Research Paper

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Health Status of Women in The Hk Region – A Empirical Study

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1. INTRODUCTION:

The health of country's female population has profound implications for the health and education of children and the economic well -being of households, as well as for the women themselves. The most direct effects of poor health and nutrition among female in India are high mortality rates throughout the life - cycle. Traditionally health care providers and researchers in the field of reproductive health have focused almost exclusively on women when planning programs and services, especially with regard to family planning, prevention of unwanted pregnancy and of unsafe abortion, and promotion of social roles in family planning and sexual and reproductive health issues.

The health of Indian women is intrinsically linked to their status in society. Research on women's status has found that the contributions Indian women make to families often are overlooked, and instead they are viewed as economic burdens.

There is a strong son preference in India, as sons are expected to care for parents as they age. This son preference, along with high dowry costs for daughters, sometimes results in the mistreatment of daughters. Further, Indian women have low levels of both education and formal labour force participation. They typically have little autonomy, living under the control of first their fathers, then their husbands, and finally their sons. All of these factors exert a negative impact on the health status of Indian women.

The United Nations defines violence against women as any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

2. AIMS AND OBJECTIVES:

The aim of present study is to investigate **Health Status of Women in HK region – A Empirical Study.** Women's status is inextricable bound up with social, cultural and economic factors that influence all aspects of their lives.

The objectives on which the research is focused are as below:

1. To know and review the historical background of HK region particularly, Gulbarga District.

2. To examine the Women's Health Status in Gulbarga and to analyse the specific factors affecting Women's Health position in Gulbarga District.

3. LIMITATIONS OF THE STUDY:

The main limitation of the study is that it is limited only to India, specifically, Gulbarga District only.

4. METHODOLOGY:

The study is undertaken with the broader methodological framework of women for her health. The study has analyzed the constraints of in equality of gender and to what extent they are able to face the challenges in the health care. The study is based on secondary data. The secondary data is collected through books, newspaper, journals, reports, etc from different libraries and also from hospitals reports, health centers and state government statistical office.

5. REVIEW OF LITERATURE:

To introduce the undertaken research, a review of the literature is present below: In this research paper, efforts have been made to review thoroughly the literature pertinent to the research paper title. It can give insight into analysis and supportive in establishing a meaningful rational for the present study.

In their study ***Shane, Barbara and Ellsberg (2002)*** illustrates that the article focuses on the reproductive health consequences of violence against women. It provides examples of research and successful programs and explores how the health sector can tack an active role in the prevention and treatment of violence against women.

Unnithan-Kumar (2003) focuses on decision surrounding pregnancy and child birth and related nation of health and healing, especially as connected with women's bodies to understand how a group of women in Basti and Jaipur, Rajasthan perceive, experience and negotiate the cultural and economic transformations n their lives. Culture plays an important role in the perception of people in context to health and medicine. Local healer remained the primary source of advice in the case of number of private medical practitioners are consulted for cold, fever, stomach upset and dizziness.

Ram and Singh (2005) have found that ante-natal care is a strong predictor of safe delivery in rural areas. Women bear their health problems in a "culture of silence' and do not seek timely health care. They often cannot travel beyond the areas of their normal activities to obtain services.

Paul and Chellan (2007) examine the post-delivery complications and treatment-seeking behaviour among married women with selected socio-economic and demographic characteristics in India from the district lived household survey during 2002-2004. The results show that 31.4 per cent women are suffering from some post-delivering conditions and among them 50.3 per cent had sought treatment. Place of residence, educational and economic level, place of delivery, full ante-natal check-ups have a significant effect on post-delivery complications and women with high age at marriage, and urban residence are more likel y to seek treatment among those who had complications.

Mane (2008) explained the sociology of population, gender inequality and health-India in a global context. One of the main barriers to better health and equitable growth is gender inequality. Empowered women contribute to the health and productivity of families and nations.

