CHAPTER VII

SUMMARY AND CONCLUSIONS

Women's social and health behaviours in various social and environmental settings affect their reproductive health and well-being. Reproductive health and Quality of life among women are major concerns to Medical Sociologists. This chapter presents a summary of the study, its findings, conclusions drawn and scope for future research.

SUMMARY

This interdisciplinary research study was undertaken by the investigator to determine the quality of life (QOL) and the reproductive health (RH) among women in the mining and non-mining regions. The objectives of the study were to: assess the reproductive health status among women in the mining and non-mining regions of Goa; assess the quality of life among women in the mining and non-mining regions of Goa; compare the reproductive health and quality of life perspectives between women living in the mining and non-mining regions of Goa; and investigate the association between bio-demographic as well as reproductive characteristics with reproductive health as well as quality of life among women. The study assumed that every woman is biopsychosocial in nature (i.e. has physical, psychosocial, emotional and spiritual aspects) and is in continual interaction with her family and the immediate environment. As QOL arises from these complex interactions, a sociological study is necessary for understanding it.

This is an empirical study, which uses an exploratory and comparative research design. The independent variable is reproductive health, the dependent
variable is quality of life, and the extraneous variables are the demographic, socio-economic, health, environmental, marriage, reproductive, psychosocial and couple characteristics. The data collection instruments were both qualitative and quantitative in nature. The instruments used for the study are: Ferrans and Powers Quality of Life Index Generic version (QLI), Reproductive Health Index (RHI) and Reproductive Health and well-being interview (RHW). Demographic and the socio-economic characteristics were inbuilt in the RHW tool. The QLI is a standardised tool. The other study tools, the RHI and the RHW were prepared by the investigator based on inputs through interviewing women, focus group discussions, discussions with experts and review of literature to determine the areas of relevance.

All the tools were translated to Konkani language and pre-tested. The tools were found to be valid and appropriate for the study. The pilot study was conducted with ten married women in Onda (Sattari taluka). The final data collection for the study was conducted over a period of four months in the selected villages. The participants in the both the mining and the non-mining regions were administered all the four tools (QLI, RHI, and RHW). Based on the objectives and the hypotheses, the data were analysed using descriptive and inferential statistics.

For the selection of a study area, a sampling strategy was planned in the rural regions in two stages using the available census list (an electoral list from the local panchayat and an enumeration list from the nearest health centers were used to identify eligible married women in the households) as a sampling frame. Pale, Surla, Velguem (Bicholim taluka) and Sonshi villages (Sattari taluka) have been selected as the mining community, Goa. Non-mining community included in the study are Poreim, and Querim (Sattari taluka). These villages formed the primary sampling units. Women in the households from these villages in the mining and non-mining
regions formed the secondary sampling units. Women from these households were randomly selected for representation in the study. A simple probability sampling method was used to select a sample of 278 married women in the reproductive age group of 15 – 45 years with 145 married women in the mining and 133 married women in the non-mining regions of Goa.

A brief review of literature was prepared on the basis of the secondary and published literature, which acts as a prelude to the presentation, interpretation and discussion of the research findings in the study. Literature regarding women’s lives in the mining regions, significance of RH and QOL are detailed in the text. In the Indian settings there is a dearth of research literature regarding inter-relationships between QOL and RH among women. The present study aims to fulfill this research gap by exploring influencing factors of reproductive health (RH) and QOL and the association between these two variables. Also the study compares RH and QOL among women in specific developmental activity like mining economic region (stressed) compared to a less stressed economic activity (agriculture). For the purpose of the study latter is conveniently termed as a non-mining region.

This study does not focus merely on morbidity, mortality, contraceptives, abortion, fertility, or reproductive infections among women without locating them in the overall social context of women in the mining and non-mining regions. Quality of life index and reproductive health index are used to measure areas that inhibit or promote women’s access and control over resources and reproductive choices. The results of the study were presented as women’s bio-demographic characteristics in four main areas: demographic, socio-economic, health and environment characteristics. Reproductive health and well-being status among women incorporates four broad parts: reproductive health, psychosocial health, reproductive well-being.
and couple support. Significant differences, association of determinants and correlation between QLI and RHI among women in the mining and non-mining regions are also examined in the study.

