**Title -Reproductive Morbidity, Health Facility and Treatment seeking behaviour among women in Uttar Pradesh (Sociological perspective of maternal morbidity)**

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**A statement of competing interests and funding support-**

As a social worker and as a woman I have interest in women health-related topics. I have conducted this study for completion of my PhD.

**A statement of any submission of very similar work- not submitted any where**

**Abstract-**

Morbidity refers to disease and illness, injuries, and disabilities in a population (Haupt and Kane, 2004). Morbidity means the incidence of sickness or injury or pain affecting a person. Available indicators show that the reproductive health situation of the Indian population is not satisfactory. Pregnancy and childbirth-related complications are the main cause of death among the female population aged 14-44 years. Although many maternal complications are unpredictable, most of these deaths are preventable.

As we all know Uttar Pradesh is the most populated state of our country with a population of 20 crores. Women in India, especially in Uttar Pradesh, are facing many challenges. Lives of women are surrounded by their family members. They have the burden of their care on their shoulders. In this study, our focus is on middle-class and low socio-economic class women of Lucknow in Uttar Pradesh. Poor women are suffering from many problems and have to face many challenges in their daily lives. They do not have access to potable water, sanitation, safe household, proper medicine and safe environment to live in. Women in urban slums too are facing many problems in their daily lives. Along with these problems they have to take care of their family members and their lives. So they have less time to think about their health and hygiene.

Gender inequalities are rooted in history. This phenomenon has originated with the evaluation of human civilizations with the division of labour between men and women, and since then it was manifested in various individual and social human life in the society. Living condition in urban slums is very unhygienic which put the burden on women health. Lack of nutritional diet, unhygienic condition, information on cleaning during menstruation and unavailability of water supply further weak women’s situation. Along with that woman has to take care of their children, husband and in-law.

**Introduction-**

Reproductive morbidity refers to illness and death from complication of pregnancy or childbirth, unsafe abortion, infection of the reproductive or genital tract and sexually transmitted infections, and the improper use of contraceptive methods.

Reproductive morbidity is explained as "any morbidity or dysfunction of the reproductive tract, or any morbidity, which may be aconsequence of reproductive behaviour including pregnancy, abortion, childbirth; or sexual behaviour" (WHO, 1990). Non-reproductive morbidity refers to morbidity occurring to women that are not associated with the reproductive system, reproduction, contraception or sexual behaviour. To cater to the need of most populous state of India many private and government facilities are working in Uttar Pradesh. But the poor population mostly avail services from the government hospitals.

Many private hospitals are also working in the urban and rural areas but the cost of treatment in these facilities is very high so the majority of the population is not able to use services from these facilities. In the absence of an alternative, most villagers get treatment from nearby practitioners who, while possessing some knowledge of drugs and dosage, lack a recognised medical qualification. Although such medical practices are illegal, a person who can provide effective, quick-acting medicine naturally becomes the first choice since the qualified practitioners are located too far away

**Sociological Perspective of Maternal Morbidity**

Gender inequalities are rooted in history. This phenomenon has originated with the evaluation of human civilizations with the division of labour between men and women, and since then it was manifested in various individual and social human life in the society.

Women have the requirement of extra nutrition during pregnancy and childbearing. But due to poor socio-economic status women are unable to take appropriate nutrition during pre and post-pregnancy. This is harmful to women and child health. In urban slums, women are living in extreme poverty and they do not have nutritious food for the family and themselves. They do not have proper sanitation and hygienic condition in urban slums. Due to this poor nutrition, unhygienic condition and unsafe environment in society women continue to face many health-related problems. In a study by the National Institute of Public Cooperation and Child Development (NIPCCD) in 2015, it was found that iron deficiency anaemia is the cause of 40% maternal death in India.

Pregnancy increases the chances of iron deficiency in women body. By repeated pregnancy iron deficiency increased in women body. Due to severe anaemia, many women in our country are dying. As severe anaemia leads to heart failure and death from shock (Ronsmans, 2008). Zinc deficiency is another reason for maternal morbidity and mortality in India. In many developing countries Zinc deficiency is very widespread that leads to increase risk of maternal mortality (King, 2000; Jou, 2010).

