A CRITICAL APPRAISAL OF HEALTH CARE PROGRAMMES FOR RURAL WOMEN TOWARDS A BETTER INDIA WITH SPECIAL REFERENCE TO U.P.

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Abstract

Today globalization is posing new challenges to the improvement of living conditions of rural habitants and we know a community can-not foster a development without an educated population. Since the dawn of civilization and growing awareness of healthy human survival there have been efforts to mobilize the resources to ensure better health and hygiene in the human community as a whole and among the rural women in particular. Rural women are facing problems in getting even basic facilities in every field primarily in Health care sector which is the major concern area of this paper.

Keywords: *Rural women, Health care, Education and Government Policies.*

Women, the word sounds so powerful. Since eternity, women have played a role more important than men and that is no exaggeration. It has been said that, you teach a female and you build up a nation and truth can't be closer than that. Women have always carried the burden of being a wife, mother, sister all on their own and we need not to explain how magnificently they have carried this position. Pandit Jawaharlal Nehru had once said, "*You can tell the condition of a nation by looking at the status of its women".*However, things have not remained the same in the recent past. The social fabric has acquired completely new dimensions. The women are considered less powerful and important than men. . India in last few decades has remained more of a male-dominated society. Women suffer from hunger and poverty in greater numbers and to a great degree than men. At the same time, it is women who bear the primary responsibility for actions needed to end hunger and improve education, nutrition, health and family income. How ironical situation Is this? The Indian constitution grants women equal rights with men, but strong patriarchal traditions persist, with women's lives shaped by customs that are centuries old.

Looking through the lens of hunger and poverty, there are many major areas of discrimination against women in India:--

Malnutrition: India has exceptionally high rates of child malnutrition, because in India women eat last and least throughout their lives, even when pregnant and lactating. Malnourished women give birth to malnourished children and this way cycle perpetuates; Poor Health: Females receive less health care than males. Many women die during childbirth. Working conditions and environmental pollution further deteriorate women's health; Lack of Education: Families are far less likely to educate girls than boys, and far more likely to pull them out of school, either to help out at home or from fear of violence; Overwork: Women work longer hours and, yet their work is unrecognized. Men report that "women, like children, eat and do nothing.";

Unskilled:Women's primary employment is in agriculture which is an unskilled job; Mistreatment: In recent years, there has been an alarming rise in atrocities against women in India, in terms of rapes, assaults and dowry- related murders. Female infanticide and sex elective abortions are additional forms of violence that reflect the

devaluing of females in Indian society; Powerlessness: While women are guaranteed equality under the constitution, legal protection has little effect in the face of prevailing patriarchal traditions.. Legal loopholes are used to deny women inheritance right; In the light of the above points one can say women live a miserable live and belongs to a marginalized society. It is more prevalent with the rural women in comparison to urban women.

Urban women in India always had more advantages and opportunities than women residing in rural places.Like better education, better economic resource, and more availability of required things for urban women. Rural women are facing problems in getting even basic facilities in every field primarily in Health care sector which is the major concern area of this paper. With the dismal picture of health care in India, not much can be expected in favor of rural women as user of the health system. The present paper is a humble attempt to critically analyze the Health status of rural women.

Health is defined by the World Health Organization (WHO) as a state of complete physical, mental, and social well being. This definition is accepted by all the signatories to the Alma-Ata Declaration on health adopted by the thirty-first World Health Assembly in 1978. This declaration gave the call of 'Health for All by 2000 AD' and accepted that Primary Health Care was a key to attaining this goal.

Health is thus not only about disease and medical care system but also about the environment around us, which influences the mental and physical state of a person. It is multidimensional phenomenon (Hema and Muraleedharan: 1983).The World Development Report[1993] considers good health as an input for increasing productivity, leading to economic growth. The National Council of Applied Economic Research considers health status as "an important indicator of the level of economic development" and it includes mainly mortality and morbidity(NCAR: 1992).