In the mining and non-mining regions most of the married women were in the reproductive age group 30-39 years. Most of the women belong to Hindu nuclear families. Women in the mining regions reported high exposure to dust from three main sources: heavy vehicular trucks overloaded with iron ore, mines sites and loading/unloading points. Women in the non-mining regions are primarily dependent on agriculture as a predominate economic activity. More women lived in the mining region for more than 20 years compared to women in the non-mining region (10-20 years). Long term stay in the region influences women's perceptions regarding QOL. Demographic characteristics among women in the mining and non-mining region are homogeneous.

Some of the women in the mining and non-mining regions completed secondary education. Less than a quarter of the women were illiterates due to poor socio-economic and traditional barriers (high cost, opposition, marriage and poor performance). There was equal representation of women in each educational category in the mining and non-mining region. More women completed elementary education in the mining region than in the non-mining region (middle school). Women had low education in the study.

Less than half of the women in the mining and non-mining regions worked before marriage. There were less working women in the mining region (involved in small family business) compared to those in the non-mining region (worked on agricultural lands) after marriage. Most of the married women were only housewives. More women in the non-mining region were working/earning outside home compared
to those in the mining region. There were few working and earning women in the study. Women had less access to economic resources and low participation in workforce.

Half of the husbands had middle school education while some were SSC. One third of the husbands had private service and some were in the mining jobs. More than half of the husbands earned within rs 4000/-. Women in the mining region were economically well off (husbands involved in mining jobs) compared to the non-mining region. More women in the non-mining region were in the middle and poor economic status (husbands involved in agricultural and private service), and some women owned houses and agricultural lands compared to women in the mining region. More women in the non-mining region were able to get financial help in times of need than women in the mining region. Some of the women were not able to meet emergency expenses. Women in the study had less control over economic resources.

Majority of the women in the mining region had access to private taps (fixed timing of water supply and reported reddish water) compared to women in the non-mining region (regular water supply and comparatively clean water). More women in the non-mining region obtained water from private taps compared to those in the mining region (bore well and ponds in addition to taps). More women in the non-mining region collected water within a short distance (less than 5 mins.) from their homes compared to women in the mining region (walk long distances). But women in the mining region reported irregular water supply, which delays most of their household and family tasks.

Majority of the women use a combination of biomass cooking fuels like wood, crop residues, and dung cake for indoor or outdoor cooking. Women in the non-mining region reported high exposure to indoor cooking smoke (use more wood and
dung) and burning of solid wastes compared to women in the mining region (discard waste in open places). In addition some women use LPG gas depending on economic ability and seasonal variation (monsoons), while some women in the mining region also use kerosene. Women in the mining region reported better housing conditions (pucca houses, in-house toilet, closed kitchen drains) than women in the non-mining regions. Most of the women are exposed to high fumes from the use biomass fuels and are unaware of its harmful health effects.

Majority of the women in the mining region reported poor air quality due to high dust exposure from ore laden trucks in the mining region. More women in the mining region perceived changes in water quality, reported loud sound/ vibrations from trucks passing through residential areas, physical stress from increased workload at home (like fetching water/ fuel wood) and land use changes (due to dumps and loss of agricultural fields). More women in the mining region reported use of biomass fuels compared to women in the mining regions (biomass and kerosene). Women in the mining region expressed changes in the quality of the home and surrounding environment. Housing and sanitation conditions were similar across women in the mining and non-mining regions.

Women in the mining and in the non-mining region had low education, low work participation, less access and control over economic resources. Women in the mining region had better socio-economic and housing conditions but poor environmental conditions than women in the non-mining region. But women in the non-mining region expressed higher satisfaction with various conditions in life and better quality of life (QLI) than women in the mining region. Quality of life index (QLI) among women was significantly higher with women’s age, years of stay, economic status and amount of illness in the mining and non-mining regions.
MAJOR FINDINGS OF THE STUDY

In the mining region the common illnesses reported among women were eye illness (eye irritation and allergy), psychosomatic illness (headaches/ weakness body aches/ tiredness) and upper respiratory illness (cold and dust allergy) compared to women in the non-mining region (also musculoskeletal illness like leg pain). Acute illness was reported more than chronic illness among women. Majority of the women in the mining region used curative health measures compared to women in the non-mining region (used preventive measures and alternative medicine). Equal percentage of the women in the study utilised government health care centers and hospitals due to a wide range of health care services (preventive, curative and restorative) provided at 'no cost’. Private health care services like doctor’s clinics and hospitals were also used among women. Women are not health conscious or aware of health seeking behaviours and preventive measures.

