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## Health Status of Rural Women in India: An Overview of Literatures

Dr. R. Hariharan

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### Keywords

women health,  
reproductive health,  
fertility,  
maternal mortality

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### Abstract

*The present paper analyses the health status of the rural women in India. The review analysed the socio-cultural constraints of women, health needs, widespread women's ignorance, women's rights, women's access to available resources, nutritional stress, fertility and reproductive health, gender discrimination and awareness of reproductive health infections. However, there is need a wide scope for research to bring a holistic view of rural women health status. Since women faces various unique health issues as compared to male, there is a need for more specific and combined research on women health status. Thus, the present paper suggests the researchers in the field of women health to bring various research for safeguarding the women health status as whole.*

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### Author Correspondence

Assistant Professor,  
Department of Economics, Government Arts College, Udhagamandalam [Deputed from Annamalai University]

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### Introduction

The present paper examines the overview of literatures on the health status of the rural women in India. The Women's health and nutritional status is inextricably bound up with social, cultural, and economic factors that influence all aspects of their lives, and it has consequences not only for the women themselves but also for the well-being of their children (particularly females), the functioning of households. Since the turn of the century, India's sex ratio has become increasingly favourable to males. This is in contrast to the situation in most countries, where the survival chances of females have improved with increasing economic growth and declining overall mortality. In India, excess female mortality persists up to the age of 30-a symptom of a bias against females. But there are wide disparities in fertility and mortality among states and, within states, between rural and urban areas. The substantially unfavourable levels of these indicators in the northern states of Bihar, Madhya Pradesh, Rajasthan and Uttar

Pradesh in relation to most southern states reflects marked social and demographic contrasts between the "Hindi belt" and the rest of India. The southern state of Kerala, for instance, has achieved fertility and mortality levels approaching those of industrial countries (*Improving Women's Health in India; 1996*). This is the status of women health in India compared other countries in the world.

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. Poor health has repercussions not only for women but also their families. Women in poor health are more likely to give birth to low weight infants. They also are less likely to be able to provide food and adequate care for their children. Finally, a woman's health affects the household economic well-being, as a woman in poor health will be less productive in the labour force (*Kamalapur and Reddy; 2013*).

### **Determinants of Women's Health**

Health status is influenced by complex biological, social, and cultural factors that are highly interrelated. These factors affect men and women differently. Women's reproductive biology, combined with their lower socio-economic status, result in women bearing the greater burden from unsafe sex-which includes both infections and the complications of unwanted pregnancy. Biological and social factors affect women's health throughout their lives and have cumulative effects. Therefore, it is important to consider the entire life cycle when examining the causes and consequences of women's poor health (*Tinker et al., 2000*).

### **The Status of Women**

The position of women in traditional Indian society can be measured by their autonomy in decision-making and by the degree of access they have to the outside world. By these measures, Indian women, particularly those in the north, fare poorly. Girls are typically married as young adolescents and are taken from their natal homes to live in their husbands' households. Then they are dominated not only by the men they have married but also by their new in-laws, especially the older females. Women are frequently prevented from working outside the home and travelling without a chaperone, and this has profound implications for

their access to health care. The money they earn, the dwellings in which they live, and even their reproductive careers are not theirs to control. In addition, the work they perform is socially devalued. This inherently inequitable social system is perpetuated through a process of socialization that rationalizes and internalizes the female disadvantage.

The consequences of women's unfavourable status in India include discrimination in the allocation of household resources, such as food, and in access to health care and education as well as marriage at young ages. The loss of a husband usually results in a significant decline in household income, in social marginalization, and in poorer health and nutrition (*Improving Women's Health in India; 1996*).

### **Women's Health in India**

Women constitute a significant part of the work force in India. The work participation rate continues to be substantially less for females than for males. Majority of the women workers are employed in the rural areas. Among rural women workers 87 per cent employed in agriculture are labourers and cultivators, about 80 per cent are employed in unorganised sectors like household industries, petty trades and services, building construction etc.

A multiplicity of factors including biological, social, cultural, environmental and economic, influence women's health status, their need of health services and their ability to access appropriate services. In particular women's health needs stem from the fact that: Women are more socially disadvantaged than men in terms of poverty, education, and power. Socially disadvantaged people are more likely to become ill. Women are more likely to use health services because of their social role as carers of children, older people, or people with disabilities and the extra strain this places on their health. Women have particular sexual and reproductive health needs, for example, menses, pregnancy, childbirth, and menopause. Women are treated differently from men in society generally because of gender inequality resulting in, for example, violence against women and sexual assault. Women are also treated differently within the health system. Women have frequently been excluded from being health and medical research participants leading to major gaps in knowledge about women's health (*Women Health NSW; 2007*).

