



Health status of women in Hudgi village of Bidar district in Karnataka

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Abstract

This study is designed to determine the Health Status of Women in Hudgi Village of Bidar District. The overall health status where health and economy have interdependency it find it's up and down gradients in women in Hudgi village. Also these appeals to it and also suggest remedies for any non-linear health distribution. Thought there was an overall improvement in the standard of living, disparities between people is directly linked economic efficiency educational status, accessibility to basic health services and also on political stability, social and cultural development. In Hudgi village women's are less educated and economically deprived, their health condition. In this context the present paper studies, Socio-economic status, Chronic Diseases and Preference of the Hospital, availability and accessibility of health care service, etc. For the present study 50 sample respondents are selected for the fact determining of women's health status in Hudgi Village, Bidar District, Karnataka.

Keywords: socio-economic and educational status, health status, chronic diseases

Introduction

India is a country where 70 percent of the population resides in a rural area and males significantly out number females, an imbalance that has increased over time. Indian women have high mortality rates, particularly during childhood and in their reproductive years. India's maternal mortality rates in rural areas are among the world's highest. From a global perspective, India accounts for 19 percent of all live births and 27 percent of all maternal deaths. The health of Indian women is intrinsically lined to their status in society, especially for those living in a rural area. Research into women's status in society has found that the contributions Indian women make to families are often overlooked. These factors have 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 weigh t infants. In rural areas where women are less educated and economically deprived, their health condition is worse.

When women are economically and socially empowered, they become a potent force for change. In rural areas of the developing world, women play a key role in running households and make major contributions to agricultural production. Polygamy, infanticide, child marriage, widowhood, rape, harassment, slavery, exploitation, child labour, subordination at home and outside, dependency, dowry, divorce etc. are some of the social evils affecting women of India. These practices have their direct or indirect impact on the health of women. Social and economic inequalities are fundamental causes of inequalities in health. Maternal and child mortality rates increase with decreasing income resulting in a twofold difference in mortality rates between those in the top annual income band and those in the bottom annual income band. Gender, caste and economic differences tell upon the health of women to a great extent in

the male-dominated society.

Poverty, inequality, and discrimination endanger women's well-being. Poverty is one of the most considerable stresses while attacking many potential sources of social support. Economic inequalities within societies are associated with reduced life expectancy and a variety of negative physical health outcomes. Discrimination maintains inequalities, condemns women to lives of lessened economic security, and exposes them to unmerited contempt.

Compared to men, women suffer more due to physical disability, obesity, pregnancy and childbirth, menopause, fertility problems, HIV / AIDS and depression. While middle and upper class women may be able to obtain treatment, lower class generally remain without diagnosis, ignorant of how to help themselves, and they suffer due to lack of treatment and medical facilities. If a physical problem is aggravated by emotional problems, any cure will be delayed. "When women are sick, there is no one to look after them. When men are sick, they can be looked after by women."(South Africa, Voices of the Poor). It is the condition everywhere.

Women's low socio-economic status can also expose them to physical and sexual abuse and mental depression with changing social values and economic pressure there is the growing number of young girls forced into prostitutions especially in poor roads and lacks of transports, as well as inadequate obstetric facilities, hinder women from receiving timely medical treatment for obstructed labour haemorrhage and other pregnancy-related.

Review of literature

Kelly (1993) ^[1] has stated that all the expenditure incurred for the direct cost was met out of pocket by the patients. Diabetes being a lifelong disorder is an expensive ailment for a very large proportion of subjects in developing societies. In the

Indian contest the financial burden is often shared by relatives of the patients. The money spent was from the family's financial resources. Although the amount spent by the upper and the lower class persons were similar, the percentage of the income spent was higher among the latter, due to their lower earning. Health insurance is not yet popular. Employee state insurance benefits although available, does not appear to be utilized fully. Lintel or no reimbursement of expenses was made by the employers of availed by the patients

Roshita *et al.*, (2011) [2] explored the possible relationship between maternal employment and child nutritional status. The present study employs a qualitative approach to explore the socio-economic and cultural environments that may influence child-care practices in families of working and non-working mothers with children of different nutritional status and types of domestic caregiver. The study identified five emerging themes, consisting of reason for working and not working support for mother and caregivers, decision makers on child food, maternal self-confidence and access to resources. It confirmed that mothers and caregivers need support and adequate resources.