Balagopal (2009) in her study of "Access to Health Care Among poor elderly women in India: How far do policies Respond to Women's Realities?" found that in developing

countries like India, poor health and inability to access health care are an important part of the experience of aging, particularly among people living in poverty.

Sinha (2011) recorded 9.8 lakh new cases of cancer last year, an increase of about 80,000 new cases as compared to 2009. In India, four lakhs die of cancer every year. The ministry data shown 25 lakh cancer patients in the country at any point in time cancer is the third biggest killer in India. In developed countries, cancer is the second leading cause of death, accounting for 21 per cent (2.5 million of all mortality). In developing country cancer rank third as a cause of death and accounts for 9.5 per cent (3.8 million) of all mortality. Cancer is a curable if detected early. The result of treatment in stag e I and II stage (early stage) 80 per cent. The number of new cases in India is expected to cross 15 lakhs. Among Indian males, lung, head and neck cancer is the most common and among women, breast and cervical cancer is the most frequent. The ministry recently rolled out the national programme on cancer across 1000 districts in 21 states.

The review of studies shows diversity among the research initiatives, for instance, an interview schedule and observation related to different books, articles in additions to these sources, we use of Census Reports, Gazetteers, newspaper and planning documents. The studies are ***Gender Inequalities and Mental Health - A Special Reference to Gulbarga District.*** Therefore, Researcher has decided to take up study related to the women's health status in Gulbarga District. To study the women's health status in Gulbarga this is very lower in rural area of India, particularly in Karnataka.

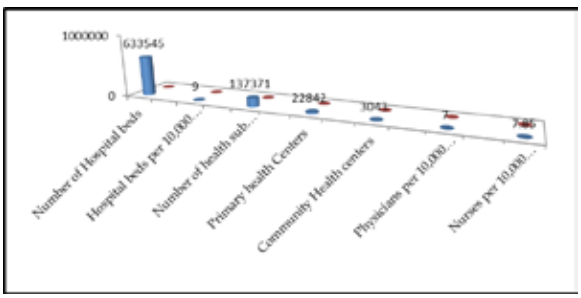
TABLE 1:
Health System and Human Resources in India

Health System stem	Number	Year
Number of Hospital beds	633545	2002
Hospital beds per 10,000 population	9	2006
Number of health sub centers	137371	2006
Primary health Centers	22842	2001
Community Health centers	3043	2001
Physicians per 10,000 population	7	2005
Nurses per 10,000 population	7.85	2004

Source: WHO, World Bank Report: 2006

When we look into the data available in public domain or health system and human resource in India during the recent years, the resources are too meagre in relation to the ever increasing population (Table 1.1). According to WHO and Word Bank Reports (2006) only 9 beds were available for 10,000 populations, whereas only 7 physician and 7.85 nurses were available for this population (WHO: 2005).

Graph: 1
Health System and Human Resources in India



Source- WHO, World Bank Report: 2006.

6. AN OVERVIEW OF GULBARGA DISTRICT:

Gulbarga district is one of the 29 districts in Karnataka State. It was a part of Hyderabad State during pre-Independence period. It became part of the Karnataka state on 1st November 1956 when the states were reorganised on the basis of Language and culture. The three districts that were transferred from Hyderabad state to Karnataka State are popularly known as Hyderabad Karnataka Region. The district is located in the Northern part of the state and lies between North latitude 17010 and 17045 and between east longitude 76010 and 77045'. The district is the biggest one in the state covering 8.49% of the area and its population is 5.9 per cent of the state.



It is bounded on the west by Bijapur district of Karnataka and Sholapur district of Maharashtra, on the east by Maheboobnagar district of Andhra Pradesh, on the north by Bidar of Karnataka and Osmanabad of Maharashtra and on the south by Raichur district of Karnataka. There are ten talukas in the district. These are Afzalpur, Aland, Chincholi, Chittapur, Gulbarga,Jewargi, Sedam, Shahapur, Shorapur and Yadgir.