Health is complex and dependent on a host of factors. The dynamic interplay of social and environmental factors has profound and multifaceted implications on health. Women's lived experiences as gendered beings result in multiple and, significantly, interrelated health needs. But gender identities are played out from various location positions like caste and class. The multiple burdens of 'production and reproduction' borne from a position of disadvantage has telling consequences on women's well-being. The present section on women's health in India systematizes existing evidence on the topic. Different aspects of women's health are

thematically presented as a matter of presentation and the themes are not to be construed as mutually exclusive and water tight compartments. The conditions of women's lives shape their health in more ways than one. Given this backdrop, the present study reviews the recent literatures in the health status of the rural women in the India.

### **Literature Survey**

The review of literature may bring some insights and vision in the women health status. Besides, the review would highlight the issues and policies for strengthening the women health status. *Jejeebhoy (1995)* have shown that women based services or those responding to women's health needs in ways which are sensitive to the socio-cultural constraints women and adolescent girls face in acquiring services and expressing health needs, have been largely lacking. The health system operates through a network of 20847 primary health centres and over 130,000 sub-centres; domiciliary services are expected to be provided by the large number of health workers (ANMs) attached to the various centres; despite this, outreach continues to be poor. Women at the grassroots are the programmes main clients, but the programme all but ignores them in its priorities, in its service delivery and communication strategies. The focus on sterilization, target fulfilment, and incentives has resulted in obscuring the spacing needs of women and their right to exercise informed choice. While poor quality of care can inhibit women from seeking health care, women's lack of autonomy in decision making or movement is also an important constraint on women's health seeking. Women's unequal access to resources, including healthcare, are well known in India, in which stark gender disparities are a reality.

*Victoria and Adlakh (1998)* reveal that Indian women have high mortality rates, particularly during childhood and in their reproductive years. The health of Indian women is intrinsically linked to their status in society poor health has repercussions not only for women but also their families. Many of the health problems of Indian women are related to or exacerbated by high levels of fertility. Unwanted pregnancies terminated by unsafe abortions also have negative consequences for women's health. Reducing fertility is an important element in improving the overall health of Indian women. Maternal mortality and morbidity are two health concerns that are related to high levels of fertility. India has a high maternal mortality ratio – approximately 453 deaths per 100,000 births in 1993. Finally, a women's health affects the household economic well-being, as a women in poor health will be less productive in the labour force.

*Mishra et al., (2006)* research on the discrimination against the girl child continues during adolescence and the lack of preparedness in meeting life situations underscores her vulnerability. Women's lived experiences as gendered beings result in multiple and, significantly, interrelated health needs. Reproductive health continues to enjoy the predominant

position on expositions on women's health in India; however, the connotations have widened implying a wider range of reproductive health conditions that women experience. Women's widespread ignorance about matters related to their health poses a serious impediment to their well-being. Women's inferior status thus has deleterious effects on their health and limits their access to health care.

*Sarajini et al., (2006)* investigated the societal values and norms operating within the framework of patriarchy impacts on women's rights at various levels of family, community, and state. Women's access to health services is much less in comparison to men. Relatively high mortality rates of women are a reflection of unequal gender relations, inequalities in resource distribution lack of access and availability of drugs and health services in our country.

*Towards National Health Assemble (2006)* concluded from the model of women's health is integrally linked to women's access to available resources, and with women's productive and reproductive roles in our society. There is urgent need to have a broader understanding of health as the interaction of socio-economic and political factors, based on the primary health care approach. This would help to address women's health needs more holistically; and provide preventive, promotional and curative care from a gender sensitive point of view. Poverty, geographical location, social exclusion based on caste, gender, sexuality, disability interact closely with factors like work, housing, environment, education to determine women's health. Women's relatively low status and the risks associated with reproduction exacerbate what is already an unfavourable overall health situation. Women are socialized in a way to devalue their health and therefore healthcare for them is given low Priority.

*Ministry of Statistics and Programme Implementation (2011)* while analysing the majority of women go through their life in a state of nutritional stress they are anaemic and malnourished. Poverty, early marriage, malnutrition and lack of healthcare during pregnancy are the major reasons for both maternal and infant mortality. The average of Indian women bears her first child before she is 22 years old, and has little control over her own fertility and reproductive health. In rural India, almost 60 per cent of girls are married before they girls bear children before they are 19. Almost one third of all babies are born with low birth weight. Infant mortality rate has been decreasing over the years. The IMR for females in India is 55 compared to 52 for males in 2008.