Women those are illiterate or less literate do not have any other mean for the livelihood. They have to earn their livelihood by odd jobs. As they earn less and they can hardly fulfil the basic demand of their families. Their husbands are also involved in small odd jobs but the family size is so big that they con not fulfil the requirement of their family. As it is tough for them to sustain their families. After the fulfilment of their basic need very less amount is left in their hands for any emergency and medicine, they were dependent on the debt. Many women suffered from different types of illness but they try to avoid seeking medical help. When their problem increase and on peak than only they try to resolve that.

Gender inequalities are rooted in history. This phenomenon has originated with the evaluation of human civilizations with the division of labour between men and women, and since then it was manifested in various individual and social human life in the society. Presence of financial, monetary, economic and social structures gender inequality. Also, the harmful effects of some cultural structures, stereotyped ideas dominate over different communities, and the ongoing phenomenon of patriarchy are major factors that create and help continuation of female inequality and weakening their status. On the other hand, women are defined as closer to nature in patriarchal ideologies because of their biological roles (reproductive role) compared with men, and thus domination of men over women is justified. According to historical and anthropological research studies, the roles which are considered for men and women are specific to the communities in specific times.

**THE RESEARCH PROBLEM**

As per the Annual Health Survey of Uttar Pradesh (2012-2013), Lucknow Mandal is having a maternal mortality ratio of 311 per 100,000(live birth), which is second highest in Uttar Pradesh. Looking into the scenario of high maternal mortality ratio, it is important to know the sociological reason for high maternal mortality and morbidity.

The high prevalence of reproductive morbidity calls for an urgent assessment. After the International conference on population and development (ICPD) in1994, social scientists and health researchers have mostly focused either on the prevalence or functioning of the health system in our country. At present, a majority of studies were focused on the level and pattern of various components of reproductive morbidity. There is a wider research gap between the perception of reproductive morbidity and facilities available for reproductive health care in existing health services. To bring these two issues under the same roof and bridge this research gap, the present study examines the levels and pattern of various reproductive problems in Lucknow district of Uttar Pradesh and the condition of the public health system which provide reproductive health services in the state. We will also seek a sociological solution to the problem.We will analyse the problem from sociological perspective to find solution to the problem.

**Location of the Study-**

The location of the study is the Lucknow district’s two localities viz. Indira Nagar and Thakurganj area of Lucknow. We have selected Lucknow district because the maternal morbidity is very high in Lucknow. We have selected the two contrast areas of Lucknow to do the comparison. The Thakurganj area is very dense and Muslim dominated . 150 samples from Thakurganj and 150 samples from Indira Nagar have been selected.

**CONCEPTUAL FRAMEWORK-**

Women/Female reproductive and sexual health status is affected by a variety of factors. The research consists of a conceptual framework for analysing the determinants of reproductive morbidity and utilisation of government /private health care system and sexual health services. Socioe-conomic background of respondents played a significant role in the reproductive and sexual health status of women. At the individual level, women's characteristics and household characteristics influence the reproductive morbidity and treatment-seeking behaviour among the women of Uttar Pradesh.

However, the poor socio-economic status of women may directly or indirectly relate to the low usage of reproductive and sexual health care services. For example, women from urban households and comparatively wealthier background are less likely to have suffered from reproductive morbidity, but strongly inclined to care to seek for reproductive health problems. On the other hand,a women from low socio-economic background women are more likely to have been affected. Lack of education and low income are possibly associated with poor utilisation of reproductive health care services. The demographic factors such as age at marriage, wastage, and parity play a significant role in women's reproductive health care. Risk factors such as very young age at entry into sexual union and childbearing, lack of education and low income are all associated with reproductive morbidity.

Various demographic factors also affect directly and indirectly influence the use of reproductive health services.

In this research, we have selected the Uttar Pradesh because it’s the most populated state of India. The women and men living there belong to different castes, religions and backgrounds.

From Uttar Pradesh, I have selected Lucknow for focused analysis because people from a different section of society are living in Lucknow.

**RESEARCH DESIGN –**

**For the purpose of this research following concepts have been used-**

Reproductive morbidity has been classified into three types, maternal morbidity, gynaecological morbidity, and contraceptive morbidity (WHO, 1990; Zurayk et al., 1993).

**Obstetric Morbidity**- Obstetric morbidity meaning morbidity during a woman from any cause associated with the pregnancy or its management, many women are facing problem during pregnancy and delivery of a child. These all-causes are coming under the obstetric category. But not from accidental or any other causes.

**Gynaecological morbidity**- Gynaecological morbidity meaning a condition, disease or non-function of the genital system that's not associated with pregnancy, abortion, or childbirth, but could also be associated with sexual behaviour.

