

**CHAPTER – VIII**

## *Summary and Conclusion*

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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. Thus, this study makes an attempt to understand the problems related to women health. The study has been divided into following Chapters:

1. Introduction-Conceptual and Theoretical Framework.
2. Review of Literature.
3. Methodology-Field and Planning of the Study.
4. Health Policy in India.
5. Health Delivery System and Utilization Patterns of Health Services.
6. Factors Affecting Health Status of Women.
7. Belief, Knowledge and Cultural Practices in Relation to Health and Nutrition.
8. Summary and Conclusion.

First chapter is divided into three Sections: Section-I related to Health Status in India, Section-II is about Women in India, and Section-III deals with the Concept of Health and Nutrition and Theories of Gender. In Section-I we have discussed (a) Health Systems in terms of Historical Perspective which includes Pre Independence, Post Independence, different Five Year Plans, Health Facilities and Man power and Health Indicators in India. Health at the conceptual level is complete well being of person which includes social, economical, physical and psychological well being. It is a state of balance in body, mind,

social and spiritual well-being. It is affected by social, environmental, hereditary and personal factors.

In the health policy a focus is made on mother and child care to decrease child mortality which is a major indicator for socio-economic development of the country. The specific health concerns related to women and especially women in rural India and that too among vulnerable and underprivileged socio-economical groups. Various Five year plans have been focused on women and child health care.

The health care of women is an emerging area of sociological studies which needs investigation and analysis of available health facilities, health man-power health concerns, and health related programs. The operations and actual execution of programme in fields at micro level is to draw a picture of the present health related problems of rural women in terms of their caste, class and religion, size of family, education of the family, culture of the area in which they are residing. It is very essential to understand the impact of various social, economical, cultural factors which are varied in terms of regional differences. This study is an effort to understand the health concerns, health infra-structure, health man-power and effectiveness of health programs for the women of different groups of women in a rural population of remote, backward and largely ignored village Dumari in a district of eastern Uttar Pradesh, Deoria.

In section – **II** we have discussed Women in India, The health of women in relation to her and food is also discussed. In section – **III** we have discussed Concept of Health and Concept of Nutrition and different theoretical approaches to understand gender discrimination.

Health status is an important indicator of the level of economic development and it includes mainly mortality and morbidity. Nutrition is the intake of food and supplements in the body which is utilized for maintaining health and energy. Theory of Cultural Dualism relate Women as a culturally constructed gender category rather than simply a biologically sex category. Developmentalism Perspective focuses worldwide attention on the need for intensified action to ensure the full integration of women in the development

process. Marxian perspective relate to physical differences between a men and women and in the process the wife's role including the nurturing gets subordinated while the economic functions of man is defined as superior and super-ordinate, and boys and girls are socialized to fulfill the roles. Perspective of Patriarchy relates to show the origin of subordination of women by men, and based on locating determination of women's subordination analytically.

Health care system in India, found a concern in ancient India and evolved through ages with many ups and downs. Indian systems of medicine like Ayurveda and Siddha were added with Unani system during Muslim period and then with European Allopathy system during the British rule. India became a sovereign independent state and the health infrastructure was not available at that time to the masses. After independence various health infrastructures, health manpower and focus to specific priority areas were planned and implemented on recommendations of various review committees through the different five year plans. Strategies for epidemic and emerging diseases are of major concern. Women, though most important in society, are largely ignored especially in rural India for their health concerns.

Uttar Pradesh is one of the largest, and densely populated and backward states of India which has many socio-economical, and thus health related problems for women. To understand the real challenges sociological studies are urgently needed. This thesis analyses health scenario and its related issues and challenges in a rural pocket of distantly located backward district of Uttar Pradesh. No such study is available with sociological perspective for understanding the health concern of rural women.

In the second chapter, we have reviewed the related literature on health. We have divided the studies in to three categories: i.e. **(1)** Health status of women and Women as a user of health services; **(2)** Health care service and health Policy; **(3)** Nutrition health Status of Women.

