REVIEW OF RESEARCH

EVALUATION OF MEDIA AND MAJOR FACTORS OF HEALTH CARE FACILITIES FOR RURAL WOMEN IN INDIA

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ABSTRACT:

The women in India belong to various socio-economic backgrounds and are sometimes marginalized or neglected on the gender discrimination when it comes to basic healthcare The fact that the typical female advantage in life expectancy is not seen in India suggests that there are systematic problems with rural women's health. Indian women have high mortality rates, particularly during childhood and in their productive years. Most women who did not receive health care during pregnancy said they thought it was unnecessary. Another reason for the low levels of prenatal care is lack of adequate health care centers. It was estimated that 16 percent of the population in rural areas lives more than 10 kilometers away from any medical facility. Keeping these issues in mind this paper focuses on various determinants of health care facilities such as: Residence, Media Exposure, Females & Partner's Education and Females & their Partner's Employment, Religion of Household Head and Female's Economic Status. Using Household data from Demographic Health Survey and by using ordered Logistic Regression Analysis, this paper seeks to examine the above mentioned socio economic factors which are responsible for poor health status of women in India on the basis of parameters like Delivery at Health Facility, Antenatal care, Level of anemia, Family planning, Knowledge of STD and Prenatal care. Health Communication is an important domain in communication arena aims at disseminating health messages to the public. In this study the role of media in giving health information to women is analyzed. The portrayal of women in media, the impact it creates on the minds of women, both urban and rural background is scrutinized separately. The responsibility of media in the rural health of women is critically studied and media's role in idealizing body images in the mind of urban women is also analysed.

KEYWORDS: *Female child mortality, Gender discrimination, Health facility, Pre natal care, Socio-economic backgrounds.*

I. INTRODUCTION

Media plays a vital role in the dissemination of information. It is called the fourth pillar of democratic polity. The role of media is not only limited as information providers, but by gradually shaping public opinion, personal beliefs and even people's self-perception, media influences the process of socialization and shapes ideology and thinking also. Health communication links the domains of communication and health and is increasingly recognized as a necessary element of efforts to improve personal and public health.

Lack of health information and education is the main barrier in achieving better health status.

India is one of the few countries in the world where women and men have nearly the same life expectancy at birth. The fact that the typical female advantage in life expectancy is not seen in India suggests that there are systematic problems with women's health.

Indian women have high mortality rates, particularly during childhood and in their productive years. The health of Indian women is intrinsically linked to their status in society. The women in India belong to various socio-economic backgrounds and are sometimes marginalized or neglected when it comes to basic healthcare. Women however, are the very backbone of any society and if one needs a healthy society, the women need to be well taken care off. Research on women's status has found that the contributions Indian women make to families often are overlooked and instead they are viewed as economic burden.

II. REVIEW OF LITERATURE

Miller (1989),Murthi, Anne and Dreze (1995), Gupta and Bhat (1997), George (1998), Bhat and Zavier (2003), Mishra., Roy and Rutherford (2004), Dyson and Moore (1983), Krishnaji (1987), Siddhanta, Nandy and Agnihotri (2003), Pandey (2003), Hill and Upchurch (1995) and Acharaya & Kumar (2004) explained the extent of gender differences in infant and child mortality in terms of gender differences in health status ,disease incidence, preventive and curative treatment and social status.

In many parts of the world, women receive less attention and health care than man do and particularly girls often receive very less support than boys. As a result of this gender bias, the mortality rates of females often exceed those of males in these countries. This is an important issue because gender discrimination that contributes to poorer health status for girls than for boys is likely to be the main pathway for excess female child mortality. Such discrimination occurs in (a girl) receives less attention than would be bestowed upon a son. She is less warmly clad, she is probably not so well fed as a boy would be and when ill, her parents are not likely to make the same strenuous efforts to ensure her recovery".

