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RURAL WOMEN HEALTH: A CRITICAL REVIEW

Rural

Bheemaraya .T. Research Scholar Dept of Sociology Gulbarga University, Kalaburagi

Dr. Raghavendra.Gudgunti Associate Professor in Sociology Govt Degree College Shorapur

KEYWORDS

INTRODUCTION:

The present study entitled "Women and Health: seeks to probe empirically into the social realities pertaining to the health status, its determinants, causes and consequences among women in Rural Society. In doing so, it strives to arrive at such findings that could be viewed as of applied, significance and ameliorative, emancipator and curative value in improving the social and physical conditions of existence of these women through policy as well non- policy measures. 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. Men and women complement each other. If men were supposed to handle outside stuff then women were more responsible for internal affairs. The only difference in this notion is, today women are equally competent behind the veils and outside world. They are more confident and one can find them in every possible sphere of human's life. No male bastion is untouched by females and that's a wonderful sign of strides made by women. Urban women in India always had more advantages and opportunities than women residing in rural places. Better education, better economic resources, and more availability of required things for urban women and yet rural women have made rapid improvements despite lacking in basic facilities. We have yet to attain the state of complete women empowerment but signs of gradual improvement are definitely there. India in last few decades has remained more of a male-dominated society.

Rural women in India is among the most disadvantaged people in the world in terms of their health status and access to accurate and appropriate health information and comprehensive, adequate and affordable health services (Racheral: 2006) Sexual and reproductive health is a particular concern for rural women, as a host of social, cultural, political, and economic factors increase rural women's vulnerabilities to pregnancy - and childbirth-related deaths and disabilities, unsafe abortion, HIV/AIDS, and reproductive cancers. Closely related to this, are the personal, relational and institutional barriers to rural women achieving their fundamental sexual and reproductive rights, their right to exercise control over their bodies and sexual and reproductive lives, which encompasses their right to decide upon such issues as contraception, marriage and abortion (Soloman, et al: 1998). Further, their overall health status is diminished by the lives they are forced to lead- lives that pivot around the harsh realities of malnutrition, illness, injury, and fatigue, frequently the consequence of long hours of demanding physical labour in unhygienic and dangerous conditions; the strains of childbirth and caring for multiple children; and not having enough to eat, which is often the result of more and better food going to male household run real women given their unmet need for contraception, poetry, proximity from clinics, and limited education, are vulnerable to using services that are not safe. Restrictive national abortion laws, such as also compound this vulnerability, making access to safe abortion services virtually impossible.

CONCEPT OF HEALTH:

Health is defined by the World Health Organization (WHO) as a state of complete physical, mental, and social well being and not merely absence of disease or infirmity. This definition was accepted by all the signatories to the Alma-Ata Declaration on health adopted by the thirty-first Word Health Assembly in 1978. This declaration gave the call of 'Health for All by 2000 AD' and accepted that Primary Health Care was a key to attaining this goal. Health systems are too often being devised outside the mainstream of social and economic development. These systems frequently restrict themselves to medical care, although industrialization and deliberate alteration of the environment are creating health problems whose proper control lies far beyond the scope of medical care (Tejada-de Rivero: 1981). Health is thus not only about disease and medical care system but also about the environment around us, which influences the mental and physical state of a person. It is multidimensional phenomenon (Hema and Muraleedharan: 1983). The 'basic needs approach' considers health as a basic needs along with food, clothing, shelter and education starting from pious, basic needs approach is utilitarian, "because fulfillment" of basic needs "contributes to utility" (Sen: 1985). Many subsequent researches also have built on the concept of health as a utility. For example, World Development Report 1993 considers good health as an input for increasing productivity, leading to economic growth. The National Council of Applied Economic Research considers health status as "an important indicator of the level of economic development" and it includes mainly mortality and morbidity (NCAR: 1992). However disagrees with this utilitarian approach. He argues that, the "value of the living standard lies in the living" and better health living and not on instrument for better living (Sen: 1985).

OBJECTIVES OF THE STUDY:

In view of the review presented above the present study seeks to focus empirically on the social realities and social conditioning of health status among the women in rural society.

1 To present a socio-cultural and demographics profile of women in rural Society
2 To ascertain empirically the socio-economic conditions and cultural status of women in rural Society.
3 To Probe empirically into the health Status of women in rural Society.
4 To explore health awareness and health seeking behavior among the respondents.
5 To identify the social determinants of health status among women in rural Society.
6 To ascertain the factors associated with the awareness level and health seeking behavior among the respondents.
7 To examine the implications of health status for other aspects of social existence and empowerment among the respondents.

CONCEPTUALAND THEORETICAL FRAMEWORK

Health is an important aspect for the survival of human. The concepts, knowledge, skills and infrastructure for healthcare have been evolved through the evolution of human civilization in various societies. However, due to gender bias the health priorities for men and women have been different in different traditions and different societies. To understand the problems related to women health this Health status in India, women in India, and concept of health and nutrition and theories of gender.

REVIEW OF LITERATURE:

To introduce the undertaken research, a review of the literature is present below: In this chapter, efforts have been made to review thoroughly the literature pertinent to the research topic and research setting. We have divided these studies in categories i.e. (1) Women health status of women and women as a user of health services; (2) Health care service and health Policy; (3) Nutrition and health Status; It can give insight into analysis and help in establishing a meaningful rational for the present study.

Doyal (1983) found that there is a scarcity of "Feminist epidemiology" the social production of women's health. There is, however, a growing body of research that traces the links between women's health and their paid and unpaid work roles messing. This is one of the strongest themes in this emergent area of investigation, one characterized by different argument that, although they appear at first glance to be contradictory point to the complex relationship between work and health. It has been shown that paid work is associated with better health and well-being among women (Brown and Harris: 1978). In contrast, there is another body of research that emphasizes the hazards of paid work as well as the impact of the social organization of work, toxic substances, and other hazards which women encounter at the work place.