So, we see, Health care is right of every individual but lack of quality infrastructure, dearth of qualified medical functionaries, and non- access to basic medicines and medical facilities thwarts its reach to 60% of population in India. A majority of 700 million people lives in rural areas where the condition of medical facilities is deplorable. Hence, Rural Health care has become one of biggest challenges facing the Health Ministry of India'

Uttar Pradesh is one of the largest, densely populated, and backward states of India which has a socio-economical and thus health related problems for women.Considering the grim picture of the fact the present paper endeavors to critically analyze the health conditions of rural women in up.

Though a lot of policies and programs are being run by the Government but the success and effectiveness of these programs is questionable due to the lack of awareness of Govt. policies and their implementation in rural areas of the districts of up.

Programs and Policies of Government

If we glance some of the important programs of government are-

Pre Alma Ata Declaration

National Health and Development Committee (1946) known as the "Bhore Committee", stressed on understanding of people's health and its importance in improving national productivity.; 1948Sokhey Committee Report on National Health.

Also known as "Sokhey Committee", which recommended state to set up plans for the protection of helpless and dependent mother and child. The striking feature of the committee was the recognition of women's economic role and concern for their health in relation to the environment.; 1952Community Development Programme; 1962Mudaliar Committee Report on Health Survey and Planning; 1966Mukheree Committee Reports on Basic Health Services; 1967Jungalwalla Committee Report on Integration of HealthServices ; 1973Kartarsingh Committee report on Multipurpose Health Workers; 1975Shrivastav Committee Report on Medical Education and Support manpower; 1977Rural Health Scheme: Community Health Volunteer Scheme-Village Health guides.

Alma Ata Declaration and beyond

1978Alma Ata Declaration – Health For All by 2000; 1980ICSSR and ICMR Report – "Health for all- An alternate Strategy"; 1983Mehta Committee on Medical Education Review; 1983First National Health Policy; 1987Bajaj Committee on Health Manpower Planning, Production and Management; 1996Bajaj Committee on Public Health Systems; 2000National Population Policy; 2002Second National Health Policy; 2005National Rural Health Mission (NRHM] The key core strategies under NRHM are- Train and enhance capacity of Panchayat Raj Institutions (PRIs) to own, control and manage public health services; Promote access to improved health care at household level through the village level worker , ASHA; Health plan for each village through Village Health Committee of the Panchayat.

Supplementary Strategies under mission- Regulation for private sector including the informal Rural Medical Practitioners (RMPs) to ensure availability of quality service to citizens at reasonable cost; Promotion of Public Private Partnership for achieving public health goals; Mainstreaming the Indian System of medicine (AYUSH) revitalizing local health traditions; Reorienting medical education to support rural health issues including regulation of medical care to medical ethics; Effective and viable risk pooling and social health insurance to provide health security to the poor by ensuring accessible, affordable, accountable and good quality hospital care.

NRHM and Convergence with different health related sectors: Common District Health society is created under NRHM to promote the convergence within the health department of various different disease related activities. The indicators of health depend as much on drinking water, female literacy, nutrition, early childhood development, sanitation, women's empowerment etc. Realizing the importance of wider determinants of health, NRHM sought to adopt a convergent approach for interventions under the umbrella of the District Plan. The Anganwadi Centre under the ICDS and Village Health and Sanitation Committees at the village level would be the principal hub for the health action.

Convergence with Indian System of Medicine (AYUSH): The officially recognized codified traditional medical systems are Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy. AYUSH is the Government approved acronym used to represent these systems. On 29.09.2014 Department of AYUSH, Ministry of Health and Family Welfare, Government of India has launched National AYUSH Mission (NAM) during 12th Plan for implementing through States/UTs.

National Health Policy 2015 Preventive and Promotive Health; addressing the wider social & environmental determinants of health: The health policy identifies coordinated action on seven priority areas for improving the environment for health. These include: The Swachh Bharat Abhiyan, This program was launched on 2nd October 2014 with a target to have clean India by 2nd October 2019; Balanced and Healthy Diets: This would be promoted through action in Anganwadi centers and schools and would be measured by the reduction of malnutrition, and improved food safety; Addressing Tobacco, Alcohol and Substance Abuse: (NashaMuktiAbhiyan) Success would be judged in terms of measurable decreases in use of tobacco, alcohol and substance abuse; Yatri Suraksha: Deaths due to rail and road traffic accidents should decline through a combination of response and prevention measures that ensure road and rail safety; NirbhayaNari- Action against gender violence ranging from sex determination, to sexual violence; Reduced stress and improved safety in the work place would include action on issues of employment security, preventive measures at the work place; Action would be taken on reducing indoor and outdoor air pollution and measured through decreases in respiratory disease especially in children, and other pollution related illnesses.