Age of menarche among most of the women in the study was 13-15 years and rest of the women had menarche less than 12 years. More women in the mining region had menarche 13-15 years compared to women in the non-mining region (less than 12 years). More than half of the women had premenstrual symptoms (PMS). More women in the non-mining region had PMS than women in the mining region. More women in the non-mining region reported excessive bleeding, abdominal pain and mood changes exacerbated by increased physical labour compared to women in the mining region. Nearly half of the women take rest to reduce their PMS in the mining and non-mining region. Menstrual problems are due to physiological and hormonal changes.

Increased women in the mining region had access to privacy and maintained menstrual hygiene compared to women in the non-mining region. Nearly fifty percent of the women in the non-mining region were not involved in any household work
during these days than women in the mining region. Socio-cultural factors and economic ability are linked to menstruation practices.

The most common family planning method used by married women was tubectomy (permanent form) and to a lesser extent temporary methods like oral contraceptive pills (OCP)/ condom/ Copper T in the mining and non-mining region. More women in the mining region reported use of contraceptives. Some of the women reported back/ neck pains, headaches, body aches and dizziness while using contraceptives. Overall there is a low usage of contraceptives, occurrence of side effects and low awareness regarding contraceptives among women in the study.

After marriage only few women reported excess vaginal discharge in the mining and non-mining regions. Majority of the women reported thick whitish discharge, while few women reported foul discoloured vaginal discharge. Majority of the women in the mining region reported excess thick whitish discharge and low abdominal pain compared to the non-mining region (discoloured vaginal discharge). Some women perceived changes in their reproductive health due to a myriad of risk factors that are described herein.

More than one-third of the women marry less than 18 years in the mining and non-mining region. The rest of the women in the region marry after 18 years. There was equal percentage of children borne to the women in both the regions. Nearly half of the women had less than two pregnancies. The rest of the women had more than three pregnancies. More than three quarters of the women of the sample had less than or three children. The rest had more than four children. These women tend to marry early, conceive early with short birth intervals and bear more than three children.

Most of the women had normal delivery, while few had a caesarean. Almost all women had an institutional delivery in both the regions. All women reported antenatal
problems (oedema, bleeding and headaches) and less than half of the women reported intranatal and postnatal problems in the study. More women in the non-mining region reported intranatal (labour cramps/ pain, nausea/ vomiting and excessive bleeding) and postnatal (leg pain, abdominal pain, excessive bleeding and vomiting) problems compared to women in the mining region. Women perceived changes problems during pregnancy and delivery due physiological changes that requires health care attention at times.

Women in the study did not take any extra care like nutritious diet, medicines (iron and calcium), vaccines, medical advise/ treatment, rest, or check ups (except during illness) during pregnancy. Most of the women did not increase their nutritional intake significantly; they just ate what they liked and what was available or affordable. Even when economic circumstances were more favourable, pregnant women ate whatever the family ate. Their dietary pattern consists of black tea, small breakfast, and two ordinary meals (vegetable/ fish curry rice). Lack of nutrition and health seeking behaviours was common among women during antenatal and postnatal period.

More women in the non-mining region had help from the husbands and maternal family for household work and to seek health care services compared to those in the mining region (emotional support). Women in the study had family support for household work, to seek health care services and emotional support from their husbands, in-laws and mother during antenatal-postnatal period. Women supported family and household tasks during pregnancy and postnatal period.

Women in both the regions view marriage and birth of a child as major events in their life. Women reported pleasant experiences associated with motherhood as new self-identity, respect and fulfillment in life. They further added that only after the birth of a child a woman’s life is complete and her life changes with regard to ascertaining
powers related to decisions over childcare and family responsibility. Gender preference (male child) is common among women due to lineage, family pressure and security.

More than half of the women reported reproductive health problems related to pregnancy, delivery, postnatal, contraception and menstruation during their reproductive life span. More women in the non-mining region reported reproductive health problems than those in the mining region due to early marriage, low education, and increase number of children and stress of child upbringing.

Ten percent of the women reported domestic violence by their husbands. While women in the non-mining region experienced physical harassment, women in the mining region reported emotional harassment. These women feared their drunken husbands as fights usually lead to emotional wars at home and broken families. Women in the non-mining region experienced more family disputes than women in the mining region. Women report that these arguments disrupt their family life. This has also mounted to emotional disturbances (fear) and mental depression among women in the mining and non-mining regions. A small percentage of the women reported mild physical ailments (aches and pains, headaches, body aches), mental tensions and psychological problems due to husband's alcoholism, family disputes, child care responsibility, and low family support. More women in the non-mining region expressed psychosocial problems than women in the mining region. Women were subjected to domestic violence at the hands of your husband or in-laws.

