CHAPTER II
THEORETICAL BACKGROUND AND REVIEW OF LITERATURE
II

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This chapter is classified into two sections: Section A deals with Theoretical Background and Section B deals with Review of Literature.

Section A

THEORETICAL BACKGROUND

INTRODUCTION

Women constitute almost 50 percent of the world's population. Most of the World's women live in low-or middle-income countries commonly assumed that the most is women, a wife, a cook, a teacher of her children and daughter-in-law and so on. Women considered the second sex, the lesser sex, the weaker sex. Various cultural values have for centuries assigned women a lower status than men in society. The girl is seen as a liability, a drain on the family's resources. Naturally she herself grows up in this hostile environment with a poor self-image and regards her own daughter in the same light.
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When a son is born, sweets are distributed to announce his birth. When a girl is born, the sound of tears rests the air. Sons are seen as an asset, essential to light funeral pyres, to ensure the continuation of the lineage, and provide economic support to their parents in the latter's old age. The girl is seen as a liability, a drain on the family's resources. Naturally she herself grows up in this hostile environment with a poor self-image and regards her own daughter in the same light.

Women are not only present workforce she is producer of future work force. Women is the mother of the race and liaison between generations. It is the women who have sustained the growth of society and molded the future of nations. In the emerging role of play. They can no longer be considered as mere harbingers of peace, but are emerging as a source of power and symbol of progress. Women have now taken up professional roles in order to create a meaning for themselves. The traditional role of a house wife has gradually changed into working women and house wife. Some of the factors are responsible for this change. These are better education, changing socio-cultural values and need for supplementary income.

Women's are injustice under the influence of patriarchy. The problem in the patriarchal society is not only on the ground.
of biological functions but also the misinterpretation of values prescribed to males and females. It is absolutely agreeable that because of our society's patriarchal nature, women status is lower than men.

Though nobody can deny the fact that Indian women have stomped almost all male bastions. She is entering into new fields including administration. Science and technology, medicine, journalism and the like but still they are in minority. Thaw number of women in top position is still low and also illiterate rural women's still work in agriculture and their related activities. It means they will involving physical work. Women education is determine their self-reliance and internal strength to determine choices in life.

**WOMEN AND NUTRITION**

Despite the fact that food production has increased over the decades, malnourishment is a major problem and a majority of Indian women belonging to the lower socio-economic strata are undernourished. Within households, the available food is distributed according to the status of the individual rather than according to nutritional requirements. Women and female children usually receive what is left over. In a study by 'a systematic sex bias was reflected in higher deprivation of girls
vis-a-vis boys. At every level girls were systematically more undernourished. Women in general and pregnant women in particular have special nutritional needs. They need three times more iron than men to replace iron lost during menstrual bleeding. Pregnant and breast-feeding women need twenty times more. Pregnancy also demands an extra 150 calories per day in the first three months much more during breast-feeding (WHO estimates put the figure at 550 calories). Women also need sufficient calcium, especially during childhood, pregnancy and after menopause. Insufficient calcium in a girls child can lead to poor development of pelvic bones resulting in difficult childbirth due to obstructed labour: in later years it can lead to frequent broken bones and a bone condition called osteoporosis. Women also require more iodine for their own health and that of their children; insufficient iodine, especially in an already deficient mother, can result in poor foetal brain development, which leads to the birth of cretins, deaf-mutes, mentally sub-normal children, children with speech defects and defects in coordination and movement.

Once a girl child is born, the cycle of under-nutrition begins. The female infant receives less breast milk and is led at longer intervals than boys. As young children girls, along with
their mothers, eat last and hence the females, resulting in poorly-developed bones and muscles and low body weight and height. Although the caloric requirement of adults is 2,200 calories, the average intake among men is 1,700 and even lower (1,400) among women. This discrepancy is further sharpened when we recall that the caloric requirements of pregnant and lactating women are even higher.

Thus, under-nutrition does not merely make a person tired and weak. It predisposes one to innumerable infections, worsening an already fatigued state. Add to this the heavy burden of work that women bear both within and outside the home.

HEALTH

The Generally accepted definition of health is "a state of complete physical, mental and social well being and not merely the absence of diseases or infirmity", used by the World Health Organisation (WHO) since 1948.

The above quote made by the WHO, makes us rethink about our health status we generally think that our physical body represents our health status. But actually the mental and emotional status makes up the health of the physical body.
Health is the topmost priority in every individual's life. Its importance is evident in old saying “Health is Wealth.” Health is not only important to lead a happy life for an individual but also necessary for all productive activities in the society. The whole development cycle of a person depends upon his intellectual caliber, curiosity and constructive thinking but all these qualities depend upon his good health. Therefore, it is necessary to ensure healthy citizen to have healthy society.

Health is complex and dependent on a host factors like profound and multifaceted implications on health. Women’s live experiences as gendered beings result in multiple and significances interrelated health needs. Women generally live longer than men because of both biological and behavioural advantages. But these advantages are overridden by gender-based discrimination. Moreover, women’s longer lives are conditions that only women experience and whose potentially negative impact only they suffer. Some of these such as pregnancy and childbirth are not diseases, but biological and social processes that carry health risks and require health care.

Health status is a key indicator of human well-being. The health of the people does not depend only on the number of doctors and hospitals, but also on clean and safe environment.
Environmental pollution affects human health in many ways and contributes to a wide variety of diseases. The World Summit on sustainable Development (United Nations, 2002) had identified health as an integral component of sustainable development and called for more efficient, equitable, accessible and appropriate health care system for the population. Poor are the agents and victims of environmental degradation (World Bank, 1992).

In 1986 the WHO in the Ottawa Charter for Health Promotion said health is "a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities".

Overall health is achieved through a combination of physical, mental, emotional, and social well being.

**ASPECTS OF HEALTH**

Following are aspects of Health status:

1) **Physical Health**

Physical fitness refers to good body health, and is the result of regular exercise, proper diet and nutrition and proper rest for physical recovery.
A strong indicator of the health of localized population is their height or weight, which generally increases with improved nutrition and health care. This is also influenced by the standard of living and quality of life. Genetics also plays a major role in people's height. The study of human growth, its regulators, and implications is known as Auxology.

2) Mental Health

Mental health refers to an individual's emotional and psychological well-being. "A state of emotional and psychological well-being in which an individual is able to use his or her cognitive and emotional capabilities, function in society and meet the ordinary demands of everyday life."

One way to think about mental health is by looking at how effectively and successfully a person function. Feeling capable and competent; being able to handle normal levels of stress, maintain satisfying relationships and lead an independent life; and being able to "bounce back" or recover from difficult situations, are all signs of mental health.

DETERMINANTS OF HEALTH

The LaLonde report suggested that there are four determinants of health including human biology, environment,
lifestyle and heath care services. Thus, health is maintained and improved not intelligent lifestyle, and healthcare services. Thus, health is maintained and improved not only through advancement and application of health science, but also through the efforts and intelligent lifestyle choices of the individual and society.

A major environmental factor is water quality, especially for the health of infants and children in developing countries. Studies show that in developed countries, the lack of neighborhood recreational space that includes the natural environment leads to lower levels of neighborhood satisfaction and higher levels of obesity; therefore, lower overall well being. Therefore, the positive psychological benefits of natural space in urban neighborhoods should be taken into account in public policy and land use.

HEALTH MAINTENANCE

Achieving health and remaining healthy is an active process. Effective strategies for staying healthy and improving one’s health include the following elements:

Nutrition
Personal health depends partially on the social structure of one's life. The maintenance of strong relationships is linked to good health conditions, longevity, productivity, and a positive attitude. This is due to the fact that positive social interaction as viewed by the participant increases many chemical levels in the brain which are linked to personality and intelligence traits.

**Sports nutrition**

Sports nutrition focuses the link between dietary supplements and athletic performance. One goal of sports nutrition is to maintain glycogen levels and prevent glycogen depletion; another is to optimize energy levels and muscle tone. An athlete's strategy for winning an event may include a schedule for the entire season of what to eat, when to eat it, and in what precise quantities (before, during, after, and between workouts and events).

**Hygiene**

Hygiene is the practice of keeping the body clean to prevent infection and illness, and the avoidance of contact with infectious agents. Hygiene practices include bathing, brushing and flossing teeth, washing hands especially before eating, washing food before it is eaten, cleaning food preparation
utensils and surfaces before and after preparing meals, and many others. This may help prevent infection and illness. By cleaning the body, dead skin cells are washed away with the germs, reducing their chance of entering the body.

WOMEN AND HEALTH

Since the last few decades, women's health has been receiving special attention all over the world. Today women's health is becoming a distinctive area. Why should it be separate from the rest of health? The answer is twofold. As an area devoted to women's health, it makes findings about women's health matters faster, and it focuses directly on topics that are major health concerns for women. Although women and men share many health problems, women also have their own health issues which deserve special consideration (V. Basil Hans). Any attempt to build or study a discipline should regard women's health as traditional as well as modern definitions. Traditionally, women's health was thought to include only issues of childbirth and reproductive health, and the early definitions, therefore, were based on the biomedical model. Thus, women's health was defined as health issues specific to female anatomy and included menstruation, childbirth, menopause, and breast cancer (Wikipedia, 2008). The biological model in health
research, however, is biased to women issues in that they minimize them into anatomical and physiological factors (Thomas, 2007):

Recent definitions encompass a broad range of influences and issues about women’s health. They recognize all diseases and disorders that affect women, include an awareness of the impact of social, cultural, economic and political influences and emphasize prevention as well as treatment (Shaw, 2008; Goldman and Marureen, 2000). The modern definitions include medical situations in which women face problems not directly related to biology for example gender differentiated access to medical treatment (Wikipedia, op.cit.). The National Academy on Women’s Health Medical Education states that women’s health is devoted to the preservation of wellness and the prevention of illness in women; it includes the empowerment of women to be informed participants in their own health care; and recognizes the importance of the study of gender differences. Similarly the American College of Women Health physicians defines the practice of women’s health care as:

“A sex and gender-informed practice centered on the whole women in the diverse contexts of her life, grounded in an
interdisciplinary sex-and gender-informed bio-sychosocial science"

Along the same lines Lalith Farid Gulli in her essay on women's health in the Gale Encyclopedia of Medicine (2002) defines women's health as,

"The effect of gender on disease and health that encompasses a broad range of biological and psychosocial issues".

The Society of Women Health Research in the United States, defines women's health more broadly than issues specific to human female anatomy to include areas where biological sex differences between women and men exist. It says that research has demonstrated significant biological differences between the sexes in rates of susceptibility symptoms and response to treatment in many major areas of health, including heart disease and some cancers (Goldman and Mavreen, op. cit.; Wikipedia, op. cit.). The Women's Health Office in McMaster University's Faculty of Health Sciences defines women's health as involving:

"Women's spiritual, emotional, cultural, and physical well being and is determined by the social, political, cultural and economic context of women's lives, as well as biology."
It further states that, "in defining women's health, we recognize the validity of women's life experiences, and women's own beliefs about, and experiences of, health. We believe that a women should be provided with the opportunity to achieve, sustain and maintain health, as defined by the women herself, to her full potential. Thus, the modern view of women's health is comprehensive in reference and analysis to include besides epidemiologic perspective, the social, environmental, occupational determinants of health, diseases and disorders. The concept brings with the birth of girl child, goes through women's entry into reproductive years to midlife, and to her aging".

Multi-sectoral approach defines "Health as a complex web of environmental, social, economic and individual factors which are interrelated with each other". Women health is critically affected by social and economic factors, such as access to education, household wealth and place of residence. Women's health status varies widely both within among countries because of such factors as local disease prevalence, health-related behaviors and women's educational attainment, exposure to health information influence on decision-making, and access to health care, poverty, environmental degradation, civil conflict, and migration also influence women's health.
Women in all parts of the world face a heavy burden of ill-health linked to sexually transmitted infections including cervical cancer. Women are particularly vulnerable to infections for both biological and social reasons they may be unable to obtain the knowledge they need to protect themselves or may not be in a position to use it.

Vast and socio-culturally heterogeneous country like India, women's multiple and often special needs are played out on a variegated terrain of age, caste, class and region resulting in a complexity of experiences. Traditional bases of social stratification such as caste and class reproduce themselves in women's lived experiences, as also do rural-urban and regional disparities. Risk factors in women's lives Health is socially determined to a considerable extent. ‘Lived experiences’ of women in India are palpate with potential risk factors that have implications for their lives and well-being. The multiple roles of household work, child rearing and paid work that women carry out has implications for their physical and mental health.