Other Government Programs are- BetiBachaoBetiPadhoYojna which was launched on 22nd January 2015 whose main aim is to generate awareness of welfare service meant for girl child and women; Bal Rashmi; The IEC Rajlaxmi and Jan Mangal Project; Immunization Programmes in India; Polio Eradication Programme; Major Nutrition Programmes in India; Integrated Child Developmental Services; Mid-Day Meal Scheme (MDMS); The NavjatShishu Suraksha Karyakram (NSSK); Safe water and Basic Sanitation Programmes in India; Access to Toilets;

Sewerage and sanitation: Technology for Rural Health Care- Several organizations are working alongside the government and NGOs to help relieve the burden on the public health system using mobile technology. India has over 900 million mobile phone users and this fact can be leveraged to employ better practices in even the remote areas.

Gram Vaani started in 2009. Using simple technologies and social context to design tools, we have been able to impact communities at large. Forty rural radio stations are able to manage and share content over mobiles and the web. Women Sarpanches in Uttar Pradesh shared learning and opinions on their work with senior government officials..Through simple education and discussion programs on mobile we make the marginalized communities aware of best practices in healthcare.

The different Five-Year Plans as from the First Plan 1951-56 to the Twelfth Plan 2012-17, health planning in India has been shaped by different strategies of overall development; In 2018, the administration of Prime Minister Narendra Modi launched, a new public health insurance program (*Ayushman Bharat),* colloquially known as "Modicare." The program is supposed to automatically cover hospitalization costs of up to 500,000 Indian rupees (USD$7,025) per year, per family for the poorest 40 percent of Indian society—some 500 million people—and establish 150,000 health and wellness centers throughout India by the end of 2020; The Indian government is

consequently pushing for extensive reforms in medical education. In August 2019, it succeeded in getting through parliament a major reform package, the National Medical Commission Bill, 2019—legislation Modi hailed as a milestone achievement to "curb avenues of corruption and boost transparency … accountability and quality in the governance of medical education."; The NITI Aayog report, '*Healthy States, Progressive India'* outlines India's performance in health and highlights the varied complexities and challenges therein, as well as the scope for improvement. Recognizing the complexities in understanding the problems of healthcare access at the federal level, the NITI Aayog uses a Health Index as a pillar for tracking health goals; To improve public healthcare infrastructure and management, the Uttar Pradesh government has been open to partnerships with international institutions like the World Bank and private foundations like the Gates Foundation. An example is the World Bank assisted, Uttar Pradesh Health System Strengthening Project (UPHSSP). This aims to enhance medical health care facilities in the state with a grant of 170 million US Dollars; There are also several ongoing public health projects and programs supported by the Gates Foundation under its 2012 agreement with the state government to improve health, agriculture and financial services to the poor.

Though the above policies of Government accepted health as an important area of women's development but receive the lowest priority when it comes to health. There is a low utilization of public health facilities in Uttar Pradesh. The health system views women as 'mother not as women'. Most of the strategies of both public and private sector centersaround mother- MCH, family planning, child survival, safe mother hood etc. Tragically this too is not adequately provided. High maternal mortality rates, unsafe motherhood, unhygienic births, diseases like TB, malaria, dysentery, cancer etc.,are common reasons for mortality in most of the urban, slum and especially in rural areas. Practically these policies are not of much utility as a woman has not realization of their own power and potential.