Few women reported discrimination at workplace like verbal abuse, misuse of authority, or aggressive actions that lead to injured self-esteem or respect. Overall few women reported problems at work, with neighbours or communities in both the regions. Most of the women interacted with others and participated in some social
functions. One third of the husbands took decisions regarding reproductive matters/choices while few couples equally participated in decision-making, while less than half of the women did not participate in decision-making regarding reproductive health choices like delay and avoiding pregnancy, spacing children, use of contraceptives, use of permanent family planning method and seeking health care in the mining and in the non-mining region. Women had low autonomy regarding reproductive choices.

Majority of the women have adequate emotional ties with their husbands in the mining region compared to women in the non-mining region. There was open couple communication with regard to family matters, financial expenditures, child’s future, home purchases and family functions. Majority of the women accept and support husband’s decisions. More women in the mining region accept husbands decisions compared to women in the non-mining region. More women in the mining region reported husband’s negative reactions (engagement in other behaviours) when they disagreed on certain issues compared to women in the non-mining region (mutually agree). Women in both the regions lack autonomy and decision making powers.

Half of the women reported major social or life events related to death of a loved one, marriage, pregnancy, delivery, children, socio-economic and spouse related matters shaped or change their present condition. These social interactions and factors impinge on their QOL. Majority of the women in the non-mining region were mainly concerned about children compared to women in the mining region (socio-economic and household situation). Women are primarily concerned about the security and future of their children and family.

Less than half of the women in the study expressed problems due to family, reproductive health, and environmental changes. More women in the non-mining
region reported reproductive and family/socio-economic problems compared to women in the mining region (environment related problems). Some of the women were satisfied and content in life, especially women in the non-mining region compared to women in the mining region.

Some women in the study had early marriage, early conception, high fertility, many children and less maternal health seeking behaviours. Women reported domestic violence in both the regions. Women in the mining region reported general illness and use of curative medicines due to easy access and availability of doctors. Women in the mining region had better menstruation practices and use of contraceptives. Women in the non-mining region expressed reproductive health problems compared to women in the mining region. But women in the non-mining region perceived higher satisfaction with reproductive health status and better RHI than women living in the non-mining region.

Women in the non-mining region had higher QLI compared to those in the mining region. Age, marital status, family economic status, presence of chronic illness, and acute illness are significant determinants among women in the study. Reproductive health index (RHI) among women was significantly higher with age, years of stay, economic status and amount of illness in the mining and non-mining regions. Age at menarche, absence of menstrual ailments, reproductive illness, age of marriage, absence of wife beating and domestic violence (family), and husband's support are statistically significant with RHI among women in the mining and non-mining regions.

There was a positive correlation between the QLI and RHI among the women in the mining and non-mining regions. Reproductive health is related to QOL among women in the study. Higher RHI leads to higher satisfaction and better well-being.
among women. QLI depends on reproductive health status among women in the mining and non-mining regions.

There is a dearth of studies in the field of Sociology of Medicine regarding reproductive health and well-being among women. Several medical sociologists, researchers and other authors cite social behaviours related to health seeking behaviours, marriage, sexuality, empowerment, autonomy, gender relations, and related aspects as influencing women’s reproductive health. Various research studies are taken into account and discussed for the benefit of supporting and comparing the results in Chapter four, five and six. A few studies are mentioned below.

Quality of life is influenced by social-cultural traditions and living conditions (housing, physical environment, social and psychological stressors in the family and at work, nutrition, and health care), which have in impact on women’s health status (Bhandari 2004: 123). Nutrition, access to appropriate health care, improved education and family planning affects women’s reproductive health (The Worlds Women 1991: 57). These factors determine her place within the family, the degree of her access to health care, education, nutrition and other accessories (Ramanamma and Prasad 1993). Social determinants like social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food, and transport influence well-being among women (Wilkinson and Marmot 2003).

