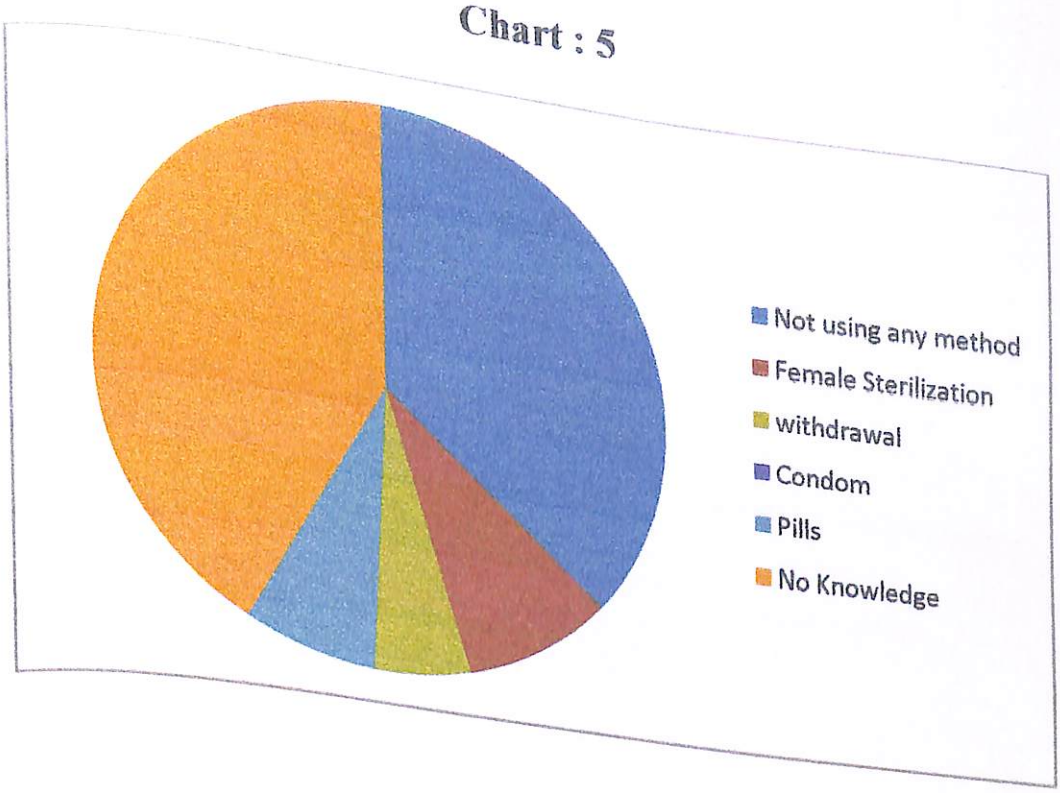
Contraceptive Method : Contraceptive method or device is a method or a device which a woman uses to prevent herself from becoming pregnant. Contraception(birth control) prevents pregnancy by interfering with the normal process of ovulation, fertilization, and implantation. There are different kinds of birth control that act at different points in the process.

What Contraceptive Method do Women use?

Table-4.8

Sl. no	Methods	No	%
1	Not using any method	40	26.67
2	Female Sterilization	10	6.67
3	Withdrawal	06	4.00
4	Condom	08	5.34
5	Pills	46	30.67
6	No Knowledge	40	26.67
	Total	150	

Chart : 5



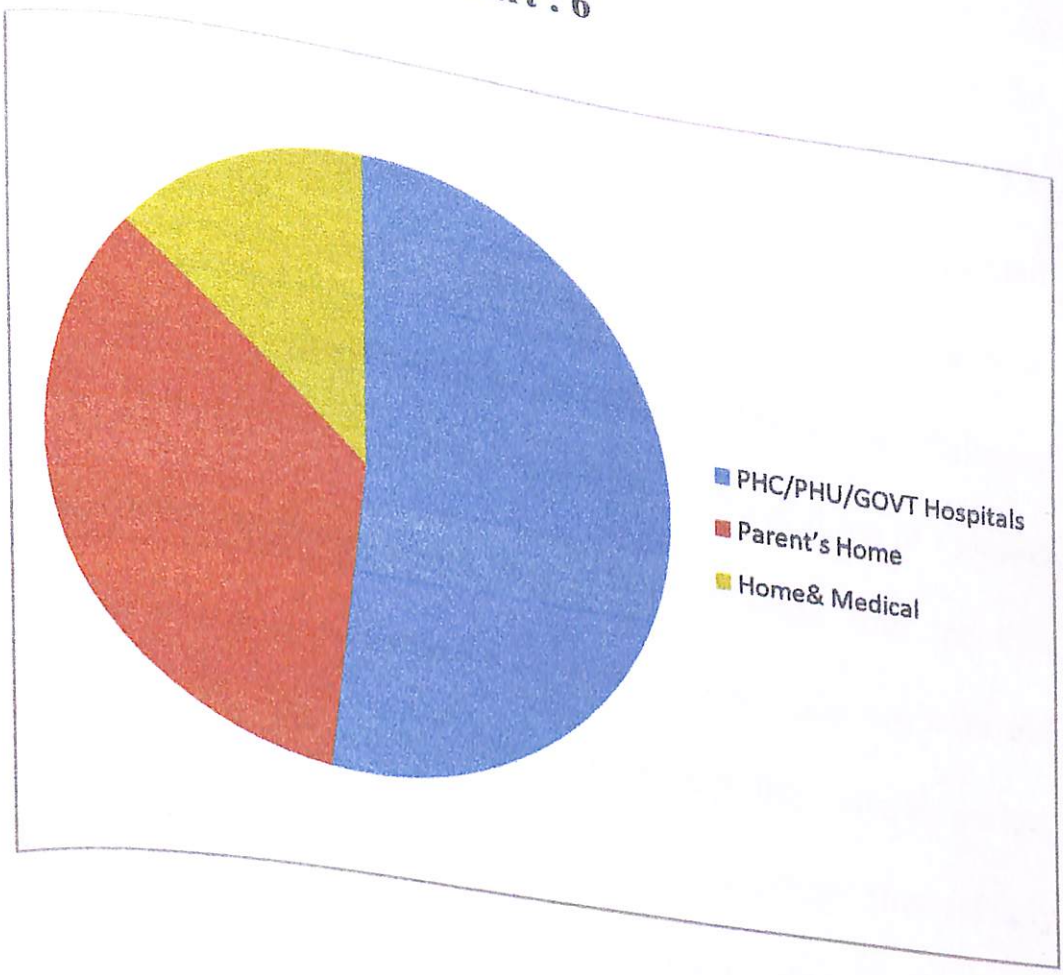
Most of the rural women have no knowledge about contraceptive method. They thought child bearing is a natural process. The children are unique gift of God. Therefore they give birth the child as long as possible.