Findings of Some Relevant Studies - Studies in Uttar Pradesh (Khan and Others: 1989) indicate that female children are discriminated when it comes to the allocation of food within household. Marked differences exist between what is fed to boys and girls, the discrepancy increases with age. According to figures obtained from the National Nutrition Monitoring Bureau, in the age-group of 10-15 years, boys are fed 31 gm of pulses a day. Girl gets only 25 gm a day.As a boy grows and takes a sedentary or active job, the gap in the degrees of nutrition widens even more. For instance women in a sedentary job get 403 gm of cereals a day. A man in a similar job gets 475 gm. (NNMB: 1980); ven when women are aware of the importance of a nourishing diet during pregnancy, cultural and economic constraints deny them access to better nutrition (Khan et al: 1988); Levels of anemia are higher in such states as Bihar and Uttar Pradesh where feeling beliefs in 'eating down' inhibit adequate diets among women (Agarwal: 1987), and rural in areas where hookworm infestation is endemic (Ramachandran: 1989); The consequences of maternal anemia for infants are equally acute in terms of prenatal mortality, low birth weight and failure to thrive (Mathai, 1989; Ramachandram: 1989). Moreover, women's poor health and nutrition's

status can also lead to repeated miscarriages, fetal wastage and infertility; Chatterjee (1990) estimates that deaths of young girls in India exceed those of young boys by over 300,000 each year and every sixth infant death is specifically due to gender discrimination. Of the 15 million baby girls born in India each year, nearly 25 percent will not live to see their 15th birt; All nutritional programmes are directed towards the needs of pregnant and lactating mothers. However, in spite of these programmes, there is nutritional deficiency in women starting from infancy to pregnancy and then again after crossing the childbearingage. Poor nutrition of girls, especially in childhood and adolescence, has serious consequences (Jejeebhoy): 1994; A better strategy would be widen the focus of the Programme and provide micronutrient supplements and nutrition education to adolescent girls and all women rather than only those who are pregnant (Pachuri: 1995).; (Rao: 1998). Rural communities adhere more rigorously to customary laws and norms of social stratification that perpetuate biases against rural women-biases which impact the allocation of assets, power, rights, status, and opportunities Rural women have less access to basic resources (e.g. social, health, educational, and agricultural service systems) compared to their male counterparts. Moreover, biases result in rural women being treated with contempt, humiliated, violated, and discriminated against, which leads to their lowered self-esteem and feelings of fear and loneliness; (Solomon, S. et al: 1998).Pregnancy often follows soon after marriage, which carries a higher risk of complications for adolescences as their reproductive systems are not fully developed. Women who marry at a young age, who often drop out of school, also have less of an opportunity to learn about their sexual and reproductive health and rights and how to access related ser; The NNMB surveys (1980) documented low intakes of Vitamin A and iron among girl children and adolescents. Vitamins A deficiency is likely to be firmly linked to high mortality and morbidity in children, and to be an underlying cause of high levels of respiratory and genitourinary tract infection in women; (Johnston: 2003).Literacy and education also play a role in rural women's reduced health status; Shukla K.P 2003 conducted the study on nutritional status on National Status on Adolescents Girls in Rural Area of Varanasi. Major findings of the study were –A considerable proportion of adolescent girls had clinical nutritional deficiency diseases. Two-third study subjects were undernourished. Anemia was significantly found and there is a need to promote sound eating habits, personal hygiene related habits in rural adolescent; (Shah: 2005). Poverty also plays a role in rural women being forced to partake in activities that increase their exposure to HIV and other; National Rural Health Mission (NHRM 2005-12) is a government flagship program launched on 12th April 2005 in 18 States across the country to provide effective health care to the rural population especially the disadvantaged group by improving across, enabling community ownership and demand for services and strengthening public health system for efficient delivery. One of the key components of NRHM was to create a bond of female health volunteers named "Accredited Social Health Activist" (ASHA) in each village within the identified states; (Dasgupta: 2006) India's maternal mortality rates in rural areas are among the world's highest. From a global perspective, Indian accounts for 19 percent of all lives births and 27 percent of all maternal deaths. There seems to be a consensus

that higher female mortality between ages one and five and high maternal mortality rates result in a deficit of females in the population; (Burnad: 2006). The violence that many rural women faces at the hands of their husbands and other family members is one of the most physically and psychologically damaging experiences faced by them; Nair & panda (2011) conducted the study and found that although India was able to improve some majors of maternal health since enactment of NHRM in 2005, country was still far behind most emerging ec; Kimuna 2012 conducted the study and found that poorest women fared worst among middle and high-income women. Researchers believe that reason for higher rates of domestic violence come from greater familiar pressures resulting from poverty; Rawat CMS, Garg SK, Singh JV, Bhatnagar M conducted the study to find out prevalence of anemia in adolescent girls of rural Meerut. Findings were- a significant association of anemia with socio-economic status, type family, father occupation, mother education, family size stressed the need to develop strategies for intensive adult education, nutrition education and dietary supplementation including anemia prophylaxis.