Reproductive health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to all functions and processes (UN 1994). Women’s status and autonomy are crucial for reproductive well-being especially in patriarchal societies (Dyson and Moore 1983; Das Gupta 1987; Jeffery and Basu 1996). Low status of women is related to low education, early age of marriage, high rate of
reproductive morbidity (IIPS 2000). Women, who work at a regular job, earn money, and perceive that their contribution is a substantial part of the total family earnings. They have more autonomy than unemployed women (Youssef 1982; Sen 1990; Mahmud and Johnston 1994). Quality of woman’s lives is crucially linked to the quality of her relationship with her husband or children. This affects their reproductive health and well-being. All these factors contribute to or constrain quality of life among women.

CONCLUSION

Women in the mining region fare better in terms of family economic status (due to spouse job and income from mining related activities) and living standards than women in the non-mining region (middle/ poor class). The positive impacts of living in the mining region are virtually seen in the rise of the family socio-economic standards in general and also increased socio-economic standards among women in particular in the region. Mining avenue has created direct and indirect employment to spouses through small and medium business opportunities and skill transfer (semi-skilled jobs like driving).

While mining has created opportunities for men in the community, women’s employment options have shrunk in the region. There are no opportunities for women in mining as this is a male dominated sector. Mining competes with agriculture, which remains the only source of livelihood for many women in the rural areas. The main visible impact of mining has been on agriculture and forests, which has negatively, affected women, who have lost a productive opportunity. As men are absorbed in mining jobs or move to the towns in search of employment and better wages, women are left to tend the household tasks, childcare and elderly care.

Women in the mining region have better family economic conditions but perceive low satisfaction levels, “...due to unemployment and low income, we have
experienced no change for a long time”. Few women felt a change in their lives only when they ventured out of homes for social functions or visits. They remarked that, “If there is employment or income, change in life situations come automatically”. Women in the mining region reported more frequency of ill-health and use of medicines compared to women in the non-mining region. Most of these illnesses are gender specific as the consequences are worse for women due to gendered conditions of socio-economic and cultural barriers like poor nutrition/ sanitation, lack of water, economic costs of ill-health and inadequate access to health care.

Quality of life among women living in the mining region is at the cost of their health (more sick days, ill-health and low immunity), environment (poor air, water and land quality), common property resources (loss of land, forest, and fuel wood), and livelihood opportunities (loss of agriculture, horticulture fields and animal husbandry). Apart from the overall physical impact on women’s lives, there is also a socio-cultural impact such as spouse harassment, alcoholism, unemployment, stress, conflicts and gender inequality in the mining region.

Few women in the non-mining region actively participate in economically productive work or income generation activities. Majority of the women in the non-mining region perceive higher contentment linked to opportunities of livelihood for spouse and children. They remarked, “...money is required in this day to purchase amenities or comforts for the whole family and without money we can not live in this world”. These women reported extensive workloads with dual responsibility of farm (agriculture) and household labour, “...the horizon of our life starts at daylight and ends in twilight and continues again from night to day”.

Marriage and household tasks hinder women in the non-mining region from taking advantage of other opportunities—to continue education, work, earn income and
participate fully in family interests. Though women in the non-mining region experience day-to-day worries, disappointments and sense of sadness, they have a positive attitude towards life. They come to terms with continuous physical or emotional subservience as the spirit of self-sacrifice makes them happy and content with their 'lot' (women of similar class and caste). They perceive devotion, time, energy and effort spent for the family as a sense of accomplishment, thus accepting their status uncritically and feel satisfied in life.

Observance of fasting, use of folk medicine, religious ways, health practices, social beliefs, and cultural norms are deeply rooted among rural women in the mining and the non-mining regions. The perception of increased burden of living arises from gender division of labour where women are sole primary providers of collective resources such as water, sufficient food and fuel wood for domestic use, in addition to health care, children's education and unpaid family labour. Whether they are healthy or not, these women largely shoulder the family responsibility and are active both inside and outside their homes. These women are primarily involved in reproductive work comprising of childbearing and rearing in addition to household production like domestic tasks to guarantee the maintenance and reproduction of the labour force. It includes not only biological reproduction but also the care and maintenance of the current workforce (husband and working children) and future workforce (infants and schoolchildren). They are instrumental in providing comfortable family life.