In the health status of women and women as a user of health services, problems of women's health, reproductive health problem are taken into

consideration. These studies point out that Indian women's health status is very low and needs more effective plans and efforts to maintain the health status of women. In the second category, studies related to the health care service and health policy we have discussed under maternal and child health services, public health facilities, quality of health system, inequalities in nutritional status and utilization of primary health service. These studies point out that Indian health care service and health policy are not very encouraging or effective and need more infra-structure. In the third category nutritional health status, of women we have found many factors affecting nutritional health status of women like food habits, nutritional needs, food intake system like women eating in last and other food systems. Women's status is inextricably bound up with social, culture and economic factors that influence all aspects of their lives, and it has consequences not only for children (particularly females) but for the whole family and the distribution of resources.

In third chapter, we have discussed the field and planning of the study. The present study has been conducted in Dumari village in Deoria district of eastern Uttar Pradesh. Uttar Pradesh is most populated state in India. The most direct effects of poor health and nutrition among females in India results into high mortality rates throughout the life-cycle. The effects of pervasive ill health extend beyond the women's health. Women's health and nutritional status influence her newborn's birth weight, and survival, her capacity to nurse child, and her ability to provide food and care to children and family members.

We have selected Dumari village in Deoria districts of eastern Uttar Prasad as our field of study because this area is a very backward. The women's health status and availabilities of government health facilities in rural areas have been analyzed. There is one primary school, one Government hospital, four Private clinics and five medical shops in the village.

In the present study the village Dumari has 540 households with a population of 4,331. We have proposed the list of 540 households and decided to take the 40 per cent from the list. The 40 per cent of 540 households comes to 216

households. These households are picked up lottery method. Thus, in total 216 household are selected and from each household, we interviewed one women.

The main objectives of our study are:

1. To examine the indicators of women's health status.
2. To analyze the factors affecting women's health.
3. To study the utilization and pattern of health services.
4. To identify the beliefs, knowledge and cultural practices in relation to health and nutrition.

In the fourth chapter studies related to the **(a)** Health Policy in India **(b)** Nutrition Health Policy and **(c)** Health Programmes in India are made.

Health Policy of 2002 aims to achieve an acceptable standard of good health amongst the general population of the country and increase access to the decentralized public health system by establishing related new infrastructure in deferent areas, and upgrading the infrastructure in the existing institutions. Nutrition policy in India is to improve the health status of the people. It will be instructive to review the development of health planning over the decades in the context of eradication of diseases, improving the medical facilities and development of health planning over the decades in the context of eradication of diseases, improving the medical facilities. Further, special attention is paid to providing potable water supply, improving nutrition, promoting the indigenous system of medicine, the rapid extension of net work of rural health. Network of rural health services with development of a large number of multi-purpose workers has started. For achieving a permanent improvement in the nutritional status of the people, there should be an increase in improved nutrition. To control other problem of iron deficiency, National Nutrition Monitoring Bureau suggested programs by improving the iron consumption in habitual diets and by enhancing their quality. To fortify a suitable food item with iron is also included. The use of iodized salt by the people would be able to reduce the incidences of goiter. Since 1959, UNICEF, WHO, FAO have been focusing on programmes for

pre-school age children, pregnant and lactating women. The mid-day meal programme in schools launched in 1962 was an effort to simultaneously increase school enrolment and improve child nutrition. The Integrated Child Development Service was started in 1975-76. It is expected to provide immunization, supplementary nutrition to child, pregnant and lactating mothers. Since policies and programs on child nutrition and their implementation could not deliver expected results. The 11th Five Year Plan which achieved an annual growth rate of 8 per cent, need to be re-looked and new initiatives are called for to tackle them during the 12<sup>th</sup> Five Year Plan.

Chapter fifth is related to the health delivery system and utilization pattern. The data for the inquiry-are related to the rural communities of the state of Uttar Pradesh.

