Rural Development through Women's Health

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Abstract— *India is one of the world's fastest growing economies, with women mainly from the middle class increasingly entering the workforce. India ranks 18th among the highest maternal mortality rates in the world with 540 deaths for every 100,000 births. Only 48% of adult Indian women are literate. Among rural women, 36.1% have experienced physical violence in their adult lives.66% of women who have experienced physical violence in their lifetimes are divorced, widowed, or deserted. Lower caste and tribal women are among those who experience the highest levels of physical violence 85.3% of women reporting violence claimed that their current husbands were the Perpetrators. According to the most recent Demographic and Health Survey analysis, only 43% of currently married women (between ages 15-49) are employed. Urban centers like Delhi and Bangalore have seen an influx of young women from semi-urban and rural parts of the country, living alone and redefining them. However, the story of economic empowerment for women is not a singular narrative; rather it is located in a complex set of caste, class, religious, and ethnic identities.*

Keywords— ***Urban, Rural, ESCR, PWESCR, SHG, NGO.***

I. INTRODUCTION

During the independence movement, women were visible and active as nationalists, and as symbols of "Mother India". Gandhi, in particular, was instrumental in creating space for women through his non-violence (and some would argue feminized) mode of protest. Gandhi's

Legendary salt march initially excluded women, but due to demands from women nationalist she later realized the power of women organizers at the local level. His inclusion of women, however, was not located within a gender equality framework, but was a means to achieving stronger and unified Indian state. The inclusion of women in the nationalist movement was also to debunk the British colonial assertion of "needing to save the poor, vulnerable women" of pre independence India.

II. WOMEN OF INDIA

India is one of the world's fastest growing economies, with women mainly from the middle class increasingly entering the workforce. Urban centers like Delhi and Bangalore have seen an influx of young women from semi-urban and rural parts of the country, living alone and redefining them. However, the story of economic empowerment for women is not a singular narrative; rather it is located in a complex set of caste, class, religious, and ethnic identities.

The Global Gender Gap Report by the World Economic Forum in 2009 ranked India 114th out of 134 countries for inequality between men and women in the economy, politics, health, and education.26 On equal economic opportunities and women's participation in the labor force, India ranked 127th and 122nd respectively.27 The number of women in the workforce varies greatly from state to state: 21% in Delhi; 23% in Punjab; 65% in Manipur; 71% Chhattisgarh; 76% in Arunachal Pradesh.28 The diversity of women's economic opportunities between states is due to the cultural, religious, and ethnic diversity of each state. Northern states like Delhi and Punjab lag far behind on gender equality measures, including the alarming sex ratio between men and women (due to son preference and sex-selective abortion), low female literacy levels, and high rates of gender-based violence.

In rural India, women's economic opportunities remain restricted by social, cultural, and religious barriers. Most notably inheritance laws embedded in Hindu and Shariat civil codes continue to marginalize women in the household and the larger community. Rural women, particularly of lower caste and class, have the lowest literacy rates, and therefore do not have the capacity to negotiate pay or contracts and most often engage in the unorganized sector, self employment, or in small scale industry. Self-help groups (SHGs) are a widely practiced model for social and economic mobility by NGOs and the government. SHGs provide women with the opportunity to manage loans and savings that can be used by members for varying needs. SHGs also are used to promote social change among the members and the community at large. Members of SHGs have used their experiences as leverage to enter other local institutions such as the Panchayat.

Rural, low caste and tribal women also make up 70% of domestic workers in India, a sector which is largely unregulated and unorganized. India's growing economy has allowed for many upper and middle-class women to enter the workforce, and while poor rural women have little access to education and training, there is a high demand for domestic workers in urban hubs.

III. INEQUALITY BETWEEN MEN AND WOMEN IN INDIA

Inequality between men and women runs across the board, including in education, economic opportunities, representation in governance, and other state and private institutions. Additionally, women in India face high rates of violence. India ranks 18th among the highest maternal mortality rates in the world with 540 deaths for every 100,000 births. Only 48% of adult Indian women are literate. Among rural women, 36.1% have experienced physical violence in their adult lives.66% of women who have experienced physical violence in their lifetimes are divorced, widowed, or deserted. Lower caste and tribal women are among those who experience the highest levels of physical violence 85.3% of women reporting violence claimed that their current husbands were the Perpetrators. According to the most recent Demographic and Health Survey analysis, only 43% of currently married women (between ages 15-49) are employed.