Siegel *et al.*, (2008) [3] stated that India has the worst stunting and iron deficiency in the world and also the largest number of people with diabetes, representing a failure in the nutrition governance system. Many nutritional surveys are conducted throughout India, but they focus on under nutrition these should be expanded to include over nutrition. Food consumption patterns and trade and agricultural policies have changed encouraging over consumption of unhealthy foods and under consumption of healthy foods.

Heman *et al.*, (1993) [4] pointed out in this study about the health is fact a multi-dimensional phenomenon. The WHO defines health to denote a state of physical mental and social well-being and not merely the absence of disease of infirmity. The levels and distribution of income the social and cultural practices and perceptions, the choice of technology with its impacts on the occupational and natural environment, all these factors influences and are in turn influenced by the physical and mental health status of a society. Paul Appasamy presented a case study of the Madras metropolitan area to show the impact of urban environmental degradation on human health.

Zimmet (1992) [5] has pointed out economic loss due to chronic ill health is associated not merely worth the cost of care but tales a heavy toll in terms of loss in productivity. Economic burden of an illness can be divided into direct indirect and intangible costs. The per capital expenditure on health care in India is only 6.4 percent of the average world spending, while India accounts for 23.5 percent of the world disability adjusted life years lost due to diabetes. Due to scant resources and burgeoning cost, health care planners and providers are being forced to cut resources worldwide. Diabetes complication account for 60 percent of diabetes relates health care cost and almost 80-90 percent of indirect coats. For example, in 1986 the total cost of type 2 diabetes in the US was estimated at 20 billion dollars but it had increased to over 100 billion US dollars in the min 1990. This increase of over 5 times in a decade amount to about one sixth of India gross domestic product.

Objectives

1. To find out the socio-economic conditions of the sample respondents households.
2. To know the different cure information about various diseases of the sample respondents.

Methodology

Fore this study primary data were collected from the sample of 50 women from regarding, data information, income wealth, and expenditure on households, sample women about health care and cure information and Diseases information, Preference of the Hospital, Health Care Services Availability.

Analysis and Interpretation

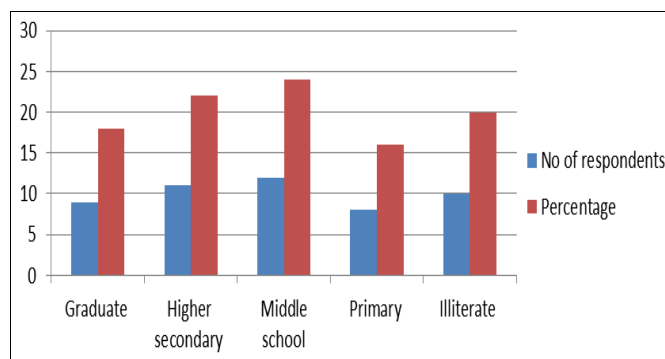
The Present study of health status of women in Hudgi village deals with the analysis and interpretation of the primary data collected from the 50 sample respondents.

Table 1: Age of the Respondents

S. No	Age	No of respondents	Percentage
1	21-20 years	20	40.0
2	31-40 years	15	30.0
3	41-50 years	12	24.0
4	Above 50 years	3	6.0
	Total	50	100.0