Sugathan, Mishra and Retherford (2001), Kishor and Parasuraman (1998), Stephenson and Tusi (2002), Bourne & Walker (1991), McNay, Arokiasamy and Cassen (2003), Dyson and Moore (1983) and Rustagi (2004) evaluated the status of women in India with different indicators such as of women's work, education, health, survival, safety and participation in public/private decision-making.

Sudha, Rajan,(1999) George (2002), Rutherford and Roy (2003), Bose (2007), Visaria (2007) examined the causes for eliminating the girl child. It indicates that they are rooted in rituals and perceptions that go back centuries: the fear of having to pay for a girl's dowry, the belief that for true salvation a son should perform the last rites, the conviction that lineage and inheritance run through the male line and that a son will look after his parents in their old age, whereas the daughters will belong to another family. Tied up to all this is the old perception of seeing only men as the bread earners

III. NATURE OF THE PROBLEM

Poor health has repercussions not only for women but also their families. Women in poor health are more likely to give birth to low weight infants. They also are less likely to be able to provide food and adequate care for their children. Finally, a woman's health affects the household economic well-being, as a woman in poor health will be less productive in the labor force and media impacts greater role in women health conditions

IV PURPOSE & OBJECTIVE OF THE STUDY

While women in India face many serious health concerns, this research paper focuses on various determinants of health care facilities such as: Residence, Media Exposure, Female's Education, Partner's Education, Female's Employment, Partner's Employment, Religion of Household Head and Female's Economic Status.

The main objective of this paper is to examine the above mentioned socio economic factors which are responsible for poor health status of women in India on the basis of different parameters like Delivery at Health Facility, Antenatal care (ANC), Level of anemia, Family planning, Knowledge of Sexually Transmitted Diseases (STD) and Prenatal care(PNC).

III. STATUS OF WOMEN'S HEALTH

In India most of the women are still not receiving health facilities. Poor condition of women can be seen in availing nutritious food, prevalence of anemia and nutritional status of women. Women's autonomy has been determined by three areas- control over finance, decision making power and freedom of movement. Women with greater freedom of movement obtained higher level of antenatal care and were more likely to use safe delivery care.

The influence of women's autonomy on the use of health care appears to be as important as other determinant such as education. According to NFHS 3 almost one out of every five women in India did not receive any antenatal care for their last birth in the five years preceding the survey. There is wide variation in the use of antenatal care services among the states. Utilization of antenatal care is almost universal in Kerala, Tamil Nadu and Goa. In addition, more than 90 percent of women received ANC in Andhra Pradesh, Maharashtra, West Bengal, Karnataka, Delhi and Punjab. The percentage of women receiving antenatal care was lowest in Bihar. In India there is broad North- South contrast between areas of low female autonomy and unfavorable demographic performance on the one hand and comparatively high female autonomy and relative favorable demographic performance on the other. The particularly high birth and death rates that continue to prevail throughout most of Northern India must be seen within the context of local kingship arrangements.

3.1 Nutritional Status of Women in India:

For women, weight and height measurement can be used to access health risks. A widely used indicator of nutritional status is the body mass index (BMI), which is defined as the weight in kilograms divide by height in meters squared (kg/m2). This indicator is used to assess both thinness and obesity. It is helpful in detecting the risk of health or nutritional disorders. A BMI of less than 18.5 indicates chronic energy deficiency (CED).

At the other end of the spectrum, women with a BMI of 25.0-29.9 are considered to be overweight and those with a BMI of 30.0 or above are identified as obese. According to NFHS-3 there are 36 % women in India have chronic energy deficiency and 13% women are overweight. Level of CED is high in the states of Chhattisgarh, Orissa, Madhya Pradesh, Bihar, Jharkhand and Uttar Pradesh. CED is particularly pronounced for rural women, illiterate women, and women living in households with a low standard of living and among those women who don't consume proper nutritious food.

3.2 Bias in the Intra-Household Distribution of Food and Nutritive Elements

In India, sex preference is mainly manifested in the form of excessive mortality of female child. The poor health status of female relatively to males is found to be due to the discrimination against females in the allocation of food and health care within household. There is gender discrimination in childhood feeding, immunization coverage, treatment seeking and nutritional status. According to NFHS-3, women consume less nutritious food than man.