4. B. 2 : Place of Delivery

Table : 4.9

Sl. No	Place	NO	%
1	PHC/PHU/GOVT Hospitals	78	52
2	Parent's Home	52	34.67
3	Home& Medical	20	13.34

Chart : 6



One of the disturbing factors contributing to ill health of women is that majority of birth take place at home. Place of birth have a visible impact on the mothers health. Mortality births that take place in unhygienic conditions or births they are not attended by trained medical personnel are more likely to have negative out put for both the mother and the child. The survey further revealed that the 34.67% of all births took place at home and 52% of births took place at Govt. Hospitals. And 13.34% of births took place at house and medical.

Out of 150 respondents the researcher found 50 respondents they were not visited to delivery centres for delivery. These respondents were asked the reason not to visit delivery centres. 5.34% of them stated that it is too expensive in hospitals. Due to economic constraints, they performed delivery at home. Due to lack of transport facility 2% of them not visited to delivery centres. Surprisingly, 4% of them told me that doctors are/were not regular to their duties. They are/were not available for the whole day and during the critical period. Therefore they do not try to visit delivery centre. Interestingly 4.67% of them are not going to centre due to fear. The respondents expressed that they are scared of visiting hospitals and meeting doctors.

4. B. 3 : Reasons for not going to delivery centre

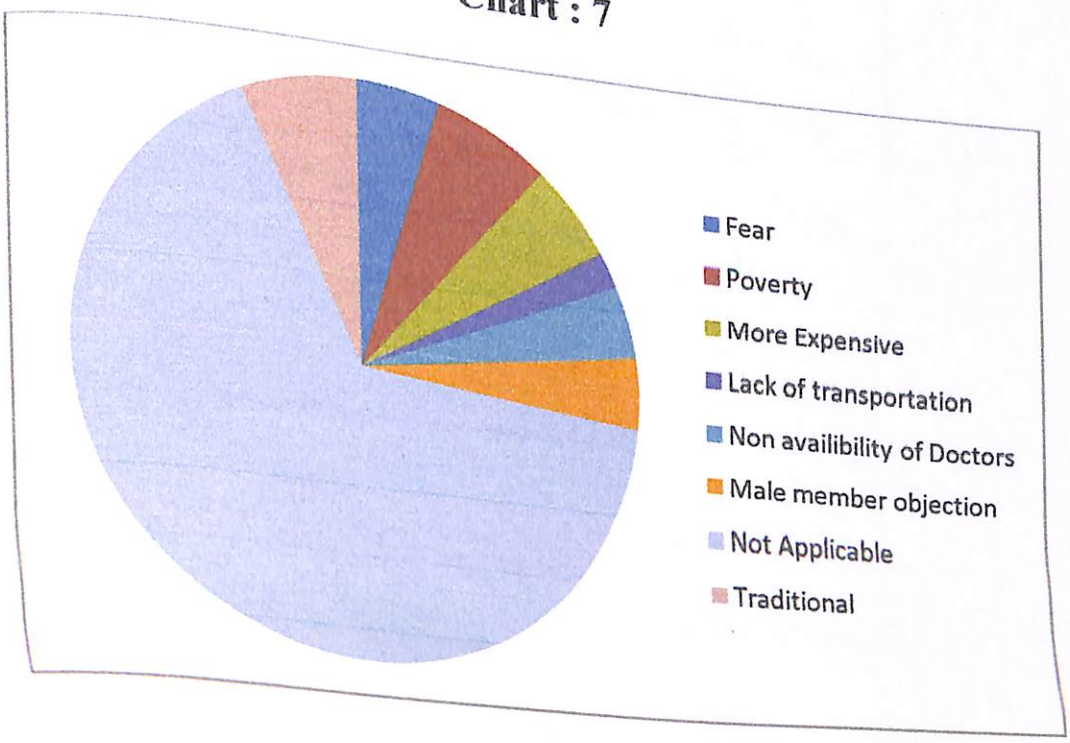
Table-4.10

Sl. No	Reasons for not going to delivery centre	No of women	%
1	Fear	7	4.67
2	Poverty	10	6.67
3	More Expensive	08	5.34

4	Lack of transportation	03	2.00
5	Non availability of Doctors	06	4.00
6	Male member objection	06	4.00
7	Not Applicable	100	66.67
8	Traditional	10	6.67
9	Total	150	

Source : Wikipedia[8]