There may be gendered risks to women's lives in the home environment. In India, a vast majority of the households rely on bio-fuels (wood, dung, etc.), for cooking being a female preserve in the household domain, the pollutants arising from the
burning of such bio-fuels affect women (and young children) disproportionately, with consequences on their health—respiratory tract infections, blindness and asthma being some of diseases that affect them (Parikh, Smith and Laxmi, 1999, also, Gopalan and Sakseena, 1999). Women’s especially those in rural areas use traditional solid fuels, such as crop residue, cow-dung and firewood, to meet their cooking needs. The burning of solid fuels indoors in open fires or traditional cooking stoves (chulhas) results in high levels of toxic pollutants in the kitchen area. As such, the use of these fuels is considered a major risk factor for lung cancer as well as cardiovascular and respiratory disease (WHO 2002). Contagious, infections and waterborne diseases such as diarrhea, amoebiasis, typhoid, infectious hepatitis, worm infestations, measles, malaria, tuberculosis, whooping, cough, respiratory infections, pneumonia and reproductive tract infections dominate the morbidity pattern, especially in rural areas.

Women in India especially those in rural areas bearing double burden on their shoulders, have never publicly voiced their concern over health needs. Even in urban areas where infrastructures and physical access to public health services is relatively far better, women get a raw lead. Even women’s general
health needs do not get the necessary attention. Many studies have indicated that women carry a high burden of chronic ailments in the absence of care or total neglect of illnesses. This situation is mainly due to women's health needs getting the least priority in the family. Gender bias in nutrition and health care in childhood, early marriage and conception, lack of voluntary check on family size and poor state of pre-natal and maternal health care services only intensify women’s health problems.

The negative effect of poverty is even more acute because of the existing gender bias against women. Poverty also leads to the belief that more mouths to feed also mean twice the number of hands to work. Thus, due to poverty, illiteracy and lack of awareness, children are considered as economic assets, this in turn results in the worsening health conditions of women.

**Determinants of Women’s Health Status**

- Individual behavior and
- Psychological factors
- Biological
- Social, Economic and Cultural

However, women's health determinants extend far aspects such as water and sanitation; workload income and livelihood;
and food are direct and recognized determinants of women’s health. Underlying these are factors of discrimination, violence, decision making, choice and mobility, which shape women’s health status and access to information and services.

**STRESSORS FACED BY MOST WOMEN IN INDIA**

- **Economic stressors:**
  
  Inadequate food for family

  Inadequate financial resources for other basic needs-
  shelter, health and clothing

- **Social stressors:**
  
  Women’s low status in family and society

  Purdah system.

- **Cultural stressors:**
  
  Oppressive interpretation of myths, stories.

  Harmful food taboos, especially during pregnancy
  (lactation)

- **Occupational stressors:**
  
  Insufficient wages and earning opportunities.

  Exploitation at work-economic, physical, sexual,

  Work overload and ignored occupational hazards.

  Migrations of self or husband.
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- **Family stressors:**
  - Status in family
  - Early marriage
  - Role expectations
  - Physical/sexual stress and violence
  - Inadequate food,
  - Work overload.

- **Personal stressors:**
  - Poor self-image
  - Frustration due to unmet needs and desires
  - Anxiety/insecurity due to physical safety
  - Deprivational stress due to loneliness

Women health play an important role in the family. As mother, her health has intergenerational effects. Since she is the chief care provider, her poor health has an immediate adverse effect on her family.

The emphasis of the social model of health on a positive concept of health contrasts with the traditional biomedical view. This has been more concerned with biological factors in the production of illness and disease and with ways of improving diagnosis and treatment once illness and disease have occurred.
WORK RELATED WOMEN HEALTH PROBLEMS

Women in the developing world spend most of their time working at survival tasks of maintaining the household and at income-generating tasks, both of which are essential to keep family and economy alive. The latter tasks for women include a long list of activities—ranging from agricultural produce processing, weaving, spinning, beedi rolling, block printing, soap making, packaging of medicines to running day care centres, typing, etc. A large number of these tasks are performed within the home where women work as price rate workers under exploitative conditions. These home-based workers are in fact ‘invisible’ as their work is not recognized as productive and majority of them do not appear in census or other official statistics as workers. Low wages, long and erratic working hours, a deplorable working environment, absence of worker’s union, coupled with the survival and reproductive tasks can only have adverse consequences on women’s health.

Subsistence agriculture is almost exclusively the domain of women in developing countries. They are usually responsible for sowing, weeding, crop maintenance and harvesting, tasks more grueling than those handled by men. Where cash crops...
grown, besides mechanization and the use of HYVs which entail more work for women, they are especially vulnerable during pregnancy to the increased and often injudicious use of dangerous chemicals and fertilizers. The intensive use of fertilizers can contaminate the water sources. Further more, with increased irrigation the water- table is rapidly depleted, forcing the women to travel long distances in search of water for household consumption. Carrying loads of water weighting as much as 25 kg on the head leads to postural defects, to arthrosis (a degenerative form of rheumatism) or cyphosis (a permanently bent back). Broken bones and fractures, pro-lapse of the uterus and miscarriages are a few of the other hazards associated with transporting the day's water supply.

Add to this the arduous task of collecting fuel wood for their energy supply. Often women spend five hours each day in search of fuel wood and carry home up to 35 kg over a long distances. Not only this is damaging to the spine but also causes problems during childbirth. Already undernourished, the physical burden of work further deteriorates their health. Where cattle dung and crop residues are the sources of energy, the problems are no fewer. Women spend more time feeding the fire and longer hours cooking. Constant exposure to biomass fuels
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has devastating consequences-benzopyrene is a by product of biomass that is expelled in quantities comparable to inhaling the smoke of twenty packets of cigarettes. It has been associated with nasopharyngeal cancer, acute bronchitis and pneumonia, and often death. Women who work in close proximity to chemicals-in agriculture or in industry are at severe risk of the process called mutation. Certain chemicals can change the genetic make-up of cells, and mutation in sperm and ovum cells causes birth defects in the unborn foetus, spontaneous abortions and stillbirths. In the families of asbestos workers and those in proximity to pesticides a higher incidence of mesothelioma has been found, indicating that children are not free from harm either.

Although one would imagine that the conditions in the organized sector would be better, the reality is quite the same. A large percentage of the women in the organized sector work as stenographers, typists and secretaries, primarily because it is easier to find women to fill these ill-paid jobs. Trichloroethylene used as a base for solvents in inks, correcting fluids, adhesives and cleaning agents has been found to cause headache, fatigue, dermatitis, nausea and vomiting. Secretarial staff are not afforded the same facilities as managers, positions usually filled
Not only do they face mental stress because their jobs are not secure, or because of sexual harassment which is not unknown, their work environment is not conducive to health. Several women suffer from pain in the back due to improper seating arrangements. Where electronic keyboards with visual display units are used, they suffer from eye-strain, the possibility of developing cataracts and postural fatigue. Let us not forget that all these women have then to fulfill their household chores of cooking, cleaning and child care. Women who work in close proximity to chemicals are at even greater risk as this can cause mutation of the ovum and hence birth defects in the unborn foetus, spontaneous abortions and stillbirths. Workers in close proximity to pesticides, asbestos, lead, mercury benzene, organic dyes, and radiation are at particular risk. Mention should be made here of the nursing profession, a profession largely regarded as a women's job, which is characterized by exploitation and harassment. This perception owes its origin to the resistance on the part of the medical profession to the registration of nurses. As a consequence of this conflict, medical nursing functions were genderised- medicine was regarded as a masculine profession, irrespective of the sex of the doctor, and nursing was seen as a feminine function. Thus, the rather than providing better opportunities for women, this set limits on their
participation in health care. As medical student, junior doctor, junior nurses both attend classes and perform ward duty sometimes twelve hours at a stretch. Yet, student of general nursing and midwifery (GNM) curriculum are given a mere Rs. 300 stipend, as against the junior doctor's allowance of Rs. 1600. While the Pay Commission undermines her role, can the nurse neglect her duties? Besides, reports of nurses being treated with disrespect and even being raped have almost ceased to be shocking.

The ANM in the rural area has an even more inferior status- the word auxiliary should really say it all. With a genderisation of the profession itself, the function of auxiliary worker was also genderised. The ANM was assigned exclusively nursing and midwifery tasks, while male auxiliary worker responsible for sanitation and disease control. The ANM suffers the most. She is not formally registered with nursing council and does not command equal status with other nurses.

While men and women alike may be exposed to many occupational and environmental health hazards, some have particular effects on women. Because many women work in the home, they suffer disproportionately from inadequate water supply, poor sanitation, and indoor air pollution. A study in
India found that rural women cooking in poorly ventilated huts were exposed to 100 times the acceptable level of suspended smoke particles—six times higher than other household members (Chatterjee 1991).

Outside the home, women workers may face the risk of sexual harassment and rape. Further more, they are more likely than men to work in industries and small enterprises with unsafe working conditions and poor regulation of such hazards as toxic chemicals, radiation, extreme temperatures, excessive noise, and violence, electronic assembly workers report a loss of visual acuity and textile workers complain of pulmonary problems, dermatitis, hand injuries, and chronic back pain (Hovell and others 1988). Exposure to toxic chemicals can cause cancer, dermatitis, miscarriage, and birth defects. Women may be particularly susceptible to some toxic chemicals for biological reasons (Rovner 1993).

When pregnant women are exposed to many of these hazards, the health of their unborn children suffers as well. Heavy work during pregnancy can lead to premature labour and when high energy demands are not compensated by increased caloric intake, to low-birth weight babies.
In India the work environment for women both in rural and urban areas is not conducive for upkeep of health and productivity environmental and health risks at workplaces have profound impact on women's health because of their susceptibilities to the toxic effects of various chemicals. These risks to women's health are particularly high in areas where there is a high concentration of polluting industrial facilities. The high incidence of depression, anxiety, neurosis psychosomatic disorders, increasing rate of suicides among women are also emerging as major problems in women-health domain. Chemicals used in agricultural and industrial operations, in food preservatives and fashion and beauty products are also causing occupational health hazards to women. The congested dwellings/work cabins and inadequate sanitary facilities make cities/offices breeding ground for various ailments. The cell phone menace, micro-oven, X-rays and sonography etc. have both positive and negative aspects (Mahapatra, 2005). Repeated pregnancies, and/or prolonged illness and absenteeism affect the income levels of women adversely, particularly when they do not have secured jobs. One has to enter the realm of cost analysis and assess the social cost, real cost and opportunity cost of women's health deprivation (Basil Hans V).
Conventionally, women were explicitly disadvantaged because of the association of reproductive activities with the private sphere. Their natural role in reproduction caused them to be considered 'non-productive' and often 'second class citizens' (Simon-Kumar, 2007). Progressive reduction in free-time disproportionate load of work in many cases, inadequate response to their personal and professional needs, harassment and violence they suffer. Lack of full respect to their privacy, treating them as always subservient to males make for the other side of the working women; these are the factors adversely affect on women health.

Health of women is affected by unfavourable environment both domestic and outside. Poor health reduces capital formation social as well as economic. This phenomenon is true both in traditional and non-traditional societies and jobs. One must understand that health deterioration of a women is more than a personal loss. It is challenge to comprehensive health security from generation to generation. Poor-health, poor-work, poor-earnings formation is affecting the wealth and welfare prospects of women, badly. Health security to women is a crucial to link labour productivity to economic security.
Another interesting area is that of women's double work, i.e. work as home-makers and as paid employees. Work is not necessarily a health-losing factor. But work and workplaces need to be healthy. Work opportunities should go hand in hand with joyful and creative living and productive working. Women have not only the right to work, but also to work and live healthily.

The multiple roles that women discharge can have deteterious effects on their health. Paid work coupled with child care and household responsibilities, child care and household responsibilities, results in role strains and little leisure for women. For women, the spillover of family related stress on work related stress is higher than it is in the case of men (Narayan, et. al., 1999 cited in Parikh, Taukari and Bhattacharya, 2004).

Effects of domestic and occupational roles on morbidity and mortality points to seemingly contrary concerns regarding the effect of employment on women's health (Hibbard and Clyde, 1991). One concern emphasizes the overload of work resulting from the combination of domestic and work roles leading to an adverse impact on the worker's health. Having children and sick/invalid members greatly increases women's total role responsibilities and is the most likely source of job-family conflicts. Women who work outside the home experience more
guilt and anxiety about fulfilling their roles as wives. In addition, particular job characteristics may be strong stressors, and in combination with family obligations, may lead to distress and health deficits.

