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To assess reproductive health status of rural women residing at loni (BK) village

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Abstract

Reproductive health represents the overall health condition of a population. Demographic profile of women in Reproductive age (15-45) and children (under 15 years) consisting 60% of the Indian population, in this population assumes that two thirds of our population are vulnerable to ill health and death. Prioritizing women's health helps achievement of the fourth and fifth goals of Millennium Development Program. Aim: The aim of this study is to assess the reproductive health status of women and to correlate the reproductive health status with selected socio demographic variable. Methods: A community based, cross sectional survey by probability simple random sampling technique use to conduct study. Sample of 250 participants were involved in the pre-test structure interview schedule. Analysis of tool consist of Section A - Socio demographic data of women and their partner, section B - Gynaec and Obstatric History, section C: Contraceptive history section D: Menstrual history , section D: sexual history and section E: Clinical examination. The collected data analyzed by using descriptive statistics such as mean, standard deviation (SD) and mean percent for continuous variables; and frequency, percentage for categorical variables. The inferential statistics like chi square test used to find association between the variables. The p value ($p<0.05$) was considered statistically significant level. The statistical software SPSS version 10 was used for the data analysis. Results: The present study found that health awareness was less and contraceptive knowledge factors were better among rural reproductive women. Out of 250 study subjects, nearly half had knowledge about care during pregnancy, in rural area. Knowledge on safe abortion found less good.

Key words: Assess, Reproductive Health, women

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1. Introduction

With the second largest population, India has emerged as one of the fastest growing economies in the world [1, 2]. Growing number of cities and city dwellers are replacing the traditional rural India and its lifestyles [3]. According to World Health Organization (WHO), adolescents are people between 10 and 19 years of age; they make 20% of the world's population, of whom 85% live in developing countries. As Adolescence is characterized by significant physiological, psychological and social changes that put

adolescents for higher risk sexual and reproductive health (SRH) problems. This has partially been because adolescents considered relatively healthy, without a heavy "burden of disease" [4, 5]. The concern about adolescent sexual and reproductive health (ASRH) has grown due to unprecedented increasing rates of sexual activity, early pregnancies and sexually transmitted infections (STI) including human immune deficiency virus (HIV) among adolescents [6,7]. Since the 1994 International Conference on Population Development (ICPD) in Cairo, Egypt, adolescent-friendly reproductive health services (AFRHS) have been recognized as an appropriate and effective strategy to address SRH needs of adolescents [7]. Nevertheless, the needs of the young people remain poorly understood or served in many parts of the world [8].Despite 35% of the world population being in the 10–24 age groups, the reproductive health (RH) needs of adolescents have neither been researched nor addressed adequately [9]. Early and unprotected sexual activity and misconceptions about HIV/AIDS are prevalent among rural adolescents [10]. There are few studies on knowledge, attitude and practice of adolescents in relation to their RH in Ethiopia showing a significant discrepancy between knowledge about and the level of services utilization in particular and poor access to RH services in general [11-14].As "age-appropriate" interventions to a particular setting are desirable to address the diverse needs and contexts of adolescents' RH, studying their knowledge, services utilization and associated factors is relevant to design appropriate program interventions and strategies in the local context [11, 15]. In Ethiopia, nearly 20% are young people of whom four-fifth live in rural parts of the country [16].Sexually transmitted infections continued to present a major health, social and economic problem in the developing world [17]. There is a dearth of information regarding the epidemiology of RTI in India for many reasons [18]. The situation may still be worse in rural areas, where there is hardly any access to the health delivery system due to difficult terrain.

Due to lack of education, superstations and taboos are still in vogue in our country. The reasons for the gap between what is the what ought to be may be the cumulative effect of lack of information, lack of education and awareness, prevalent myths, misconceptions, superstitions, etc. the ethnic composition, cultural background, beliefs, customs and faith don't permit the individual and groups to discriminate their age old practices and to adopt new system. Hundreds of worldwide research and evaluation have shown that education of women is strongly associated with the confidence to adopt new ways, the willingness to do and use health services. However, few attempts have made particularly in rural settings, for addressing their critical concerns or providing them with the necessary SRH services. The purpose of this study is to assess reproductive health status of rural women and their health needs.