6.1 A Brief History -

Gulbarga is locally known as Kalaburgi and its Urdu form is Kalburgi. As early as 1445 A.D. Abdul Razzak makes a reference to it while describing the boundaries of Vijayanagara Empire as extending up to the extremities of the country Kalaburgh. The term Kalaburgi in Kannada connotes a stony land or heap of stones and this bears references to the nature of the landscape and the soil of this region. The name Gulbarga is quite the opposite. In Persian language, 'Gul' means flower and 'Berg' means a leaf. This means a flower with a leaf. It is also possible that the name Gulbarga is associated with the name of the King Gulchand, for according to historians the fort at Gulbarga was originally built by him and was subsequently strengthened by Ala-Ud- Din Bahamani. Till the 16th Century, the area was popularly known as 'Kalburgi' and thereafter it came to be called Gulbarga. (Government of Karnataka, Karnataka State Gazetteer- Gulbarga District, p.p1-2).

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The area has a rich cultural heritage. The area was ruled by Chalukyas and Rashtrakutas. During the period of King Nrupatunga, the great literary work "Kavi Raj Marg" was shaped. The work on Mathematics by Mahaveeracharya and the work entitled "Mitakshara" by Vijnaneshwara also originated here. The area was also well ahead in the field of education. The "University at Nagai" in Chittapur and the "Mahammad Gawan Madarsa" in Bidar are its evidence. During the 12th century, a Social Reform Movement took place, here, led by Shri Basaveshwara, and Shivasharanas. This was a move for social integration and equality. Gulbarga is also the seat of great Sufi Saint Hazrath Khaja Banda Nawaz. It is indeed unfortunate that this great heritage has been forgotten over a period of time to the point that the area has become one of the most backward areas of Karnataka. If this area is to be included into the main stream growth of the state and the Nation, it requires a very serious and concerted effort.

This position has not changed even after five decades of development. This is evident from the bottom position of the district (in ranking) based on economic development index for the period 1960 to 2000 and also Human development Index and Gender Development Index (Karnataka Human Development Report, 1999 and 2005).

6.2 Gulbarga District in Karnataka State- A comparative view-

The district is one of the most backward in Karnataka State. This position has remained unchanged over the last fifty years. In recent years a High Power Committee was constituted by the Government of Karnataka to look into the problem of regional imbalances in the state. The Committee (popularly known as Nanjundappa Committee) submitted its report in 2001. The committee, on the basis of various socio-economic indicators, assessed the development of 175 talukas in the state. The Talukas are grouped into four categories as follows:

- Relatively developed talukas
- Backward Talukas
- More Backward Talukas
- Most Backward Talukas.

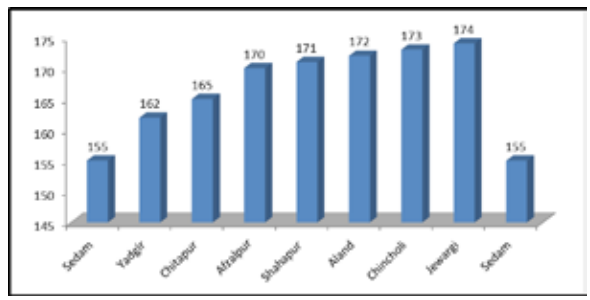
The Committee has identified nine of the ten talukas in Gulbarga district as the` most backward talukas. The Gulbarga Taluka has been identified in the `backward' Category.

Table – 2
Most Backward Talukas of the study area in Gulbarga District in Karnataka State

Taluka	Rank in the state (N-175)	Index
Sedam	155	0.72
Yadgir	162	0.67
Chitapur	165	0.65
Afzalpur	170	0.62
Shahapur	171	0.62
Aland	172	0.61
Chincholi	173	0.57
Jewargi	174	0.57
Sedam	155	0.72

Source: Report of the High Power Committee for Redressal of Regional Imbalances in Karnataka, Govt. of Karnataka, Bangalore 2002.