In her study, a Chatterjee (1985) view that in spite of equalitarian health policy the, situation of an infant and child more or less remains unchanged. Data were collected on infant child mortality in 18 states related with age, sex and rural urban residence. The mortality rate was tabulated by various health care factors.

Mukhopadhyay (1989) conducted a study to determine the possible effects of working women status on some selected physical and mental health traits by comparing a group of working mothers with non-working counter parts. In general, the two groups of mothers hardly differ with respect to their physical health (for example, blood pressure, pulse rate etc) and mental for example, anxiety score, general health score, etc) health traits. The present study was conducted in Calcutta. Women's multiple responsibilities and attendant role conflicts have negative consequences for their health.

Soman (1994) attempted to explore the nature and implication of planning for women's health in India. It traces the strategies and priorities in planning during and after independence, followed by the evolution of maternal and child health (MCH) programme. It discusses some major implications of women's health, and examines the role of non-governmental organizations (NGOS) in health development in India. He found that there is a need for understanding women's health in its totality, embracing 'maternal health' as well as the general ill-health' of women together. Since the mid-1980s, 'maternal health' has been supplemented by 'women's health care in health planning.

In their study Shane, Barbara and Ellsberg (2002) illustrates that millions of girls and women suffer from violence and its consequence because of their sex and their unequal status in society. Violence against women (after called gender based violence) is a serious violence of women's human rights. Yet little attention has been paid to the serious health consequences of abuse and the heath needs of abused women and girls. This 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.

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.

Rani (2005) examines some of the factors related to sexual and reproductive health and its effects on adulterants and young married girls. The major factors, considered here, include socio-economic conditions, demographic aspects like menarche and marriage related issues, nutrition, anthropometry, prenatal, natal and post-natal care, and various customs prevailing in the community.

Paul and Chellan (2007) examine the post delivery complications and treatment-seeking behavior 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 likely to seek treatment among those who had complications.

Balagopal (2009) in her study of "Access to Health Care Among poor elderly women in India: How for 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 stage 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 Health facilities, except for village health guides in rural Andhra Pradesh increased during the 7 years from NFHS-I (1992) to NFHS II (1998). Andhra Pradesh is one of the most successful Indian states in providing MCH, even though urban - rural differentiate still existed. Health input, utilization and output showed a positive net change, which indicated an improvement in Health facilities and their utilization contributed to positive health indicator output. There was increase in health input, utilization and output during the intra survey period. At the same time contraceptive use has increased. Overall, urban rural differentials still existed.

Latha (2005) conducted a study of health as an asset, the most valued resources in an individual's life. Acquisition of this is influenced by bio psychicsocial and cultural factors. Individual's orientation to health is significant predictor of health goals, health behavior. Multivariate analysis results in the emergence of a single function discriminating the clinical subjects. The patient group was found to be more internally oriented positive about the disease management. The results confirm the susceptibility to disease as strong motivator for learning about health. The need for in individual resource building through awareness and skills, training is emphasized.

(Wagner & Greenlick 2001)At the same time though, good quality health information can successfully substitute for consultation with health professionals, thereby enhancing women's sense of autonomy and potentially having positive fiscal benefits. A random household survey of 1,812 parents (mostly mothers), co-ordinate through Stanford University USA, demonstrated that the provision of good quality health information decreased pediatric consultations with doctors in the following year.

(Burton 2010) Many women are able to carry out their work as usual during pregnancy, but pregnant workers in jobs that require heavier physical activities, long periods of standing, and repetitive work can require job accommodations to protect the health of the mother and the unborn child. Pregnant workers might require accommodations such as assistance with heavy lifting, more frequent breaks, and the option to sit while working or to work different shifts. Studies have found that occupational lifting is associated with early and late miscarriage; the more lifts and the more total weight lifted per day, the higher the risk (Strandberg and Larsen K et al. 1989, 404-414). Shiftwork, which alters workers' sleep cycles, has negative effects on physical and mental health, including increased risk of breast cancer, irregular menstrual cycles, miscarriages, ulcers, insomnia, high blood pressure, and heart disease.

(World Health Organization 2011b). Women are biologically more susceptible to certain diseases and may demonstrate or experience symptoms differently than men. There are also different social

expectations of roles and responsibilities which expose men and women differently to health risks and their abilities to access health care and preventive services. However, there is also a great deal of variation of health risks and access to health care services among women, and among men. It is well known that social factors such as income and employment, level of education, age, living conditions, social safety networks, and ethnicity also play an important role in people's health status and access to health care services

Conclusion:

Although on paper it seems gender equity has been achieved, in practice, this is not the case. Women throughout India are often treated as second-class citizens. They have lower rates of school attendance and achieved grade level; higher rates of malnutrition, anemia, and mental disease; and earn 66% less in wages for the same jobs, as compared to men.1,2,3 Indian women also fall victim to domestic violence, traditionally do not own land, and frequently play no part in household decision-making. Attacks such as rape, acid throwing, and bride burning are too common, while traditions such as child marriage, dowry, and female infanticide have been difficult to extinguish.

The status of Indian women is further portrayed by beliefs surrounding the menstrual cycle. In some areas, when a woman is menstruating, she is viewed as a gateway to hell. During this time, women are considered unholy and frequently are forbidden from sleeping in the house, cooking, and having contact with others. Anything touched by her must be thrown out. If one accidentally comes into contact with a menstruating woman, s/he must seek purity by touching a cow, a holy being. Without the presence of a cow, a person may sprinkle themselves with cow urine or in other cases, take a bath.

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