

Health Condition of Rural Women; Few Observations from the Identified Social Groups

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Abstract: In India, the majority of the people living in rural areas is poorly served and at best receive only rudimentary healthcare. The health of women in rural India may be one of the worst in the world. Social discrimination against women has resulted into neglect of women's health from womb to tomb. In India, 63 percent of all married women are engaged in household work, which roughly includes 8 years of their averages life span of 50 years within the kitchen alone. The rural women have to bear the exclusive burden of managing all the activities at home. The day-to-day life of rural women is full of hardship, deprivation and struggle for bare survival. There are certain norms that affect women's health like attitude to marriage, age of marriage, the value attached to fertility and sex of the child, the pattern of family organization and the ideal role demanded of women by social conventions. It is against this backdrop, the paper attempts to examine the daily work load and health condition of rural women in the sampled villages of the selected social groups of Kamrup district, Assam. The sample villages have been identified using Composite Z-scores on the basis of 11 indicators related to socio-economic status of women.

In order to materialize the objectives data from both primary and secondary sources have been used. Data have been interpreted with the help of statistical techniques like percentage, Mean, Standard Deviation, Coefficient of Variance, Z-scores and Multi Variant analysis. A link is established between rural women and their health condition which is found at the lowest level among char communities followed by tea garden, scheduled tribe and scheduled caste communities. Positive correlations are observed between fire wood used, number of children per woman and number of diseases. Again positive correlation is found in between number of disease and daily workload of the women.

Keywords: Rural women; Health; Workload.

1. INTRODUCTION

In India, the majority of the people living in rural areas is poorly served and at best receive only rudimentary healthcare. The government of India has launched a National Rural Health Mission (NRHM) on 12th April 2005. The NRHM objectives indicate the motivation on the part of government to correct the rural-urban, inter-state and gender inequalities in health as a priority. United Nations Human Development Report (UNHDR) 2005 states that India does well on economic growth but fares poorly on human development. High infant

and maternal mortality rates, skewed sex ratio, rising rural unemployment and stagnating agricultural wages are some areas of grave concern. Most of the government operated rural health sub-centers, primary health centers and Anganwadi centers are on the verge of collapse.

Maternal Mortality Rate (MMR) in Assam stands at 450 per 100000 live births. The main causes of deaths being toxemia, hemorrhage and anemia. Birth Rate in rural areas is 28.7 per thousand live births. A 1996 Multi-Indicator Cluster Survey (MICS) report showed that only 28.2 percent of the rural women went for antenatal checkup. According to Coverage Evaluation Survey report (1996) conducted in different district Iron Folic Acid (IFA) prophylaxis tablets distribution programme, 60-65 percent of the pregnant women are covered while the rest 40 percent needs to be covered under the programme. Infant mortality rate in 1998 was 80 per 1000 live births. On an average about 50-60 percent of children are given BCG and less than 50 percent are given DPT in the various district of Assam as revealed in the National Family Health Survey Report of 1999.

Women face higher risk of malnutrition, retardation in growth and development, disease, disability and even death in the age group between 14-45 years. Female children though biologically stronger when born than their counterparts have morbidity and mortality rates higher than the males. There are certain norms that affect women's health like attitude to marriage, age of marriage, the value attached to fertility and sex of the child, the pattern of family organization and the ideal role demanded of women by social conventions. They determine her status in the family, the degree of her access to medical care, education, nutrition and other accessories of health. Improvement in the female health status depend on a number of income generating skills, decision making and availability of basic support services to carry out their multiple roles. Therefore the measures to improve their health status would call in for multi-sectoral package simultaneously for health as well as in social front. Keeping this perspective in view an attempt has been made in this paper to examine the health condition of rural women with regard to the identified social groups of Kamrup district of Assam.