Chart : 7



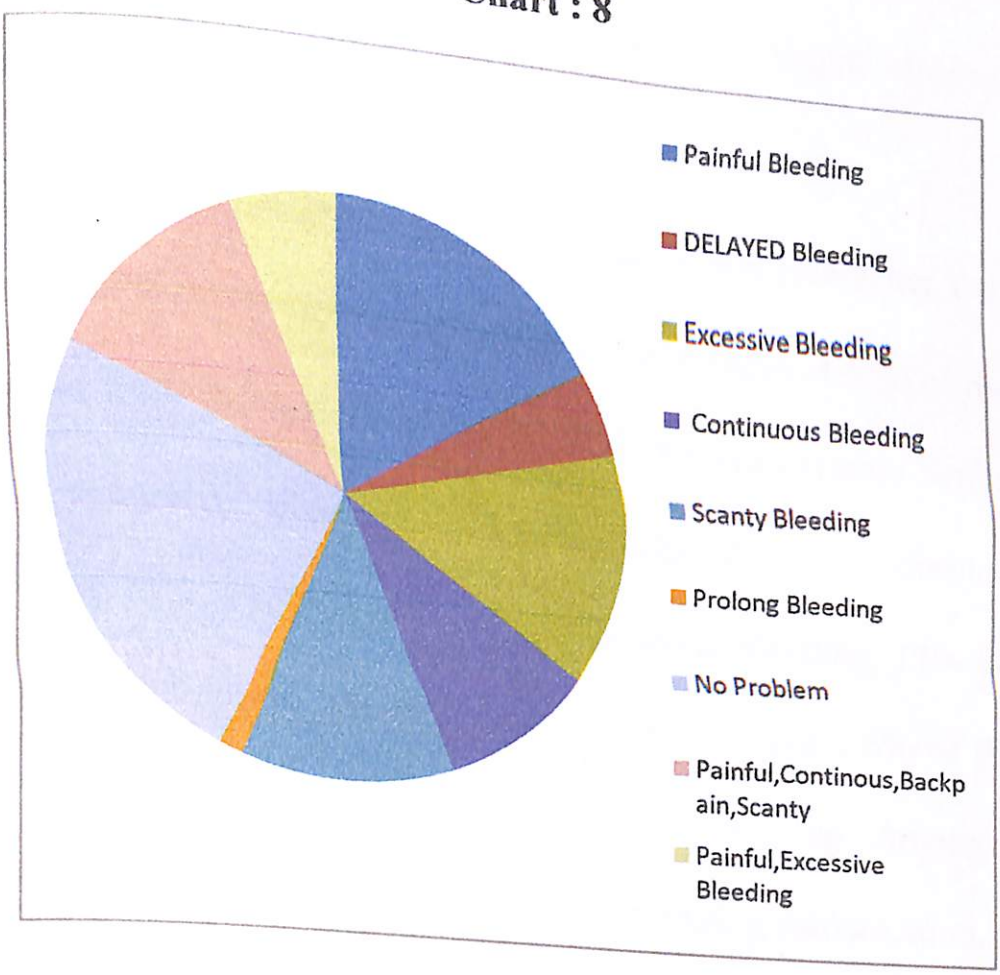
4. B. 4 : Nature of Menstruation

Table-4.11

Sl. no	Nature of Menstruation	No	%
1	Painful Bleeding	25	16.67

2	DELAYED Bleeding	07	4.67
3	Excessive Bleeding	20	13.34
4	Continuous Bleeding	14	9.34
5	Scanty Bleeding	18	12.00
6	Prolong Bleeding	02	1.34
7	No Problem	37	24.67
8	Painful, Continuous, Back pain, Scanty	18	12.00
9	Painful, Excessive Bleeding	09	6.00
10	Total	150	

Chart : 8



Menstruation is a normal physiological phenomenon for females indicating her capability for procreation. However, this normal process often associated with some degree of suffering and embarrassment.

Menstrual is a women's monthly bleeding. For girls between the ages of 12to 18 lives can be difficult as hormones and other developmental changes begin to occur. Most girls get their first period or menarche, around the age of 12, although anything between 9 and 16 years is normal .The age of Menarchy is affected by genetic and environmental factors. While menstruation cycle is usually described a monthly event lasting 28 days, this is only the case for about 60% of women respondents in Bajali –Revenue Circle, the study area.[9]

Most women experience period pains, the researcher found 16.67% of the respodents suffered from period pain. 4.67% of them suffered from delayed bleeding. 13.34% of them severely suffered from excessive bleeding. 9.34% suffered from continuous bleeding 12% scanty bleeding 1.34% prolong bleeding. 12% have painful, continuous, scanty bleeding with back pain. 6% of them have suffering from painful and excessive bleeding. Among the 150 respondents 24.67% have no problem during menstruation.

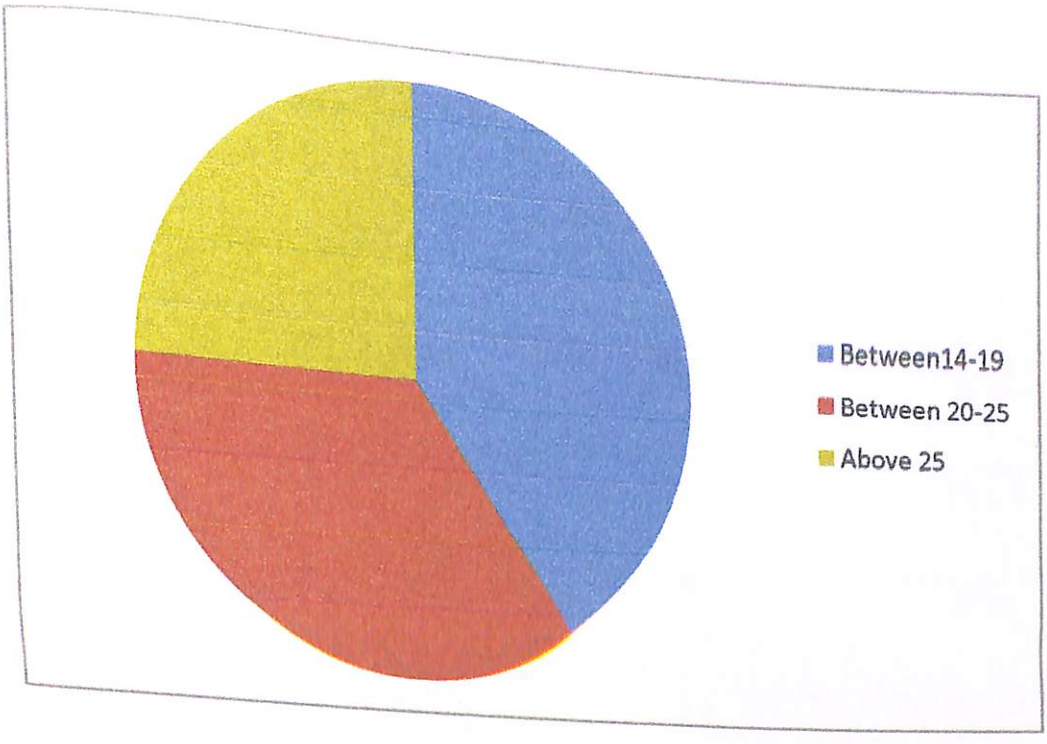
4. B. 5 : Age at first Conception

One of the important indicators of reproductive health of mother is the age at first pregnancy. Early childbearing contributes to increasing fertility while delaying having children reduces fertility level. When investigated it was found that the rural women get pregnant soon after marriage. Thus, earlier the marriage earlier the pregnancy. This implies that the age at marriage indicates the on set of pregnancy at a very early age for the rural women in the selected area.

Table : 4.12

Sl. No	Age at the first conception	No of women	%
1	Between14-19	61	40.67
2	Between 20-25	52	34.67
3	Above 25	37	24.67

Chart : 9



The table 4.12 shows that majority of the women got married at the age of 14-19 years which indicates the highest fertility (40.67%). The fertility decreases the age at marriage increases. The women who got married at the age above25 years show the lowest fertility (24.67%). The present study shows that earlier age at marriage is one of the factors that lead to higher fertility of the population.