Exclusion of tribal population from the mainstream economic development process needs understanding in the context of traditional Indian social system. A thousand year old caste system has resulted in the formation of a highly marginalized tribal population. Caste determines an individual's socioeconomic position, occupation, and many other aspects of life, inherited from his or her parents. Out of four main divisions, the Brahmins, who are entitled to be the priests, scholars, and philosophers are at the top of the hierarchy, with the shudras' or the labourers and servants, also known as untouchable, at the bottom. The traditional Hindu caste system excludes the lower castes including the tribal's, from mainstream society and exploits them in various natures [19, 20]. The advantageous position within the social structure with privileged access to resources provides the upper castes with more opportunities than for the lower castes. Thus, there is an association between socioeconomic position and caste of an individual [19]. A recent study conducted to assess the Source of Knowledge, Mode of Transmission and discussion about Reproductive Tract infection and sexually transmitted diseases for tribal women. A list of married tribal woman with at least one living child in the age group of 25-45 years is the sampling unit of the study. Adopting stratified random sampling technique 400 tribal women selected from each region, totaling a sample of 1200. The data pertaining to the study collected from both

primary and secondary sources. Results of the study reveals that respondents from the districts of Kadapa are highest percentage (50.50) are heard followed by (47%) from Warangal district and (43%) in Vishakhapatnam district are low. Information and communication technology is the major source to know about the RTIs/STDs (61.25 Warangal, 55.45 Kadapa and 66.90 Vishakhapatnam respectively). Majority (60%) Warangal district and Kadapa (51.50%), Visakhapatnam (73.50%) of the respondents are did not discussed RTI/STD problems with their husbands are partners. Health education regarding the risk factors of unhygienic menstrual practices, non-intuitional deliveries and illegal abortions must be impart to the women in the study area in order to bring about a behavioral change to protect them from communicable diseases [21].

Aim and objective

1. To assess the reproductive health status of women
2. Correlate the reproductive health status with selected socio demographic variable.

2. Materials and methods

A community based, cross sectional survey carried out in Loni (Bk) Village Maharashtra. Sample consists of 250 reproductive (15-45yrs) age group women are selected by probability simple random sampling technique [22]. The expert validation and pre-test structure interview schedule was used to collect the data. The tool consist of Section A: Socio demographic data of women and their partner [12 items], Section B: Gynaec and Obstetric History [12 items], Section C: Contraceptive history [10 items], Section C: Menstrual history [8 items], Section D: sexual history [10 items], Section E: Clinical examination [5 items]. After obtaining the informed consent, data was collected [23]. The collected data analyzed with descriptive and inferential statistics wherever required. After seeking the written informed consent all the participants were interviewed and assessed.

The collected data analyzed by using descriptive statistics such as mean, standard deviation (SD) and mean percent for continuous variables; and frequency, percentage for categorical variables. These were to understand the distribution of subjects on the socio demographic and other variables to assess the reproductive health status of women [24]. The inferential statistics like chi square test used to find association between the variables. The p value ($p<0.05$) was considered statistically significant level. The statistical software SPSS version 10 was used for the data analysis.

3. Results

Socio demographic characteristics of antenatal mothers:

More than half (52%) of antenatal mothers were in the age group of 21 – 23 years, nearly half (46%) of antenatal mothers had primary school education. Majority (85%) of them were housewife, while (83%) of them were belongs to Hindu religion. Only mere percent (9%) of participants had monthly income Rs. 7000 and above. One-third (37%) of participants consumes vegetarian diet, while most (88%) of them residing at rural area whereas (21%) of participants received information on breast-feeding through mass media's.

(Table: 1)

Above table shows most of (41%) the women were from 15-25 age group and (20%) of them were form 30 -45 age group. All are married. Most (38%) the women had secondary education and very few (2%) women had education of graduate. Maximum (47%) of them were house wife, very few (1%) of them are doing business and (2%) are in Govt service. half of (52%) of them are from Hindu religion. 44% of them had less than <5 members in the family and only (18%) women's has 7-10 members in the family.