**Contraceptive Morbidity**- Contraceptive morbidity meaning a condiction from efforts (other than abortion) to limit fertility, whether they are traditional or modem methods (WHO, 1990).

The present research involves two levels of analysis: individual level and community level. First is an individual-level analysis of factors associated with reproductive morbidity of women/females treatment-seeking behaviour. This would assess the influences of social, economic, religious and other intermediate factors on reproductive health problems and treatment-seeking behaviour of women of Uttar Pradesh. Final1y, a community-level analysis that examines the availability of reproductive and sexual health facilities in selected two different localities of Indira Nagar and Thakurganj area of Lucknow district in Uttar Pradesh has been carried out.

**UNIVERSE AND SAMPLING**-

Interview scheduled were prepared and used for collecting data on reproductive morbidity and to assess the type of services women are accessing from public health facilities for treatment of reproductive morbidity. Total of 300 samples were interviewed. 150 Samples each were collected from Thakurganj area and Indira Nagar area respectively. The random sampling technique has been used for the data collection.

**TOOLS OF DATA COLLECTION**-

The interview schedule method was used for collecting primary data. Few case studies were also carried out for the indepth study.

**METHODOLOGY-**

Based on the primary data, associations between reproductive morbidity and treatment-seeking behaviour and spatial, socioeconomic, demographic, and programmatic factors are examined.

In this study, we have used statistical techniques like cross-tabulations and multivariate analysis such as logistic regression and multinomial logistic regression model, SPSS as appropriate for studying differentials by socio-economic and demographic characteristics and net influences of these. For those reporting reproductive morbidity, treatment-seeking behaviour is studied first, using cross-tabulations and the net effects using a multinomial logistic regression model. Chi-Square Tests used to check the two different data sets. Since the data was not normal, so we applied two non-parametric tests, i.e, Kruskal Wallis test and Mann-Whitney U test.

In this study we have tried to show the data by different charts and pictorials bar diagrams.

**Analysis of Data-by SPSS Pakage**

**Document on Reproductive Morbidity, Health Facility and Treatment Seeking Behaviour among Women in Uttar Pradesh**

* **Normality of the data**

The null hypothesis to be considered here will be-

Ho : Data is normally distributed.

|  |  |  |  |
| --- | --- | --- | --- |
| **Tests of Normality** | | | |
|  | Kolmogorov-Smirnova | | |
| Statistic | Df | **Sig.** |
| RM | .430 | 300 | **.000** |

**Table-1.1**

**RM is the Reproductive Morbidity**

**Interpretation:-** Since p-value = 0.00 < 0.05, the null hypothesis is rejected and we conclude that the data is not normally distributed.

* **Awareness and Perception among married women of Uttar Pradesh about reproductive and sexual health problems like RTI, STI and HIV/AIDS.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Cross Tabulation** | | | | | |
|  | | | **RTI\_new** | | Total |
| **Yes** | **no** |
| **RM** | **yes** | Count | 0 | 98 | 98 |
| % of Total | **0.0%** | 32.7% | **32.7%** |
| **no** | Count | 60 | 142 | 202 |
| % of Total | 20.0% | 47.3% | 67.3% |
| Total | | Count | 60 | 240 | 300 |
| % of Total | 20.0% | **80.0%** | 100.0% |

**Table-1.2**

RTI\_new is the variable computed for health problem RTI

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Cross Tabulation** | | | | | |
|  | | | **STI\_new** | | Total |
| **Yes** | **no** |
| **RM** | **Yes** | Count | 0 | 98 | 98 |
| % of Total | **0.0%** | 32.7% | **32.7%** |
| **No** | Count | 15 | 187 | 202 |
| % of Total | 5.0% | 62.3% | 67.3% |
| Total | | Count | 15 | 285 | 300 |
|  | | % of Total | 5.0% | **95.0%** | 100.0% |

**Table-1.3**

STI\_new is the variable computed for health problem STI

**Crosstabulation**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | | **HIV\_new** | | Total |
| **Yes** | **No** |
| **RM** | **yes** | Count | 0 | 98 | 98 |
| % of Total | **0.0%** | 32.7% | **32.7%** |
| **no** | Count | 20 | 182 | 202 |
| % of Total | 6.7% | 60.7% | 67.3% |
| Total | | Count | 20 | 280 | 300 |
| % of Total | 6.7% | **93.3%** | 100.0% |