Some women are exposed to physical, chemical, and biological hazards on the job. Employed women may also suffer strain and exhaustion due to job stress and overload.

Employment may have beneficial or harmful effects on a women's physical and mental health depending on her marital status, her husband's contribution to home labour, her parental status, her attitude toward employment, and characteristics of her job.

In an effort to understand the gravity of the occupation-related health problems of women in the country, the National Commission on Self-Employed Women and Women in the Informal Sector (1988) explored a variety of illnesses found amongst women workers in various unorganized production sectors. They found a high incidence of a variety of illnesses including postural problems, problems of contacts with hazardous materials, heavy work, lack of safety measures, lack of rest, and deplorable work environment. In the agricultural sector, it was found that the women suffer from a variety of
ailments such as generalized body ache, cough, respiratory allergies, injuries, toxicity, etc.

Use of pesticides was another source of work-related health problems, though women did not consider it important and causing much immediate harm to them. Women are not put to work in fields on the days in which spraying of insecticide was done. They are employed only the next day. But the employers seldom give any information to their women workers about the hazards of insecticides and their health impacts, acute or chronic. Nor are the men (who spray the insecticides) are provided with any security measures by the employers. They are not informed about the health hazards of insecticide use of all. In order to reduce the cost of production, many of the land owners endanger the workers health as well as the health of the community by neglecting to observe proposed ratios of dilution in the preparation of pesticides. The usual proportion is 100 litres of water for 100 grams of insecticide. While the land owners encourages the workers to mix up only half of the required quantity of water as a lower amount of water needs relatively less spraying time and therefore lower wages. Indeed, higher concentration of pesticides contents in the food grains. Across the globe, there is ample evidence to prove the ill-effects
The biggest risk in rural women health from domestic environment. Because they spend a great amount of time at home doing household work. Poor drinking water, smoky kitchen, poor sanitary facilities, garbage and solid waste in everywhere, food cooking in unhygienic conditions, poor ventilations, and crowding are bad affect on the women's health. Rural women face great pressure of work, it is household work and long hours of work increase the risk of illnesses.

Occupation is an important criteria of a person to lead life properly. Without occupational health they can't enjoy their livelihood. Occupational health is the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations by preventing, departure from health, controlling risks and the adoption of work to people and people to their work. Health hazards in the place of work involve surveillance of systematic approach to the analysis of occupational accidents and occupational disease. Occupational hazards are common in industry. The workers may be exposed to absorption through skin, ingestion, injection, and accidental
puncture of wounds, inhaling, absorption and ingestion are the most common rules for most of the hazardous materials. An industry worker may be exposed to so many hazards depending upon their occupation. They are physical hazards, chemical hazards, psychosocial hazards, etc.

Physical hazards the agricultural may be exposed to extremes of climatic conditions such as temperature, humidity solar radiation which may impose additional stresses upon them. They may also have to tolerate excessive noise and vibrations. Inadequate ventilation and the necessity of working in uncomfortable positions for long periods of time.

Women in the chemical and textile industries report tendinitis, chemical and noise-induced miscarriages, hormonal disorders and restrictions on lavatory use. Building industry workers have to contend with sinusitis, varicose veins, back strain, RSI and a high prevalence of sterility. Workers in the house-hold electrical goods industry report problems associated with robotization, long working hours, attention deficit disorders, and competitive work practices. Problems in the mental working industry include RSI, restriction on lavatiry use, noise levels and the rapid introduction of new technologies. Farm women complain about varicose veens caused by long hours of arduous
work, dyes, pesticide poisoning and sunlight-induced skin problems, stress, depression and emotional upset are common to all industries.

The women described their chronic health problems and exposure to most of the above factors. Their workplace is generally also their home.

Other problems identified include a lack of occupational health services, especially for reproductive health; violence against women; lack of childcare provision; lack of quality leisure time; unfulfilled other basic needs, like housing—electricity, transport, lack of representation in trade union structures. Proper hygiene facilities for women workers; guaranteed equal access to retraining and vocational training; guaranteed job retention after termination or childbirth.

Stress at work is a growing problem for all workers, including women. Many job conditions contribute to stress among women. Such job conditions include heavy workload, job insecurity, poor relationship with the supervisors, work that is repetitive and monotonous. Other factors such as work and family balance issues may also be stressors for women in the workplace. Moreover, the women are more likely to have difficulty in taking breaks, days off or holidays.
Thus, the health hazards faced by working women are both physical and mental, violating their health, self-respect and dignity. Despite constitutional guarantees and talk of equality between the sexes, women workers continue to be exploited in both the unorganized and organized sectors. Denied equal opportunities, equal wages, equal service conditions, and subject to all form of discrimination and harassment, it is no wonder that they suffer from physical and mental trauma.

WOMEN AND HEALTH CARE SERVICES

Traditionally, women as mothers, wives and sisters were the providers of health care within the home. Their knowledge about child care and several home remedies was handed down from one generation to the next, an oral tradition that is part of our societal heritage. However, with the 'pharmaceuticalisation' of health care and the 'medicalisation' of childbirth, women have been relegated to the background. Although almost 75 percent of our health system workers are women they are largely at the periphery. They have no decisive powers, acting only as couriers of a system out of their control. Although 67 percent of deliveries are conducted by dais, they are regarded as untrained health assistants who do not form a part of the 'formal government health structure'. Even trained personnel-nurses, for instance-
play a subservient role vis-à-vis doctors and are given little of no support or understanding. Thus, as long as caring, nurturing, nursing and healing were part of satisfying a family's needs, women were regarded as 'wise' and their knowledge and skills respected. Once these activities became associated with profits and economic gains, the medical profession came to be dominated by men and capital-intensive technology. Not only were women marginalized in terms of their role as providers of health, but their own health became the focus of warped and distorted notions. The uterus came to be looked upon as the source of all their problems which came to be diagnosed as mere 'hysteria'-i.e., uterus-related.

A women's access to health services is vital. Because a woman has the responsibility of caring for the health of her entire family, her knowledge of nutrition and health is important both for herself and the health of the family. Various studies have shown that households discriminate against girls in terms of health care. Hospital records show more male admissions than female, studies show that girls are taken to less qualified doctors than boys, more money is spent on the treatment of boys, boys rather than girls have access to more timely care, and
girls receive less immunizing vaccines against childhood diseases well.

Women’s access to health services is constrained by several factors. First, the time spent on child care, housework and in the occupational sphere leaves them with little time to think about their health, often resulting in their neglecting their illnesses in the early stages. Second, the clinics offer women no privacy. Third, most clinics are staffed by men, and women show a great reluctance to be treated by them. Fourth, the expenses and time incurred in traveling long distances and in meeting clinic and drugs fees are also constraining influences. Finally, women’s awareness of available facilities—even if they were to use them—is lower than that of men. Despite the fact that women are seen primarily in the role of mothers, several studies have shown that few pregnant women are actually registered at health centres and in fact, the MCH programme has been able to reach out to less than half the pregnant women in India.

New strategies have to be designed to increase women’s access to and role in the health care system in order to ensure better health for the woman, as also better child survival. In 1985, the World Conference in Nairobi to review and appraise
the UN Decade for Women put forth the following recommendations:

- Creating and strengthening basic services for the delivery of health care.
- Increasing the participation of women in higher level health institutions through legislation and training.
- Integrating fully and constructively female traditional healers and birth attendants into the health system.
- Strengthening promotive, preventive and curative health measures through a supportive health infrastructure free of commercial pressure.
- Designing and constructing accessible, acceptable health facilities in harmony with patterns of women’s work, needs and perspective.
- Encouraging local women’s organizations to participate in primary health care activities, including traditional medicine, and devising ways to support women is taken responsibility for self-care.

In addition, a special programme of education and training geared especially toward the adolescent girls will, it is hoped, go a long way in redressing past follies and in enabling them to prepare for a better future.
POVERTY AND WOMEN HEALTH

Is it not a paradox that in a society where women are revered as Annapurna, the provider of nourishment, within the household it is they who bear the major brunt of malnutrition. In practice, lofty ideals have not found an image in the attitudes and behaviour of our society. Differentials continue to persist in the care and upbringing of sons and daughters. Indeed, deprivation of women for the sake of her family is glorified.

Throughout their lives females receive less food than do males, both quantitatively as well as qualitatively. The high cultural and economic premium on the male child and the perception of the girl as non-productive and an expensive economic drain, particularly at the time of her marriage, are reflected in the nutritional intake and breast-feeding and weaning practices. Starting with breast-feeding, girl infants receive less milk, less frequently and over shorter periods than their male counterparts.

Low levels of maternal nutrition combined with frequent child-birth harm the whole family. Nonetheless, when the food is scarce, it is often men who get it first, then the children-boys before girls. Women's own quality of life is the lowest priority. It is a societal norm to underestimate activities traditionally...
performed by women and to overlook the magnitude of burden on them as compared to men. According to a study conducted by ASTRA in 1981, while women average about six hours a day on survival-related and agricultural tasks, men average only four hours a day on the same. Taking into account the time spent on domestic work—cleaning, sweeping, washing clothes and utensils, and child care—and productive work, the study concluded: ‘if we disaggregate human energy, the contribution of men, women and children is 31 percent, 5 percent, and 16 percent, respectively (as percentages of total human hours per household per day).

Most of the energy expenditure of women is on daily, life-supporting tasks which must be performed regardless of season and which are generally not shared by men. The shortage of season employment opportunities makes it doubtful that men spend a lot of energy in non-agricultural activities. The total calorie expenditure of men may, in fact, be significantly lower than women.

Where females have a high economic status, they may receive a larger share of food and health resources, where their economic value is lower they remain of a considerable disadvantage. Two particular aspects of women’s economic value
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have been related to their survival—their labour force participation and their inheritance of property, including the payment of dowry. One hypothesis suggests that rice cultivation in the southern region of the country generates greater demand for female labour and hence supports higher female survival rates, compared with wheat cultivation in the north.

Inadequate nutritional intake and consequently widespread anemia among women has serious implications for women’s productive as well as reproductive ‘success’, as the relationship between anemia and work performance on the one hand, and low birth weight on the other, are well-established.

It is indeed a vicious circle: perception of women as the presiding deity of the household, glorification yet underestimation of her activities, nutritional deficit, socioeconomic pressures, double energy demands and early, frequent and prolonged childbearing, unbearable pressures generation after generation. The price of modernization and development are also added to her burden—long treks to fetch water and fuel wood in the event of environmental degradation.

The primary goals of population health are maintaining and improving the health of the entire population and reducing inequalities in health. This model is premised on the belief that
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health status is influenced by an array of factors, known as the determinants of health. These include: income and social status, social and working conditions, physical environments, social environments, biology and genetic endowment, personal health practices and coping skills, healthy child development, health services, gender and culture.

According to the Canadian Research Institute for the Advancement of Women's (CRIAW) Women and Poverty fact sheet, there are numerous health problems that relate to women's poverty. These include acute and chronic ill health, susceptibility to infectious and other diseases, increased risk of heart disease, arthritis, stomach ulcers, migraines, clinical depression, stress, breakdown, vulnerability to mental illness and self-destructive coping behaviours.

Low-income women report that financial limitations, stress and isolation wear them down emotionally and physically. Poverty undermines self-confidence, making it more difficult to be healthy and to provide a positive environment for children. The challenges of living in poverty are manifold. They include finding work, locating better paid jobs, and finding adequate housing and subsidized child care to facilitate work or school involvement. With limited resources, women must meet the
nutritional, clothing and other needs of children and themselves, and get emotional support from others. Many are trapped in a cycle that opens few avenues. Low-income women struggle to meet minimal living standards, leaving them with limited resources for change.