2. OBJECTIVES

Following are the objectives of the paper

- to see the health facilities of the women at home
- to see the medical facilities for the women
- to see the daily workload of the women
- to see the women against their number of children
- to find out the facilities related to delivery of the women

3. DATA BASE AND METHODOLOGY

The study is based on both primary and secondary sources. Secondary sources of data have been collected from different volumes of census of India, statistical handbook, District Rural Development Agency (DRDA), National Rural Health Mission (NRHM) and from different published books and journals. In order to collect Primary data an intensive field survey has been carried out following a random sampling method with the help of questionnaire administered through personal interviews. All the secondary and primary forms of qualitative data are transferred into quantitative form. A three stage of sampling units have been applied for the collection of primary data.

The first stage of sampling consists of identification of community development block viz Boko, Chandrapur, Hajo, Kamalpur and Sonapur C.D. block to represent the Schedule Tribe, Schedule Caste, Char Community, General Caste and Tea Garden community population respectively. The second stage of sampling considers selection of two sample villages from each of the blocks. For this purpose Composite Z-score method is employed using eleven socio economic indicators related to women. The Z-score value of the villages of each block are grouped into five categories like Low (Less than -7.5), Lower Medium (-7.5 to -3.5), Medium (-3.5 to 0.5), Upper Medium (0.5 to 4.5) and High (4.5 to 8.5). Two villages one from Lower Medium (LMV) and the other from Upper Medium (UMV) are considered from each block. The third stage of sample unit takes into account identification of household with the help of random sample techniques. Here fifty women members are taken into consideration in each village except the sample villages of Sonapur C.D. block where the sample unit has to be restricted to twenty women members only.

4. ACCESS TO HEALTH FACILITIES

Some of the health facilities found among the women members in the sample villages are discussed below

4.1 Drinking water facility: The drinking water facility in a household is important because it can affect the health status of house hold members, particularly children. In the sample villages river water is used for drinking water either as a lone source or in combination with others, percentages of households depending on these source is around 30%. In sum

drinking water facility is found to be much below the desired level as Tap water is almost absent. Tube well is procured by a considerable percentage of households which ranges from 10 to 70% households across the villages. This situation has an impact on the daily workload of women (Table: 1) where women has to spend 30 minutes to 1 hour daily in fetching water for drinking purposes.

4.2 Sanitation facility: The NRHM strategy integrates health with sanitation and hygiene, nutrition and safe drinking water. The sanitation facility depicts a gray scene where sanitary latrine is availed by a small percentage of households which varies from 8 to 24% across the sampled villages. The rest of the households depends on non-sanitary latrine, and even open space, percentage of households varies from 20 to 60% and 10 to 60% respectively. (fig: 1).

4.3 Ventilation facility: Ventilation facility in the selected households is found to be absent in a considerable share of households of tea garden and char community percentage of households being as high as around 80%. Poor ventilation is a cause of indoor air pollution and has a negative impact on health of the dwellers. (fig:2)