HIV\_new is the variable computed for the health problem HIV/AIDS

**Table-1.4**

The null hypothesis to be considered here will be:-

Ho : There is no association between RM and RTI\_new, RM and STI\_new, RM and HIV\_new.

|  |  |  |  |
| --- | --- | --- | --- |
| **Chi-Square Tests** | | | |
| Pearson Chi-Square | Value | Df | **Asymptotic Significance (2-sided)** |
| RTI\_new | 36.386 | 1 | **.000** |
| STI\_new | 7.66 | 1 | **.006** |
| HIV\_new | 10.396 | 1 | **.001** |

**Table-1.5**

**Interpretation:-** Since p-value < 0.05, we reject the null hypothesis and conclude that **RM** is **associated** to **RTI\_new, STI\_new,** and **HIV\_new**. Also there is a weak association between them.

**From table-1.2**, we can say that about 80% of married women are unaware about RTI among which who had suffered from Reproductive morbidity (RM) have no knowledge about reproductive tract infection (RTI).

**From table-1.3**, we can say that about 95% of married women are unaware about STI among which who had suffered from Reproductive morbidity (RM) have no knowledge about STI.

**From table-1.4**, we can say that about 93% of married women are unaware about HIV/AIDS among which who had suffered from Reproductive morbidity (RM) have no knowledge about HIV/AIDS.

Hence**, the women in age-groups (15-49 years) who had suffered from reproductive morbidity are unaware about the reproductive and sexual health problems.**

* **To understand the treatment seeking behaviour of women for reproductive morbidity at public health facility of Uttar Pradesh**

1. Treatment by making decisions:-

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Cross Tabulation** | | | | | | | | |
|  | | | **Decision making** | | | | | **Total** |
| **Not**  **answered** | **Husband** | **myself** | **both** | **in laws** |
| **RM** | yes | Count | 5 | 81 | 0 | 0 | 12 | 98 |
| % of Total | 1.7% | **27.0%** | 0.0% | 0.0% | 4.0% | 32.7% |
| no | Count | 0 | 167 | 15 | 17 | 3 | 202 |
| % of Total | 0.0% | 55.7% | 5.0% | 5.7% | 1.0% | 67.3% |
| Total | | Count | 5 | 248 | 15 | 17 | 15 | 300 |
| % of Total | 1.7% | 82.7% | 5.0% | 5.7% | 5.0% | 100.0% |

**Table-2.1**

|  |  |  |  |
| --- | --- | --- | --- |
| **Chi-Square Tests** | | | |
|  | Value | Df | **Asymptotic Significance (2-sided)** |
| Pearson Chi-Square | 41.110 | 4 | **.000** |

**Table-2.2**

The null hypothesis to be considered here will be:-

Ho : There is no association between RM and decision making for treatment of women.

**Interpretation:-** Since p-value = 0.00 < 0.05, the null hypothesis is rejected and we conclude that **reproductive morbidity** is **weakly associated** with the **decision making for the treatment of women who had suffered from gynaecological morbidity.**

From table-2.1, we can say that the decision for the treatment of gynaecological morbidity among the married women is mostly taken by their husbands (= 27%)

Treatment seeking behaviour for reproductive morbidity:-

1. **Treatment seeking behaviour for reproductive morbidity**:-

**Cross Tabulation**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | **seeking treatment** | | | | | **Total** |
| **not**  **answered** | **govt. hospital/ clinic** | **private hospital/ clinic** | **MBBS doctors(private)** | **mid wife** |
| RM | Yes | Count | 62 | 27 | 0 | 0 | 9 | 98 |
| % of Total | 20.7% | **9.0%** | 0.0% | 0.0% | 3.0% | 32.7% |
| No | Count | 142 | 0 | 21 | 31 | 8 | 202 |
| % of Total | 47.3% | 0.0% | 7.0% | 10.3% | 2.7% | 67.3% |
| Total | | Count | 204 | 27 | 21 | 31 | 17 | 300 |
| % of Total | 68.0% | 9.0% | 7.0% | 10.3% | 5.7% | 100.0% |

**Table-2.3**

|  |  |  |  |
| --- | --- | --- | --- |
| **Chi-Square Tests** | | | |
|  | Value | Df | **Asymptotic Significance (2-sided)** |
| Pearson Chi-Square | 84.538 | 4 | **.000** |

**Table-2.4**

The null hypothesis to be considered here will be:-

Ho : There is no association between RM and treatment seeking behaviour among women at public health facility.