The official poverty line-is nothing short of poor quality of life in Uttar Pradesh despite the state being endowed with abundant natural resources. Among Indian states, Uttar Pradesh has some of the worst health indicators. For every, 1000 babies born, 73 die within a few days. Many of the health problems of Indian women are related to or exacerbated by high level of fertility. However, there are large variations in fertility level according to education, religion, caste and place of residence. 3.8 fertility rates in Uttar Pradesh the most populated state in India having a total fertility rate of over 4 children per women (RHS 2008). Overall 100,000 Indian women die every year due to pregnancy related factors.

In the villages, water is mostly obtained from the hand pump. Drinking water quality is deter-mental in deciding health of person as many water-born diseases of human being are related to majority of them don't have any toilet facility in their house. Most of the government hospitals in this study we have discussed health infrastructure. There are only 186 gynecologists, 135 Pediatricians and 3340 Nurse /Midwife, while requirement is of 515 Gynecologist, 515 Pediatricians, and 7295 Midwife/Nurse. 45 per cent people depend on healers and quacks in Uttar Pradesh. Deoria district has only one district hospital, 9 community health centers, 15 primary health centers, 61

additional primary health centers, 317 sub centers, 49 Ayurvedic hospitals and 27 homeopathic centers. Health infrastructure in Dumari village consists of one government hospital, 4 private clinics and 5 medical shops. No. of anganwadi workers and Asha are four and there is only one nurse.

The socio-economic background of a respondent is directly related to her status in the society. Majority of the respondents are in mid age-group of 36-54. Majority of the women in this study are scheduled caste, nearly 47 per cent are from backward caste. This is due to the fact that the studied area is dominated by backward and schedule caste population. The data clearly shows that family annual income of 40 per cent the women is in the range of 30,001-50,000 rupees. Nearly 54 per cent women are illiterate and they are still not much aware about the benefits of family planning and good education. Majority of the respondents used drinking water from pump. Drinking water quality is detrimental in deciding health of a person as many water-born diseases of human being are related to it. Approximately fifty per cent respondents conveyed that they don't have any toilet facility in their houses. Most of the women, i.e. 84 per cent prefer government hospitals during pregnancy and for other health related issues. They are not in a position to pay the hefty bills of the private health care. Approximately eighty per cent of women replied that ultra sonography service is not available in government hospital and approximately ninety per cent replied that there are no pathological facilities in hospital and nearly ninety per cent women told about non-availability of operation theater.

Chapter sixth is related to the factors affecting the health of women. Illnesses of women have serious and far-reaching consequences for the health of her children, family and community. Every year, about 10 million women endure life-threatening complications during pregnancy and childbirth, sometimes leading to long term disability. In the present study we found that many factors combine together and affect the health of women. The social and economic environment, the physical environment and the person's individual characteristics and behavior all are responsible for wellbeing. In our study, approximately 81 per cent families organize cultural activities before birth of child. Nearly half of the women go to doctor at the time of child birth for care of her health in pregnancy. Although most Indian women believe that they have

little or no control over pregnancy and its outcomes. Certain beliefs, customs, and taboos surround pregnancy and the prenatal period. Approximately 88 per cent of families have special food were cooked as a part of cultural activities for the care of pregnant lady. We found during survey that approximately 70 per cent of women suffer from anemia and nearly 37 per cent suffer from different physical weakness. This is a major health problem in villages of Uttar Pradesh. Anemia during pregnancy accounts directly for 15-20 per cent of all maternal deaths in India, and indirectly for much large proportion. Many women said that poor economy background influence their health. We found in our study that 65 per cent women did not go for regular checkup of health. Availability of health checkup facilities is not very encouraging in Dumari village. Nearly 61 per cent girls & women were cared by their husband properly; nearly 29 per cent women were aware about vitamins. Reasons for no or partial treatment in which approximately 86 per cent women replied poverty, nearly 75 per cent women got information by Anganwadi workers about health awareness.