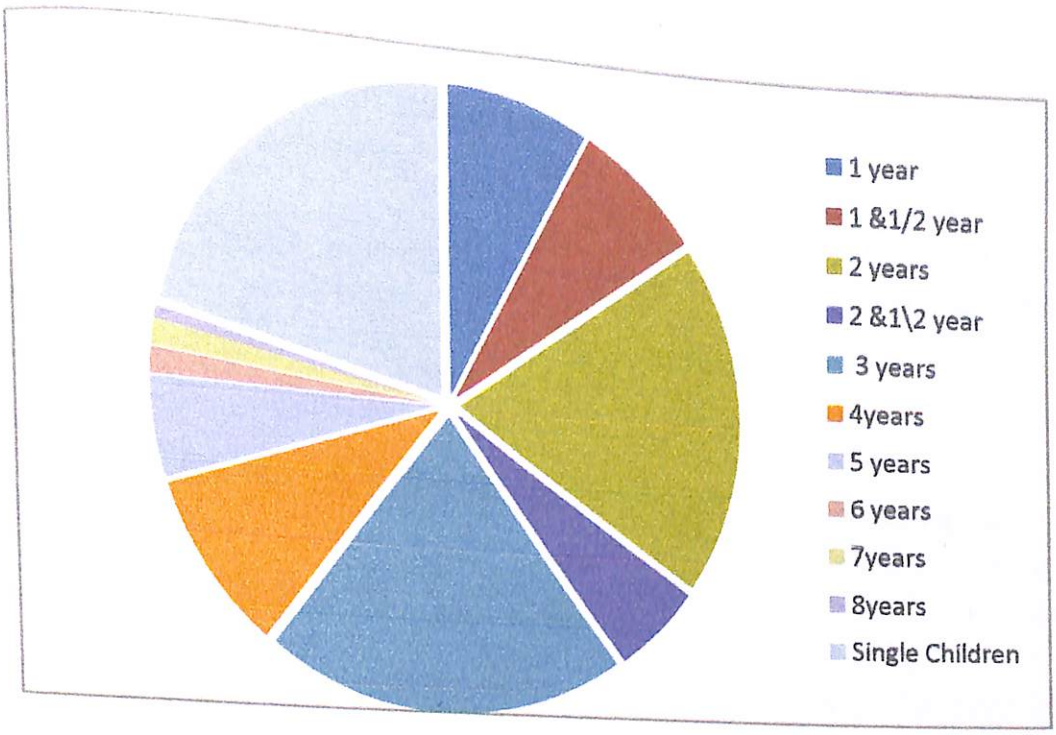
Early child bearing is fairly common in India. In case of age at first pregnancy it was found the 40.67% of the respondents had their first pregnancy between the age group of 14-19 years. 34.67% became pregnant between the age group of 20-25 years and 24.67% of them conceived after their 25 years of age.

4. B.6 : Spacing between of Children

Table : 4.13

Sl. No	Age Gap	No of Women	%
1	1 year	12	8.00
2	1 &1/2 year	11	7.34
3	2 years	29	19.34
4	2 &1\2 year	08	5.34
5	3 years	31	20.67
6	4years	14	9.34
7	5 years	08	5.34
8	6 years	02	1.34
9	7years	02	1.34
10	8years	01	0.67
11	Single Children	32	21.34
12	Total	150	100.00

Chart : 10



While analysing the age gap between the children of the selected respondents it was found that 8% of them had 1year of age gap between their children and 7.34% of them had one and half years of age gap and 19.34% of them had 2 years gap and 5.34% of them had 2 and half years of age gap between the children. Accordingly 20.67%, 9.34%, 5.34%, 1.34%, 1.34%, 0.67%, of 3, 4, 5, 6, 7, 8, years of age gap between the children. Only 21.34% mother has single children.

Most of the rural women had no knowledge about the method of contraceptive. Majority of the women consider it as

shameful and they are reluctant to discuss it with anyone. Use of contraceptives, sexual contact and sexual abuse were not considered to have any role with the poor reproductive health of the women according to the respondent's perception. The researcher found that 63% of women had no knowledge about contraceptive.

Pregnancy is one of most essential aspect of women. Motherhood is a pride of every married woman. But in rural areas most of the women suffers from pregnancy related problems. They are not conscious about their health. Due to overburden of work, negligence, illiteracy, male member's dominance, the rural women suffers from pregnancy related problems.

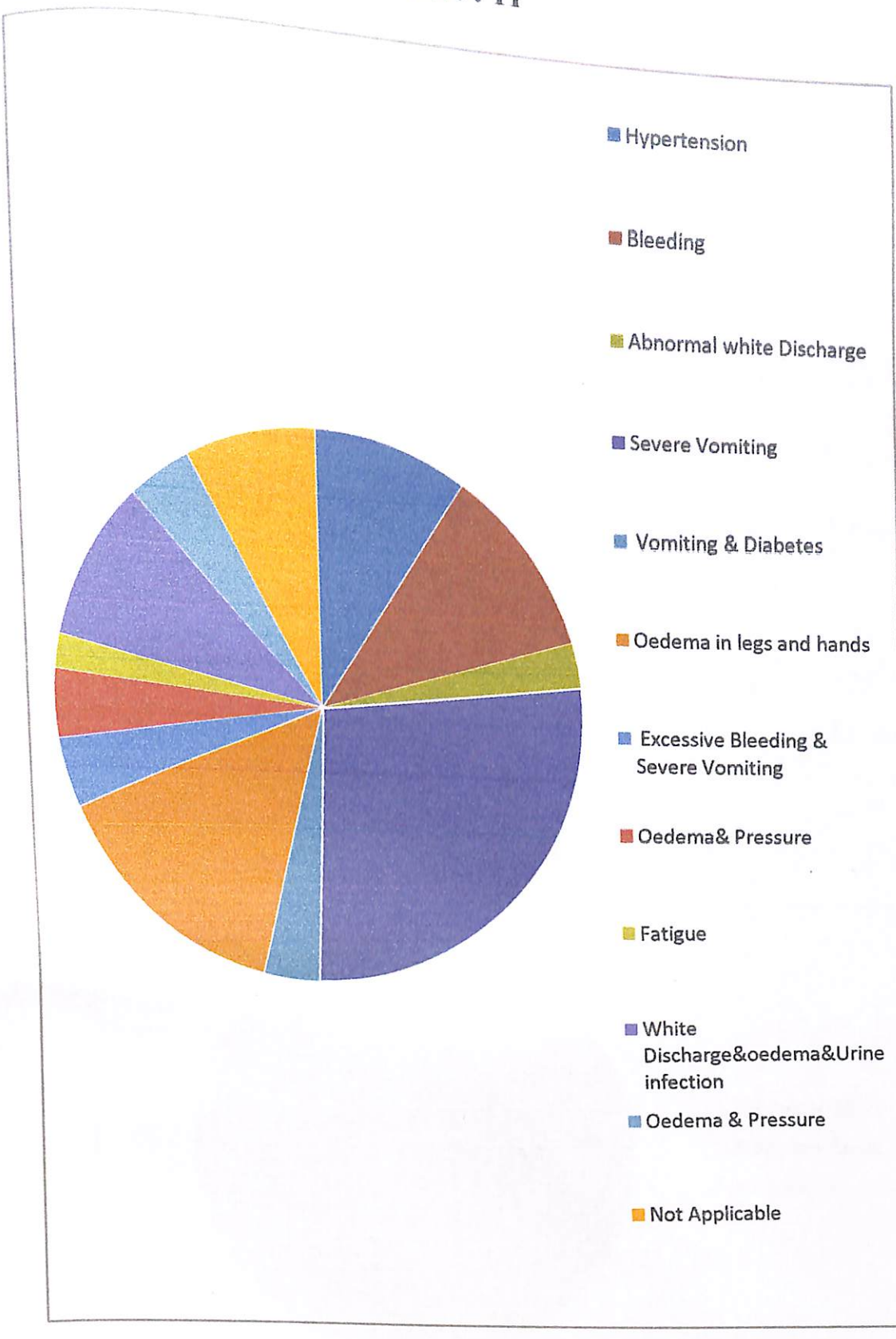
4. B. 7 : Problems associated with pregnancy