*Sengupta (2011)* say that women's health is of great importance both for their own sake and for the sake of future generations, but paradoxically remains the weakest and the most discriminated against in most countries. Maternal care in India has definitely improved in India since 1992 - 93, but with only 76 per cent women accessing any ante natal care and only 40.85 of births happening in a health facility, there is a long way to go. There is also a clear rural -

urban gap in maternal care in India. Gender discrimination is strong in accessing health services as well. Women are already facing severe disparity, both in employment and incomes as well as in access to healthcare, and are now made to bear a disproportionate burden.

*Bhargava (2012)* has cited the rural women in India get less opportunity to attend higher level of schools and therefore lack in knowledge and information about health and its perspectives. This paper examines regional variations and pattern of perceived awareness of reproductive health infections (RTIs) among rural women in India. Around the world, reproductive health is one of the issues in improvement of overall health. The concern remains even more challenging where a large section of women is barred to attend schools and bound to abide 'culture of silence'. Consistent increase in population and degrading societal values broadens the gap of achieving equilibrium. Therefore a timely check on ongoing programs is required to reduce the health problems of rural women of the country.

*Giri (2012)* has explains reproductive health is a universal concern, but it is the special importance for women. Women's reproductive health is a vital part of her general health and is a reflection of health during childhood and crucial during adolescence and adulthood plays a pivotal role in being healthy beyond the reproductive years and affects the health of the next generation reproductive system.

*Gogoi (2012)* paper tries to examine the reproductive health complications during pregnancy, delivery and after delivery and its association with use of maternal health care services using third round of DLHS (2007-08) data. The present study results show that 44 per cent women reporting of complication like paleness, giddiness or weakness, 32 per cent have excessive fatigue and 28 per cent of have swelling of body and face during pregnancy. There is a positive relationship between use of maternal health care services and percentage of delivery and post-delivery complications. Factor analysis shows that women had foetus and discharge related complications during pregnancy also reports of having labour related complications during delivery.

*Jakhar (2012)* modified that globally women constitute almost half of the total population. Health of women is a matter of concern as due to child bearing and rearing processes women's health in terms of nutrition as well as medical care needs particular attention. Haryana is economically among well-developed states yet the recent national family health survey recorded that one third of the total women are having poor nutritional status with is measured in terms of BMI. The same study also revealed that in Haryana only half of the total expecting women received full antenatal care and only 26 per cent women had institutional deliveries. The study is primarily based on primary data collected through household survey of 487 households were chosen by stratified random sampling method from eight villages spread

over eight districts in Haryana. A total of 620 women in 15-49 age groups in all 487 households were measured for nutritional levels and health care. Nutritional levels has been studied by two methods, one is anthropometric measure. BMI and another is food intake. Health care has been studied by levels of antenatal care and care during child birth i.e. institutional deliveries.

*Mishra (2012)* have highlighted the identifying issues and problems in the occupational health of women remain a challenge. Much of women's work remains unrecognised, uncounted, and unpaid: for example work in the home, in agriculture, food production and the marketing of home-made products. Women's occupations are fluid and multi-dimensional. Within the paid labour force, women are disproportionately concentrated in the informal sector, beyond the scope of industrial regulations, trade unions, insurance, or even data collection. Women may undertake paid work at home, or combine part or full time paid work with household work and the care of children, the sick, and the elderly. The effects on health of women's multiple roles are still poorly understood. Much of the current literature on women and paid work, especially which concerned with mental health, is not sufficient. Present paper tries to analyse effect of different occupations on the health of 300 women living in Lucknow City of Uttar Pradesh, chosen by random sampling.

*Naruka (2012)* investigated the women's health plays a pivotal role in society, but, they are more vulnerable for pregnancy complications, and obstetric morbidities which affect not only their own health but also their children and family health. Their health status is affected by utilization of health care services which are provided to them. In Uttar Pradesh, only 20.7 per cent pregnant women visit health facilities for antenatal care, 9 per cent receive Iron and Folic Acid tablets, 21.8 per cent delivers their child at health facility and only 15 per cent mothers received postnatal health check-ups. The present study attempts to examine role of demand side factors and supply side factors in determining the utilization of maternal health care services in Uttar Pradesh using data of National Family and Health Survey III, 2005-06. The data will be analysed through a bi-varitate analysis to examine association and differentials and logistic regression model to analyse net effect of demand and supply side factors on maternal health care utilization.

*Shahani (2012)* has cited the strong interrelationships between women health and development underscore the need to address the women reproductive health and its status. The study is descriptive in nature and utilises qualitative data. The primary aim is to establish relationship between empowerment of women especially in terms of their reproductive behaviour and overall development. The paper argues that increase access to resource is a major factor towards ensuring the much desired empowerment. Moreover, lack of reproductive health constitutes a significant deprivation of well – being. This paper seeks to examine the

usefulness of the capabilities approach to an analysis of reproductive health of women. With its direct focus on defining development as enhancing people's well-being, the capabilities framework has strong potential to reinforce efforts to advance reproductive health of women. The proposition lies beneath is linked with the direct effect between women reproductive health and development.