WOMEN AND MEDICAL TECHNOLOGY

From time immemorial, medical technology for women has been hazardous, often drastic and barbaric. Backaches and indigestion were once treated with the application of leeches on the vulva and cauterization of her female parts. Female castration was the remedy for problems diagnosed as erotic tendencies, masterubation persecution mania, attempted suicide and dysmenorohoea. Medical technology, with its old and new reproductive methods, has not remained idle since, and in fact might well eliminate the female sex altogether. Once, sex determination tests-amniocentesis-were carried out to detect foetal abnormalities. Today, amniocentesis is being done to detect the sex of the unborn child and abort it if it is found to be female. Sex pre-selection techniques are becoming even more popular, as they allow couples to choose the sex of their child before the woman becomes pregnant.
The debate about sex pre-selection is closely linked with the debate about abortion. Abortion has been legalized in India under the MTP Act – not so much out of a concern for women's rights as one more method of population control. While abortion on medical grounds or following rape can be justified, its rampant misuse as a family planning method cannot be encouraged. Health personnel and others are increasingly concerned at the alarming incidence of deaths due to illegal abortions, often in the most unhygienic conditions. While 6 lakh women are stated to be dying due to illegal abortions, the number of deaths due to so-called legalized abortions is not known.

Let us not forget that the fight is not against technology per se, but the exploitative social structure that seeks to control women's minds and bodies.

CHILD BIRTH

Today, although the majority of childbirths in India still take place in villages at the hands of so-called 'untrained dais' the modern medical system is rapidly taking over. Sedation, induction of labour, superficial interventions like episiotomies, increased use of forceps and caesarian sections are fast
becoming normal procedures, apart, that is, from other costly and unnecessary tests like ultrasounds and amniocentesis

Childbirth practices are not designed with the mother in mind. The lithotomic or dorsal position in which a woman gives birth decreases the normal intensity of contraction, hinders the mother's voluntary efforts to push the baby out, and obstructs the spontaneous expulsion of the placenta. This results in the placenta often leading to hemorrhage, and increased need for episiotomies because of increased tension on the pelvic floor, and stretching of the perineal tissue.

Induction of labour hinders the normal progress which is unhurried, and hence prevents the mother from being able to withstand the discomfort and pain. Ironically, the much-lauded Laboyer's method of natural childbirth has its roots in India and can be given the indigenous term 'dai method'. In the Netherlands, where experienced midwives conduct natural home deliveries, there is a lower incidence of birth trauma and infant deaths. Why then are we allowing the modern system to [adversely] take over women's health? It is no longer the 'mother delivering the child as naturally as possible, but the doctor delivering the child caught up in the contradictions of the medical system'.
Similarly, while the once-popular method of placing premature babies in incubators is giving way to the Kangaroo method in which the mother's body helps to maintain the newborn's temperature our dependence on incubators appears to be increasing. Large hospitals often separate the newborn from the mother immediately after birth to a nursery. Not only at fixed times but also alienates the mother from her child. As a result, women often have problems lactating and babies contract gut infection. Although many hospitals have discontinued this, the process cannot be enough.

The food industry is also to blame for weaning babies away from the breast towards artificial and commercial food. Often, the poorest women are the victims, who first buy these products out of scarce resources and then dilute the food with water to make it last as long as possible. Further more, the water they use to dilute the milk and wash nipple and bottle is often contaminated, thus leading to severe diarrhoeal infections and even death. The incidence of diarrhea among such infants is ten to twelve times greater. Once again, it was a network of women's organizations that formed IBFAN-International Breast-Feeding Action Network and forced medical establishments and the WHO
to take note of the fact that women were being victimized at the
cost of their own and their children’s health.

Thus, priority to safe motherhood has tragically not arisen
out of a genuine concern for women but out of an epidemic of
workshops and seminars. Will this suffice if attitudinal changes
do not take place, if women continue to be ascribed a low status,
and especially if man continue to dominate the decision-making
process both within the home and at the level of policy
formulation?

Until women have better access to health care, as also
access to better health care, unless the system can ensure the
survival of children [to convince women of the need for less
children], unless women have access to education, their plight
will be difficult emeliorate. Kerala should serve as a model to
enhance women’s health and status. Yet, it is once again
women’s groups alone which are raising their voice on the issue
of biased policies and decision-making.

WOMEN AND MENTAL ANGUISH

Health cannot be fragmented or reduced to a single causal
factor and women’s mental health is no exception. Good mental
health is intrinsically important, conferring a subjective sense of
emotional well being on the individual women and extrinsically important, representing a significant resource to the broader society in which she lives and works.

Just as biological or endocrinological factors alone do not adequately explain women's mental health status or gender disparities in affective disorders (Piceinelli and Homen, 1997), neither do they explain the disproportionate burden of reproductive health problems women face worldwide. These problems are intimately connected to the social, educational (including health educational) economic and political disadvantages women experience and have significant psychological consequences of their own. They have received inadequate attention by policy makers (Okojie, 1994).

Little education, early age at marriage, adolescent pregnancy, repeated pregnancies at short intervals due to lack of access to or the cultural unacceptability of family planning, son preference and less food being given to girls and women, all increase the likelihood of reproductive health problems. All are influenced if not caused by social and cultural, not biological forces.

The splitting of body from mind and the identification of women and their health with the body in general and
reproductive functioning in particular has led to a neglect of women's mental health and its social structural determinants. Using biological difference from men as the chief organising principle, women's health, in the past, was seen to fit within the ambit of absterics and gynaecology. Within this biomedical framework, women's health was confined to such biologically based issues as breast and cervical cancer, pre-menstrual syndrome, contraception, pregnancy and childbearing, psychoendocrine problems postnatal disorders and disorders of menopause.

The preceding discussion can leave one in no doubt of the mental trauma and anguish to which the women is subjected as a consequence of discrimination in all spheres of her life. While there are several reasons for women to suffer high degrees of stress, any statistics must be viewed with caution for there is a tendency for male psychiatric doctors to more easily categorise women as mentally ill.

Yet, for most women in India, the stress of domestic and occupational work leaves them with little time for self-awareness and their own psychological needs. Furthermore, placed in an alien, often hostile, environment in the homes of their in-laws, they are virtually cut-off from their natal homes and have no
sympathizer to share their problems. These bottled feelings can in time manifest themselves psychologically.

While men more easily manifest their problems-through alcoholism, drug use, etc., - women's problems are neglected, to be suffered in silence and isolation. The factors that contribute to women's ill-health begin with the process of socialization itself-the physical and mental trauma of discrimination between the sexes, within the family and in the occupational sphere, violence within the home, experience with sexual abuse or rape, oppressive norms of marriage with the institution of dowry taking a hold of their lives, illiteracy and lack of educational skills, intimidating and often violent conjugal homes with little or no help from their natal homes -the list is endless. These factors, combined with the fact that the 'adjustments' to be made are always the responsibility of the women, take their toll on the ability of the women to survive in the larger social milieu. Those who fail to do so collapse psychologically and become psychiatric survivors.

Mental health is an area that has been completely ignored by the government, and psychological treatment is only a very small part of the overall health care system. In India, the concept of availing of psychiatric treatment is still new, often looked upon
with suspicion, and associated with insanity. Most women find solace in indigenous methods—through spiritual or religious healing, or a study of stress and mental hardship.

Besides providing services for mental health, the government and concerned individuals must destroy the root of these problems which lies in the very social structure from where they arise.
Section B

REVIEW OF LITERATURE

This section presents the review of studies undertaken on women work, health and health services.

Rani Kappor (1985) has expressed on working conditions of the women workers of the samples and their participation in trade union activities. The study qualitatively measured the working conditions and developed a 17 point scale consisting of separate questions framed on different working conditions. Author has advocated on wages fringe benefits, health and safety travel to and from work, hours of work, steady employment, physical work environment, recruitment relationship with supervisors, and relation with fellow workers. Study findings summarized that a majority of the i.e., 80 percent women workers working in the industrial units felt that their jobs were insecure and only 20 percent of them (those of the public sector) felt that they had stable jobs. Similar response pattern is found among the women workers of the non industrial units except those working in public sector organizations they had stable jobs, their differences in the perceived job securities are more visible in public and private sector units rather than in industrial and non industrial.
Study shows that the degree or extent of participation among the women workers of industrial units is very low as compared to the women workers of non industrial units. 73 percent women workers of the industrial units do not participate in trade union activities as against 51 percent of non industrial women workers. Only 27 percent from the industrial women workers and 49 percent from the non industrial women workers participated in trade union activities.

Sudarshan Iyengar and Ashok Bhargava (1987) presented a brief review of the health and family welfare programme in Gujarat and points out that the programme is not only expensive but also generally ineffective moreover the single minded approach to family planning has meant a neglect of primary health care, with programmes such as those combating malaria and tuberculosis, crucial to achieving improvements in health status, have been grossly neglected.

The study assumed of women that the emphasis on terminal method of family welfare was correct in the context of high fertility rate in Gujarat. The study findings shows that control of communicable diseases was the single most important plan component till fourth five year plan and since then it was relegated to second place. Almost one and half of the total plan
outlay's (all plan outlay's taken together) has been allocated for the family welfare programme. Buildings new primary health centers (PHC”s) and strengthening old ones received third priority largely due to minimum needs programme (MNP). About one- seventh of the total plan outlay's (all plan outlay's taken together) has been allocated for MNP. It should be mentioned that from sixth five year plan onwards MNP included a major outlay for multipurpose health workers scheme with an objective to integrate the services of vertical programmes like malaria and TB control into primary health care at village level. Further the study observed that the gap in the availability of health infrastructure widens towards the upgraded facilities. The establishment of sub centers appears to be near the norm largely due to the family welfare sub- centers which constitutes 58.8 percent of all types of sub centers. The study suggested that there is urgent need for a drastic change in priorities for the allocation of funds to different health and family welfare programmes and the approach to render health services in an integrated fashion.

Savitri Arputhamurthy (1990) perceived that the factor responsible for the existence of sex discrimination in the Indian situation in general and in Tamil Nadu in particular and to find
out the justification for the existence of sex discrimination in agricultural labour market. Discrimination within the market implied that "workers who are distinguished by some characteristic (such as sex, caste, status, etc.,) that does not affect their present capacity but are treated less favourably in a given employment than other who are of on greater capability but are not marked off by the characteristic. Study was based on primary and secondary data. The primary data collected from the selected sample villages of the study area namely Madurai district through personal interview method. The sample villages were divided into developed and less developed areas.

The study results revealed that there exists wage discrimination on account of sex was found to be Rs. 3.97 and difference in wages between developed and less developed areas was Rs. 1.87. In the study area, therefore, the average wage for male labourers ranges between Rs. 7.45 and Rs. 9.32 and for female labourers, it ranges between Rs. 3.48 to Rs. 5.35. Further, the sexual division of labour, noticed that the nature of agricultural operations performed by male and female labourers do differ from village to village. Women are discriminated against in the matter of sexual division of labour both in the developed and less developed areas. However, the severity is greater in the
The average percentage of wage differential in total operation for the sample villages as a whole was 45.59. However there is very close relationship between agricultural development and wage differential. Wage differentials narrow as agricultural development takes place and job segregation by sex gets reduced. Study concluded that special laws should be passed in favour of reverse discrimination in the interest of women and implemented with real force and commitment. The duty of the educated women who have the rural background to undergo training courses and with the missionary zeal, receiving stimulation from the government and voluntary agencies, to go to the villages and spread the message of equality and inculcate in them legal awareness on a war footing.

Vilma S. Santana, et.al., (1997) hypothesized that the role of informal work in the origin of mental dys-functions among women in an urban area of Brazil, taking into consideration the potential effect of other job characteristics and family -related variables. Study used cross-sectional study data. It was estimated the association between informal jobs and high number of psychological symptoms. The study population was composed of 327 women randomly selected from a community in
the city of Salvador, Brazil. Women who reported having a job without a formal contract were classified as informal workers. Psychological symptoms were collected through a validated questionnaire, the QMPA. Study results shows that informal workers had lower hourly salaries, spent less time in paid activities, and more time in housework duties than formal workers. Women in the informal sector, they intended to change their occupation and less satisfied with their work. Further, informal workers were less educated than formal workers and had lower per capita family income and the same distribution of race and religion. Further, high QMPA scores were more prevalent among informal workers, with a crude prevalence ratio of 1.88 (95% CI:1.24-2.85). Results shows that simultaneous adjustment for time spend for housework and paid work confounders slightly decreases the association to 1.68 (95 %CI:1.08 - 2.60), with a small decrease in the confidence interval. Further, informal work was associated with a number of psychological symptoms among women living in a poor urban area. Family head or having more than 8 hours of total work-time per day, were potentially independent risk factors for psychological symptoms. However, the positive association between informal jobs and high QMPA scores remained at approximately 1.68 after adjustment for both factors.
Rekha Singh and Asha Kwatra's (1998) study illustrated that the health behaviour of the tribal of Bastar. The tribal groups were in constant interaction with the natural surroundings and depend upon plants and herbs collected from the forest for care of common ailments. Study revealed that the tribal community has not fully aware of the health care facilities available to them and they have strong believe in their system of traditional health care. Study was based on primary data sample comprised 100 respondents and information on health practices was collected using an interview schedule. A list of villages in selected blocks was prepared and three villages from each block were randomly selected. A list of tribal pregnant women was procured from Anganwadi of the selected villages. Thirty three tribal pregnant women were selected each from Hohandiguda and Tokapal block and thirty four were selected from Jagdalpur block.