Table : 4.14

Sl. No	Problems	No. of women	%
1	Hypertension	14	9.34
2	Bleeding	17	11.34
3.	Abnormal white Discharge	04	2.67
4	Severe Vomiting	41	27.34

5	Vomiting & Diabetes	05	3.34
6	Edema in legs and hands	22	14.67
7	Excessive Bleeding & Severe Vomiting	06	4
8	Edema & Pressure	06	4
9	Fatigue	03	2
10	White Discharge & edema & Urine infection	14	9.34
11	Edema & Pressure	06	4
12	Not Applicable	12	8
13	Total	150	100.00

Chart : 11

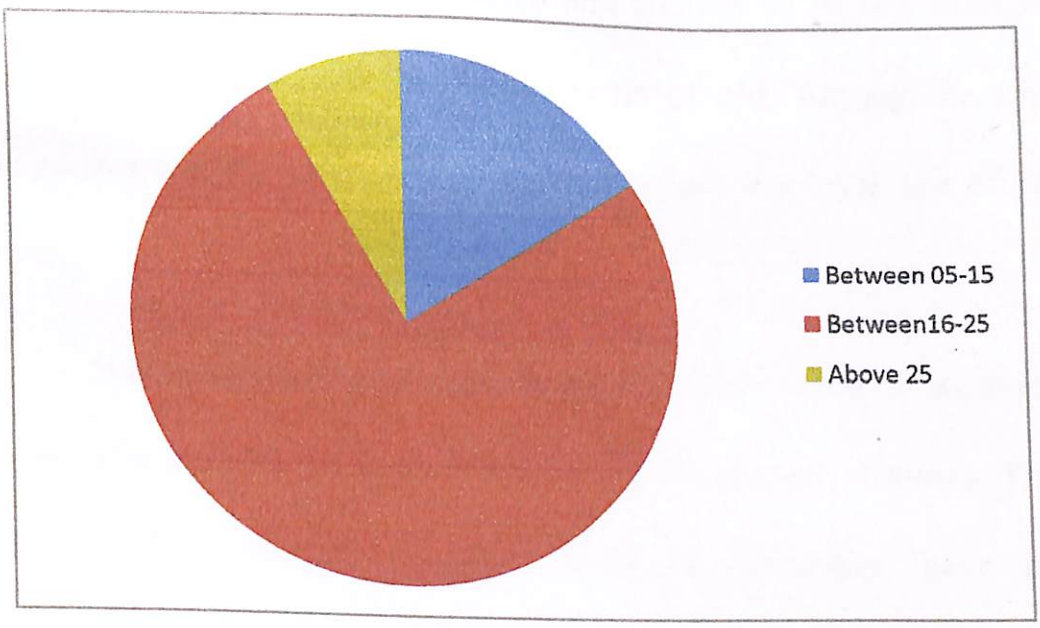

Hypertension
Bleeding
Abnormal white Discharge
Severe Vomiting
Vomiting & Diabetes
Oedema in legs and hands
Excessive Bleeding & Severe Vomiting
Oedema& Pressure
Fatigue
White Discharge&oedema&Urine infection
Oedema & Pressure
Not Applicable

4. B. 8 : Age at Marriage

Table : 4.15

SL No	Age at Marriage	No of women	Percentage of women	Son	Daughters	Total
1	Between 05-15	24	16%	52	47	99
2	Between16-25	114	76%	139	130	269
3	Above 25	12	8%	13	12	25

Chart : 12



Age at marriage and child bearing is a very important aspect for the well –being of the mother as well as for the baby. Young

women who bear the child during adolescence are likely to get pregnant again sooner than women who bear their first child when they are in their thirties. Early pregnancy therefore has a tendency to lead a large family with a possibility of facing serious health hazards thereof.

The table 4.15 reveals that the majority of rural women got married between the age group of 16-25. But it is quite evident that women belong to the age group of 50-80 early married. Again numbers of sons are more than the number of daughters. It is the indication of preference to the male child as sons are expected to care for parents as they age. Surprisingly one of the women got married at the very early age of 05 and another 07 before attained puberty. They are now 78 and 80 years of old. Among the 150 respondents 20% of them got married before the legal age of 18 years.