The pattern of food consumption that men are more likely than women to consume milk or curd regularly. Men are less likely than women to completely abstain from eating chicken, meat, fish, or eggs. The last row of each panel shows the frequency of consumption of fish, chicken, or meat. Overall, 33 percent of women and 24 percent of men are vegetarians according to this measure.

3.3 Maternal Health

Maternal health is a major indicator of status of women as it depends on socio economic conditions and facilities provided by government. Poor status of maternal health reveals the low status of women in the society. In India a higher percentage of women are not receiving health facilities during pregnancy which has direct and indirect effect on survival condition of women as well as their child.

3.4 Trends in Maternal Care Indicators

The trends in key maternal care indicators over time. All of the measures improved substantially between National Family Health Survey-1 and National Family Health Survey-3. The first

two ANC indicators (percentage with any ANC and at least three ANC visits) improved much more rapidly between NFHS-2 and NFHS-3 than between the first two surveys. The other three indicators improved at a more even pace throughout the period. Over the entire period between NFHS-1 and NFHS-3, most of the indicators improved at a rate of about one percentage point per year. The slowest increase was in the percentage that had at least three antenatal care visits. All of the indicators except the timing of the first ANC visit increased much more rapidly in rural areas than in urban areas.

Despite these improvements, at least half of women did not receive appropriate care for their most recent birth. Thus, renewed efforts are required to ensure that women are provided with adequate antenatal and delivery care.

3.5 Anemia among Women and Men in India

Anemia is a major health problem in India, especially among women and children and it can result in maternal mortality, weakness, and diminished physical and mental capacity, increased morbidity from infectious diseases, prenatal mortality, premature delivery and low birth weight. NFHS show gender differential in anemia levels for women and men .55.3 % of women and 24.2 % percent of men whose hemoglobin level was tested were found to be anemic. Thirty-nine percent of women are mildly anemic, 16 percent are moderately anemic and 2 percent are severely anemic. The prevalence of anemia for ever-married women has increased from 52 percent in NFHS-2 to 56 percent in NFHS-3. Therefore, the anemia situation has worsened over time for both women and young children.

3.6 Antenatal Care

Almost one in four women (23 percent) who gave birth in the five years before NFHS-3 received noantenatal care (ANC), ranging from one percent or less in Kerala, Goa and Tamil Nadu to 66 percent in Bihar. In addition to Bihar, at least 40 percent of pregnant women did not get any antenatal care in Jharkhand, Arunachal Pradesh and Nagaland.

NFHS-3 shows the most common hurdle among the eight asked about are the distance to a health facility and the least common is getting permission to go. Notably, almost one-fifth of women report that not having a female provider is a concern and for one-tenth of women, finding someone to go with them is a problem.

3.7 Family Planning Knowledge and Use

Knowledge of contraception is nearly universal: 98 percent of women and 99 percent of men age 15-49know one or more methods of contraception. Over 94 percent of women and men know about female sterilization. Male sterilization, by contrast, is known only by 79 percent of women and 87 percent of men. Ninety-three percent of men know about condoms, compared with 74 percent of women. More than four in five women and men know about contraceptive pills. Knowledge of contraception is widespread even among adolescents: 96 percent of young women and 97 percent of young men have heard of a modern method of contraception. Two-thirds of currently married women have used a family planning method at some time in their lives. Since NFHS-2, ever use of any method among currently married women has increased by 11 percentage points. The increase is greatest for spacing methods; ever use of condoms and the rhythm method has increased by 6 percentage points each.

In general we can say that most women who did not receive health care during pregnancy said they did not because they thought it was unnecessary. Thus, there is a definite need to educate women about the importance of health care for ensuring healthy pregnancies and safe childbirths. Another reason for the low levels of prenatal care is lack of adequate health care centers. It was estimated that 16 percent of the population in rural areas lives more than 10 kilometers away from any medical facility.