The study findings show that tribal women hardly go for medical check-up during their pregnancy. Out of the total tribal pregnant women surveyed only 28 percent of them went for medical check-up. 15 percent of them went for the first time while 2 percent were going weekly. 4 percent were going fortnightly and 7 percent were going monthly. It was found that they were not aware of the medical facilities. As far as
immunization was concerned, only 59 percent from Block-III, 18 percent from Block-II and 6 percent from Block-I were immunized. Only 24 percent of respondents were taking iron tablets during pregnancy. The pregnant women who stayed near the cities were the only goers for pregnancy medical check-up. These women were found to be aware of the need for a regular medical check-up. The major sources of receiving information by the tribal women were found to be Anganwadi workers, PHC and educated relatives. Majority of them still believe that their system of managing nutrition and health care during pregnancy was better than the outside medicines.

**Duraisamy Malathy and Duraisamy P. (1999)** focused on women in the professional and technical market in India and emphasized on gender-discrimination in case of employment and earnings. The author used secondary data from sources like Census of India (various years), NSSO 50th round, DHTP Survey Reports (1981) etc., to analyse the women's share as well as gender discrimination, education and employment and earnings in the professional and technical labour market. To analyse the secondary data author used Dencen Index method. The study findings shows that the rate of unemployment is higher for the higher levels of education and illiterates female at every level of
education and it is more in urban than in rural areas. Further, the unemployment rate of women is higher than that of men in law education (teaching), engineering and technology, dentistry, veterinary science and social sciences.

The study highlights that the average earnings of women are lower than men's earnings at all ages and earnings of men and women distributed across various occupations reveals that the difference is smaller in self-employed compared to wage workers and there is much more parity in the earnings of men and women in construction, teaching and administration and accounts. The study also pointed out the fact that women are discriminated against wages and the wage discrimination on range from 55 to 70 percent depending on the educational specialization and sector of employment. Lastly, the study favoured non-discriminatory labour market policies and affirmative action to reduce discrimination in the labour market.

**Nirmala and Sham Bhat K. (1999)** has studied on female work participation in India and emphasized on labour market in case of primary and non-primary sectors across 22 Indian States. Author collected data from the sources like Census of India, Economic Survey and Statistical Abstract of Indian Union for the Census years 1961, 1971, 1981 and 1991, covering 22 major
Indian States. Pooled time series and cross-section data also used. The statistical tools like simple averages, percentages, ratios, multiple linear regressions and correlation matrix used. Author highlighted the trend in female work participation across the selected Indian states during the Census years revealed a distinct decline between 1961 to 1971. The trends in primary and non-primary sectoral work participation showed a fall in female workers in the farmer sector.

The results indicate marital status to be leading to a significant rise in female work participation owing to increased economic burden on the family. Further, the study findings indicated that even as the country steps into the next millennium the socio-economic status of Indian women leaves a lot to be desired. Half the human resources remains still under tapped or untapped, which needs to be drawn into the mainstream of development process. The author suggested for the recommendations of New Education Policy needs to be strictly implemented in all states of the country and all provisions of the various Acts and policies effectively implemented with a strong political will and commitment.

Sudha Deshpande's (1999) study focused on the emerging urban labour market for women in urban slums. The study
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perceived that liberalised economic policies introduced by the Government of India in 1991 were intended to outcome the financial crisis facing the country at that time. The study was based on a survey households living in three slums of Mumbai. The study stated that women form the biggest ‘minority’ among the socially discriminated in India. Liberalisation was expected to affect them in many ways.

It was predicted that women’s participation in the labour market would increase due to a genuine increase in the demand for cheaper female labour relatively to dearer male labour. Further, she has perceived that the data from the National Sample Survey Organization for Mumbai, however, suggest that the reform had a positive effect on these groups in terms of an increase in their real wages. But study focused on these beneficial effects could not be expected to spread evenly over all groups of workers and population in Mumbai. Further, the study highlights the data from the NSSO did not lend support to most of the dismal predictions regarding the effect on the reforms on the emerging labour market in Mumbai. But the study warns that the impact of reforms was not likely to be same on all groups of workers. The study concluded that vulnerable sections
of Mumbai's population were the worst hit in the labour market that had emerged in the post-reforms period.

Kalpagam V. (1999) has addressed about the women's domestic duties and constraints for labour market participation in rural and urban India. The study analysis relies on data drawn from NSSO reports. The study brings to our notice that on the one hand, Andhra Pradesh records the lowest percentage (42.7) of housewives engaged in maintenance of kitchen, garden, poultry, dairy and free collection of fish, firewood etc., followed closely by Maharashtra and Karnataka. On the other hand the state of Assam, Haryana and Himachal Pradesh shows a slightly higher percentage than Tamil Nadu and also shows that percentage of housewives engaged in the free collection of fire wood etc. While rural women in Orissa have a markedly higher preference for work in their household premises followed by rural women in Bihar. The women of rural Rajasthan do not indicate such willingness.

Further, the study indicated that 50 percent of women in urban areas in Orissa fetch water, only 3.4 percent do so in Punjab. Even in tailoring such difference between state exist. However, there is greater proportion of urban women than rural women seemed more committed to domestic duties in terms of
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time involvement. Study also indicated that finance assistance that women required and initial finance on easy terms i.e., start up capital was required by half of the urban women willing to accept work. Study suggested that the patriarchal dominance in households can only be countered by strengthening women's bargaining position and making access to resources and income.

Ratna Sundarshan and Rupinder Kaur (1999) study perceived women's employment in tobacco industry and emphasized on vulnerable section in case of wages and health impacts. Study used secondary data from National Sample Survey's 50th round. The study highlights that the utilization of household female labour depends on the availability of remunerative opportunities of work. Study considered that working and living conditions of women bidi home workers, the bargaining position of the workers in general and of women home workers in particular involved in the various stages of bidi production is weak. Further, the study focused on exploitation of workers takes many forms like insufficient supply or raw materials, tempering with the raw material such as wetting of tobacco before distribution, high wages cuts under various pretexts, high quality of rejection, improper maintenance of records by contractors, multiple role of sattedars vis-à-vis the workers etc.,
and economic and sexual exploitation. Further, study supports the view that presence of nicotine in tobacco causes various health problems for tobacco users and those who work with tobacco. The continuous contact of bidi makers with tobacco and inhalation of tobacco dust while working results in serious ailments like asthma, tuberculosis and cancer. Bidi workers also develop problems like backache, joint-pain, arthritis etc. due to long sitting in a particular posture.

Study findings shows that estimates of employment in the tobacco industry range from 3.5 to 26 million and a substantial proportion (62 percent) of this employment goes to woman. More interestingly the bulk of the employment generated by the industry is in bidi making. Any changes in policy relating to tobacco use will therefore adversely affect the vulnerable section of bidi rollers if however tobacco use is likely to decrease control then the problem before use is one of trying to generate new livelihoods for bidi workers. The study suggested that transition will require policies aimed at increasing skills productivity and access to resource as also reconstruction of gender roles and a change in thinking grading appropriate female spaces.

Jill Astbury and Meena Cabral (2000) presented evidence based review which contains a reappraisal of the status of tobacco workers.
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women's mental health problems in different regions of the world. Report updated and reactualized a first publication on psychosocial and mental health aspects of women's health issued by the Divisions of Mental and Family Health in 1993. Document adopts a health determinants framework for examining the evidence related to women's poor mental health. From perspective, public policy including economic policy, socio-cultural and environmental factors, community and social support, stressors and availability and access to health services, are all seen to exercise a role in determining women's mental health status. Document collected and analysed the latest research evidence pertaining to the study of these issues and identifies the most pertinent risk factors and social causes that account for much of the poor mental health of millions of women around the globe. Document highlights that the current gaps in knowledge that must be addressed through cross-cultural epidemiological, behavioural and operational research, especially in the developing countries. Document considered the differences between women and men, the impact of poverty and violence, as gender risk factors, on women's mental health. In relation to the 1981 WHO definition of mental health, both poverty and violence can be seen to significantly interfere with the promotion of subjective well being, the optimal development.
and use of mental abilities and to be incompatible with justice and conditions of fundamental equality.

Nakkeeran N. (2003) observed about the conditions of women's work, status and their relationship with child mortality and fertility in a south Indian village. The aim to explore the comprehensiveness of the term 'conditions of women's work' and how it reflects the entire milieu of women's situation and bring out the relationship between structured socio-political inequality and women's status in the society and contextualises gender within a caste hierarchy. Paper was based on data from a 15-month long village study conducted between 1995 and 1997 and essentially an anthropological one supported with quantitative data from a sample survey covering 120 families using schedule.

Study findings point out that total birth-ratio was highest among the marginally landed, by the landless and the lowest among the large landowners. Across three castes, the average number of birth is highest among the Vanniyar households. Arunthathiyar women have experienced relatively lower average births than Vanniyars. Women of Gounder households have the lowest average number of births. Paper noted that the rate of fall is not uniform across the different land holding categories. In all sections, an increase in birth ratio as one move from the younger
cohorts to older cohorts. Further, the total infant death ratio and child death ratio are the highest among the marginally landed by the landless and are least among the large landowners. Women in poorer households and lower caste groups not only had higher infant and child mortality but also less access to health services. Close to 80 percent of all births experienced by women in the sample households has taken place at home. However, the decline is not uniform for different land holdings groups or caste groups. Further, one-fourth of the births experienced by the women in the sample household are attended births. The remaining three-fourth of the birth is un-attended. The data from the Primary Health Centre (PHC) revealed that in 1995 out of 240 eligible couples using planning methods in the village, 210 (87.5 percent) were covered with female sterilization, 12 with oral pills, 15 with conventional contraceptives and three with IUD. Study concluded that the strong influence of women’s work on their health and how this shapes and is shaped by access to fertility control and the changing agricultural scene, low accommodation of women into the expanding non-agricultural sector coupled with traditional patriarchal social relations has progressively tightened the position of women in both domestic and public realm.
Milind Deogaonkar (2004) reviewed the effects of growing socio-economic inequality in Indian population and its effect on the health care system and the factors responsible for the difficulties in health care delivery in an unequal society and its effect on the health of a society. Study stated that dismal and unequal spending on public health, the infrastructure of health system itself is becoming ineffective. The most peripheral and most vital unit of India's public health infrastructure is a Primary Health Centre (PHC). In a recent survey it was noticed that only 38 percent of the essential manpower and only 31 percent have all the essential supplies (defined as 60 percent of critical inputs), with only 3 percent of PHCs having 80 percent of all critical inputs. Further, the poor are unable to afford and access hospitalization in a very large proportion of illness episodes, even when it is required. The delivery of a mother, from the poorest quintile of the population is over six times less likely to be attended by a medically trained person than the delivery of a well off mother, from the richest quintile of the population.

Study point out that access difficulties to healthcare due to geographical, socio-economic and gender distance. The issue of geographic distance, in a large country like India with limited means of communication, direct effect of distance of a given
population from primary healthcare centre on the childhood mortality is well documented. It has been shown that the effect of difficult access to health centers is more pronounced for mothers with less education. Further, healthcare access problem is noticed in cases of 'urban poor', data from urban slums show that infant and under-five mortality rates for the poorest 40 percent of the urban population are as high as the rural areas. Further, gender distance, health of society is reflected from the health of its female population. Gender discrimination makes women more vulnerable to various diseases and associated morbidity and mortality. Gender discrimination in healthcare access becomes more obvious when the women are illiterate, unemployed, widowed or dependent on others. Further, burgeoning but unregulated private health care sector makes the gap between rich and poor more apparent.

Preet Rustagi (2004) addressed that importance and significance of gender-related development indicators for assessing relative levels of progress or backwardness of women's status across the states of India. The complexities of gender-related development through an analysis of individual indicator covering issues of women's work, education, health, survival, safety and participation in public/private decision-making.
Study was based on secondary data from Census of India 1991, 2001.