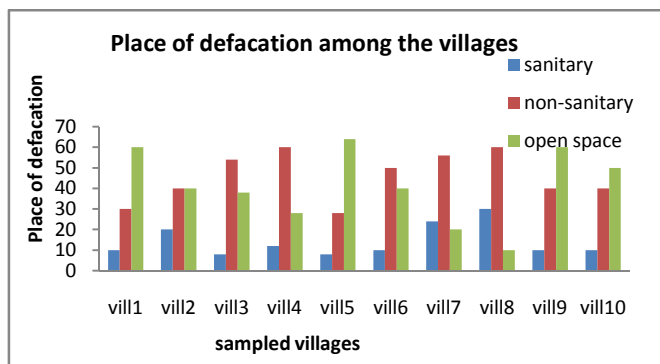


Fig 1: Sanitation system of the women's household in the sampled villages

Source: field survey

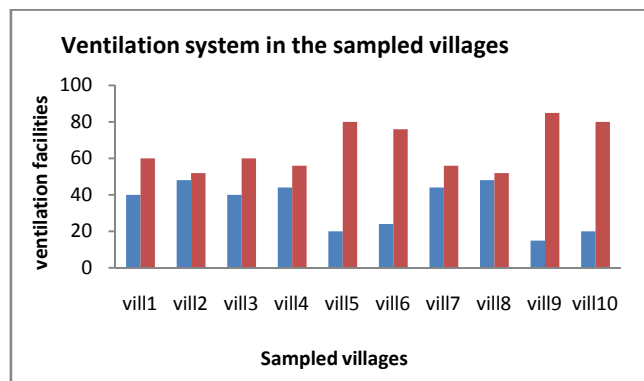


Fig 2: Ventilation system in the women's household of the sample villages

Source: field survey

4.4 Kitchen facilities: The kitchen environment is most crucial in victimizing women because almost all women spend a considerable amount of their life in the kitchen. Kitchen work includes other processes that are involved before and after cooking such as rice and pulses cleaning, besides serving food and feeding the young and so on. In the present study kitchen is found either in the living room or attached with the living room. A nominal share of households have separate kitchen. However, the Schedule Tribe community by tradition has separate kitchen, the percentage of households is 92%. Again 8% households have kitchen attached with the living room. In the sample villages of Chandrapur C.D. block, 72% households have kitchen attached with the living room, 15% households have kitchen within the living room and 13% have separate kitchen. In the sample villages of Hajo C.D. block 56% households have attached kitchen, 28% households have kitchen within the living room, 10% households have separated kitchen and 6% cook in open air.

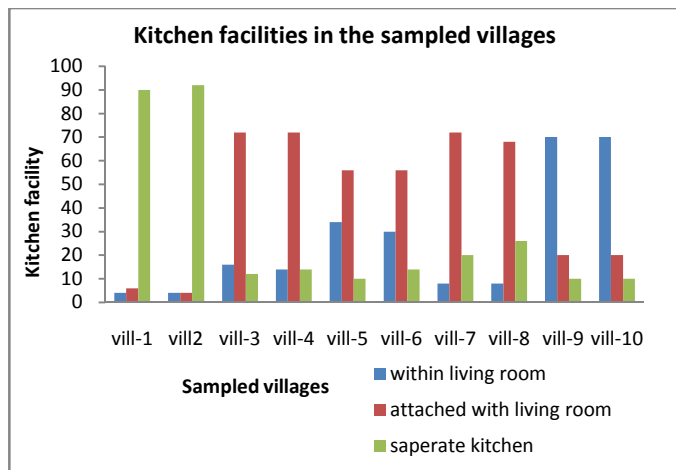


Fig 3: Kitchen facilities of the women's household in the sampled villages

Source: field survey

In the sample villages of Kamalpur C.D. block, 70% respondents' kitchens are attached with the living room, 8% households' kitchen are found within the living room and 22% have separated kitchen. In both the Tea garden areas of the Sonapur C.D. block 70% households have kitchen within the living room, 20% households have kitchen attached with the living room and 10% respondents cook in the open air or angoon. From the field survey it is found that the place of cooking is determined by the economic condition as well as by the social customs of the family. Most of the kitchens are environmentally harmful, unsafe and unhygienic. (fig: 3). Among the household features, place of cooking is important because the concentration of smoke particles is quite high when cooking is done indoors in a multipurpose room/veranda without partition or in an attached kitchen inside the house. Cooking is mostly done with fire wood in traditional cook stove. Emission from such source condition harmful

pollutants combined with confined space without ventilation and long cooking hours (Table: 2) results in health hazard causing respiratory diseases to women. Smoke from biofuels contains several hazardous pollutants viz. particulate matter, carbon monoxide, nitrogen dioxide, formaldehyde, polycyclic organic matter including carcinogens like benzo (a) pyrene, benzopyrene. Exposure to indoor air pollution from combustion of unprocessed biomass fuels is an important cause of morbidity and mortality in the rural areas where the use of biofuels is quite high. Further indoor air pollution is said to cause various respiratory diseases, viz. acute respiratory infections, chronic obstructive pulmonary diseases, lung cancer, asthma, tuberculosis, low birth weight, cataract etc. (WHO/PEP/1992-3, Geneva.).