In the study changes in socio-economic, educational, health and home environmental conditions affect women's QOL in the mining and non-mining regions. Yet women in the non-mining regions perceived better QLI than women in the mining regions. Access to resources (property and material possessions), couple relationships, children (education and marriage) and social security (regular income and jobs) are
basic essentials that influence women’s satisfaction with life. Important areas in women’s life in the mining and non-mining regions are marriage, husband (family income and decision-makers) and childcare (child bearing and rearing). Their sense of satisfaction is perceived by family support and happiness, social security and welfare, children education and marriage, and spouse’s job and income. Areas of least control for the married women in both the regions are education, job, motivation to work, control over resources, autonomy, empowerment, and decision-making.

The gendered distribution of roles or division of labour (central role in reproducing the social order) and power relations have reduced decision making among women and have forced them into positions of subordination. In the study it is evident that women’s low educational levels work load, social expectations, traditions and gender norms limits their work opportunities, participation in decision making and capability to shape their own lives. Cultural norms, gendered roles and spouse’s influence alter the way women make choices and affect their reproductive well-being.

In the mining and non-mining region women’s role in biological reproduction or procreation (childbearing/ child-rearing), low participation in social and economic production signifies gender division of labour within the household and in all spheres of life. Disruption of education among women leads to low participation in economic activity, in addition early age at marriage leads to early reproduction, childbearing, and powerlessness. The most important period in the life span of these women is the reproductive period, which extends from menarche to menopause; the intervening periods are marriage, pregnancy, childbirth and contraception. These conditions are determined by socioeconomic, cultural factors and utilization of health care, which vary among women in both the regions.
Some of the women in the mining and non-mining regions have early marriage, early conception and high fertility. Most of the women had a normal delivery and institutional care. More women in the mining region reported better menstrual practices and use of contraceptives compared to women in the non-mining region. Some women in the mining and in the non-mining region are exposed to domestic violence (physical/ emotional harassment) due to husband’s alcoholism and family harassment face a myriad of risk factors that affect their reproductive well-being.

More women in the non-mining region reported musculoskeletal, menstrual, vaginal, antenatal, intranatal and postnatal ailments compared to women in the mining region. These are reproductive health problems that originate during one stage and persist in the succeeding stages and are compounded by social factors. Symptoms, such as backaches and pain in the extremities, persist throughout live but are conceptualised differently. While in their youth pain is characterized as reproductive problems, in higher age groups among women, they are seen as aches and pains. Among women in the non-mining region, whose identity is still centered on their roles as wives and mothers, the experience of musculoskeletal illness/ pain is related to reproduction. Among women in the higher age groups, this pain is associated with work and ageing.

Woman’s vulnerability to reproductive changes at each stage in the life cycle adds stress. Many of these health problems are related to a particular life situation, e.g. continuous physical labour with little rest, inadequate nutrition (deficiency of specific nutrients), lack of supportive care, amount of illness, fatigue and inadequate health care. Although these difficulties take the form of biological disorders, social factors play a major part in causing them. Their health constraints affect their choice/
initiatives, family and social roles. Gender discrimination, family attitudes (use of contraceptives, early marriage, early conception and sole burden of childcare), access to health care, social support heightens women's vulnerability during the reproductive years.

During pregnancy women face specific problems and are not able to recognise danger signals during pregnancy, though the proportions of deliveries assisted by health care provider have increased in the mining and non-mining region. They remarked that, "pregnancy is a special problem because of the big change that takes place when a woman conceives and then bears children...she remains unwell for nine months". They perceive various difficulties and problems during these stages, which require spouse and family support, "...especially cultural connotation about everything". General health problems were perceived as curable in a few days, but changes in pregnancy persist for nine months, as they are not able to consume medicines. These women in both the regions attach significance to specific health problems in relation to pregnancy, childbirth and postnatal care, as it entails the health of the foetus and the unborn child. Self-care, family assistance and support are crucial during these stages.

Early age at marriage among these women determines the duration of time exposed to the risk of pregnancy and reproductive illness. Women's capacity to conceive and bear children brings them to the arena of the health care more often than men in the study. Very often they are healthy but are either seeking access to fertility control or support during pregnancy. However, these 'natural' processes sometimes take an unnatural course, causing problems that require health care. During pregnancy, childbirth, and the post-partum period women's circumstances, diet, work load, rest and conditions at delivery have a strong influence on reproductive well-being.
Marriage and birth of a child play a major role in women's life in the mining and non-mining regions. There is strong son preference with its roots in social mores, which contributes to increase in 'wanted or unwanted fertility' is primary cause of abortion (hidden) in the mining region. Women attach emotional and psychological connotations to the issue of either 'having children' or 'not wanting to have more children'. Some women have no freedom to choose or to make decisions on —when to have children, how many children, what kind of children (girls or boys) or where and when to access health care.