Table 1: Socio demographic data of women

S. N	Name of variable	No	%
1	Age		
	15-25	104	41
	26-35	101	39
	36- 45	50	20
2	Marital status		
	Married	255	100
	Unmarried	--	--
3	Education		
	Illiterate	32	13
	Primary	92	36
	Secondary	98	38
	Graduate	28	11
	Post graduate	05	02
4	Occupation		
	Housewife	120	47
	Daily wages	98	38
	Private service	30	12
	Govt. service	05	02
	Business	02	01
5	Religion:		
	Hindu	158	52
	Muslim	29	35
	Christian	57	08
	others	11	05
6	Total family member		
	<5	112	44
	5-7	98	38
	7-10	45	18

Table 2: Socio demographic data of partner (Husband)

S. N	Name of variable	No	%
1	Age		
	<25	36	14
	25 -35	112	44
	36- 45	75	29
	>45	22	09
2	Education		
	Illiterate	16	06
	Primary	30	27
	Secondary	105	40
	Graduate	32	13
	Post graduate	38	14
3	Occupation		
	Daily wages	103	41
	Private service	57	22
	Govt. service	05	02
	Business	38	15
	others	52	20
4	Income (Rs)		
	<3000	45	18
	3001-5000	65	25
	5001- 10,000	105	41
	>10,000	40	16

Above table shows that the most (44%) of women's husband age is between 25-35 yrs and very few (9%) women's husband had more than 45 years age. most of the partners (40%) has secondary education. Very few (6%) of them were illiterate. Near half (41%) husband's occupation were daily wages only (2%) of them has Govt. service. Most (41%) of them are from middle-income group 5001-10,000 Rs. and (18%) of them are below <3000 Rs/- Income group.

Table 3: Gynec and obstetric history

S. N	Name of variable	No	%
1	Age of Menarche		
	10-15	120	47
	15-18	118	46
	>18	17	07
2	Age of marriage		
	13-18	98	38
	19-24	96	38
	25- 30	61	24
3	Age of 1st pregnancy		
	14-24	178	70
	25-35	59	23
	>35	18	07
4	Age of first child		
	0-1 yrs	55	22
	1-3 yrs	57	22
	3-6 yrs	28	11
	7-12 yrs	45	18
	13-18 yrs	31	12
	>18 yrs	39	15
5	Age of last child		
	0-1 yrs	36	14
	1-3 yrs	58	23
	3-6 yrs	56	22
	7-12 yrs	30	12
	13-18 yrs	37	14
	>18 yrs	38	15

Above table shows near half (47%) of women had menarche at 10-15 years age and very less (7%) women had menarche at >18 years age. Most (38%) of the women age at marriage was 13-18 yrs,19-24 yrs respectively only (28%) of the women marriage age was <25- 30 years. Highest (70%) of the women has first pregnancy at the age of 14-24 yrs and very few (7%) of the women has first pregnancy at the of >35 years. Most (22%) of the women's age of the first child has 0-1 and 1-3 yrs respectively and (15%) of the women's has the age first child is >18yrs.

Nearly one fourth (23%) of women's age of last child is 1-3 yrs and (12%) of the women has the last child is between 7-12 yrs.

Table 4: Health problems experienced during last pregnancy if the child is 3yrs or less

S.N	Name of Health problem	No	%
a	Nausea & vomiting	60	23
b	Giddiness	8	3
c	Breathlessness	7	3
d	Any other	08	03
e	Bleeding	05	02
f	Aches & pain	72	28
g	Convulsions	5	02
h	Urinary problems	12	05
i	Weakness/Tiredness	18	07
j	Backache	30	12
k	Abdominal pain	30	12
l	No problems	00	0

Above table shows Most of the women experience health problem during last pregnancy among that one third (28%), Aches & pain (23%) of experienced, Nausea & vomiting other problem,(05%) of them having urinary problem and bleeding, very few (2%) convulsion.

Table 5: Place of delivery of the last child

S. N	Place of delivery	No	%
1	Government hospital	30	12
2	Private hospital	120	47
3	PHC/CHC	55	21
4	Home	50	20

Above table shows Nearly half (47%) women's place of the delivery of the last child was at private hospital, very less (12%) of them at Govt. hospital and (20%) of them delivered at home.