Place of birth and type of assistance during birth have an impact on maternal health and mortality. Births that take place in non hygienic conditions or births that are not attended by trained medical personnel are more likely to have negative outcomes for both the mother and the child.

Anemia, which can be treated relatively simply and inexpensively with iron tablets, is another factor related to maternal health and mortality.

IV. HEALTH STATUS OF WOMEN IN INDIA AND MEDIA

India is one of the few countries in the world, where women and men have nearly the same life expectancy at birth (kilbourne, 1990). Recently there is a great decline in the sex ratio in India. The most extreme expressions of the preference for sons are female infanticide and sex selective abortions. Apart from that, women are prone to many life threatening diseases, but they get less health care than men even as children. Poor health has repercussions not only for women but also their families. Women in poor health are more likely to give birth to low weight infants. They are also less likely to be able to provide food and adequate care for their children.

Unwanted pregnancies terminated by unsafe abortions also have negative consequences for women's health. The high levels of maternal mortality are especially distressing, because the majority of these deaths could be prevented if women had adequate knowledge about health services either proper prenatal care or referral to appropriate health care facilities (jejeebhoy and Rao 1995). In fact the leading contributor to high maternal mortality ratios is lack of access to health care (The world bank 1996). Studies have found that twenty percent of all maternal deaths in india is caused by anemia (The world bank 1996).

Women do not even have the knowledge about anemia a simple reason for death which can easily be avoided if they get the knowledge. India has the highest incidence of cervical cancer in the world which could be reduced by a simple papsmear test. News reports say that female infanticide has reached the one crore mark in the last decade in India. And everybody knows that hundreds of women are killed every year on every front and every imaginable pretext. If this trend continues there is possibility of women becoming an extinct species.

Despite the alarming growth of the epidemic AIDS, most women in India have little knowledge of AIDS. The NFHS found that a large majority of Indian women had never heard of AIDS. There were many misconceptions among those who had heard of the disease. "Health information is the most important resource in health care and health promotion, because it is essential in guiding strategic health behaviors, treatments and decisions" (kreps, 1988). But Indian media's role in creating health awareness among women in India is very minimal. Apart from some government funded programmes on AIDS, contraceptives and immunizations, media's commercial face had not allowed them to care about women's health in India.

V. MEDIA IMPACT ON URBAN WOMEN AND THEIR HEALTH STATUS

When there is a lack of knowledge about their basic health in rural areas among women and media not doing any role in giving health literacy or awareness, in urban areas the stereo typing of women and body image distortation shows media has no concern about the health of women altogether.

As media images glamorizing the extremely thin continue to rule newspaper and magazine covers, an increased number of women are becoming worried over their bodies and therefore engaging in unhealthy eating behaviors such as excessive dieting. They are running behind any weight reducing technique, through tablets or imported machines, fascinated by the "Reduce 20 kgs in 10 days" type of advertisements.

Most of the television commercials are aimed at women being the main consumers. All advertisements compel women to worry about their hair, skin, complexion, body sizes etc. One advertisement talks like "Being fair" is the only solution to all women's problems. Starting from teen age girl to middle aged women in urban areas all women are conscious about their skin and body structure. In short Indian media's aim is to create beauty awareness among women rather than health awareness.

By promoting the ideal difficult to achieve and maintain the cosmetic and diet product industries are assured of growth and profit. The media's effect on women is troubling because it creates major body dissatisfaction in women which leads to low self-esteem, depression, obesity and eating

disorders such as bulimia. The tragedy is many women internalize these stereotypes and judge themselves by the beauty industry's standards. Thus the role and responsibility of media in Rural women's health is completely absent whereas the mental health of urban women is affected by their stereotyping body images.

VI. CONCLUSION

Girls in India are discriminated against in other ways as well – fewer months of breastfeeding, less nurturing and play, less medical treatment if they fall ill, less special food, less prenatal attention. As a result, girls are far more susceptible than boys to disease and infections, leading to poor health and a shorter lifespan. It is this lifelong discrimination in nurturing and care that is the real killer of girls, less visible and less dramatic, but as unequivocally lethal as female foeticide and infanticide (UNICEF, 1998).