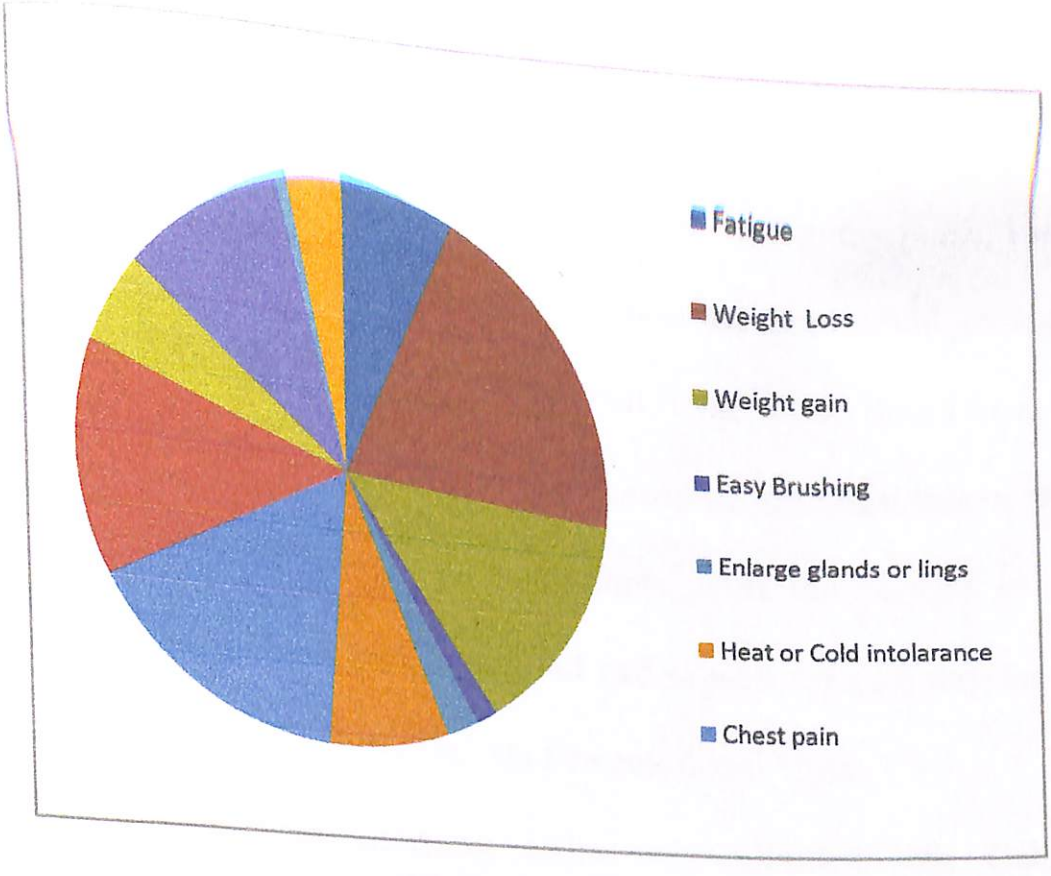
Basically people in rural areas are more prone to diseases especially women are more impacted by the various diseases. The villages like Nizsathisamukha, Barbhala, Barsahan, have no medical facilities and lack of awareness about health status, least accessibility of treatment and other factors are influencing on women to get the diseases.

4. B. 9 : Incidence of Various Diseases

Table : 4.16

Variable	No.	%
Fatigue	10	6.67
Weight Loss	30	20.00
Weight gain	21	14.00
Easy Brushing	02	1.34
Enlarge glands or lings	03	2.00
Heat or Cold intolerance	11	7.34
Chest pain	24	16.00
Headache	20	13.34
Depression	08	5.34
Headache, Diarrhea, Depression	15	10.00
Headache, Depression, chest pain, Weight gain	01	0.67
Weight loss, Depression, Others	05	3.34

Chart : 13



The data on various diseases faced by rural women of various villages of study areas have presented in table 4.16. It proved that rural women suffer from multiple health problems.

4. B. 10 : Case Study I

Usha Devi : Aged about 40, Usha, when interviewed, revealed to the investigator the painful and horrible memory connected with her pre-natal and post natal motherhood. Victim of the outworn tradition, Usha had to stay deprived of medical treatment during pregnancy. Healthy diet was a remote dream. Pathetic road condition, inadequate vehicles and other deficiencies forced Usha to travel in a bicycle from

Kharadhara (in BTAD) to Barama Hospital barring the risk of abortion. '' I was advised to go to Guwahati for the delivery as the baby was due. No money in my purse, I was at a loss. Then an idea occurred to me that I could get some financial help from my parental home. In no time I came to Patacharkuchi from where instead of my treatment, a feast was arranged.I had to comply with the wishes of the members of my family and had to wait for next day for the journey to Guwahati, said an emotional Usha.

Next morning Usha was admitted into Gauhati Medical College Hospital with unbearable pain and tension in her mind. The attending Doctors recommended Caesarean and a baby of under weight was born. It was instead of joy of celebration; the new born become the source of grief and panic as it was born with multiple deficiencies.

4. B. 11 : Cases Study II

Sarala Goswami : Sarala Goswami aged 65 reveal to the investigator a blood freezing account related to her initial preganancy. Dogma oriented, superstition governed a typical Brahmin family paid little attention to her mental and physical health. Husband duty bound away from home,

could not attend on her .Mother –in –law, governed by rigid norms, paid little attention to her worries. "When I told to my mother in law about visiting a doctor, she straight way refused citing her own state in the past. I had to meekly succumb to her instruction and stayed away from visiting a doctor. I was also denied the required food, not to speak of nutritious one during the last phase of my pregnancy, recalled emotional Sarala. I was made to sleep on sack placed on the kaccha floor. The pain experienced was beyond measure. I requested mother –in-law for my husband present beside me which she set aside without hesitation. I was asked to sleep with my arms and legs stretched out. A local mid-wife Maya Devi Das roped-in with her timely help at last male baby was born amidst great anxiety-said and awestruck Sarala." After delivery her genital was stitched with big-eyed needle used exclusively for stitching cloth.

4. B. 12 : Cases Study III

Jili Seal : Age- 45. Her story of pregnancy and child birth is appalling. When interviewed, the investigator obtained shocking information from her about how she had to endure pain, neglect, indifference and ridicule '' I was

barely 20 when I conceived my first baby. Deprived of food, adequate rest, medical check-up, I was in a critical situation. Mother in –law hardly paid any heed to my physical and mental condition. I was bored of my existence, revealed a nostalgic Jili, a mother of three children. '' I insisted on the balanced diet during pregnancy for the proper growth of the foetus. But mother –in-law a victim of superstition, set aside my request and told me that having adequate nutritious food would contribute to the over-weight of the foetus, she had the conviction that over-weight baby would not have and easy release from the womb. Since in our time there was not adequate medical staff locally, recalled an emotional Jili.

Notes and References :

1.Sachdeva,Bhushan Vidya, "An introduction to Sociology"-pp.329-31.

2. Rawat, H.K., "Contemporary Sociology"-pp.250-51.

3. Dr. Vatsyan, "Rural and Urban Sociology"p-117.

4.Ibid: p.290.

5.Goel,S.L. &Goel Aruna, "Women Health Education", p.-82.

6..Dr.Chandrashekhar B.-"Reproductive Health Problems of Women in Rural areas", p.-97.

7. Wikipedia, p.-01.

8. Ibid: p.-100.

9. https://www.medicalnewstoday.com.art, p. 01.