Table 6: Type of attendant at delivery

S. N	Type of attendant at delivery:	No	%
1	Doctor	76	30
2	ANM	88	34
3	Trained dai	50	20
4	Untrained dai	41	16
5	Relatives	00	0

Above table shows most (34%) women's delivery conducted by ANM, and (30%) by Doctor and (16%) women delivery attended by untrained Dai.

Table 7: Treatment sought for health problems experienced after delivery

S. N	Treatment sought for Health problem	No	%
1	No treatment	29	11
2	self medication	12	5
3	Home Remedies	80	31
3	Treatment from PHC	43	16
4	Private Hospital	15	6
5	Govt. Hospital	29	11
6	others	47	18

Higher (31%) of the women had used the home remedies for health problem and very few (5%) taken self medication. only (11%) sought treatment from Govt. hospital and (6%) from private hospital.

Table 8: Treatment sought for health problem during last pregnancy

S. N	Treatment sought for Health problem during last pregnancy	No	%
1	No treatment	4	2
2	self medication	21	8
3	Home Remedies	29	11
4	Treatment from PHC	102	40
5	Private Hospital	65	26
6	Govt. Hospital	29	11
7	others	5	02

Most (40%) of women sought treatment from PHC during last pregnancy and very few (2%) of them had sought other treatment during last pregnancy and (11%) of them sought treatment from private hospital and used home remedies for health problem during last pregnancy respectively.

Table 9: Type of deliveries

S. N	Type of Delivery	No	%
1	Normal vaginal	159	62
2	cesarean section	70	27
3	Forceps	0	0
4	Episiotomy	26	10

Highest (62%) women had normal vaginal delivery and (27%) of them had cesarean section.

Table 10: History of abortions

S. N	History of Abortions	No	%
	No. of abortions		
1	Month of pregnancy at	112	44
2	which terminated:		
3	spontaneous	62	24
4	induced	50	20
5	Legal	50	20
6	illegal	62	24
7	Legal abortion :		
8	private clinic	40	16
9	Government Hospital	18	07
10	PHC/UHC	04	02

Nearly half (44%) of the women had history of abortion among that (24%) women had spontaneous abortion and (20%) of them had Induced abortion. Only (20%) had legal and (24%) had illegal abortion. Most of (16%) had done the abortion in private clinic and only (07%) has done the abortion at Govt. hospital and very few (2%) done the abortion at PHC/CHC.

Table 11: Interval between pregnancies

S. N	Interval between pregnancies	No	%
1	Any prenatal sex determination done before induced abortion?		
a	Yes	29	11
b	No	21	04
2	Causes of induced abortion:		
3	Fetal anomalies	12	5
4	Medication	09	04
5	Sex determination	29	11

Many (11%) of them done sex determination before induced abortion. very few (4%) has not done sex determination before induced abortion. Most (11%) has done abortion due to sex determination, (5%) due to fetal anomalies (4%) due to medication.

Table 12: Contraceptive history

S. N	Contraceptive History	No	%
1.	Are you aware of contraceptive?		
A	Yes	220	86
B	No	36	14
2.	Are you using any contraceptive?	178	70
A	Yes	77	30
B	No		
C	If yes what :	108	42
A	Temporary	70	27
B	Permanent	02	1
C	Vasectomy	68	26
D	Tubectomy		
3.	Temporary methods –	20	8
A	OCP	30	12
B	Copper-T	50	20
C	Condoms	06	2
D	coitus interrupts	02	1
E	safe period		
4	Experienced any side effects :		
A	Yes	59	23
B	No	99	39
5.	If yes what?		
A	Nausea	19	7
B	Vomiting	10	4
C	Abd. pain	30	12

6	Since when?		
A	< 1 year	30	12
B	2-5 year	15	6
C	>6 yr	04	1
7	Treatment taken for side effects		
A	No treatment	05	2
B	self medication	04	1
C	Home Remedies	09	03
D	Treatment from PHC	15	06
E	private Hospital	11	15
F	Govt. Hospital	10	4
G	others	05	02
8	Emergency contraceptive pill		
A	Aware	197	77
B	Not Aware	58	23
C	Use?	05	02

Highest (86%) of the women were aware about contraceptives out of them (70%) of them using contraceptives. Among them (42%) women using temporary method and (27%) of them were using permanent method of contraceptives.