5. MEDICAL FACILITIES

In India, an important cause of death among neonates is neonatal tetanus, which is caused by infection of the newborn by tetanus organisms. Neonatal tetanus is most common when the delivery takes place in an unhygienic environment and unspecialized instruments are used for cutting the umbilical cord. When tetanus developed, where expert medical help is not available, as is common in many rural areas, the fatality rate is close to 100 percent. Immunization of children has been identified as a major step towards ensuring child survival and that helps in convincing people about the concept of small family norm. In the present study only 22% households have been provided Tetanus Toxoid Vaccination, 16% households women are provided Iron/folic acid tablets. Pulse/polio Vaccination is available by 50% households, 31% free Vaccination have been provided in the households and 28% ASHA karmees are found in the sample villages. The Accredited Social Health Activist (ASHA) is a female voluntary worker in the rural area. For Malaria protection DDT is not sprayed in the sample villages of Hajo and Kamalpur C.D. block whereas in the rest of the study area the same is sprayed in a small share of households. (Table: 1).

The medical facilities in the study area are studied in terms of distance required to avail the facilities like dispensary, hospital, maternity and child welfare centers, primary health center, primary health sub-centers, family planning centers and community health center. It is noticed that the villages with relatively better socio-economic status are availing medical facilities better (average distance is around 3 km.) than that of the lower level villages where villages have to cover as long as 7 km. distance for availing medical facilities.

6. WOMEN AS A HOUSE HOLD WORKER

Household work is essential for sustaining our social and economic structure. But at the same time it is petty, isolated, monotonous, involving unending hours of hands and unrewarding work. Though highly labour intensive it is yet

unpaid. Thus, housework has no fixed hours, no holiday and no pay and it is done almost exclusively by women.

6.1 Daily workload of women: Village women often do several tasks simultaneously. Most of the rural women have to bear the exclusive burden of managing all the activities at home like cooking, child care, washing cloth and utensil, cleaning house, fetching fuel and water, mudding floor, animal rearing and other many kind of work. Again they have to visit the social ceremony, religious functions and relatives' house on time. So for such type of day to day work she has to be busy for whole day. As she is the mother, wife and in laws at her joint family, she has to take care of all family members from food to cloth. From morning till night the women members have to be busy with their work. From the field survey report it is found that, the average time required for cooking is 2.2 hours, followed by 1 hour in child care, 0.45 hours in washing cloth, 0.40 hours in washing utensil, 0.35 hours in cleaning house, 0.50 hours in fetching water, 0.35 hours in fetching fuel and 0.20 hours in animal rearing. So it is

found that in a day the women have to work almost 8 to 10 hours and enjoy 1 to 2 hours as leisure time. (Table: 2). This figure seem to rest at similar levels across the sample villages.

These types of high household work have adverse effect on the health condition of women causing serious illness including Respiratory problems, digestive problems, skin Problems, backache, body ache, head ache, cold /cough, diarrhea/ dysentery, weakening of eyesight, exhaustion, dizziness, fatigue, tuberc ulosis, ulcer, tumors, heart disease etc. (WHO /PEP/1992-3, Geneva.). The situation is all the same in the sample villages where women have diseases like backache, bodyache, head ache and cold /cough. Percentage of women suffer varies from 20% to 52% across the sample villages. Women seem to suffer from diarrhea may be due to lack of quality source of drinking water facilities. As revealed in the drinking water facility women has to fetch water from rivers and ponds almost in all villages which may lead to the diseases like body ache, ache in the limbs, waist and shoulders.(fig: 4).

Table 3: Linkages between Rural Women’s Household work and Health

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Women’s work	Risk Factors	Illness / Health
1. Household work/ Animal Husbandry work	Heavy workload, long hours, exposure to dust, house dust, tobacco, exposure to hazardous chemicals, carbon monoxides, lead, fungi, drudgery, repeated movement of few parts of body, postural problems, constant strains on eyes, poor light, low nutritional status	Respiratory problems, digestive problems, skin Problems, backache, bodyache, head ache, cold /cough, diarrhea/ dysentery, weakening of eyesight, exhaustion, dizziness, fatigue, tuberc ulosis, ulcer, tumors, heart disease, cancer.
2. Fetching water/ Fuel	2. Walking long distances, carrying heavy load, heavy physical strain even during pregnancy	Adverse effect on reproductive system, abortions, still birth, LBW, prolapsed, PID, septic. 2 Body ache, ache in the limbs, waist, shoulders. Adverse effects on reproductive system, miscarriages, prolapse

Source: 1. WHO, 1992, Indoor air pollution from biomass fuels, WHO/PEP/92-3, Geneva.