Graph–2
Most Backward Talukas of the study area in Gulbarga District in Karnataka State



6.3 Gulbarga Population –

Gulbarga district is (in the second stage of demographic transition) experiencing rapid growth of population since 1951. The decimal growth rate increased from 14.5 per cent (1951-61) to 24 per cent (1981-1991), and has come down to 21 per cent in the decade 1991-2001. The population of the district as per the 2001 census is 31, 30,922 of which the male population is 15,92,789 and female 15,38,133. The sex ratio is 966 per 1000 males. This is slightly above the state average of 965 and well above the national average of 933. In all 72.8 per cent of the population is rural, which is higher than the State average of 64.7 per cent. This indicates the rural character of the district.

Table - 3
Population Distribution in Gulbarga District

Tahsil	Total population	Rural %
Aland	261891	88.1
Afzalpur	160736	89.3
Gulbarga	245414	36.3
Chincholi	206502	92.3
Sedam	156026	79.5
Chitapur	238532	65.0
Jevargi	216075	91.8
Shorapur	293133	87.0
Shahpur	249819	85.1
Yadgir	250173	76.8
Gulbarga District	2278301	72.8
Karnataka	34889033	66.0

Source: Village Level Directory, (Census 2001).

The rural literacy in the district is very low. The rural literacy and sex ratio are indicated in the following table.

Table -4:
Sex Ratio and Rural Literacy

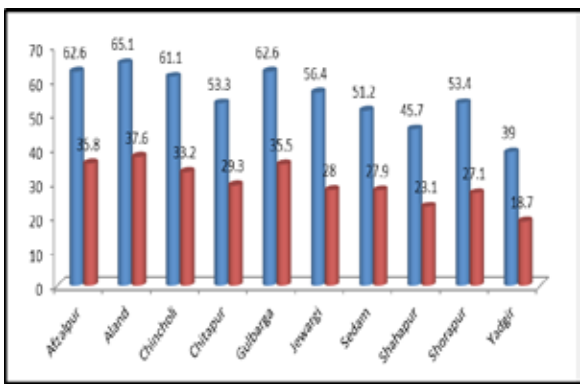
Taluka	Sex Ratio		Literacy (%)		
	Total	0-6 age group	Male	Female	Total
Afzalpur	950	944	62.6	35.8	49.5
Aland	955	913	65.1	37.6	51.6
Chincholi	981	939	61.1	33.2	47.2
Chitapur	983	951	53.3	29.3	41.3
Gulbarga	962	934	62.6	35.5	49.3
Jewargi	969	934	56.4	28.0	42.4
Sedam	1021	969	51.2	27.9	44.8
Shahapur	986	948	45.7	23.1	34.5

Shorapur	981	949	53.4	27.1	43.4
Yadgir	992	970	39.0	18.7	28.9
District	977	945	54.9	29.4	42.3

Source: Census of India 2001, District Population Booklet Gulbarga Series 30.

The rural female literacy rate is low in Yadgir, Chittapur, Jewargi and Chincholi. The sex ratio in the 0-6 age group is lower than the sex ratio for total population in rural areas. This issue needs special attention.

Graph-3:
Sex Ratio and Rural Literacy



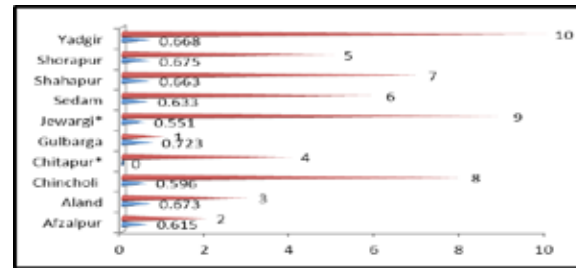
6.4 Human Development in Gulbarga District-
Recently the Karnataka Government has taken the initiative to prepare a Human Development Report at the district level. The Human Development Index is estimated for the ten talukas in Gulbarga district. The position of the talukas is indicated in the following table.