Study findings shows that standard definitions of economic activity indicate low rates of Female Work Participation Rate. At all India level, only 30 percent of women are defined as workers, main or marginal. Among the states, Kerala has lowest FWPR, while Uttar Pradesh, West Bengal and Punjab are also states where female work participation is low. Further, all Indian states have registered improvements in female literacy rates. Rajasthan, with the worst literacy levels among women in 1991 (as low as 20 percent), has doubled its proportion of literate women in a decade to 44 percent in 2001. Chattisgarh, the newly-formed state, and Madhya Pradesh are the other states with similar levels of improvement in women’s literacy. Study selected the indicators on health status of women in the states of India are: mean age at marriage, total fertility rates, anemia levels in women and couple protection rate. Despite the legally stipulated minimum age of 18 years at marriage, girls still get married before attaining this age in the states of Madhya Pradesh, Rajasthan, Andhra Pradesh, Bihar, West Bengal and Uttar Pradesh. Further, the number of childbirths among women from the states of Meghalaya, Uttar Pradesh, Rajasthan,
Nagaland, Bihar and Madhya Pradesh is even higher. Although declining for the country as a whole, the total fertility rate is close to replacement level in only some of the states. Low total fertility rates are recorded in the states of Goa, Kerala, Karnataka, Himachal Pradesh and Tamil Nadu. This reveals the low proportion of girls in the states of Punjab, Haryana, Gujarat, Himachal Pradesh, Rajasthan, Uttar Pradesh and Maharashtra. The declining trend is almost universal, except for the states of Sikkim, Tripura, Kerala and Mizoram. Further, the infant mortality rate among females for India from Sample Registration System is 71, while the male infant mortality rate is lower at 70.

**Babar T. Shaikh and Juanita Hatcher (2004)** perceived that health seeking behaviour and the determinants of health services utilization especially in the context of developing countries. However, very few focused studies have been seen in Pakistan in this regard. Study examined health seeking behaviour and health utilization in the context of physical, socio-economic, cultural and political. Therefore, the utilization of health care system, public or private, formal or non-formal, may depend on socio-demographic factors, social structures, level of education, cultural beliefs and practices, gender discrimination, status of women, economic and political system itself. Study
stated that family size parity, educational status and occupation of the head of the family associated with health seeking behaviour besides age, gender and marital status. However, cultural practices and beliefs have been prevalent regardless of age, socio-economic status of the family and level of education. Women are usually not allowed to visit a health facility or health care provider alone or to make the decision to spend money on health care. Thus women generally cannot access health care in emergency situations. Despite the fact that women are often the primary care givers in the family, they have been deprived of the basic health information and holistic health services. In Pakistan, having a subjugated position in the family, women and children need to seek the permission of head of the household or the men in the family to go to health services. Study concluded that policy makers must understand health behaviours and health care use at the district level, and give enough credence to these facts so that policies could be designed appropriately.

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from NFHS-II covering 4,374 eligible women between 15-49 years of age in Karnataka was being used to collect information on various aspects of women's health. Wherever necessary data from the 2001 Census and Sample Registration Scheme (SRS) were also used for comparison with all the Indian level.

Study findings shows that illegal child marriages are still practiced. Social comparison for marriage of all women at the right age and as early as possible is still strong among parents in Karnataka. People living in rural areas are more conservative than those in urban areas in this respect, as nearly half the girls are married between 10 to 14 years. Further, the nutritional requirements of women are not fully met. More than one third of women (39 percent) have a high prevalence of nutritional deficiency. These nutritional problems are particularly serious among younger, rural illiterate, scheduled tribe women, working women, who are not self-employed and women living in households with a low standard of living. The haemoglobin level was 94 percent compared with 88 percent in India whole. Overall 42 percent of women had some degree of anemia, 27 percent of women were mildly anemic, 13 percent were moderately anemic and 2 percent severely anemic. This prevalence was found to be higher among rural women (46 percent) than urban areas. A
large majority (86 percent) of mothers received antenatal checkups in Karnataka (65 percent all India). Among them, 70 percent received care from other health professionals and only 5 percent from health workers at home. Study suggested that Legislation prohibiting marriage for girls under 18 years must be strictly implemented, education must extend to at least 10 years of schooling for girls. An alternative approach to popularizing male sterilization must be adopted through client counseling.

Muhammad Hasan Imam (2004) examined that the female students perception and awareness of their own illnesses and nature of their medical problems. Study information was collected from semi-structured interview and informal talks with 200 female students of Rajshahi University between 1997 to 2000. Selection of students was between 18 to 25 years and interview was accidental or purposive.

Study findings shows that 40 percent didn’t know a regular check-up. Most of them consulting doctors and taking medicine only at the time of illness. 40 percent didn’t know whether they were in good health. Because unaware of meant by sound health. Further, while 35 percent health was quite well, 25 percent disagreed, and 40 percent did not know and only 20 percent agreed upon the need for exercise. When cross checked,
40 percent taking balanced food but felt weak and underweight. 30 percent students who were not health conscious suffered from indigestion (10%), lower abdominal pain (3%), dysentery (4%), frequent respiratory congestion (5%), migraine (2%), and insomnia (9%). Further, by hygienic conditions, 65% students mentioned bodily and personal cleanliness. Another 30% hygiene meant clean bedroom, clean bathroom, and clean clothes. Study findings also shows that psychological problems of students. Students expressed fear (20%), tension (35%), palpitation (30%), depression (40%), frustration (33%), nervousness (25%), exam phobia (36%), and memory failure (40%) as the major problems. Study concluded that it should not be exaggerated in the name of “female disease” illness is being gendered.

Rajesh Kumar and Aggarwal Poonam Kaushi (2004) addressed that the pattern of public health delivery mechanism, the level of client satisfaction and reason for dissatisfaction in Punjab. Study emphasized that the staff behaviour and effectiveness of treatment as perceived by the users and the reasons for the underperformance of the public sector in health care services in Punjab. Study based on the primary data collected from the Reproductive and Child Health-Rapid
Household Survey (RCH-RHS) in the year 1998-99. The sample size consisted of 18,700 households (14,036 rural and 4,664 urban) from all the districts of Punjab. In all, study interviewed 15,933 eligible women in the age group of 15-44 years. The data was collected through International Institute for Population Sciences, Mumbai, and provided to different Population Research Centres on behest of the Department of Family Welfare, Ministry of Health and Family Welfare, Government of India.

Study findings shows that a health functionary visited only 10 percent of the sampled households in rural Punjab, three months prior to the date of the survey. Rupnagar district reported the maximum visits (21%) followed by Nawanshahar, Sangrur, and Jalandhar districts (17%, 14%, and 14% respectively). Ludhiana district reported the least visits (4%), followed by Firozpur, Bhatinda, and Moga districts (5%, 5%, and 7% respectively). Further, female health workers accounted for 65 percent of all home visits followed by the male health workers (34%). Anganwadi workers also visited some households (9%). Kapurthala district reported maximum visits by the female health workers followed by Fatehgarh Sahib followed by Muktsar and Moga. Further the majority of the clients were satisfied with
the female workers visits to their households. Study point out that the households prefer to visit public health institutions in case of illnesses that are perceived to be more serious in nature. Households more likely visited the quantum of sub-centre visits (28%) in rural areas to avail of some preventive services linked to ante-natal, post-natal including family welfare services. Study concluded that public sector in order to maintain its share in curative services, must strive to provide qualitative health services. Further, people need to be educated on the availability of diagnostic facilities at the government institutions.

Thresia C.U. (2004) focused lives of women agricultural workers and socio-economic and demographic profile of women workers in Kerala. Study perceived health status and the health problems of the women and the ways they adopt to cope with such problems. Study collected data from the agricultural women workers using pre-tested interview schedule, and discussions with men workers, health personnel, panchayat officials, elected representatives, trade union office-bearers, and some key informants from the panchayat. Study also used secondary level data from various official sources such as Panchayat Office, Office of the Agricultural Workers Welfare Fund, Krishi Bhavan, District Panchayat Office Primary Health
Centre and Sub Centre, and Trade Union Offices. Study findings show that a major proportion of the significantly high levels of perceived health problems among them are constituted by chronic skeletal muscular problems. The lives of these women are played by high level of occupational and often poverty-induced diseases, reproductive health problems. The high rate of utilization of public sector medical care institution due to low socio-economic status of workers. Further, more than one-third of them live in un-electrified house. Two-thirds of the households do not have latrine facilities. The low status of the SC households (more than the OBC workers) is reflected in landlessness and lack of housing facilities and caste discrimination. Also the high degree of dependence of SC youngsters-even the well-educated among them in the agricultural sector reflects their social backwardness and inability to find proper job opportunities or achieve placements. Further, it seems that despite shouldering the double burden of work-within home and outside home. Nearly four-fifths of the households are not able to have two square meals a day round the year.

Study concluded that population issues health care services at the primary level and family welfare services did not
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have much of welfare components except birth control and related programmes negligence of general health problems and public health issues and reproductive health care services did not contribute much to be cultural empowerment of women.

Joseph B. et.al., (2005) observed poor nutritional status among garment industry workers. Study was undertaken to know nutritional intake of the workers in terms of calories, proteins, fats and specific minerals and the relationship between the dietary intake and the nutritional status of the workers. The study was based on 24-hour recall method for semi-quantitative dietary intake, in which 111 women were interviewed. The women were selected on the basis of the free time they had during the investigators visit to the factory. A Software Programme called Annapurna which calculated the intake energy, protein, fat and iron among other nutrients against the recommended intake for each women was utilized. The BMI classification is based on the cut-off suggested by the World Health Organisation.

The study findings shows that taking in to account the WHO recommended criteria of BMI<18.5 general physical examination of the employees in the factory revealed that more than 25 percent of women were undernourished. Out of the 111
workers, only 6 (5.4%) consumed calories in excess than what is recommended. However, of the 29 who were malnourished 23 (79.31%) consumed calories less than that recommended. Who were of normal BMI, 49 (80.33%) consumed low calorie than the required amount. So study findings demonstrates that the under-nutrition in this group of workers is more likely due the inherently deficient calorie intake among them. 19 (17.12%) out of the 111 workers consumed normal amount of protein or more. Study suggested that the factor management should try all the means at their disposal to improve the diet of the workers both in terms of quality and quantity and nutrition education programme must include the importance of iron in the diet and factor that inhibit and enhance its absorption.

Rachel Kimerling and Nikki Baumrind (2005) investigated racial and ethnic disparities in access to specialty mental health services among women in California as well as factors that might account for such disparities. Study used secondary data from 2001 California Women's Health Survey (CWHS), a population-based, random-digit dial annual property survey sponsored by the California Department of Health Services and designed in collaboration and departments and a cross-sectional examination of a probability sample of 3,750 California women.
The main indicators of access to services were constructed that accounted for need and enabling and demographic variables. Study also used the Anderson behavioral model to examine racial and ethnic variations in access to specialty mental health services. Bivariate relationships were examined by using odds ratios. Logistic regression equations were used to examine multivariate models and obtain adjusted for all odds ratios.

Study observed significant racial and ethnic variations in access to specialty mental health services. African-American, Hispanic and Asian women were less likely than white women to report perceived need, even after frequent mental distress had been taken into account. Among women with perceived need, African-American and Asian women were less likely than white women to seek mental health services after differences in insurance status had been taken into account. Among women who sought services, Hispanic women were less likely than white women to obtain services after adjustment for the effects of poverty. Need and enabling factors did not entirely account for the observed disparities in access to services. Study findings shows that only 57.8 percent of women who reported perceived need sought mental health services. However, among who sought services, 88.1 percent had used services in the previous
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year. Study noted that specialty mental health care only did not assess mental health treatments that are often provided in primary care settings, such as pharmacologic treatments. Study concluded that additional research is needed to identify gender and culture-specific models for access to mental health services in order to decrease disparities in access. Factors such as perceived need and decisions to seek services are important factors that should be emphasized in future studies.

Jyoti Parikh and Saudamini Sharma (2005) addressed that the linkages between gender, energy, poverty and health in the state of Himachal Pradesh in India while explained the connections with empowerment and emphasized the need for management and technology support. Study investigated that whether access to energy on a sustainable basis empowers women by freeing them from daily drudgery enabling them to surge ahead in life, appropriate indicators of energy consumption, household assets, health, literacy etc., and how women view this problem in terms of their own economic, environment and health priorities.