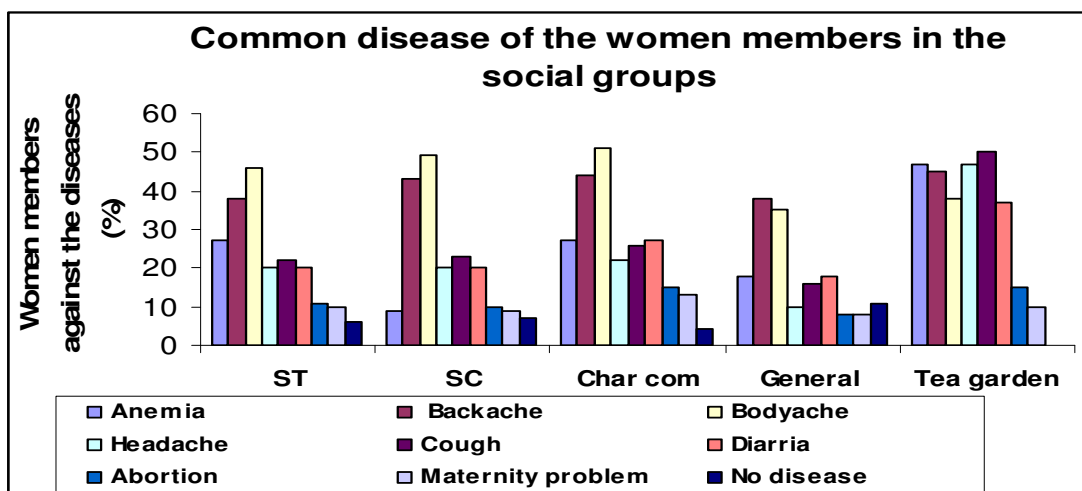


Fig: 4: Common disease of the women members in the social groups

Source: Field survey

7. WOMEN AS A MOTHER

The role of women as a mother is crucial which is examined in the present study in terms of number of children per women. As revealed in fig 2 women in the char community has maximum number of children mostly 3 to 4 and above 4, percentages of women being 40% and 30% respectively. Number of children per women is relatively high in the tea garden community followed by schedule caste, schedule tribe and general caste.