In permanent method (27%) of women, undergone Tubectomy and very few (1%) used vasectomy. Among them (23%) women experienced side effects i.e. Nausea (7%), Vomiting (4%), Abdomen Pain (12%).

In Temporary method Temporary methods – most of them (20%) Condoms, Copper-T (12%), and very few (1%) safe period and (2%) used Coitus interrupts.

Nearly (23%) of the women experienced side effect in that (12%) of them experience side effect < 1 year and very few (1%) women experienced side effect >6 year. Among them (15%) has taken treatment from private Hospital, (04%) Govt. Hospital, and very few (1%) has taken self medication, (1%) of them not taken and treatment for side effect

Highest (77%) of the women were aware about Emergency contraceptive pill and very few (2%) of them were using the emergency contraceptive pills.

Table 13: Menstrual Hygiene

S. N	History of menstrual hygiene	No	%
1	Do you have bath after menses?	253	99
A	Yes	03	1
B	No		
2	Do you wash your parts with soap and water at the time of menses?	220	88
A	Yes	30	12
B	No		
3.	What do you use sanitary pad or cloth?	102	40
A	Sanitary pad	153	60
B	Cloth		
4	How often do you change the pad or cloth?		
A		46	18
B	1-2 hours	209	82
4	3-5 hours		
A	If using cloth how do you wash it and dry it?	227	39
B	Soap and water with sunlight	58	23
5	Soap and water with dark place		
A		100	39
B	What type of cloth do you use?	40	16
C	Cotton	13	05
6	Polyester		
A	Nylon or silk		
B	What is the disposal practice?	30	12
C	burial	225	88
7	Wrap with paper and burn		
A	Thrown away	--	0
B	Do you have sexual intercourse at the time of menstruation?		
8	Yes	--	-
A	No	--	100
B	If yes		
	With condom	--	-
	Without condom	--	-

Above table shows Highest (99%) of them were taking bath during menses and only few (1%) were not taking bath during menses .Most (88%) of women wash parts with soap and water at the time of menses and only (12%) were not wash part with soap and water. More than half (60%) of them were using cloth and (40%) were using sanitary pad. Highest (82%) of them were change the pad after 3-5 hours only few (18%) changing the pad after 1-2 hourly. Most (89%) of them

wash the cloth with soap and water and dry it in sunlight. Among them (39%) of them were using cotton cloth and other (16%), (5%) were using polyester and nylon cloths respectively. Highest (88%) women were using disposal method of pad were wrap with paper and Burn it and only (12%) of them were using Burial method of disposal of pad. None of them is doing intercourse during menses.

Table 14: Personal history

S. N	Personal history	No	%
1	Alcohol		
A	Yes	--	0
B	No	255	100
2	Tobacco		
A	Yes	112	44
B	No	143	56
3	sleep		
A	Normal	205	80
B	Insomnia	50	20
4	appetite		
A	Normal	233	91
B	Loss of appetite	22	09
5	bowel & bladder		
A	Normal	244	96
B	Abnormal	11	04
6	Habits/addiction		
A	Present	121	53
B	Absent	134	47
7	Medical history		
A	Htn	08	3
B	Dm	27	11
C	Thyroid	05	02
D	Others.	15	06

Above table shows, none of the women has history of Alcohol. Most (44%) of them have the habit of tobacco chewing. Highest (80%) has normal sleeping pattern and only (20%) of women complains of Insomnia. Most (91%) of women has normal Appetite and only (06%) of them has loss of appetite. Highest (96%) has normal Bowel and Bladder only (04%) of them complains of abnormal Bladder and Bowel pattern. Most (53%) of them having habit /addiction. Medical history (11%) of the women had DM, (03%) HTN, and very few (2%) had thyroid and (6%) having history of other medical problem.