Low fertility has decreased the share of the burden borne by few women in these regions. Though the number of children has declined women have low participation in workforce, less earnings and less access to economic resources. As such they depend on spouse earnings to live and raise children. In addition they have low autonomy and control over decisions that affect them as they are tied with disproportionate bearing of the costs of child rearing. They lack freedom to be active in directing their own life.

Women in the mining and non-mining region view marriage as a means of security in terms of positive aspects like improved standard of living, approval and respect from others, feeling of self confidence and overall happiness, though they expressed lose of freedom to do things they enjoy. They lack freedom to be active in directing their own lives. It is perceived as stability of union and welfare of children in nuclear families. Marital relationships in joint family minimise intimate, harmonious and egalitarian interactions between the spouses in the mining and non-mining regions. While their spouses view marriage more in terms of responsibilities and duties rather than companionship. This acts as an inhibiting factor in forging an equitable and mutually satisfying relationship among spouses in both the regions.
In the study there is a strong emphasis on fertility and motherhood, as a woman’s role in the family is primarily child bearer, especially once she is married in both the regions. Gender specific roles are viewed within the sanctity of marriage and family life. Family related processes such as marriage, childbirth and child rearing are social stressors impinging on women’s social well-being in view of the cultural imperatives. Socio-cultural factors including marriage duration of marriage, economic constraints, living environment, limited private time and others are associated with changes in the level of happiness in marriage, which promotes or hinders family stability among these women.

Women in these regions primarily bear the grunt of reproductive labour and succumb to dependence on practices associated with poor lifestyle and low well-being (e.g. depression, worry, tension, and feeling low) in the study. Starting from the most intimate social labour, i.e., reproductivity and child rearing, it is seen that women have low autonomy or control over her reproductive choices, sexuality, fertility as well as on the major decisions regarding the upbringing of her own children.

Women in the mining and non-mining regions experienced reproductive-health problems, vulnerability during childbearing years, spouse harassment and family problems. Culture, education, work, exposure to health services, access to mass media, women’s pre-disposition, child bearing, decision making and amount of illness during the reproductive age place undue stress on these women. Low employment opportunities, educational attainment, access to land, credit, and income leads to low autonomy among women and lack of control over reproductive health choices. These dimensions are shaped by gender bias and inequity leading to low autonomy among women. Even if women have equal economic and social resources like their husbands, socio-cultural norms regarding appropriate women’s behaviour internalised since
childhood prevent these women from resisting husbands continuing power over reproductive health and well-being matters.

Socio-cultural norms related to attitude towards marriage, number of children, sex of the child, age of marriage, the value attached to fertility, ability to obtain health services, and use of contraceptives affect women’s reproductive well-being in both the regions. Education, income, place of residence, pattern of family organization and the ideal role demanded of women by social conventions and values also play a significant role. Low education and restricted mobility deprives women of information about their rights, cultural notions about women’s bodies contribute to practices that result in continuing ill-health, environmental factors increase women’s workload and drudgery and have adverse effects on their health.

Low education, increased number of children to enable the family to diversify incomes, poor nutrition, stress and weak role in decision-making related to reproductive matters take a toll on women’s physical and mental health and well-being in both the regions. Women in both the regions are to a less extent socially and domestically oppressed than women in other parts of the country, a situation, which provides them access to education, and health care. But the fact that women still occupy low positions in spite of better conditions within social and domestic hierarchies—by virtue of gender roles alone—has social and health implications at various reproductive life stages.

This study highlights the prevalence of gender roles (biological and social reproducers) primarily through the role first as wife and child bearer and second as caretaker that continue to prevail among married women and the patriarchal societal structures and pressures (marriage, fertility) that uphold them, which does not make them autonomous. In the present study vulnerability, lack of autonomy, unequal social
status and limited access to economics resources inhibit woman’s capacity to seek health care. Socio-cultural, health, marital, reproductive, autonomy, pre-disposition and well-being factors affects women’s health ideals (Murray 1998).