Chapter - 5

Conclusion

Good health is a prime criterion for every one in the society which contributes to human well-being and economic growth. Healthy women can contribute to the society who generate new generation to the society. Nutrition for women would help them to serve as productive members of the society to develop the consequent health generations. The Government has responsibility to take necessary and compulsory policies to improve the literacy rate and quality education as well as to provide adequate employment opportunities for women, which might explore positive impact on the women's health concerns.

The Government can also improve the health status of women by strengthen and expanding essential health services as well as by frequent counseling on safe sex awareness in educational and nutritional needs and gender based violation.[1]

Usually in the rural areas, when the women are suffering with major health problems, they will not expose and do not consider their illness as a disease due to their low status in the family, negligence, work load, ignorance. Normally during pregnancy certain physiological changes occur in women. Majority of the women feel that these changes are minor health problems and are not serious. They will not seek any medical care. They will try to tolerate it or

adjust it by adopting diverse activities. But when these problems interfere with regular activities then they seek medical advice. None of the family members do not bothered about the health problems of female members of the family. Interestingly, they are dependent to the male members of the family to get them needed medical attention. Her health is little concern for others in the family. She endures all hardships and consequently her health deteriorates. Such is the life of a woman in our society neglected, oppressed, repressed and exploited. So we can not expect a healthy society where the main force of the society, i.e. the woman who herself is perpetually sick.

5.1 : Measures for the uplift of women's health status

The studies have explored that the health status among rural women is quite grime. But it needs to be revamped to make India a healthy and wealthy nation. Therefore, in the following section it is tried to suggest some measures for the uplift of the present bleak scenario. The following suggestions would help the women to uplift themselves.

- First of all, prevailing social attitude regarding fertility should be corrected. Sex of the child is considered an important thing.

And the women are generally held responsible for it. Further, lots of misconceptions regarding pregnancy, child birth, child care etc. Prevail which render medical advice redundant. As a consequence the mother suffers from malnutrition, iron deficiency, resulting in ill health. An urgent need is to spread general awareness about health and education about pregnancy and other related problems. This has to be done not only among women, but also man. Simple precautions taken at appropriate time are bound to yield positive effects regarding poor health status of women.

- Medical care still remains inaccessible for a large section of the population. Inadequacy of staff medical supplies an equipment and rush reduce the quality of the existing health services. In rural areas not even the minimum medical facilities by trained personnel is available. Distance and inaccessibility have to be reduced for the improvement of women's health.
- The recent activity of various women's organization has also exerted some impact on this issue. As a result, rural women are becoming conscious about their health problems. There have been demands for more rural health centres, trained nurses,

mid-wives etc. Rural health workers, with rudiments of medical knowledge, trained and licensed to push an injection and with knowledge of the locally prevalent disease, should be organized to meet better health care in the rural societies.

- Women should be made aware of their constitutional and legal rights.
- The attitude of the husbands and family members should be changed towards the women. Husband should come forward to share her burden.
- The Non-Government Organizations have played most important role in spreading awareness on issues like population education, Sanitation, nutrition and other health aspects, equitable opportunities in employment.

5.2 : Measures to strengthen Women Empowerment

From the discussion of the above we can understand that for empowerment of women some basic needs are necessary. Such necessities are some social, some economic, political and some are psychological as well. A discussion of the same can be made as follows:-

5.2.1 : To Upgrade the Status of Women

In the family atmosphere most of the female members feel inferior to male members. From olden times, women act as workers and do not take part in decision making. This attitude needs change to make women as part and parcel of the family by carving out an important place for her. Swami Vivekananda repeatedly stressed the need for cultivating the faith in one self:

"The idea of faith in ourselves is of the greatest help to us. If faith in ourselves had been move extensively taught and practiced, I am sure a very large portion of the evils and miseries that we would have vanished."

Though out the story of mankind, if any motive power has been more potent than another one the lives of all great men and women, it is that of faith in themselves. Born with the consciousness that they were to be great they come great. Prof. V. C. Kulandaiswamy, Former Vice-Chancellor, IGNOU, New Delhi, delivered the convocation address at the Eleventh Convocation of the Avinashilingam Institute for Home Science and Higher Education for Women Deemed University, Coimbatore. He said

"Women's studies should concentrate on the nature of opportunities that now emerge for women to prepare themselves for playing an equal role-not necessarily identical role-with men in the affairs of the society. The research studies should consider the areas of disability, the handicaps, the impediments and the prejudices that women face and devise of educating and enabling men and women to remove them."[2]

5.2.2 : Low Morale: Need of Creating Positive Attitude

At present women possess low moral which is a depressing situation where she does not get a sense of belongingness. We must develop positive attitude in her by enlightening her about her creative potential for contributing to the overall development of self, family and society. Dr. A. S. Desai, Chairperson, University Grand Commission, delivered the Convocation address at the annual convocation on the S. N. D. T. Women's University, Mumbai. She said, "While education for women is a necessary condition for social development, it has to be accompanied by increasing levels of awareness with respect to the place of women in a patriarchal society, the means to change their position and role, as also to assure that

women's rights are seen as an important and major component of human rights.

All this leads us to consider the importance of empowerment of women achieved through both education and greater social awareness. No one, ever in history, has achieved rights without a struggle. Women have to unite across caste, class, ethnicity and religion, if change has to be brought. Political empowerment is now made possible for women at the local levels through the 73rd and 74th Amendments to the Constitution. It has brought a million women opportunity to participate in decision-making and politics at he village, block and district levels as also in the urban municipal corporations. Educated women have a major social obligation to participate in this great experiment, uniquely launched in our country by reserving one-third of the seats at this level. Expansion of women education will serve no meaning if women do not participate in policy and decision making.[3]

5.2.3 : Dependence on Men since Childhood: Need Independence from Early Stages

In Indian villages, girls remain dependent upon father, brother or cousin and this very feeing continue in their married life. We must give capacity building training to girls in schools to be independent. It does not mean breaking the linkages of family rather it leads to strengthening the bond on an equal platform.

5.2.4 : Change of Attitude of Men towards capacity of Women.

Men have built an impression through observation that women are inferior and they cannot face emerging situation. This attitude has to be changed through positive examples from our country and abroad. Pictures of women doing all types of work need to be screened and shown to both men and women.

Sri K. Anbazhgan, Minister of education, government of Taminadu, delivered the Convocation address at the eight convocation of Avinashilingam Institute for Home Science and Higher Education for Women (Deemed University), he said, "women's empowerment is a complex issue having many social ramifications. It cannot be solved by women alone. Men also should understand the need for women's empowerment and support their cause. Women should learn to articulate their needs and rights in clear terms and work for men,

without at the same time upsetting the domestic harmony and family life. They have to work tirelessly in their march towards their empowerment and a life with an identity of their own." (University News January13, 1997) Untill women become independent, the independence of the nation is meaningless.