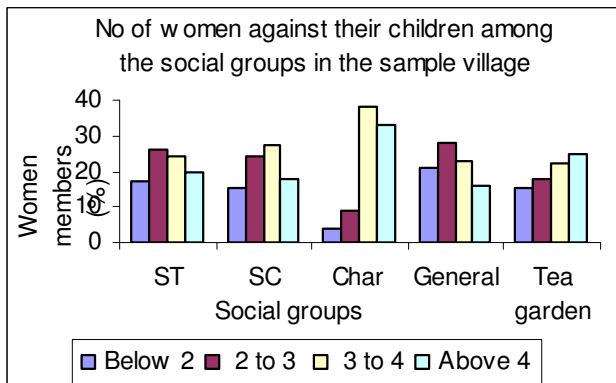
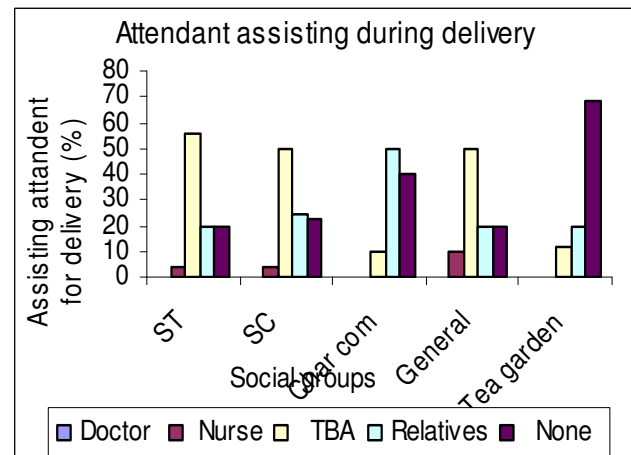
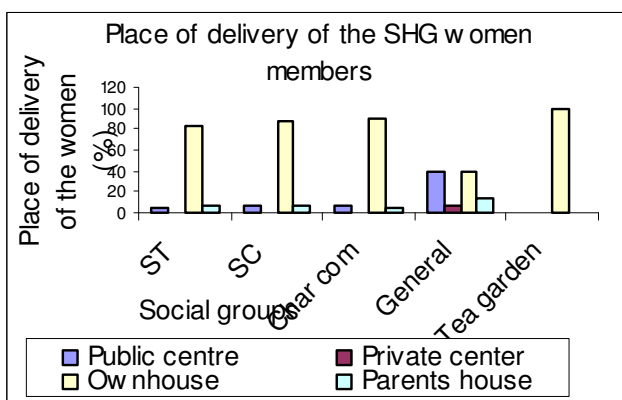


Fig 5: Women against their number of children among the social groups

Source: field survey

7.1 Place of delivery: From the standpoint of child survival and the health of the mother, it is advantageous for babies to be born under hygienic conditions with the assistance of a trained medical practitioner. Fig: 3 presents the place of delivery in the house holds of the sample villages. Only 15 % of birth occurred in medical institutions out of which 13% in public institutions and 2% in private medical institutions. 78% women have received delivery in own house and only 7% delivery is done in the parent’s house. The proportion of births taking place in medical institutions is lower among births to older women than among those to younger women.



Source: field survey

Fig 6: Place of delivery and attendant assisting delivery of the SHGs women members

According to NFHS report the antenatal visits, tetanus immunization, and iron and folic acid supplements, institutional deliveries are also more common among the births of well educated women than among the births of poorly educated women, more common among Hindus than among either Muslims or Christians, and are less common among the births to women of schedule tribes than among births to other women. (NFHS report, 1992-93). (Fig: 6)

7.2 Attendance assistance during delivery: The great majority of birth in the house holds is delivered without assistance from a formally trained medical person or doctor. (Fig: 6). The similar situation is observed while interviewing the women respondents in the study area. The situation is worst in case of tea garden community followed by char community where percentages share of women in aforesaid category rest at 70% and 40% respectively. Among the deliveries 4% are attended by nurse/midwives where as 48% are attended by Traditional Birth Attendants (TBA). Because a large proportion of births take place at home, it is not surprising to find that relatives and neighbors play a major role in assisting deliveries. Institutional delivery plays a very vital role in reducing the maternal and infant mortality since institutional delivery is always safe. Regarding the access to rural health facilities it was observed that very few went to qualified doctors. Regarding their reproductive health most of them reported that they did not go for antenatal and postnatal check ups. Nearly 80 percent reported that delivery was conducted at home by dais or by relatives. With reference to NFHS report (1992-93) such kind of women are likely to have delivery complications like caesarean, septic, uterine rupture, perennal tear, tetanus, obstructed labour etc. (Fig:6).

8. CONCLUSION

From the discussion it is found that the health condition of the rural women are yet in a poor condition as a result of varied work load, exposure to inefficient cooking inaccessibility to health facilities namely drinking water, sanitation facilities, ventilation facilities, cooking facilities, medical facilities etc. besides it is found that the health condition of women is adversely affected as they are over taxed with repeated child birth under improper place of delivery.