Reproductive behaviours, fertility, maternal experiences and couple relationships affect women’s reproductive well-being in these regions. Women in the mining region reported lower subjective satisfaction levels than the importance levels (health ideals) related to quality of life (measured by QLI) and reproductive health (measured by RHI). They had similar if not better socio-economic and reproductive status than women in the non-mining region. Since their health ideals were higher, so their satisfaction level with QLI and RHI were low. Ironically women in the non-mining region reported equal and higher importance and satisfaction levels with QLI and RHI. They also reported slightly higher satisfaction with QLI and RHI compared to women in the mining region.

Women in the mining region report similar satisfaction levels as they share similar health ideals. But women in the mining and non-mining regions have varying satisfaction levels as they have differing health ideals. Women in the non-mining region were satisfied with the QOL and RHI domains that they considered to be of relatively fair importance in life, and maintained a satisfactory overall QOL and RHI. Women in the mining region had low satisfaction with the QOL domains, which they considered to be of great importance, this contributed to their low overall QOL. The qualitative narratives are validated and supported by quantitative results in the study. At the same time, this study supports the argument that women in the non-mining region are at an advantage in terms of decision-making and access and control over economic resources compared to women in the mining regions. What is very clear when women from both the regions are considered is that, for all spheres of life
related to satisfaction and importance, women in the non-mining region exhibit far better levels of RHI and QLI than women in the mining region.

How women perceive their quality of life and reproductive health in the mining and non-mining regions depends on economy, education, employment opportunities and participation in decision-making. Better reproductive health and well-being among women in early reproductive life leads to improved QOL. This reiterates the argument that QOL and RHW are dynamic in nature and are dependent on social and cultural behaviours among women in rural mining and non-mining regions. Reproductive well-being is inextricably linked to women’s reproductive status, freedom, status and autonomy. As reproductive health status improves quality of life among women also increases.

From the study it is evident that women’s low education, low social and economic participation, lack of access to material and financial resources, poor physical and mental health and early marriage influence their role functioning and work productivity. Physical/ emotional ill-health, low use of contraceptives and gender preference among women stems from gender division of reproductive tasks like biological reproduction, workload, and child care. In conjunction spouse harassment, lack of bargaining or negotiating capacity, poor social participation and family disharmony disrupts couple relationships and leads to low reproductive well-being among women. The findings show that reproductive health issues are paramount concerns among married women in the rural mining and non-mining regions of Goa. The findings accentuate that continued dominance of reproductive health issues plays a role in women’s social status, self-esteem and self-worth.

Women’s low autonomy and bargaining or negotiating capacity has a significant impact on the demographic and health behaviours by altering women’s
relative control over fertility and contraceptive use and by influencing their attitudes (number of children) and abilities (obtain health services for themselves and their children) in the mining and non-mining regions. Women’s autonomy/empowerment is the key pathway linking bio-demographic characteristics (socioeconomic, cultural and health factors) and reproductive health (fertility, marriage, couple processes, quality of care during pregnancy and ability to exercise reproductive choices) in the mining and non-mining regions.

This study highlights important socio-cultural factors and behavioural practices that affect reproductive health and well-being among women. The study also establishes the relative importance of social and health aspects of reproductive health and quality of life among women and the potential impact of reproductive health on quality of life among women in the mining and non-mining regions of Goa.

LIMITATIONS

The researcher could identify the following limitations.

1. There is a low representation of women belonging to marginalised social class, education and ethnic backgrounds in the present study. In the general population, women belong to heterogeneous groups. Inclusion of women from heterogeneous population increases generalizability of the study findings. A stratified random sampling of a representative group of eligible women in the population could have overcome this limitation.

2. In-depth ethnographic studies could have enhanced the interpretation of the findings in addition to the qualitative interviews undertaken in the study.

SCOPE FOR FURTHER RESEARCH

Several research studies regarding reproductive health among women undertaken in India emphasise quantitative figures and ignore qualitative aspects
related to everyday life situations. This is a research area related to sociological aspects among women, which has been probed in a small way and in which much can be further explored through ethnographic research.

Based on the study, the following recommendations for further research have been made.

- Further sociological studies among women of various groups to conceptualize and analyze finer aspects of reproductive health and well-being.

- A correlation study could be undertaken to assess the psychosocial correlates (such as, autonomy, empowerment, decision making, gender) among women in various environments.

- The study can be replicated in various settings on a large scale for married women to increase the validity and generalisation of the findings.

- An exploratory study of the knowledge, attitude, practices, beliefs and reproductive behaviours among women could be assessed.

- A comparative study on determinants of QOL and RH among women with different socio-cultural backgrounds could be pursued.