5.2.5 : Women Elected Representatives of PRIS given way to their men Folk: Need of talking Independent Decisions

Women representatives in PRISs must be trained in the art and science of decision-making so that they are not influenced by extraneous factors. They should discuss among other women and take their opinion. They must develop leadership qualities. K. D. Ganhrade in his article, "Gandhi and Empowerment of Women- miles to go", Smt. Savita Sing (International Centre of Gandhian Studies and Research, Gandhi Samiti and Darshan Samiti, New Delhi), "The 73th and 74rd Constitutional Amendments on Panchayati Raj and Nagarpalika with 33 percent reservation for women has created political space for women. But in most cases they exercise "proxy" power on behalf of men. In reality women have never been able to get more than ten-percent seats in Parliament or other bodies of decision-making. It is hoped that 81st Constitutional Amendment when passed

will give 33 percent reservation of seats in Parliament and State Legislatures. This will go a long way to have their say. We should be ashamed of ourselves that after more than half a century of freedom we have neither been able to clothe our women nor able to provide them something as basic as secure and adequate number of toilets and shelter even in the capital city of India."

5.2.6 : Lack Of Interest and Enthusiasm: Need of Enthusiasm

Women lack interest in PRIs on account of warm attitude to PRIs by State Governments. To make life worthwhile and fruitful, they must generate enthusiasm within themselves. A goal and attach ourselves to the Alter with a spirit of dedication, reverence and love/ Once they have surrendered themselves to it, the idea itself will provide them with the inspiration and strength. Then nothing can hinder the process of women's march towards that goal and the ideal. The love for the ideal will overcome and vanquish all the hurdles from the idea, and if it comes to that, life itself will be cast-off with a smile, a dedication at Alter.

5.2.6 : No Forum to Exchange Ideas: Need for all Women Forum

Elected representatives of three tiers should meet once in three months. At present elected representatives rarely meet at one platform to form opinion upon different activities being carried out at various levels. There is a need to have a quarterly meeting of all the elected members to exchange their view points. In this way, there would be more participate while deliberating on important issues.

5.2.7 : Women MLAs and MPs do not take interest

All taking women problems, need of proper protection and empowerment but the initiative of the women MLAs in State Legislatures and women MPs in the Parliament do not take sufficient pain for their own cause. In this respect all the major women forum and bodies should continuously pressurize the women MPs and MLAs to do so.

5.2.8 : Even the Women themselves do not struggle for their empowerment

In the changing dimension of power struggle it is now a well known fact that power has to be acquired. Once acquired it needs to be exercised, sustained and preserved. Women have to empower themselves. It is in a multi-dimensional process which about enable individuals or groups to enable to realize their full identity and power

in all spheres of life. Discrimination of women is well known, traditional customs are some dis-favourable to women so women have to struggle on their own way.

Notes and References

1. Raju Kowsalya,Shanmugam Manoharan: " Health Status of the Indian Women- a brief report.p-111

2. University News, December, 6, 1999, p.27.

3. University News, April.6, 1999; p.27.

Annexure

Annexure : 1

Questionnaire

1. Name of the respondent :
2. Address :
3. Age :
4. Husband Name :
5. Occupation :
6. Age at the time of Marriage :
7. Age at the time of first child birth :
8. Number of Children :
9. Still Birth :
10. Place of delivery :

    (Reasons for not going to delivery centre)

11.

    a. Fear

    b. Poverty

    c. More expensive

    d. Lack of transport facility

e. Non availability of doctor

f. Male members' objections

g. Not applicable

Medical supervision

Number of termination of pregnancy

14. Diet during pregnancy

15. Relation with husband

16. Gap of delivery

17. Pre-natal and post natal care

18. Rest during pregnancy

19. Use of contraceptive

20. Economic condition

21. Anemia

22. Nature of Menstruation

a. Painful bleeding

b. Delayed bleeding

c. Prolonged bleeding

d. Excessive bleeding

e. Continuous bleeding

f. Scanty bleeding

g. Inter Menstrual bleeding

23. Problems associated with pregnancy

a. Hyper-tension

b. Bleeding

c. Abnormal white discharge

d. Severe vomiting

e. Gestational diabetic

f. Edema in legs & hands

24. Incidence of various diseases

a. Fatigue

b. Weight loss

c. Weight gain

d. Easy brushing

e. Enlarge gland or lings

f. Heat or cola intolerance

g. Chest pain

h. Headache

i. Diarrhea

j. Depression

k. Others

l. Heat or colelintalerence, Diarrhea, Depression

m. Headache, Diarrhea, Depression

n. Fatigue Depression

25. Habits of the Respondents

a. Eating pan, beedi, coffee

26. Type of family

a. Nuclear

b. B. Joint

Date :

Signature

Annexure : 2

PHOTO FEATURE

Unhygienic Environment

Rural Women with their Child

Post-Natal Care-I

Post-Natal Care-II

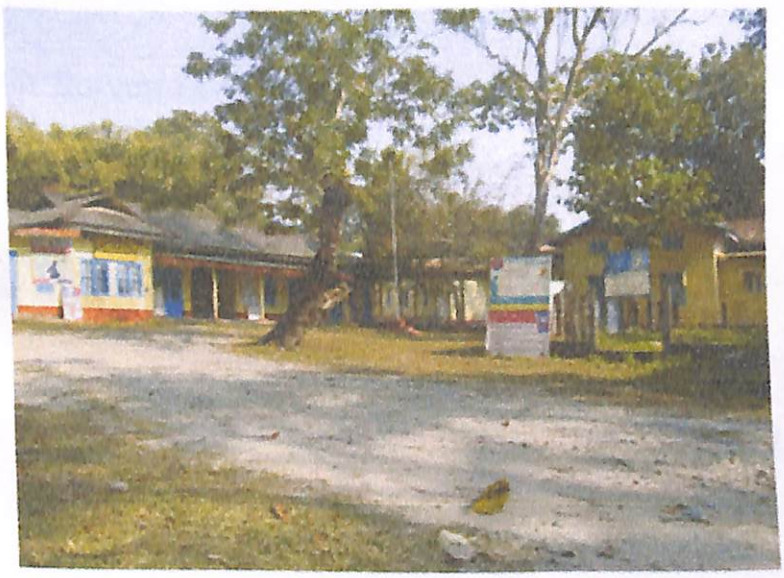
Traditional Baby Care

Pre-Natal Care

Village Women

Baby with her mother

Empowerment Initiative



Nityananda B.P.H.C.

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