IV. (A) HEALTH ISSUES

The women's reproductive health and rights, and added new commitments addressing the right of women to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Taking a holistic and life-cycle approach to women's health. Increase women's access throughout the life cycle to appropriate, affordable and quality health care, information and related services.

- Strengthen preventive programmes that promote women's health.
- Undertake gender-sensitive initiatives that address sexually transmitted diseases.
- HIV/AIDS and sexual and reproductive health issues.
- Promote research and disseminating information on women's health.
- Increase resources and monitor follow-up for women's health.

(b)Other health issues

Although there is a tendency to focus on women's reproductive health, countries have also reported on progress in other areas. For example increased attention to the early detection of breast and cervical cancer; recognition of violence against women as a health problem; efforts made to address women's mental health issues; attention to gender-specific factors in addiction, primarily relating to tobacco use; efforts made related to nutrition and eating disorder.

(c)Sexual and reproductive health

Despite some progress, considerable challenges continue to exist in the area of sexual and reproductive health. Reproductive health problems are the leading cause of women's ill health and death worldwide. Death and disability due to sexual and reproductive health accounted for 18 per cent of the total disease burden globally and 32 per cent of the disease burden among women of reproductive age in 2001.

More than half a million women in the developing world die during pregnancy and childbirth due to preventable causes, with over 90 per cent of those in Africa and Asia.32 Unsafe abortions continue to imperil women's reproductive health in developing countries. According to WHO estimates, 19 million unsafe abortions were carried out in 2000, with Asia, Africa and Latin America accounting for the highest numbers.

Many developing countries face contraceptive shortages as a result of rising demand for contraception. Around 200 million women who wish to space or limit their childbearing lack access to contraception. In some countries, contraceptive services are only available to married women. Other barriers to women's use of contraception include legal barriers, socio-cultural attitudes and lack of information

V. RESERVATION FOR WOMEN

In 1976 the Committee on the Status of Women in India was established and published a report recommending an increase in elected women at the grassroots level, which led to the introduction of the 33.3% reservation at the Panchayat level in 1988. It was only in 1993 that an amendment in the constitution made the proposed reservation at the Panchayat (village level governing councils) a reality.

The Women's Bill in April 2010, which gives 33.3% reservation for women in all levels of Indian politics, took 14 years after its introduction to finally pass by the Rajya Sabha (the upper house of parliament). It is yet to be passed

by the Lok Sabha (the lower house of parliament). The reservation bill will ensure 181 out of the 543 seats at the Parliament level, and 1,370 seats out of the 4,109 seats at the State Assembly level.44 This is a historic move in the Indian political landscape, as currently women occupy less than 10% of seats in the national Parliament.

The Women's Bill will also significantly change the demographics of class and caste among women politicians in leadership positions in the Indian political structure. It will create a path for women from lower classes and castes (who are currently confined to local-level governance) to enter state and national level governments. In addition to the existing reservations for scheduled castes and scheduled tribes, one third of the SC and ST candidates must be women. Other Backward Class (OBC) members are not included in the reservation due to the wide disagreement about who constitutes OBC and a lack of existing data on the OBC population.

VI. WOMEN'S ECONOMIC, SOCIAL, AND CULTURAL RIGHTS

The movement to assure women's economic, social, and cultural rights (ESCR) as basic human rights is just emerging in India. The movement aims to locate women's rights within the larger human rights framework, and by doing so moves away from looking at women's issues only within the framework of violence against women and reproductive rights. ESCR attempts to look at the broader issues facing women, namely poverty, housing, unemployment, education, water, food security, trade, etc. While the human rights movement on ESCR is largely contained at the international policy level, there are emerging social movements around the world. In the Indian context, projects like the Programmed on Women's Economic, Social, and Cultural Rights (PWESCR), for example, is creating linkages between the international human rights movement and the local articulation of women's rights. PWESCR aims to build a women's rights movement in India that creates equality in all spheres of women's lives. By empowering women economically and socially, ESCR provides for a broader discourse on rights that moves women's rights from a victim centered approach to one that cuts across other fundamental human rights issues.

Women's economic opportunity in India is a rapidly changing landscape. Women are increasingly entering the workforce—particularly women professionals—and are creating change, but there remains a large number of invisible women workers in unorganized and volatile sectors. However, organizing at the local level, albeit small, widespread. Implementation of national and state level policies lags behind in ensuring that women workers have equal pay and are free from exploitation.

