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WOMEN EMPOWERMENT AND HEALTH STATUS OF RURAL IN TAMILNADU

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ABSTRACT

The health status of women in India is an area which so far has received inadequate scholarly attention. The limited evidences from the few studies available present a dismal picture. India is one of the few countries where life expectancy of women has been less than that of men till very recently. For rural women this still holds good .More girls than boys die in infancy and childhood. This higher female infant and child mortality is a rare phenomenon not found even in countries with far higher mortality rates than, India, and is believed to be the consequence of the discriminatory treatment of the female child. It is seen that 'Deaths of young girls in India exceed those of young boys by at least one-third of a million every year. The vast majority of women have not had even a single year of schooling. Given their lack of resources and education, the women have little option but to work and earn money for their families' subsistence. Only 13 percent of the women are home-based. Marriage is universal for women, and the vast majority marry and begin childbearing while still in their teens. The average age at marriage is 16.9 years, far below the average of 20.22 reported for Tamil Nadu . 59 percent of currently married women in the 15-44 age-group were married before they were 18, 96 percent before 20 and only 4 percent were married after they were 20 years old.

KEYWORDS :*women health, lack of health awareness, poor health facilities.*

INTRODUCTION:-

Women in India constitute about 50 % of the total population and comprise one third of the labour force. It is, therefore, important that when considering the economic development of this segment of the population, due attention is given to their socio-economic empowerment. The empowerment is one of the key constituent elements of poverty reduction, and as a primary development assistance goal. The promotion of women's Empowerment as a development goal is based on a dual argument, that social justice is an important aspect of human welfare and is intrinsically worth pursuing, and that women's empowerment is a means to other ends. In this contemporary world, women need to gain the same amount of power that men have. Now, it is time to forget that men are the only holders of power. In India, women are still facing different obstacles in male-dominated cultures. The things are related to women's status and their health

status in future. However, Indian women are slowly getting empowerment in the sectors like education, politics, the work force and even more power within their own households. The worth of civilization can be arbitrated by the place given to women in the society.

In our country, women have reached a long way eventually and have discovered a new path for them to come. Women rights are human rights. The concept of feminism is very vogue. Feminist usually deals out balky attention. Women's right and changes effort to win equality for women have containing women's suffrage, feminism, women's property rights, equal opportunity in work and education, and equal pay. Now, the future of women is seeking out. In traditional societies, even more than elsewhere, women's empowerment does not occur easily or overnight. In India some women project cases described, there was evidence of such change beginning, to which the project had apparently contributed. It was most noticeable among certain types of women. Perhaps one of the most important emerging lessons is that women's groups themselves, in their social aspects, play a role in such empowerment.

The principle of gender equality is enshrined in the Indian Constitution in its Preamble, Fundamental Rights, Fundamental Duties and Directive Principles. The Constitution not only grants equality to women, but also empowers the State to adopt measures of positive discrimination in favor of women. Empowerment is the one of the key factors in determining the success of development is the status and position of women in the society. We put a special focus on empowering women and girls, because we believe they hold the key to long-lasting social change in communities. Empowering women must be a united approach, a cause that requires continued attention and stewardship by all. We need to augment our efforts for empowering women and enhance their progress. It is our moral, social and constitutional responsibility to ensure their progress by providing them with equal rights and opportunities. Today women with their smartness, grace and elegance have conquered the whole world. They with their hard work and sincerity have excelled in each and every profession. Women are considered to be more honest, meticulous, and efficient and hence more and more companies prefer hiring women for better performance and result.

The health status of women in India is an area which so far has received inadequate scholarly attention. The limited evidences from the few studies available present a dismal picture. India is one of the few countries where life expectancy of women has been less than that of men till very recently. For rural women this still holds good .More girls than boys die in infancy and childhood. This higher female infant and child mortality is a rare phenomenon not found even in countries with far higher mortality rates than, India, and is believed to be the consequence of the discriminatory treatment of the female child. It is seen that 'Deaths of young girls in India exceed those of young boys by at least one-third of a million every year. Every -sixth infant death is specifically due to gender discrimination.'. What is more, the gap shows no signs of narrowing: the ratio of female to male mortality in childhood has remained at around 1.1 since 1970 (Registrar General of India, Sample Registration System, various years).