**Interpretation:-** Since p-value = 0.00 < 0.05, the null hypothesis is rejected and we conclude that **Reproductive morbidity** is **associated** with the **treatment seeking behaviour among women at public health facility.**

From table-2.3, we can say that only 9% of the women seek treatment for gynaecological morbidity at the public health facility.

**Conclusion-**

The present study is to focused on the reproductive morbidity and treatment-seeking behaviour for women in Lucknow District of Uttar Pradesh.

The maternal morbidity is still a considerable burden in the country, though there is scaling-up of institutional as well as safe delivery; more accessibility and availability of health facilities; and increased awareness to receive modern care. The major areas investigated here are preconception, antenatal care, institutional and safe delivery, obstetric and gynaecological morbidities and STDs/HIV/AIDS among women.

Education and economic activities are vital components of women's status. The respondents in the study areas have very limited access to the labour market and female literacy ratio is poor. 99 percent of them are unskilled labour (in garments factory, as maid and embroidery work). The low economic participation and education make it difficult for women to bargain for power in the family. They have also the paucity of access in decision-making. The glimpses of health status are not favourable. A considerable section of women has malnutrition, the complication in the earlier pregnancy and also, teenage delivery.

The nutrition level is significantly associated with the status of women. The level of malnutrition reduces as the status of women improves. The general awareness rises along with status and that would act to maintain better nutrition level, and downsize the number of these marginal women having malnutrition.

Risky morbidities during pregnancy and delivery are swelling, abdominal pain, haemorrhage, obstructed labour and prolonged labour, retained placenta. High-risk diseases during pregnancy, delivery and the postpartum period are significantly interlinked. Haemorrhage, high-risk morbidity, is high among urban slums women and women having malnutrition. It is interlinked with the haemorrhage at delivery and the postpartum period. Similarly, women having swelling and lower abdominal pain are also more likely to have complications (obstructed and prolonged labour) during delivery and the postpartum period(lower abdominal pain).

A substantial section of 12 percent women seeks care from traditional sources. Public hospitals (Government Institutions) and local clinics are mainly preferred by 67 percent of the women of the lower and middle-class population. 12 percent of women are going to un-authorised services providers as these service providers are easily available in their locality and they charge very fewer charges from Rupees 20-50.

Another major reason for women’s unmet need is the anticipated social opposition from husbands, families, communities, and religious leaders, to the use of contraceptives and to women’s desire to regulate fertility. Women may be discouraged from regulating their fertility in societies where this is frowned upon or in societies where more births and more children are encouraged (Casterline and Sinding 2000; Jejeebhoy et al 2014; Hardee et al. 2014; Jain et al. 2014). Women may also internalise these norms as it is evident among newly married women and couples who aspire to get pregnant right after marriage to prove their fertility in contravention of their desires for family planning. In India, the prevalence of male child preference is a major hindrance to the use of contraceptives–women who do not have as many male children as they or their families desire, may be deterred from using contraceptives (Kulkarni 2020).

These social pressures are amplified when women feel they do not have their **partners’ support or engagement** in family planning. Men may not participate in discussions on family planning, leaving the burden of decision-making and social opposition on women. Women may also fear that their partners would disapprove, refuse, or respond with violence to any conversation on using contraceptives. Women’s inability to negotiate contraceptive use with their partners is yet another element of social opposition that can exacerbate their unmet need.

In this study, it was observed that with increasing educational and socioeconomic status, contraceptive practice is increasing. We found that awareness towards the family planning methods was good but contraceptive practices are poor because of lack of knowledge and fear of side effects. Due to socio-cultural pressure also women are hesitant in taking or adopting family planning method.

**Provider attitude plays a very important role in the delivery of services.** Healthcare providers and frontline workers (FLWs) may reflect societal values and stereotypes attached to religion, gender, class, and caste, that can negatively affect health-related communication and decisions. Provider attitude may also reflect a healthcare provider’s personal preference for one form of contraceptive over others, following which they may not share complete information on all available contraceptives with women.