Study revealed that girls below the age of five years and female in the 30-60 age group (who are usually the chief cooks in a family) are at higher risks than the males in the same age groups. Illiteracy and smoking habits have also affected the
respiratory health of individuals in the state. Further, about 70 percent of the women in the 30-45 age group are involved in cooking and about 53 percent women who are above 46 years are not involved in cooking. The women in the age group of 30-45 years, who are usually the main household cooks, are thus more exposed to smoke and indoor air pollution than other family members. Comparative gaps shows for two districts in Himachal Pradesh, Shimla and Sirmour, i.e., that the main health problems that occur daily due to fuel wood. In the two districts studied, 64 percent and 39 percent of women suffer daily occurrences of backache compared to 42 percent and 65 percent who have daily coughing attacks. The survey attempted to gain an insight into the view of respondents regarding willingness to shift to clean fuels and found that in urban places like Shimla an overwhelming 83 percent are ready to shift to clean fuels as compared to 43 percent in Sirmour, which is poorer and more remote. People cited time saving being the chief reason to shift to clean fuels. Also, respondents had a higher willingness (94%) to pay for ventilation in houses rather than for improved stoves (34%). Study concluded that the main energy users, women supply biomass energy that amounts to 10 percent to 80 percent of total energy supply in various developing countries. There is an economic burden on the poor
in terms of the equivalent number of days spent in fuel collection and suffering from ill health. Regular exposure to harmful indoor air pollution has negative health effects.

Krishan K. Kaushik et. al., (2006) examined the relationship between health status, expenditure on health and education and per capita income in one of the hill states of India. Study based on secondary data for the period 1971-2001 for Himachal Pradesh. Data on four variables; a measure of the population’s health status (infant mortality rate), real per capita expenditure on medical and public health (RPCHE), real per capita expenditure on education (RPCE) and a real per capita income (RPCI) has been retrieved from various issues of statistical outlines of Himachal Pradesh; Economic Survey of Himachal Pradesh. for the period 1971-72 to 2000-01. Study used Johansen’s methodology to test the existence and uniqueness of co-integrating vectors among the I(1) variables. Study results shows that the health expenditure – health status relationship is different from health expenditure – income relationship as there is a lack of causation in the latter relationship and one way causation flows from per capita expenditure on medical and public health to health status. Further, causality that flows from per capita expenditure on education to infant mortality rate is
stronger than the impacts of real per capita income on health status. The results show evidence in favour of causality running from per capita expenditures on medical and public health to health status is stronger than the evidence in favour of causality running in the reverse direction; for three of the six VAR models, the results imply that real per capita health expenditure has a significant impact on health status. Study suggested that health expenditure is an important determinant of better health status and is therefore a key tool available to policy makers.

Cook R.J. and Ngwena C.G. (2006), addressed that the general improvement of women's access to health care, as well as the specific improvement of their ability to receive reproductive and sexual health services, are both essential to achieving the Millennium Development Goals (MDGs). Study identified three legal principles that are key to advancing women's reproductive and sexual health. First, law should require that, for instance, religious ideology or morality. Second, legal guidance should be clear and transparent, so that services providers and patients know their responsibilities and entitlements without litigation to resolve uncertainties. Third, law should provide applicable measures to ensure fairness in women's access to services, both general services and those only women require. Legal
developments are addressed that illustrate how law can advance women's equality, and social justice.

Further, study stated that an accountability process has to be effective, transparent and accessible. Accountability processes are an important part of the legal framework to ensure women's access to health care. Where societies of gynecologists and obstetricians have taken a leadership role in holding themselves and other health institutions accountable in the broadest sense of the term for improving the reproductive and sexual health of women, their legitimacy and influence have grown. In taking such initiatives, they will contribute significantly to the achievement of the Millennium Development Goals.

Mridula Ramanna (2007) examined that the opinions of men-women doctors, civic leaders and philanthropists who were involved in campaigning for better healthcare for expectant mothers and in dealing with the reluctance of Indian women to consult male doctors and also investigated the health of women mill workers, which led to debates in the Bombay legislative council and ultimately in the passing of the Maternity Benefits Act in 1929. Study also contributed to an understanding of a vital area of medical history. This study was based on secondary data like Annual Report of the Muncipal Commissioner of
Study made efforts to tackle maternal health, a vital public health concern, has revealed some significant facets. First, it has shown that Bombay’s medical fraternity, British and Indian, made attempts to delve deeper into the causes of high mortality, besides attributing to the characteristic explanations of ignorance and customs. Further, the records shows that investigations were made to see if there were health problems peculiar to Bombay city. Secondly, differing opinions within the BMC are apparent, as to who had to be given priority in getting relief; the poor or the lower middle class. The zeal of Turner was irksome to seasoned civic leaders like Wacha, who warned of sanitarians and their catchwords. The health department of the BMC under Turner’s direction and with the support of the semi-official BSA and LWS, initiated schemes to promote better maternal care. Two-thirds of births in the city were still attended by unskilled women, at home, but the same number of children were born healthy and this was certainly the effect of the visits by municipal health workers and the dissemination of information. Thirdly, as in the capital, in other cities of the
Presidency, too, welfare activities, whether the establishment of maternity homes or the promotion of better healthcare, were both semi-official and non-official. They were the results of the combined efforts of men and women reformers, donors and activist doctors. Study concluded that not just through maternity facilities, but by promoting urgent improvements in housing, bringing down food prices, the education of the public on the need for a balanced diet and the organisation of a blood transmission service.

Murthy M.S.R et.al., (2007) examined that advances in medical care and services urban women prefer home deliveries by public facility compared to private facility and the differential utilization of health facilities by short and long term migrants particularly for delivery services in urban India. Study based on secondary data from NFHS-1 and 2 on urban India. The sample consists of 27534 respondents (NFHS-1) and 14913 (NFHS-2) conducted in the year 1990 and 1999 respectively. The place of birth data for the last birth consists of a sample of 10163 for NFHS-1 and 4048 for NFHS-2. Place of delivery for the lost child has dependent variable. Educational status, religion, ratio listening, living status of child, and sex of the child born were the independent variables.
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Study results shows that 58.5 percent (1991) and 59.5 percent (1999) of respondents not utilized any antenatal, lack of knowledge of services 12.8 percent (1991) and financial cost 14.7 percent. Multinomial regression revealed that a good proportion of short-term migrants, respondents with low levels of education, lack of media exposure (radio, newspaper reading, and T.V), low standard of living, are more log odds of using home and public facility than private facility. Further, a good proportion of Hindus preferred home and public facility in comparison to private during 1991 (NFHS-1) whereas it is quite opposite during 1999 (NFHS-2) with reference to other religious populations. The log odds are more prominent for home deliveries with reference to private facility. The log odds are somewhat less prominent for public facility with reference to private facility. It shows that some public facilities are functioning well. Though private facility is expensive women with good standards of living, media exposed, and higher levels of education have favoured private facility. Study concluded that migrant status seems to play an important role in seeking medical assistance.

Esther dulfo Michael Greenstore Remahanna's (2008) study examined that indoor air pollution (IAP) from biomass fuels and traditional cooking stoves may be a service health threat,
The study findings show that indoor air pollution is indeed a significant health threat in rural areas where households rely on traditional chulhas for their cooking needs. Further, study found a high incidence respiratory illness i.e., about one third of all adults and half of all children experienced symptoms of respiratory illness and 10 percent of adults and 20 percent of children experiencing a serious cough. However, the choice of stove use is correlated with other factors that effect health (such as income levels and empowerment of women). Study cannot fully disentangle the effect of using a clean stove from the effect of being the type of household that would use a clean stove.

Veena Shatrugna et.al., (2008) examined that the relationship between occupational work and bone health and the stress of heavy occupational work on women bodies undernourished in
Theoretical Background And Review Of Literature

detrimental to bone health in women from the low socio-economic group from Hyderabad, India. Study investigated the relationship between occupational activities and the bone parameters measured by dual-energy X-ray absorptiometry in 158 women from low-income group in India. Study included women involved in three occupations with different bone-loading patterns bidi cigarette makers, sweepers, and construction workers. Study stratified random sample of fifty-five women (aged 30-60 years) per occupation group were randomly selected.

Study stated fact that under-nutrition as indicated by low body weights and low BMI coupled with inadequate calcium intakes may be the major determinant of poor bone health in women. Due to the absence of adequate nutrition, women engaged in relative work and load-bearing activities were not associated with better bone health. Study indicated that under-nutrition might affect the relationship between occupational activities and bone parameters. Study highlights shows that anthropometric parameters, parity and percentage of menopausal women did not differ significantly between the three groups and dietary intake of Calcium was low in all the groups. Due to the different body sizes in these regions, bone mineral
density (BMD) values of overall group at all the sites were much lower than those reported from developed countries.

**Occupational and Environmental Medicine (2008)** considered appropriate to take up the issues of ergonomic study of women workers, health and safety aspects in small-scale labor-intensive industry. Study examined musculo-skeletal problems among women workers in spinning section of woolen textile industry, the risk group pertaining to respiratory disorders and the volumetric lung functions of the workers with the risk of respiratory disorders. Study was based on primary data. Data were collected using questionnaire based on workload, working posture and related health and safety problems. Study conducted cross-sectional observational type of survey in spinning section of small scale labour-intensive woolen textile factory by name “Kanakadas Kuri Sangopan Kendra” in village Sindholi of Belgaum district, Karnataka state. Out of 350 workers in the spinning sections, 100 females in the age ranging between 30 to 45 years were randomly selected.

Study findings shows that 91 percent of the subjects suffered from at least one work-related musculo-skeletal pain in relation to length of occupational exposure. However, percentage of musculo-skeletal pain the number of sites of pain due to work
and further analyzed whether pain was due to working posture only or spinning activity only or related to both working posture and spinning activity. There was 10-15 percent rise in pain at the end of day’s work as recorded by pain score. Further, pain in various parts, neck pain were 19 percent and back pain were 47 percent because the women in a long sitting posture without backrest and maintained this position for at least eight hours a day. Scapular muscles on the right side were involved in stabilizing shoulder was raised as high (>90 degrees) in spinning action, while pulling thread. This muscle work involved trapezius, deltoid and triceps action concentrically in lifting and while coming to starting position slowly, eccentrically.

Sima Roy and Aparajita Desgupta (2008) observed that the health status of the women engaged in a ‘papad-making’ industry and the occupational factors influencing their health status and their felt health needs. It was cross sectional descriptive type observational study. Study chosen slum area of Kolkata by random sampling method and compete enumeration method was adopted. Data were collected by interview and clinical examination of the women engaged in this occupation with a pre-designed and pretested schedule and proportions and Chi-square statistical analysis also used.
Study findings show that 77.5 percent in the reproductive age group and none are below 14 years. 82.5 percent are married, 87.5 percent are literate, 77.5 percent belong to the nuclear family and 78.8 percent of the married women had two or less than two children. Most of them belong to poor socioeconomic status. Health profile of the study population shows that musculoskeletal was commonest health problem. Pallor (75%), anular stomatitis (25%), pedal edema (17.5%), poor oral health (15%), hypertension (12.5%), epigastric tenderness (10%), scabies (7.5%) were found on examination. The ablution habit of the study population was not satisfactory. Study concluded that need exists for a participatory occupational health programme for this working population.

Indian Journal of Occupational and Environmental Medicine- (2008) examined musculo-skeletal problems among women workers in spinning section of woolen textile industry, the risk group pertaining to respiratory disorders and the volumetric lung functions of the workers with the risk of respiratory disorders. Study was based on primary data. Data were collected using questionnaire based on workload, working posture and related health and safety problems based on related studies and with suggestions from the experts in the field. Study
conducted cross-sectional observational type of survey in spinning section of small scale labour-intensive woolen textile factory by name "Karnataka Kuri Sangopan Kendra" in village Sindholi of Belgaum district, Karnataka state during the period September 2005 to April 2006. Out of 350 workers in the spinning sections, 100 females in the age ranging between 30 to 45 years were randomly selected. Study findings shows that 91 percent of the subjects suffered from at least one work-related musculo-skeletal pain in relation to length of occupational exposure. However, percentage of musculo-skeletal pain the number of sites of pain due to work and further analysed whether pain was due to working posture only or spinning activity only or related to both working posture and spinning activity.