Trends in Life Expectancy At Birth By Sex Are As Follows
(Source: Registrar General of India, Sample Registration System, various years)

YEARS	RURAL		URBAN		TOTAL	
	Male	Female	Male	Female	Male	Female
1988-92	47.85	46.82	57.60	58.02	49.47	48.62
1992-96	48.40	47.53	59.92	61.66	52.69	52.33
1996-10	48.64	47.82	61.08	63.68	54.89	55.35

The trend of excess female mortality is pronounced till the age of 35. High rates of maternal mortality contribute to excess female mortality in the reproductive years, the mortality rate being more than 50 per cent higher for females than for males. Maternal mortality rates in India (at 500 per 100,000 live births) are among the highest in the world, and more than 50 times the average for industrialized countries. Even this may be an under-estimate. Frequent pregnancies compound a woman's lifetime risk of dying from maternity-related causes. The absence of trained attendance at birth for the majority women contributes greatly to high rates of maternal mortality. As recently as 1988, 66 per cent of all births in the country took place without trained medical attendance, and only 22 per cent of births took place in medical units . Pregnancy outcome - the probability that a pregnancy results in a full-term, healthy live birth-is an important indicator of women's health status. According to community studies from different parts of the country, there were above 139 unsuccessful pregnancies per 1000 . In comparison, the rates range from 71 per 1000 pregnancies in South Korea to 126 per 1000 in Costa Rica . The levels of pregnancy wastage for women from poorer communities are steeper, in some cases reaching even a high of 300 per pregnancies.

Current Health Status of Women

Socio-economic Characteristics

The women covered by this study belong to a section of the rural population that suffers extreme social and economic deprivation. They live under harsh circumstances and bear a heavy work burden. 95 percent of the women belong to the Scheduled Castes and the remaining 5 percent to Backward Castes. About 60 percent of them come form agricultural households that are totally landless. Most of these landless households (80percent) do not even own the sites on which their huts stand, while 60 percent do not own any other productive assets, including livestock. This group is completely dependent on agricultural wage labor for its subsistence. The vast majority of women (85 percent) have not had even a single year of schooling. Given their lack of resources and education, the women have little option but to work and earn money for their families' subsistence. Only 13 percent of the women are home-based (hot working outside the home, and not participating in any regular remunerative activity).

Further analysis shows that non-participation in paid workis related more to women's reproductive responsibilities, being higher among young mothers than among any other demographic or socioeconomic category. Three-quarters of the women are wage laborers in agriculture, while the rest work on their own or leased farms. Only 2 percent are engaged in salaried employment, usually in their own villages as teachers and helpers in the Balwadis and state-sponsored nutrition (feeding) centers. Wages in agricultural employment are very low, and do not exceed Rs. 10 per day for women, hardly enough to buy one kilo of rice, the staple food. Hours of work on the other hand, can extend from dawn to dusk, and in peak seasons are even longer. Housing conditions are poor: 75 percent live in mud huts with thatched roofs, with only one room inclusive of kitchen. There is little space around the

houses. These are crowded together in a locality called the 'cheri', specifically allocated in every village under traditional land tenures for habitation by the 'untouchable' Scheduled Castes. Public wells and taps (47 percent each) are the main sources of water for all purposes, while about 6 percent have to rely for water supply on irrigation pump sets belonging to landed households. In most cases the source of water is at least five minutes away, and gathering water from public taps takes a couple of hours. Water supply in summer is unpredictable, with water levels in wells dipping and taps often running dry.Toilets are virtually non-existent. Only 5 women a toilet in their homes, and the remaining 1012 use the fields.

Demographic Profile

The picture that generally emerges is one of women characterized by a low age at marriage trapped into high fertility and repeated pregnancies by high rates of child loss, which not only increases their risk of pregnancy wastage, but also seriously compromises their health and well-being.

(a) Age at marriage

Marriage is universal for women, and the vast majority marry and begin childbearing while still in theirteens. The average age at marriage is 16.9 years, far below the average of 20.22 reported for Tamil Nadu.59 percent of currently married women in the 15-44 age-group were married before they were 18, 96 percentbefore 20 and only 4 percent were married after they were 20 years old. However, a shift in the age atmarriage is indicated, on analyzing age at marriage by current age of women. There is a jump from medianage at marriage of 15 for women above 25 years of age, to 18 for women who are currently below 20 yearsold.