*Upadhyay (2012)* have shown that epidemiological transition in India has led to double burden of diseases with surging prevalence of non-communicable diseases. Research on non-communicable diseases among women have remained less focused mainly because these diseases are often associated to life style and women lifestyle has been assumed to be less variant and dynamic. The study has used data from NFHS-3. Appropriate bivariate and multivariate analysis has been carried out on a sample of 40,817 and 83,568 urban and rural women. Findings reveal that the prevalence of diabetes and goiter is more than double among urban women as compared much difference. This brings into light that though urban women are more prone to non-communicable diseases, rural women points to the socio-economic and environmental factors such as more use of chullas for cooking food. The study strengthens the need to improve the living conditions and lifestyle of women residing in urban as well as rural areas in order to improve their health status and well-being.

*Vaidyanathan (2012)* has witnessed declines in mortality over the years; these improvements have not been shared equally by all sections of society. While gender differentials have narrowed, females are exposed to high maternal mortality. Although the decline in child mortality has accompanied the decline in general mortality, very high death rates are observed among children under five. Rural mortality is higher than urban mortality in all age groups and especially among the younger age groups. There are great variations in mortality between different states of India. While the mortality rates of some states like Kerala and Goa are comparable to the best in Asia, others like the EAG states have very high mortality rates. Health programmes need to be focused up particular target groups like women and children, infants in the neonatal and prenatal stages, elderly men and women, rural areas and backward states. Drastic reductions in mortality can be achieved by providing better antenatal and postnatal services in rural areas, immunization of children and pregnant women and by ensuring spacing of births and laminating high – risk pregnancies. Further reductions immortality can be achieved only by programmes outside the domain of health services such as providing safe drinking water, environmental sanitation, nutrition etc.

*Vijayanthimala (2012)* study has been undertaken to study the nutritional status among the adults of different states through primary and secondary data. Anthropometric measurements namely height and weight were measured and BMI (kg/m<sup>2</sup>) was calculated

subsequently to measure the nutritional status. The paper will address issues for gender inequality along with analysis of some case studies. Gender refers to the behaviours or patterns of activities that a society deems appropriate for men and women for example boys are encouraged to be tough and outgoing; girls are encouraged to be homebound and shy. These differences are gender differences and created by society which hampers the overall well-being of women. Many developing countries including India have displayed gender inequality in education, employment and health. The paper also emphasizes current interventions (programmes/schemes) at central and state levels and analyse their effectiveness in improving women's nutritional status.

*Kushwah (2013)* found that every day, approximately 1000 women die due to complications of pregnancy and childbirth nearly all of these deaths are preventable. Health care access is important for women as women's body changes throughout her life time, from fetal development to post menopause. Many women also face huge social, economic and cultural barriers to having lifelong good health. Additionally women provide the majority of family health care by caring for both aging parents and children. Women manage health through their domestic work, through cleaning, sweeping, drawing water, washing clothes dishes and children and preparing food. Although efforts have been taken to improve the status of women, but the constitution dream of gender equality are miles away from becoming a reality even today.

*Ravi and Kulasekaran (2013)* noted that the maternal mortality rate shows a wide gap between rich and poor countries. Among developing regions South Asia has the second highest MMR at 280 maternal deaths per 100,000 live births in the global context. It is well recognized that women's current age plays an important role in the utilization of medical services. It concludes that trend of delivery at health institution was remarkably increased but there were strong differentials in low social status women. Ignorance and dominance of mothers-in-law were main reasons contributing to home delivery.

From the above reviews, the socio-cultural constraints of women and adolescent girls face in acquiring services and expressing health needs is discussed. Women high mortality rates, particularly during childhood and in their reproductive years are highlighted. Women's widespread ignorance, women's rights, women's access to available resources, nutritional stress, fertility and reproductive health, gender discrimination and awareness of reproductive health infections (RTIs) are discussed. Besides, reproductive health complications, occupational stress, pregnancy complications and challenges of women health are discussed.

## Conclusion

The rural women health status of the women is discussed and found that the women health remains to be a challenging issue. There is a need of strong interrelationships between women health and development underscores the need to address the women reproductive health and its status. Epidemiological transition in India has led to double burden of diseases with surging prevalence of non-communicable diseases. However, there is need a wide scope for research to bring a holistic view of rural women health status. Since women faces various unique health issues as compared to male, there is a need for more specific and combined research on women health status. Thus, the present paper suggests the researchers in the field of women health to bring various researches for safeguarding the women health status as whole.

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