As UN Secretary Kofi Anan had stated, "Gender equality is more than a goal in itself. It is a precondition for meeting the challenge of reducing poverty, promoting sustainable development and building good governance." This recognition is currently missing in India. Transforming the prevailing social discrimination against women must become the top priority. This must happen at war footing before it gets very late to improve the social and economic status of women.

In this way, a synergy of progress can be achieved. As women receive more education and training, they will earn more money. As women earn more money - as has been repeatedly shown - they spend it in the further education and health of their children, as opposed to men, who often spend it on drink, tobacco or other women.

No policies or campaign would be successful without public support, awareness and proper implication. There is a need to raise the voice against gender discrimination in health care facilities and to improve the status of women at the every possible level and should it not be stopped until and unless this problem is totally removed from the society.

Women health is the basis of any society. There can be development in any sphere, politics, economics, and science and so on.., but nothing can be achieved when the core of the society, women's health is neglected. The health of the future generation depends on the health of present women. So this is not a feminine problem, it's a social problem. And media should take the responsibility and real concern over women by looking into their health rather than their skin and beauty.

VII REFERENCES

1. Jejeebhoy, shireen. J and sowmya Rama rao, 1995,"Unsafe motherhood: A review of reproductive health" monica das gupta and T.n.krishnan eds, Bombay.
2. Heise, lori.l, 1994, violence against women the hidden health burden, World Bank discussion papers 255, Washington, dc.
3. Women's health in India, Victoria A velkott and arjun alakha, International programs centre.
4. Kreps, G.L. (1988) The pervasive role of information in health care; Implication for health communication policy, J.Anderson (ed) communication year book, newbury park, CA,sage. 5. www.harvard health publications.html
5. AIDS Analysis, 1996,"India, a rapid and extensive spread of HIV', Incorporating AIDS and Society,vol.2,no.5,p.11 8.
6. Anand,Meenu(2006) commoditization of women The Irony;"Women's watch"vol.3, issue 3, April-Jjune 2006.NFIW
7. A. Sen, Many Faces of Gender Inequality, Frontline, 18 (22), Oct. 27 - Nov. 09, 2001.
8. Census of India 2011, Office of the Registrar General & Census Commissioner, India.
9. Shelah S. Bloom, David Wypij, Monica Das. Gupta, Dimensions of Women's Autonomy and the Influence on Maternal Health Care
10. Utilization in a North Indian City, Demography, 38(1), Population Association of America, 2001.
11. Bhat, P. N. Mari and. A. J. Francis Zavier, Fertility Decline and Gender Bias in Northern India, Demography, 40(4), Population Association of America Northern India,2003,637-657.

12. Rohini P. Pandey, Selective Gender Differences in Childhood Nutrition and Immunization in Rural India: The Role of Siblings,
13. Demography, 40(3), Population Association of America, 2003.
14. Bhat, P. N Mari, K Navaneetham, and S. Irudaya Rajan, Maternal Mortality in India: Estimates from a Regression Model, Studies in Family Planning, 26(4), Population Council India, 1995.
15. K. S. Sugathan, Vinod Mishra, and Robert D Retherford, Promoting Institutional Deliveries in Rural India: The Role of Antenatal
16. Care Services, National Family Health Survey Subject Reports, 20, International Institute for Population Sciences, Mumbai. 2001.
17. K. B. Pathak, Griffith Feeney, & Norman Luther, Alternative Contraceptive Methods and Fertility Decline in India, National
18. Family Health Survey Subject Reports, 7, International Institute for Population Sciences, Mumbai,1998.
19. SRS Bulletin, 45(1), Sample Registration System, Office of the Registrar General; India, 2011.
20. Ansley J. Coale, Excess Female Mortality and the Balance of the Sexes in the Population: An Estimate of the Number of "Missing Females||, Population and Development Review, 17(3), Population Council, 1991.