There was 10-15 percent rise in pain at the end of day's work as recorded by pain score. Further, pain in various parts, neck pain were 19 percent and back pain were 47 percent because the women in a long sitting posture without backrest and maintained this position for at least eight hours a day. Scapular muscles on the right side were involved in stabilizing shoulder was raised as high (>90 degrees) in spinning action, while pulling thread.
Study suggested that work modification in order to decrease fatigue advisable to provide a frequent short pause that is 10 minutes followed by every 50 minutes of work. Seats with adjustable back rest supporting the lumber region are recommended to reduce postural strain and low back pain, which is likely to result in the long run without any back support. The axis of the wheel should be at the same height as the axis of the shoulder to avoid extra muscular effort and discomfort/pain to the workers.

**Lakshmi Devi K. R.'s** study aimed at identifying the determinants of female labour force participation in Kerala based on micro level data. The study was a modest attempt to identify the factors at the micro level. And mainly focused on the inter linkages between job preferences, levels of educational and the employment studies of woman, the relationship between female employment background, various such as parents and households solid economic status and other household conditions and the inter relationship among gender, work and household relationship in terms of role of women in decision making. This study is based mainly on primary data collected from a random sample of 502 household spread over five grama panchayats and one municipality in Thrissur district of Kerala.
A multi stage random sampling technique was used for the selection of households.

The study results reveals the economic role of woman may become detrimental to woman dissemination of knowledge to woman about new technologies is essential for equipping them on par with men in the production processes. Upgradation of skills alone would go a long way in improving women's productivity and their earning potential and about all calculating in them a sense of belonging women have very little input at the highest level of policy making with the result that policies often become insensitive to the needs and preferences of different sections of woman. Unless policies are framed whether for employment generation or for overall development with sensitively to the woman's needs they are unlikely to yield the desired results. Further, any programme to be successful should teach woman to be economically productive because that is the only solution for their employment. Education is a major influence in the woman's struggle for economic power. Its effects on the gender hierarchy are immense. Higher levels of educational facilities not only current but future socio economic achievement also. But technical and job oriented rather than
Babu B.V. et al., observed the utilization and satisfaction of government health care system by the community in East Godavari district of Andhra Pradesh. This study is community based cross sectional method and utilized both qualitative and quantitative methods. The study data drawn from 12 villages sample from four blocks of the district during September – October 1999. Study's quantitative data presents that majority of people are satisfied with the visits of health workers to their locality.

The study findings shows that the visits of peripheral health workers were regular and their services were relevant to the needs of the people and more women are satisfied with these services than men. Almost 60 percent of people are satisfied with the services available at different health care institutions. The qualitative data revealed that some members reported that they had no faith on the treatment available at government health institutions. Some members of the vulnerable communities expressed their dissatisfaction with the health care providers by citing incidences of discrimination due to caste and economic condition and some respondents were also dissatisfied with the
functioning of the health care services and the attitude of health care providers at different health institutions. A substantial number of people have no trust on the local health system by virtue of which they prefer the services of private practitioners.

Zakir Hussain and Mousumi Dutta (Husain) study endeavoured on the interaction of the organizational processes in the IT industry with the patriarchal family. This study described how the changing economic context weakens the economic incentives to curb empowerment of women. The study is based on a primary survey of 114 women workers in Kolkata's IT sector and ITEs sector.

The study observed that the economic status of respondents to be high. About 70 percent lived in their own houses, while one out of every three respondents had a car, while the respondents from the software segment most well off (73 percent owned a house, and 51 percent owned a car), respondents from the miscellaneous category appeared least well off (only 43 percent owned a house, while 14 percent owned a car). This is not surprising as this sector does not require any technical qualification, and so any person capable of speaking English may join this sector. Further study argued that as employment is no longer linked to economic survival in such
families, women are free to seek psychological satisfaction and sense of fulfillment from work. The survey results lead us to question existing research conclusions on the status of women working in the IT/ITEs sector. Assuming women has passive agents, earlier researchers have argued that the interaction of the corporate environment with traditional values has resulted in the imposition of additional burden on women working in the IT/ITEs sector. This study highlights the deliberate nature of choices made by working women. However, the constraints imposed by a patriarchal society and the organizational processes in the IT/ITEs industry raise conflicting expectations and call for convergence of their multiple objectives. In this situation, working women's decision-making is better framed in terms of a satisfying model.

Sathiyavan D. and Duraisamy P. examined the impact of health status on wages and labour supply of man and women (within the labour – leisure) in Tamil Nadu. The authors make a pioneering attempt in the Indian context to incorporate the health dimension in wages and labour supply analysis. Study has used primary data from a multi-stage stratified random sampling method selected the sample village and households. Total of 284 farm households were interviewed. Study's empirical
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evidence shows that the bivariate association between good health and daily wage rate and annual days worked are positive. Further, regression analysis highlights that a ten percent increase in body mass index increase the daily wage rate of males by 7 percent and that of females by 2 percent. Thus findings establish importance of physical strength and good health on labour market productivity in the rural areas. Study also indicated that a 10 percent increase in body mass index would increase the male and female labour supply by 20 and 11 percent respectively. Thus, findings clearly implied that good health and physical strength are important fact that determine labour supply besides the conventional variables such as wages and income. Study concluded that better health contributes to higher labour productivity and health status of the people is not only an end in itself but also means to increase economic growth and suggested the policy instruments to be adopted to improve the health status of the population.

Martha Fetherolf Lufti's study emphasized that the trends and pattern of female employment, problem of gender inequity in work participation, identify the factor for inter-district variability in female labour force participation and also addressed the recent issues in women’s employment with special reference to
the state of Tamil Nadu. Study based on secondary data relating to 2001 Census. However, data relating to other periods and other sources are also quoted wherever necessary.

Study findings shows that female work participation in Tamil Nadu has increased only marginally during the decades 1991-2001: work participation is more among rural than urban women, gender disparity in work participation is relatively higher in urban than rural areas and there is no occupational diversification among women. The concentration of women workers in the occupation of agricultural labour is an indicator of women's disadvantaged position, increased economic disparity and poverty. Further, in rural Tamil Nadu, there is increase in unemployment on one hand and greater casualisation of labour force on the other. Study suggested that education, training, skill formation and access to resources are the vital input for women to face the challenges of emerging opportunities under the process of globalization and also to achieve the goals of empowerments and equity.

Srinivasan K. et.al., examined that to improve the maternal and child health services in 4 primary health centers (PHCs) in Bellary and Raichur districts of Karnataka and assessed that the consistency in recording symptoms, signs and some clinical
observations of pregnant women by three examiners the junior health assistant, medical officer of the PHC and a private medical practitioner. However in the absence of sophisticated equipment and facilities in PHCs and sub-centres, periodic clinical examination of pregnant women and provision of additional services can be expected to increase awareness among women in the community about the need for antenatal care and motivate them to visit a health centre regularly for an antenatal check-up. Study was used to medical graduate who had training in clinical examination for risk assessment of pregnant women and their new born children. One hundred seventy-four pregnant women were examined independently by the three examiners on the same day for 4 symptoms reported by the women themselves, 4 signs assessed by the examining person and 9 simple clinical observations. Agreement rates in each examiner pair for each parameter were assessed. Further, study findings shows that lacked consistency with a high frequency of disagreement even on simple parameters, not only between the JHA and doctors but also between the two doctors. For example, the agreement rates for 'pulse rate' presence of a 'pale tongue' and duration of pregnancy between the two doctors were as low as 48%, 59% and 61%, respectively. These large agreement rates are disconcerting. However, lack of concern for the health of
mothers and sloppiness seems to underlie the poor consistency between the results obtained by two independent examiners. Study concluded that need for a regulatory and monitoring mechanism to ensure the quality of health care provided by healthcare personnel in rural areas under Government Programmes an urgent need for mandatory periodic refresher course on maternal care for JHAs and MoS efforts should be made to change the attitude of providing maternal health care.

**Basil Hans V.** examined the health issues of women in India in relation to their work environment productivity and welfare. It focused on two broad areas of gender-based differences and inequalities, viz. the link between gender and economic productivity, and the development of human capital. Study highlights view of women’s health is comprehensive in reference and analysis to include besides epidemiologic perspective, the social, environmental, occupational determinants of health, diseases and disorders. However, these are emerging and evolving definitions and cannot be called as entirely new or final. For instance the aspect of “reproductary health” which has surfaced prominently in recent times has been in the roots of women’s health, its knowledge and practice. Further under-enumeration in the country's data collection system, operational
biases etc have led to "invisibility of women in the economy". From ploughing to harvesting, from cooking to fatal child care activities, in India more than 20 activities that women do but are not valued as productive activities. "Missing women-syndrome" has adversely affected the allocative efficiency and distributive justice, both at the micro level and the macro level of economic activities. Study stated that women have not only the right to work, but also to work and live healthy. India can ill-afford to ignore this vital aspect of development. A sound manpower planning is needed to take care of this need by women. Study concluded that gender sensitization is touching vital aspects of human development-health, education skill and enterprise. Gender sensitivity approach and Reproductive and Child Health (RHC) Programme to holistic view of women's life-personal life, family life, community life, work, and life after retirement. Laws, rights and duties in an integrated manner, in an effective will be able to accomplishment empowerment by serving as a check on gender discrimination. The road to travel is indeed challenging, the stress has to be on "togetherness" and solidarity of women and men.

Himanshu Sekhar Rout examined about the effect of income and education of the household on its health expenditure. Study
based on primary data from Jaipur district of Orissa. Data collected by sampling method from the top ten districts in terms of rural population. Multistage random sampling method was adopted to select household. Regression analysis was used and descriptive statistics are estimated. Study results shows that in Rural Orissa, an average person spends around nine percent of his/her income on health expenditure from his pocket. A linear regression results indicated that a rupee increase income brings about 62 paise increase health expenditure of a person and an educated person on an average spends three paise more in rupee than the uneducated person on health expenditure in rural area. It shows that income has greater positive effect on health expenditure than education. Further, study stated that as disposable income of the household increases, individual takes more care of his life, hence health expenditure increases but at a particular level of income, due to high life risk, health expenditure becomes independents of income and perfectly elastic. Further, this study highlighted that a person in rural area spends 46 percent of what a person in urban area spends on health expenditure from his own pocket as his/her income is only around 41 percent of his/her urban counterparts. But a person in rural area spends around nine percent of his/her income on health care from his own pocket which is more than a
person in urban area who spends only around eight percent of his/her income. This is because i) Government spending on health care is more in urban than rural area which reduces peoples expenditure on it from their own pocket; ii) in urban area, government and people take more preventative measures than rural area which reduces people’s expenditure on curative care, iii) urban people take more precautionary measures for health care due to their higher education than rural people; and iv) a person in rural area spends more to transport cost, which is one of the main component of the health expenditure, to avail the medical facility, than a person in urban area, as it is available far away from his/her residence.

Annigeri U.B. and Nayanatara S.N. perceived that the nature of interventions about different permutations and combinations of preventative, promotive and curative care: or about the institutions of health care delivery (liberal, private public, mix, etc. on payment or free etc), have to be consistent with the resource costs, incidence pattern of mortality and under nutrition, socio-economic background of the morbid population and such other factors. Empirical study was carried out in selected four districts viz. Belgaum, Bijapur, Dharwad and Dakshina Kannada of Karnataka during 1995 representing developed, backward, medium developed and coastal regions.
respectively. The sample size was 2039 households spread over four districts in proportion to the number of households in each district to the total number of households in four districts. The required information was gathered from randomly selected households both in rural and urban areas. Study findings show that probability of sickness was higher for the non-communicable diseases for the age group 15-60 years. In the case of younger age group the probability of sickness for the communicable diseases was higher. The overall morbidity percentage for four sample districts in Karnataka as revealed from the children on an average sickness lasted for about 9 to 12 days for the patients suffering from acute diseases, it was longer due to as 1156 to 1821 days for chronic diseases. Average duration was longer due to illnesses like paralyses, cardiovascular diseases, typhoid, T.B. accidents and the respiratory diseases. Total period of lost work per person, less than sickness period was around 7 and 29 days for acute and chronic diseases respectively. The sample population in the four districts of Karnataka lost 890 active and healthy years due to illness for the reference period. Further, the household survey based estimates provide the minimum in the range of the costs of morbidity. The hospital records and interviewing patients would provide more meaningful cost estimates. Non-communicable diseases are costlier than communicable diseases.
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