(Table: 15)

Most (35%) of the women has low back pain. Highest (27%) has low back pain <1 years and (0.7%) of them has low back pain >1 yrs. Many (36%) of them has history of vaginal discharge among them (23%) has <1 yrs and (13%) has history of >1 years vaginal discharge. only (18%) of the women has history of abdominal pain and among them in that (16%) has from <1 year and (2%) has >1 year.In menstrual problem (8%) of women has Dysmenorrheal, (07%) Menorrhagia, (02%) Hypo menorrhea, (28%) has Irregular Cycles. (34%) of women has primary Infertility and (12%) of them has secondary fertility In Urinary complaints (04%) of women has Dysuria, (11%) increased frequency of urine. (01%) Mass per vagina, (5%) Genital ulcer, (31%) Genital itching, (14%) Enlarged lymph nodes in groin, only (2%) Post coital bleeding, (7%) of the women has Lump in the Breast. Highest (80%) of the women had Treatment taken for the complaints most of them (24%), (23%) of them taken treatment in PHC/CHC and private hospital respectively and (17%) of had taken treatment in Government hospital for complains.

SN	Symptoms of reproductive morbidity	No	Percentage
1	Low Backache		
A	Yes	89	35
B	No	166	65
2	Since		
A	<1yrs	70	27
B	>1yrs	19	7
3	Vaginal Discharge		
A	Yes	92	36
B	No	163	64
4	since		
A	<1yrs	59	23
B	>1yrs	33	13
5	Low Abdominal pain		
A	Yes	46	18
B	No	209	82
6	Since		
A	<1yrs	41	16
B	>1yrs	05	2
7	**Menstrual problems** :		
8	Dysmenorrhea		
A	Yes	21	08
B	No	234	92
8	since		
A	<1yrs	18	7
B	>1yrs	03	1
9	Menorrhagia		
A	Yes	17	7
B	No	238	93
10	since		
A	<1yrs	11	4
B	>1yrs	06	2

11	Hypomenorrhoea		
A	Yes	06	2
B	No	249	98
12	since		
A	<1yrs	06	2
B	>1yrs	00	0
13	Irregular Cycles		
A	Yes	72	28
B	No	183	72
14	Since		
A	<1yrs	60	83
B	>1yrs	12	17
15	**Urinary complaints :**		
16	Dysuria		
A	Yes	09	4
B	No	246	96
17	since		
A	<1yrs	06	02
B	>1yrs	03	01
18	Increased Frequency since		
A	Yes	29	11
B	No	226	91
19	Mass per vagina		
A	Yes	03	01
B	No	252	99
20	Since		
A	<1yrs	3	1
B	>1yrs	0	0
21	Genital ulcer		
A	Yes	13	5
B	No	242	95
22	since		

A	<1yrs	8	62
B	>1yrs	5	38
23	Genital itching		
A	Yes	80	31
B	No	175	69
24	Since		
A	<1yrs	44	17
B	>1yrs	36	14
25	Enlarged lymph nodes in groin		
A	Yes	38	14
B	No	217	86
26	Since		
A	<1yrs	19	50
B	>1yrs	19	50
27	**Infertility**		
	primary		
A	Yes	87	34
B	No	168	66
28	since		
A	<3yrs	50	57
B	>3yrs	37	43
29	secondary		
A	Yes	31	12
B	No	69	88
30	since		
A	<5yrs	23	74
B	>5yrs	08	26
31	Dysparunia		
A	Yes	14	05
B	No	241	95
32	since		
A	<1yrs	8	57

B	>1yrs	6	43
33	Post coital bleeding		
A	Yes	06	2
B	No	199	98
34	Since		
A	<1yrs	4	2
B	>1yrs	2	1
35	Lump in the Breast		
A	Yes	18	7
B	No	237	93
36	since		
A	<1yrs	8	44
B	>1yrs	10	56
37	Treatment taken for the complaints:		
A	Yes	204	80
B	No	51	20
38	**Where**		
A	PHC/CHC	60	24
B	Govt. Hosp	44	17
C	Private	58	23
D	others	42	16
E	After how many days of onset of complaint		

Table 16: Sexual history

S. N	Sexual History	No	%
1	Sexually active		
A	Yes	200	78
B	No	55	22
C	One partner	252	99
D	multiple partners	3	1
2	Protection used (condoms)		
A	Yes	0	0
B	No	0	0
3	Do you wash your parts after intercourse?		
A	Yes	23	13
B	No	222	87
4	No. of coitus per week		
A	<3 time/wks	104	80
B	>3	51	20
5	Sexual History of the partner		
	Faithful		
A	Yes	252	99
B	No	03	01
6	Multiple partners		
A	Yes	03	1
B	No	252	99
7	Condom used		
A	Yes	0	0
B	No	0	0
8	Does the wash his part after intercourse?		
A	Yes	76	31
B	No	178	69

Above table shows that more than half (78%) of the women are sexually active. Highest (99%) of them has single sexual partner and only (13%) of them wash their part after intercourse. Highest (80%) of the women has <3 time/wks No. of coitus per week.
Most (99%) of women's husband were faithful only (01%) of husbands have multiple partner history. Many (31%) of the partner wash his part after intercourse.