VII. FACTORS AFFECTING ACCESS TO HEALTH CARE

During the ten-year review and appraisal of implementation of the Beijing Declaration and *Platform for Action*, many countries reported that urban women had much better access to health services than women in rural areas, including indigenous women. A lack of human and financial resources limits primary health care in rural and remote areas. Indigenous women in many parts of Latin America, for example, often have difficulties in accessing health care, as health coverage is generally low in rural areas, where they are concentrated. In addition, most indigenous communities are remote and lack access to transportation to reach urban or peri-urban medical centers. Indigenous women are often triply disadvantaged due to their ethnicity, their sex and their predominantly rural residency patterns, resulting in a lack of attention to their needs in existing health programmed. Indigenous women are also often reluctant to access health services because they are more comfortable with their communities' traditional medical knowledge and midwives, and they are not understood or are poorly treated by modern health providers. Furthermore, cultural beliefs about modesty and sexuality prevent health providers (especially males) from examining them. In rural areas, low levels of literacy can be a major obstacle preventing women from identifying health problems. A 10-year study in rural Egypt published in 1999 found that perceptions women held about their own health were the single most important factor governing their utilization of health services. The majority of women with reproductive tract infection, genital prolapsed and anemia did not seek health care services as they considered these conditions to be normal.

VIII. IMPROVING REPRODUCTIVE HEALTH

A number of strategies have been developed to address issues related to women's reproductive health. One of the key strategies at the national level is to ensure that the breadth of issues covered is consistent with the elements agreed to at the International Conference on Population and Development which encompass a state of complete physical, mental, social well-being, including.

- Access to appropriate, safe, effective, affordable, acceptable methods of family planning based on informed choice and dignity.
- Services for safe pregnancy and childbirth.
- Prevention, diagnosis and treatment of reproductive tract infections and sexually transmitted infections, including HIV/AIDS.
- A satisfying, safe sexual life.
- Elimination of violence against women and girls, including female genital mutilation/cutting, domestic violence and trafficking.

IX. CONCLUSION AND POLICY PRESCRIPTIONS

Empowerment of women has considerable hurdles. In spite of them women empowerment in India took a stagnant shape. The women trait plays a major role on overcoming various kinds of obstacles in their empowerment. The encouragement of women entrepreneurship has been carried out on various levels as well as from various from platforms. Moreover the positive change in traditional mentality of so called Indian society has been observed. The little skill enhancement efforts as well as moral boosting attitude of family hikes the performance of women by miles. The skills enhancement through encouraging entrepreneurship results in empowerment of women which is prime need of our Nation. Contextual factors in planning and implementing women's empowerment programs, it would be useful to undertake similar studies in differing contexts. women's empowerment had been diluted and that while women's programs were emphasizing individual empowerment of women, the focus on facilitating empowerment of whole groups of women and building a movement for women's equality was getting marginalized. Women's empowerment programs tend to be marginalized due to societal attitudes and due to men being in decision-making positions, whether in the family, at workplace, or in the government. Sensitizing and changing societal attitudes, including those of men, therefore becomes a major challenge Developed for sensitizing male planners, administrators, policy makers, media producers, etc. Action research studies need to be commissioned to capture how a balance between economic and social empowerment. Networking, building alliances and linkages at all levels is essential components for community support and for policy changes if women's empowerment programs have to achieve any degree of success. Workshops, exchange programs, study visits can be organized to facilitate and strengthen the required support systems.

Thus the role of the government and other development actors like social activities, NGO‟s and others should be to promote the involvement of women in the economic sphere. The increasing participation of women and greater gains from it will not only economically make them independent but will also help in a long way in the overall development of such regions. Amidst the poor scope of industrialization and other bigger large scale employment generating opportunities the government has always failed with every policy framework to stop the persistent migration from these regions which has negatively affected the development of such regions. The government should strictly follow the policy of supporting the existing female work force which is very essential and only best possible alternative in front of them to deal with the problem of migration of women mainly in agriculture and allied activities and also in low income generating activities like MNREGA. It is further important to emphasize that agriculture and allied activities are largely carried out merely for subsistence. Further the participation of males is very less relatively to females in agricultural and allied activities. Females in agriculture and low wage employment the government support becomes essential to such section of the population. The government support should focus on supporting the active female workforce through imparting skill development to get them involved in the higher paid work or to step up in entrepreneurship development. The government should further act on removing the barriers in the female's workforce participation which largely constitutes of the health problems. The other major emphasis should be on the supportive programs for the development of agriculture activities as the women.

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