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Table 1: Access to Health Facilities among the women in the selected households of the sampled villages

Name of the Social	Groups Of the Villages	Number of house holds availing health facilities										Average distance from Medical facility **
		Drinking water facility					Vaccine and Free Medicine					
Groups		River	Well	pond	Tube well	Tap	Tetaneous / to xoid	Iron / Folic tablet	Pulse / polio	Free Vaccine	DDT For malaria	
Schedule Ttribe	LMV	0 (0)	40 (80)	5 (10)	5 (10)	0 (0)	10 (20)	9 (18)	28 (56)	20 (40)	5 (10)	4 km.
	UMV	0 (0)	35 (70)	5 (10)	10 (20)	0 (0)	10 (20)	9 (18)	28 (56)	21 (42)	5 (10)	3 km
Schedule Caste	LMV	5 (10)	5 (10)	5 (10)	35 (70)	0 (0)	10 (20)	9 (18)	30 (60)	23 (46)	8 (16)	4 km
	UMV	0 (0)	10 (20)	5 (10)	35 (70)	0 (0)	10 (20)	9 (18)	30 (60)	23 (46)	8 (16)	3 km.
Char Comm. Unity	LMV	10 (20)	15 (30)	20 (40)	5 (10)	0 (0)	5 (10)	4 (8)	12 (24)	10 (20)	0 (0)	7 km.
	UMV	5 (10)	15 (30)	15 (30)	15 (30)	0 (0)	5 (10)	4 (8)	12 (24)	10 (20)	0 (0)	6 km
General Caste	LMV	10 (20)	10 (20)	10 (20)	20 (40)	0 (0)	15 (30)	12 (24)	34 (68)	10 (20)	0 (0)	4 km.
	UMV	0 (0)	11 (22)	5 (10)	30 (60)	4 (8)	15 (30)	12 (24)	34 (68)	10 (20)	0 (0)	2 km.
Tea * Garden Groups	LMV	5 (25)	6 (30)	4 (20)	5 (25)	0 (0)	9 (45)	2 (10)	5 (25)	4 (20)	4 (20)	4 km.
	UMV	2 (10)	4 (20)	4 (20)	10 (50)	0 (0)	9 (45)	2 (10)	5 (25)	4 (20)	4 (20)	4 km.

Source: Field Survey. Figure in the parenthesis indicates percentages. * The each Tea garden has only 20 women members in the block. [** Medical facility includes Dispensaries, Hospitals, Maternity & Child welfare center, Primary health center cum sub center, Family planning center, Community health center etc, LMV, UMV=Lower &Upper medium village]

Table 2: Daily household work load of the women members among the social groups

Name of the Social Groups	No. of the Villages	Daily household workload of women SHGs members									
		Cooking	Child care	Washing cloth	Washing utensil	Cleaning house	Fething water	Fething fuel	Animal Rearing	Busy schedule in the day	Leisure time
Schedule Tribe	Vill-1	2.26	1.16	0.6	0.36	0.56	0.45	0.6	0.7	8.20	1.14
	Vill-2	2.32	1.22	0.42	0.34	0.33	0.38	0.27	0.39	8.30	1.44
Schedule Caste	Vill-3	2.18	1.2	0.56	0.34	0.38	0.38	0.32	0.32	8.40	1.22
	Vill-4	2.22	1.18	0.36	0.46	0.34	0.52	0.3	0.29	8.24	1.52
Char Community	Vill-5	2.2	1.28	0.64	0.44	0.35	0.86	0.28	0.22	9.10	1.18
	Vill-6	2.2	1.24	0.72	0.43	0.36	1.18	0.3	0.28	9.20	1.42
General Caste	Vill-7	2.14	1.1	0.42	0.39	0.3	0.76	0.3	0.25	7.30	1.68
	Vill-8	2.2	1.17	0.42	0.34	0.31	0.36	0.31	0.26	7.20	2.28
Tea * Garden Groups	Vill-9	2.25	1.1	0.35	0.37	0.27	0.45	0.35	0.32	8.30	1.2
	Vill-10	2.2	0.75	0.4	0.37	0.22	0.4	0.3	0.3	8.40	1.3

Source: Field Survey. Figure in the parenthesis indicates percentages.

* The each Tea garden has only 20 women members in the block.