Table 17: Clinical examination

S. No	Clinical examination	No	%
1	Weight :		
A	30-40 kg	51	20
B	41-50 kg	102	40
C	>50 kg	102	40
2	Height:		
A	140-150 cm	75	49
B	150-160 cm	128	39
C	161 cm& above	30	12
3	Pallor		
A	Present	102	68
B	Absent	153	32
4	Vital sign: pulse		
A	60-70/min	23	09
B	71-80/min	130	51
C	>80/min	102	40
5	Breathing		
A	15-20/min	58	23
B	21-25/min	188	74
C	>26/min	08	03
6	BP		
A	110/70- 120/80 mm of hg	75	29
B	122/82- 130/90 mm of hg	151	59
C	>134/92 mm of hg	30	12

Above table shows that less than half (40%) of women has 50 kg and >50 kg weight respective only (20%) of the women. is between 30-40 kg. Nearly half (49%) of women has the height between 140-150 cm and only (12%) has height of above 161 cm. Most (68%) of women clinical examination shows that pallor is present. Half (51%) of women has pulse between 71-80/min and (40%) of the women has pulse rate >80/min and very few (9%) of the women has pulse rate between 60-70/min. Highest (74%) women has 21-25/min breathing and only (3%) of women has breathing more than >26/min. More than half (59%) of women has blood pressure between 122/82- 130/90 mm of hg and very less (12%) of the women has >134/92 mm of hg blood pressure.

4. Discussion

Reproductive health knowledge is important for women as woman's health and well-being, contraception, as well as those of her family may depend on her being able to delay the birth of her first child or space the birth of her children [25, 26]. Women started antenatal care at a relatively early stage of their pregnancy (before 4-month pregnancy), and 78.2% of women made six or more antenatal care visits during their entire pregnancy, but present study found that most of the respondents made three or four antenatal care visits during their entire pregnancy which was not similar to Palestine study [27]. Women are often aware of benefits of family planning. Women's decision about use, non-use, or discontinuation of family planning methods can be affected by their perceptions of contraceptive risks and benefits, concerns about how side effects may influence their daily lives and assessment of how particular methods may affect relationships with partners or other family members [28]. A study was conducted to understand the family planning (FP) knowledge and current use of contraception and its predictors among women of the Mru people– the most underprivileged indigenous community in Bangladesh [29]. Only about 40% of respondents had ever heard FP messages or about FP methods– two fifths of the national figure (99.9%). The current use of contraception was much lower (25.1%) among the Mru people than at the national level (55.8%) [30]. Unsafe abortions still contribute to 13-50 % of the maternal mortality in some of these countries. Only three respondents have actually dealt with abortion related cases. A few respondents said that they have dealt with issues like adultery, extra marital relations, etc. but not with abortions. The source of their information on abortion was, therefore, media or other reports and TV as like my study subjects. However, seventeen of them were interested in knowing more about abortion and abortion laws [31]. The present study found that health awareness was less and contraceptive knowledge factors were better among rural reproductive women. Out of 250 study subjects, nearly half had knowledge about care during pregnancy, in rural area. Knowledge on safe abortion found less good.

Conclusion

Most dimensions of health of women of reproductive age had a significant association with educational and income levels, and their reflection on negative experiences in women's health is alarming. Women's health is the basis for family and society's health, thus, efforts to make a healthy society as a platform for women's health are essential. In policymaking, in addition to the goal of reducing income disparities, attention must also be paid to women's education that actively contributes to maintaining their health. Making necessary arrangements for education and employment of women, while maintaining respect for their roles as mothers and wives, appear a necessity.

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