**Quality care**, including a **mix of contraceptive methods**, needs to not only be available but also affordable and easily and consistently accessible, especially in regions and within communities that report high unmet need. India has expanded its basket of contraceptive choices and included additional methods for spacing, but the rollout and availability of the new contraceptive methods have been slow and uneven, leaving the opportunity to improve the last-mile reach of quality reproductive healthcare services in underserved regions. Improving the quality of care can reduce unmet need among women by creating demand of contraceptives among new users, preventing attrition among current users, and closing the gap when women are without contraception but do not desire to be pregnant, as happens when women are considering switching contraceptives or planning to return to contraceptive use after childbirth.

**BOOKS -**

1. Acharya, Laxmi Bilas and John Cleland. 2000. Maternal and Child Health Services in Rural Nepal: Does Access or Quality Matter More? Health Policy and Planning 15 (2):223-229.
2. Ager, Alastair and Katy Pepper. 2005. Patterns of Health Service Utilization and Perceptions of Needs and Services in Rural Orissa. Health Policy and Planning 20 (3): 176-184.
3. Bali, Prema and R. A. Bhujwala. 1969. A Pilot Study of Clinic Epidemiological
4. Batliwala, S. (1994). The Meaning of Women’s Empowerment: New Concepts from Action. In Sen, G.; Germain, M. and Chen, L.C. (eds.), Population Policies Reconsidered – Health, Empowerment and Rights. New York: Harvard University Press.
5. Bhat, Ramesh. 1995. *Private Health Care in India: The Private/Public Mix in Health Care in India,* IHPP Reprint Series, International Health Policy Program, Washington,D.C. World Bank.
6. Chakarabary, Gurupada. 1998. Scheduled Castes and Tribes in Rural India: their Income, Education and Health Status. .Margin 30 (4) 100-130
7. Das, N. P., and Urvi Shah. 2007. *A Study of Reproductive Health Problems among Men and Women in Urban Slums with Special Reference to Sexually Transmitted Infections.* Baroda: Population Research Centre.
8. Garg, S., N. Shanna, P. Bhalla, R. Sahay, R. Saha, V. Raina, B. C. Das, S. Sharma, and N. S. Murthy. 2002. Reproductive Morbidity in an India Urban Slum: Need for Health Action. *Sexually Transmitted Infection*78 (1): 68-69.
9. Goodburn, A. Elizabeth, Rukhsana Gazi, and Mushtaque Chowdhury. 1995. Beliefs and Practices Regarding Delivery and Postpartum Maternal Morbidity in Rural Bangladesh. *Studies in Family Planning* 26 (1): 22-32.
10. Hasnain, N. (2004). Indian Society and Culture. New Delhi: Jawahar Publishers and Distributors. Kar, P. K. (2000). Indian Society. Cuttack: Kalyani Publishers
11. Hodoglul, Nuriye Nalan Shane, Ozek Beire, and Berto Munevuer. 1999. Prevalence of Reproductive Tract Infection in Family Planning Clients in Trabzon, Turkey.*Sexually Transmitted Infection* 75: 437-438.
12. Hulton, L. A., Z. Matthews, and R. B. Stones. 2007. Applying a Framework for Assessing the Quality of Maternal Health Services in Urban India. *Social Sciences and* *Medicine* 64: 2083-2095.
13. Michael A.Koeing . Shireen Jejeebhoy, Cleland.C.John and Ganatra Bela –Reproductive Health in India -New Evidence
14. Manuela Colombini, Colleen Dockerty, and Susannah H. Mayhew-Barriers and Facilitators to Integrating Health Service Responses to Intimate Partner Violence in Low- and Middle-Income Countries: A Comparative Health Systems and Service Analysis –Studies in Family Planning 48(2)
15. Michael A. Koenig, Kanta Jamil, Peter K. Streatfield, Tulshi Saha, Ahmed Al-Sabir, Shams El Arifeen, Ken Hill and Yasmin HaqueInternational Family Planning Perspectives-Maternal Health and Care-Seeking Behavior in Bangladesh: Findings from a National Survey
16. Nicole B. Ippoliti, Geeta Nanda, and Rose Wilcher-June 2017 Studies in Family Planning 48(2) Meeting the Reproductive Health Needs of Female Key Populations Affected by HIV in Low- and Middle-Income Countries: A Review of the Evidence
17. Ravi Shamika, Ahluwalia Rahul, Sofi,-Health and Morbidity in India 2004-2014, Booking Institution India Centre No -6, Second floor, Chanakyapuri,New Delhi
18. Rao Shankar, C. N. (2005). Indian Society. New Delhi: S.Chand & Company Ltd.
19. WHO, UNICEF, and UNFPA. 2003. Maternal Mortality(v in 2000: Estimation Developed by WHO, UNICEF, and UNFPA. Geneva: World Health Organisation.
20. WHO. 1990. Measuring Reproductive Morbidity, Report of a Technical Working Group,Geneva: World Health Organisation.
21. WHO. 1991. Infertility: A Tabulation of Available Data on Prevalence of Primary and Secondary Infertility, Programme on Maternal and Child Health and Family Planning, Division of Family Health, World Health Organisation, Geneva.
22. Yesudian C. A. K. 1994. Behaviour of the Private Sector in the Health Market of Bombay. Health Policy and Planning 9 (1): 72-80.
23. Zurayk Huda, Hind Khattab Nabi, Younis Mawahb El Mouelhy, and Mohamed Fadle. 1993.Concepts and Measures of Reproductive Morbidity. *Health Transition Review* 3 (1):17-39.