Sources: computed from the primary data

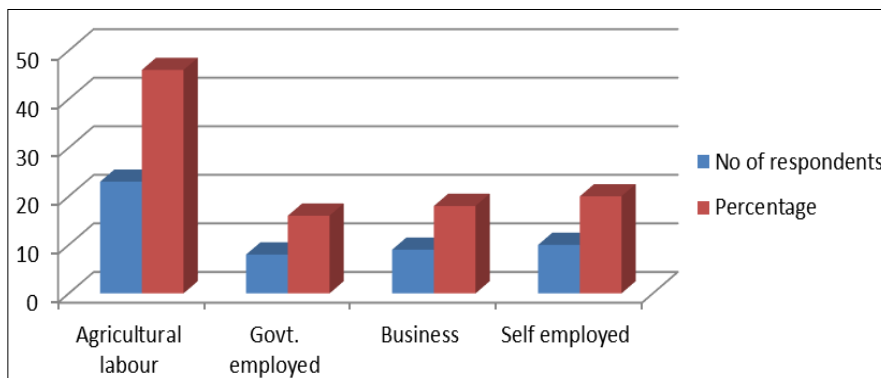
The above table-1 shows the age-wise classification of the respondents. The table reveals that 20(40.0 percent) respondents are in the age group of 21-30 years. 15 (30.0 percent) are in the age group 31-40 years. 12(24.0 percent) respondents are in the age group of 41-50 years and 3 (6 percent) respondents are in the age group of above 50 years. The research concludes that majority of the respondents are in the age group of 21-30 years.



Sources: computed from the primary data

Fig 1: Educational status of the respondents

The figure 1 shows the educational status of the respondents. Among the 50 respondents. 12(24.0 percent) respondents studied only middle school. Higher secondary are 11(22.0 percent) respondents. 10 respondents are illiterates and 9 (18.0 percent) respondents studied post graduate level. 8 (16.0 percent) studied only primary level. From this table we conclude that the majority of the respondents have studied up to middle school education.



Sources: computed from the primary data

Fig 2: Occupation of respondents

The above figure 2 shows the occupational status of the sample respondents. Out of 50 sample respondents, 23(46.0 percent) respondents are working as agricultural labours, 10(20.0 percent) respondents are self-employed. 9(18.0 percent) respondents working as business and 8(16.0 percent) respondents work as government employees. Majority of the women respondents are agricultural labours.

Table 2: Monthly income of the family

S. No	Monthly Income	No of respondents	Percentage
1	Less than Rs.2000	10	20.0
2	Rs.2001-4000	12	24.0
3	Rs.4001-6000	22	44.0
4	Above Rs.6001	6	12.0
	Total	50	100.0

Sources: Computed from the primary data

The above table 2 shows monthly income of the respondents. It explains that 22(44.0 percent) respondents income range is between Rs. 4001-6000., 12 (24.0 percent) monthly income is between Rs. 2001-4000. Again 6 (12.0 percent) respondents having a monthly income of above Rs.6001, and 10 (20.0 percent) respondents monthly income is less than Rs.2000.

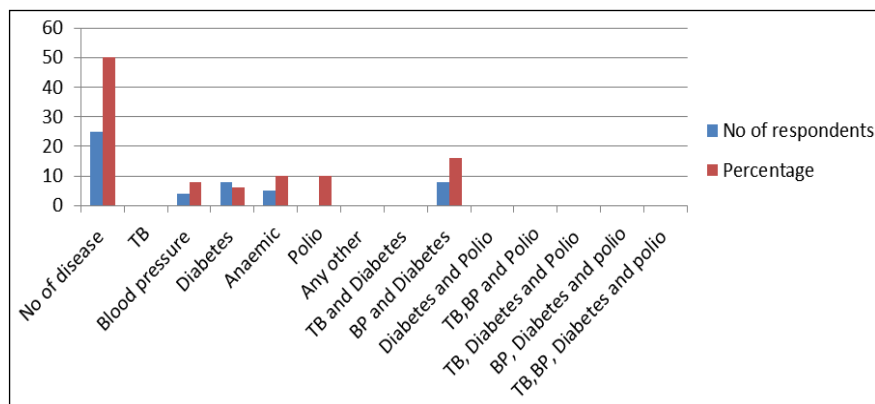
That majority of the (44.0 percent) respondents are having income range between Rs.4001-6000.