(b) Fertility

Fertility is high: the average number of children ever born to women in the 45-49 age-group is 5.12. The totalmarital fertility rate (TMFR), calculated on the basis of number of births to women over the last one year, is5.75, higher even than the all-India figures for rural SC of 5.56 in 1978. When computed on the basis ofchildren ever born, the total marital fertility rate is 5.04. Even this is higher than the corresponding rate for women of rural Tamil Nadu, which was 4.8 in 2010 .

Materials and Methods of Data

The present study is an attempt at addressing some of these questions through a case study of women from a rural poor population in Tamilnadu. The focus is especially on women's reproductive health, about which far less is known as compared to their other health problems. The health status of an individual depends on two interrelated factors: (a) the frequency with which he/she falls ill, and (b) action taken in the event of illness, such as self-treatment and professional medical help. The following set of factors has been considered, as having a major influence on women's health at the household level Household resource base.1. Women’s access to resources. 2. Demographic characteristics of women, such as age and parity. These factors also have a role to play in women's health-seeking behavior: i.e. what women do when they have a health problem. The functioning of Women’s Health in a Rural Poor Population in Tamil Nadu these factors becomes evident through their influence on women's self worth; women's awareness of illnesses and their causes; and the time, money and social support at their disposal. The community's health culture and the accessibility, quality and range of health services provided are also major influences on whether women feel Inclined to seek medical help. Two indicators art used to express women's susceptibility to illness: Prevalence Mp = Number of women ill/Target Population and Frequency MP = Number of times illness reported /Target

Population. Contraceptive prevalence and place of delivery are the preventive health measures considered, while type of health care resorted to in case of illness, including self-care, constitute the indicators related to curative care. Women's access to resources is expressed in terms of their educational status, and participation in the labor force.

The data were collected by a non-governmental rural women's organization (NGO) committed to health promotion among Scheduled Caste women, in Karur district of Tamil Nadu, South India. The choice of households was not random, but consisted of all the 145 households and 127 women covered by the NGO's activities. The majorities of them are illiterate and landless agricultural wage workers and belong to the Scheduled Castes. They live in abject poverty, and have limited access to basic amenities and services. Consequently, the morbidity profile and health-seeking behavior found in this study is not representative of the general population, but perhaps more indicative of the worst possible scenario. The data pertain only to married women in the reproductive age group of 15 to 40 years, who form the main clientele of the NGO. The numerous health problems of older women, single women or unmarried adolescents have therefore not been captured. A number of steps were taken at the data collection stage to ensure reliability of data collected. These included limiting the reference period of illness reported to 24 hours; using a checklist of specific symptoms rather than asking general questions on prevalence of illness; talking to the women concerned on an individual basis; and carrying out clinical examinations on a small sub-sample of women to get a rough estimate of the probability of false positive or false negative reporting. 95 percent of the women belong to the Scheduled Castes and the remaining 5 percent to Backward Castes. About 60 percent of them comeform agricultural households that are totally landless. Most of these landless households do not even own the sites on which their huts stand, while 60 percent do not own any other productive assets, including livestock. This group is completely dependent on agricultural wage labor for its subsistence.

Analysis of Data

The vast majority of women have not had even a single year of schooling. Given their lack of resources and education, the women have little option but to work and earn money for their families' subsistence. Only 13 percent of the women are home-based. Marriage is universal for women, and the vast majority marry and begin childbearing while still in their teens. The average age at marriage is 16.9 years, far below the average of 20.22 reported for Tamil Nadu . 59 percent of currently married women in the 15-44 age-group were married before they were 18, 96 percent before 20 and only 4 percent were married after they were 20 years old. However, a shift in the age at marriage is indicated, on analyzing age at marriage by current age of women. There is a jump from median age at marriage of 15 for women above 25 years of age, to 18 for women who are currently below 20 years oldFertility is high: the average number of children ever born to women in the 45-49 age-group is 5.12. The total marital fertility rate (TMFR), calculated on the basis of number of births to women over the last one year, is 5.75, higher even than the all-India figures for rural SC of 5.56 in 2010 . When computed on the basis of children ever born, the total marital fertility rate is 5.04. Practically none of the women who had been married for less than five years were practicing contraception. After the fifth year of marriage, the proportion increased steeply, and was highest for women who had been married for 16 to 20 years. Seventy-five per cent of all deliveries took place at home assisted by a traditional birth attendant. The remaining 25 per cent took place under the medical supervision of the auxiliary nurse midwife or, less often, of the doctor in the health center or hospital. For rural Tamil Nadu, the proportion of untrained attendance at delivery was far lower (41 percent), while even for rural India it was lower than the present case (67 percent). To make an impact on women's susceptibility to disease would thus call for