**Articles/Journals**

1. Annual Health Survey of Uttar Pradesh 2013-2014 ,Office of the Registrar General Census Commissioner,India
2. Bang, R. A., A. T. Bang, M. Baitule, Y. Choudhary, S. Sannukaddam, and O. Tale. 1989.High Prevalence of Gynaecological Disease in Rural Indian Women. *The Lancet* 1(8629): 85-88.
3. Bang, Rani A., Abhay T. Bang, M. Hanimi Reddy, Mahesh D. Deshmukh, Sanjay B. Baitule,and Veronique Filippi. 2004. Maternal Morbidity during Labour and the Puerperium in Rural Homes and the Need for Medical Attention: A Prospective Observational Study in Gadchiroli, India. *International Journal of Obstetrics and Gynaecology* 111:231-238.
4. Bhat, P. N. Mari. 2002. *Levels and Differentials in Maternal Mortality in Rural India: New Evidence from Sisterhood Data.* Working Paper Series No: 87. New Delhi: NationalCouncil of Applied Economic Research. Available online at: http://www.neaer.org.
5. Bhatia, Jagdish c., and John Cleland. 1995. Self-Reported Symptoms of Gynaecological Morbidity and their Treatment in South India. *Studies in Family Planning* 26 (4):203-216.
6. Bhatia, Jagdish C., and John Cleland. 1996. Obstetric Morbidity in South India: Results from a Community Survey. *Social Science and Medicine* 43 (10): 1507-1516.
7. Chellan, Ramesh and P. M. Kulkarni. 2006. Influence of Socio-Economic and Demographic Factors on Gynaecological Morbidity and Treatment Seeking Behaviour in NorthEastern States of India. *Demography India* 35 (2): 303-318.
8. Chellan, Ramesh. 2004. Gynaecological Morbidity and Treatment Seeking Behaviour in South India: Evidence from Reproductive and Child Health Survey, 1998-99. *Journal* *of Health and Population in Developing Countries.* Available online at: http://www.jhpdc.unc.edu.
9. Chellan, Ramesh. 2007. Determinants of Contraceptive Morbidity and Health Seeking Behaviour in India. *The Journal of Family Welfare* 53 (2): 7-25.
10. Dasgupta, S. 1995. Reproductive Morbidity. *Journal of Indian Medical Association* 93 (2):55-57.
11. District Level Household and Facility Survey, 2007-08 Uttar Pradesh , Ministry of Health and Family Welfare :10;22
12. Hardee Karen, Agarwal Kokila, Luke Nancy, Wilson Ellen, Pendzich Margaret, Farrell Marguerita and Cross Harry Reproductive Health Policies and Programs in Eight Countries: Progress Since Cairo .International Family Planning Perspective-volume 25, January 1999
13. India, Registrar General. 2013a. *Sample Registration System Statistical Report 2006, Report Number* 4 *of 2007.* Delhi: Controller of Publication.250
14. Jahnavi Daru, Javier Zamora, Borja M Fernández-Félix, Joshua Vogel, Olufemi T Oladapo, Naho Morisaki, Özge Tunçalp, Maria Regina Torloni, Suneeta Mittal, Kapila Jayaratne, Pisake Lumbiganon, Ganchimeg Togoobaatar, Shakila Thangaratinam, Khalid S Khan Risk of maternal mortality in women with severe anaemia during pregnancy and post partum: a multilevel analysis. www.thelancet.com/lancetgh Published online March 20, 2018 <http://dx.doi.org/10.1016/S2214-109X(18)30078-0>