Access to healthcare services is a critical task,and rural residents face a variety of access barriers.According to Healthy People 2020, access to healthcare is important for: Overall physical, social, and mental health status; Disease prevention; Detection, diagnosis, and treatment of illness; Quality of life; Preventable death; Life expectancy

Rural residents often encounter barriers to healthcare that limit their ability to obtain the care they need.The barriers to healthcare access in rural areas are-; Distance and Transportation:- Rural populations are more likely to have to travel long distances to accesshealthcare services; Health Insurance Coverage:-Individuals without health insurance have less access to healthcare services.; Social Stigma and Privacy Issues: - patients can feel fear or shame such as counseling or HIV testing etc.; Workforce Shortages; Healthcare workforce shortages impact healthcare access in rural communities; Women's ignorance about Government policies; Women's ignorance about diseases and their serious consequences; Women's ignorance about environment and environmental pollution; Women's ignorance to retain their autonomy and freedom to sustain the resources of survival; Women's lack of resources to medical aids; Grip of orthodoxy and superstition.; Idea of guilt and shame; Lack of rationale insight.

Conclusion

The data shows that one of the leading causes of death in UP is diarrheal diseases. This raises concern about the ability of the public health institutions to treat common ailments such as diarrhea.UP, Bihar, and Jharkhand are the lowest ranked states in terms of overall quantity and quality of public health infrastructure in India.

Hence, we see improving access to information through a range of health education strategies has been a significant component of all the national health programs in India. This includes information about immunization schedules, dissemination of treatment protocols such as for TB, Diarrhea, leprosy and communication for behavioral changes to prevent HIV/AIDS and other life style diseases The Pulse Polio Immunization Programme and the Leprosy Control Programme have been cited as having successful social mobilization components utilizing several innovative

approaches for effective communication.. National Health Policy – 2015 acknowledges the limited accountability of existing health education programs. The NRHM promotes health education on a sustained basis in multiple ways. It urges ASHA, ANM, AWW and VHSCs in coordination to organize village health and nutrition days. Many states have organized Health Melas (Fairs) to spread health awareness to masses.

If we have to restore the real health conditions for women, we have to eliminate the ignorance through organized methods. Education plays a pivotal role like communicating government policies, good information about conducive and healthy environment, imparting the idea of cleanliness, scientific and rational attitude to health..The mission of Make in India will be accomplished with educational awareness programs. It will give new suggestions and recommendations for the policy makers because a big segment of population of women is illiterate and not living good and healthy life, so to make reforms and seek the attention of policy makers it is essential that this segment of population should be added in the government policies of diversified population especially the rural women of Today, India is the world's largest democracy, with a population of over 1.37 billion people in 2019. Given current trends, India is expected to overtake China's population by 2027. The country's literacy rates have risen to 69.1 percent, with male literacy at 75.7 percent and that for females, 62 percent. The country's burden of disease, for one, specifically non-communicable diseases, has risen in recent years. Yet, India's expenditure on health remains stagnant at approximately 2.25 percent of total central budgetary expenditure. This figure comes to just over one percent of Gross Domestic Product (GDP), well below the 2.5-percent goal set by the National Health Policy of 2017. Indeed, the country's contribution to the global healthcare infrastructure is highly inadequate, despite the highest-ever budgetary allocation of INR 690 billion to health for 2020-21, a six-percent rise from 2019-20

As the Indian government strives to provide comprehensive health coverage for all, the country's rapidly developing health system remains an area of concern. There are disparities in health and health care systems between poorer and richer and underfunded health care systems that in many cases are inefficiently run and under regulated.

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