Table 3: Monthly health Expenditure

S. No	Health Expenditure	No of respondents	Percentage
1	Health expenditure	3	6.0
2	Less Than Rs.200	10	20.0
3	Rs.201-400	20	40.0
4	Rs.401-600	15	30.0
5	Above Rs.600	2	4.0
	Total	50	100.0

Sources: Computed from the primary data

The above table 3 explains the monthly health expenditure of the family. 20(40.0 percent) respondents are spending between Rs.201-400, monthly for health. 15(30.0 percent) respondents are spending between Rs. 401-600. 10(20.0 percent) respondents are spending less than Rs.200. 2(4.0 percent) respondents are spending above Rs.600, and 3(6.0 percent) respondents are spending nothing on health. The majority of the 20(40.0percent) respondents are having health range between Rs. 2001-400.



Sources: Computed from the primary data

Fig 3: Chronic Diseases in the Family

The respondents have given specify the diseases in primary health centre in. Out of the 50 sample women respondents, 25(50.0 percent) respondents have no diseases, 8(16.0 percent) respondents are having Diabetes, 4(8.0 percent)

respondents or Blood, 8(16.0 percent) respondents BP and Diabetes and 5(10.0 percent) respondents are having Anaemic, and other Diseases. The most of the respondents are having Blood pressure and other diseases.

Table 4: Preference of the Hospital

S. No	Preference of the Hospital	No of Respondents	Percentage
1	Govt. Hospital	15	30.0
2	Private Hospital	8	16.0
3	Both the Hospital	27	54.0
	Total	50	100.0

Sources: Computed from the primary data

The above table 4 explains preference of the hospitality. It shows that out of 50 samples. 27(54.0 percent) respondents use both private and Government hospitals. 15(37.8 percent) respondents use Government hospitals, only 8(16.0 percent) respondents go to private hospitals in the study area. Hence, people in the study area preferring Government hospitals more than private hospitals.

Table 5: Health care services availability of respondents

S. No	Nearest Health Care Facilities	Number of Respondents	Percentage
1	1 Km	35	70
2	1-2 Km	10	20
3	Above-2 Km	5	10
	Total	50	100

Sources: Computed from the primary data

The table 5 shows that health Care Services availability of respondents out of 50 samples. 35(70.0 percent) respondents using 1.Km. Health care service and 10(20.0 percent) respondents or using hospital in 1-2 Km and 5(10 percent) respondents or using above-2 km, majority of the sample respondents or health care service using is 1 km.

Findings

- Majority of the respondents (40.0 percent) are below the age group of 30 years.
- Majority of the (24.0 percent) women respondents have studied up to middle school education.
- Most of the (46.0 percent) women respondents are working as agricultural labours which are seasonal in nature.
- Most of the families (44.0 percent) are having income range between Rs. 4001-6000 monthly.
- More than (40 percent) of the respondents spending Rs.401-600 for health.
- Almost half of the respondents are having some diseases.
- Some of the families have chronic diseases (16.0 percent) like blood pressure and diabetes.
- Most of the respondents (54.0 percent) in the study prefer government hospitals than private hospitals.
- Most of the 35(70 percent) respondents are using health care services in 1Km.

Suggestions

- Primary health center facilities should be increased.
- Creating more knowledge to the women's for awareness.
- Number of doctors should be increased in primary health centre.
- Government has to connectable in providing nutrition for women.
- Primary health centre should give friendly treatment.

- Avoiding careless while handing the patient

Conclusion

Summing up, it may be said that women health vulnerable to diseases and special emphases may be given to this aspect of the problem. No doubt government schemes are helping in the rural women health. The quality of women health is necessary as a basis condition of social, economic and political development of the nation. But as everywhere in India there is the gap between intension and implementation poverty and ill-health are mutually related and work in vicious circle. Hence, side with women's health schemes, poverty eradication programmes should also toned up. The efforts of the government are in the right direction but the problems are ill-health. Expenditure on this an investment because the women's health of nation improves the wealth to nation.

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