Table- 5:
Composition of Human Development Index in Gulbarga District 2006

Taluka	Health Index	Rank
Afzalpur	0.615	2
Aland	0.673	3
Chincholi	0.596	8
Chitapur*	0. 686	4
Gulbarga	0.723	1
Jewargi*	0.551	9
Sedam	0.633	6
Shahapur	0.663	7
Shorapur	0.675	5
Yadgir	0.668	10
District	0.656	

Source: *DHDR Gulbarga 2008.*

Graph-4:
Composition of Human Development Index in Gulbarga District 2006



6.5 Gender-Role Attitudes-
Two-thirds of women in Karnataka believed that it is justifiable for a husband to beat his wife under some circumstances. Women were most likely to say that wife- beating is justified if a woman shows disrespect for her in-laws (52%) or if she neglects the house or children (49%), goes out without telling her husband (41%), and argues with husband (35%). A similar proportion of men in Karnataka (63%) agreed that wife-beating is justified in some circumstances, including 47 percent who believe that disrespect for in-laws and 45 percent who believe neglecting the house or children were justifications for wife-beating. Even among women and men who had completed at least 10 years of schooling, about half (48-51%) agreed that a husband is justified in beating his wife for one or more specified reasons.

7. CONCLUSION
Women constituting around half of the population play a distinct role in the development of our nation Women, the word sounds so powerful. Since eternity, women have played a role more important than men and that is no exaggeration. The world would not have been the same lovely adorable and livable place without wonderful contribution so selflessly made by women. It has been said that, you teach a female and you build up a nation and truth can't be closer than that. Women have always carried the burden of being a wife, mother, sister all on their own and we need not to explain how magnificently they have carried this position. The research paper main highlights that to know the historical background of Gulbarga district and some aspects pertaining to women's health status are covered in Gulbarga district.

References:

1. Chatterjee Meera, Indian Women: Their Health and Economic Productivity, World Bank Discussion Papers 109, Washington, DC. **(1990).**

2. Shetty P.S., Food and nutrition. In Detels, R., J. McEwen, R. Beaglehole and H. Tanaka (eds.) *Oxford Textbook of Public Health* (fourth edition), New York: Oxford University Press, 149-170 **(2004).**

3. Duggal R., Health and nutrition in Maharashtra. In Government of Maharashtra (2002). *Human Development* Report: Maharashtra, New Delhi: Oxford University Press, 53-77 **(2002).**

4. Mishra M., Duggal R. and Raymus P., Health and healthcare situation in Jalna, Yawatmal and Nandurbar.(Report submitted to the Indira Gandhi Institute for Development Research (IGIDR), Mumbai as part of the Maharashtra Human Development Report Follow-up Study sponsored by the UNDP, New Delhi, and the State Planning Board, Government of Maharashtra). Mumbai: Centre for Enquiry into Health and Allied Themes (CEHAT) **(2004).**

5. Dube L., on the construction of gender: Hindu girls in patrilineal India. In Karuna Channa (ed.) *Socialisation, Education and Women: Explorations in Gender Identity.* New Delhi: Orient Longman 166-192 **(1988).**

Volume : 5 | Issue : 4 | April 2016 • ISSN No 2277 - 8179 | IF : 3.508 | IC Value : 69.48

6. Nandraj S., Beyond the Law and the Lord: Quality of Private Health Care. Economic and Political Weekly, **29(27),** 1680-1685 **(1994).**

7. Basu A. and Kurz. K., Reproductive health seeking by married adolescent girls in Maharashtra, India, *Reproductive Health Matters*, 9(17), 52-62 **(2001).**

8. Madhiwalla N., Nandraj S. and Sinha R., Health households and women's lives: A study of illness and childbearing among women in Nashik district, Maharashtra. Mumbai: Centre for Enquiry into Health and Allied Themes (CEHAT) **(2000).**