policies and programs that make a perceptible dent in poverty levels, and those specifically aimed at enhancing women's access to resources. Changing women's health-seeking behavior seems to be a more hopeful avenue for action. Through health education and awareness-raising programs which reach out to women (especially, those in poverty groups), and through programs aimed at enhancing their self-confidence and self-image, women have to be encouraged to initiate self-treatment or seek medical help when ill, to actively seek antenatal and delivery care, and more importantly, to feel entitled to good health and care. National level surveys on morbidity and mortality and the use of health services need to include specific questions on aspects such as women's reproductive health problems, their use of health services, and factors that restrict their access to health and health services. Despite pious platitudes on the importance of women's well-being for national development, women's health has remained a neglected issue for far too long. It is action that is urgently needed.

CONCLUSIONS

To summarize, the burden of illness borne by the women covered by this study is enormous, and far higher than that reported from similar health interview studies. The interplay between poverty and gender discrimination seems to be the lynch-pin in any explanation of women's health problems here. Growing up in landless families, eking out a hand-to-mouth existence, children, especially girls, drop out early from school and join the labor force or manage the household while the mother engages in wage work. Girls are married early and are under tremendous social pressure to bear children immediately, a typical situation of a high mortality social group where fertility is highly valued. Inadequate nutrition together with heavy manual labor on land and low age cause high pregnancy wastage, and in turn extend the period of childbearing to the woman's entire reproductive span. It is worth noting that in a poverty group such as this, participation in the labor force increases the risk of morbidity and is not an indicator of better status but of greater deprivation. Changing women's health-seeking behavior seems to be a more hopeful avenue for action. Through health education and awareness-raising programs which reach out to women (especially, those in poverty groups), and through programs aimed at enhancing their self-confidence and self-image, women have to been courage to initiate self-treatment or seek medical help when ill, to actively seek antenatal and delivery care, and more importantly, to feel entitled to good health and care.

REFERENCES

1.Chatterjee, Meera (2008) Indian Women, Health and Productivity. Policy, Research and External Affairs Working Paper, Washington D.C. World Bank..

2.Bhatia, J.C. (2009) A Study of Maternal mortality in Anantapur District, Andhra Pradesh, India. Bangelore Indian Institute of Management..

3.Registrar-General of India (2009) Sample Registration System 1988, New Delhi, Ministry of HomeAffairs, Government of India.

4.Sundari, T.K. (2009) 'Can Health Education Improve Pregnancy Outcome? Report of a GrassrootsAction-Education Campaign', Journal of Family Welfare, March.

5.Casterline, John B. (2009) 'Maternal Age, Gravidity and Pregnancy Spacing Effect on Fetal Mortality'.Social Biology, Vol. 36, Nos. 3-4,186-212.

6.National Sample Survey Organization (1980) 28th Round Survey on Morbidity (2003-04),Sarvekshana, July-October.

7.National Council of Applied Economics Research (2001). Household Survey of Medical Care,NCAER, New Delhi.

8.National Nutrition Monitoring Bureau (2000) Consolidated Report for 1975-79. National Institute of Nutrition, Hyderabed.
9.National Council of Applied Economics Research (2002) Rural Household Health Care Needs and Availability. NCAER, New Delhi.
10.Indian Council of Medical Research (2010) Report of the ICMR Working Group, American Journal of Clinical Nutrition, 35:1442.
11.Department of Family Welfare (2009) Family Welfare Program in India Year Book (2005-2007)Government of India, Ministry of Health and Family Welfare, New Delhi, 178-181, Table C-12.
12.Registrar General Of India (2009) Survey Report on Levels, Trends and Differentials in Fertility. India, Ministry of Home Affairs, New Delhi.
13.Registrar-General of India (2008). Fertility, in India - An Analysis of l981 Census Data. Census of India 1981, Occasional Paper No. 13 of 2008, Demography. Division, Ministry of Home Affairs, NewDelhi.
14..National Institute of Health and Family Welfare (2005) Levels of Fertility, Mortality, Family Welfare,and Utilization of Health and Family Welfare Services--A Baseline Report of Eight Project Districts of Madhya Pradesh, October.
15.Murthy, G.V.S. et al. (2007) 'A Study of Pregnancy Wastage In a Rural Area of Haryana', Health and Population: Perspectives and Issues, No. 10, 26-34.

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