The seventh chapter is related to beliefs, knowledge and cultural practices in relation to health and nutrition. Food is a basic necessity of the life and allround development of a person depends upon good nutrition. Family plays an important role in shaping the food habits which are passed from one generation to another. The fact that women need extra nutrients during pregnancy is hardly realized in many communities. On the contrary a pregnant woman diet is restricted both qualitatively and quantitatively, thus, precipitating or aggravating various nutrition deficits. Poverty in the village is greater, which results in the lower intake of nutritive food. In this Uttar Pradesh village, perhaps the poor intake of nutrition is much due to the traditional food-habits of the people. Being agriculturist, they have no idea of a balanced diet. One is apt to consume more pulse and vegetables than milk and curd. Most village-folk largely depend on wheat and rice. Corn and *bajra* preparation is usually excluded from their diet. It is only occasionally (rarely) taken. The ceremonial food-preparation also lacks nutritive value. Thus the food-habits appear to be largely responsible for an unbalanced diet in the region. Consequently, they result in the occurrence and

breaking out of several diseases. It is not only the intake of food, but also the norms of eating habits which are vitally important for good health. Norms of eating food and practice of serving the food among the family members are governed by traditional and cultural beliefs that females are subordinates of males. Even today, people in rural areas indulge in discrimination in the distribution of food-items between males and females within the family. The most obvious and commonest reason stated is that males need more energy as do hard manual work, and they are the bread-winners and chief earners in the family. Overall, it seems that cultural subordination of females in decision-makings is responsible for unequal distribution of food. The beliefs, customs, attitudes traditions prevalent among women folk cause various deficiency diseases. Approximately 97 per cent of women had wheat flour as a meal, nearly 88 per cent had rice, 87 per cent women use ***arhar dal***, seventy per cent use ***massor dal*** daily. Most nearly sixty per cent take cereal once in a day.

All the consume women grain, whereas three-fourth women consume pulses, approximately 70 per cent take vegetables, nearly 60 per cent women take milk/curd, nearly fifty five per cent take butter. More than ninety five per cent take sugar. One fourth of women take rest of less than 1 hour daily, and approximately forty five per cent of women take rest for 2-3 hour.

The concept of ‘hot’ and ‘cold’ food is quite familiar to all of us. Foods like eggs, ***Bajra***, and fruits like papaya, tubers are supposed to be ‘hot’ foods. All the fruits and vegetables like citrus fruits, cucurbits and green leafy vegetables and certain other foods like buttermilk, curd are considered to be cold foods. Little less than ninety five per cent women believe that deficiency of food is the cause of diseases, nearly 75 per cent women believe that family tension and anxiety is the causes of diseases, nearly three-fourth of women believe that improper care in childhood is the cause of diseases. Around 60 per cent women believe that seasonal change is the cause of diseases, one fourth of women believe that hereditary composition is the cause of diseases. Nearly fifty five per cent women believe that improper habit of taking food is the cause of diseases. Around fifty four cent women believe that improper storage of water is the cause of diseases.

Approximately fifty per cent women believe that bad sanitation is the cause of diseases, nearly 63 per cent women believe that malnutrition and food deficiency is the cause of diseases. We found in the present survey that three-fourth of women replied that preference is given to male for serving the food, approximately 93 per cent women replied that male need more energy. More than ninety per cent women replied that boys need more & better food than girls. Approximately 60 per cent women keep monthly fast, and nearly ninety three per cent women replied that they keep fast for their husband & son, and approximately 98 per cent women replied that they have fast for the goodness of their families.

Health is a composite concept which includes social, economical, physical and psychological well being. It is a state of balance in body, mind, social and spiritual well-being. Over a period of time health of the country has improved however, the good health of women is still a challenge in the country as maternal mortality rate is very high and nutritional levels is also not impressive. The improvement in the health and nutritional status of women is deterring by her poor accessibility to the health care facilities. It is further marginalized by the distribution and serving of food norms in the patriarchal system of community. The poor health infra-structure facilities provided by the state are also deficient which deter poor scheduled caste and backward caste women for upgrading their poor health status.

Thus, it is lower social status in the families, caste hierarchy and deficient health infra-structural provisions by the state government which are responsible for her poor health and nutritional status.