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STATUS OF RURAL WOMEN (A CASE STUDY OF ROHTAK DISTRICT)

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Abstract : The paper tries to examine the status of Rural Women in rohtak district. Nowadays the status of rural women has become one of the most important concerns of 21st century. But practically women empowerment is still an illusion of reality. We observe in our day to day life how women become victimized by various social evils. Women Empowerment is the vital instrument to expand women's ability to have resources and to make strategic life choices. Empowerment of women is essentially the process of upliftment of economic, social and political status of women, the traditionally underprivileged ones, in the society. It is the process of guarding them against all forms of violence. The study is based on primary sources of data as well as secondary sources of data. The study reveals that women particularly in rural area are relatively disempowered and they enjoy somewhat lower status than that of men in spite of many efforts undertaken by Government. It is found that acceptance of unequal gender norms by women are still prevailing in the society. The study concludes by an observation that access to Education, Employment and Change in Social Structure are only the enabling factors to Women Empowerment.

INTRODUCTION:

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 burdens. There is a strong son preference in India, as sons are expected to care for parents as they age. This son preference, along with high dowry costs for daughters, sometimes results in the mistreatment of daughters. Further, Indian women have low levels of both education and formal labour force participation. They typically have little autonomy, living under the control of first their fathers, then their husbands, and finally their sons. All of these factors exert a negative impact on the health status of Indian women. 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 labour force. The position of women in traditional Indian society can be measured by their autonomy in decision-making and by the degree of access they have to the outside world. By these measures, Indian women, particularly those in the north, fare poorly. Girls are typically married as young adolescents and are taken from their natal homes to live in their husbands' households. Then they are dominated not only by the men they have married but also by their new in-laws, especially the older females. Women are frequently prevented from working outside the home and travelling without a chaperone, and this has profound implications for their access to health care. The money they earn, the dwellings in which they live, and even their reproductive careers are not theirs to control. In addition, the work they perform is socially devalued. This inherently inequitable social system is perpetuated through a process of socialization that rationalizes and internalizes the female disadvantage. The consequences of women's unfavorable status in India include discrimination in the allocation of household resources, such as food, and in access to health care and education as well as marriage at young ages. The loss of a husband usually results in a significant decline in household income, in social marginalization, and in poorer health

and nutrition. Women constitute a significant part of the work force in India. The work participation rate continues to be substantially less for females than for males. Majority of the women workers are employed in the rural areas. Among rural women workers 87 per cent employed in agriculture are labourers and cultivators, about 80 per cent are employed in unorganized sectors like household industries, petty trades and services, building construction etc. A multiplicity of factors including biological, social, cultural, environmental and economic, influence women's health status, their need of health services and their ability to access appropriate services. In particular women's health needs stem from the fact that: Women are more socially disadvantaged than men in terms of poverty, education, and power. Socially disadvantaged people are more likely to become ill. Women are more likely to use health services because of their social role as carers of children, older people, or people with disabilities and the extra strain this places on their health. Women have particular sexual and reproductive health needs, for example, menses, pregnancy, childbirth, and menopause. Women are treated differently from men in society generally because of gender inequality resulting in, for example, violence against women and sexual assault. Women are also treated differently within the health system. Women have frequently been excluded from being health and medical research participants leading to major gaps in knowledge about women's health. Health is complex and dependent on a host of factors. The dynamic interplay of social and environmental factors has profound and multifaceted implications on health. Women's lived experiences as gendered beings result in multiple and, significantly, interrelated health needs. But gender identities are played out from various location positions like caste and class. The multiple burdens of 'production and reproduction' borne from a position of disadvantage has telling consequences on women's well-being. The present section on women's health in India systematizes existing evidence on the topic. Different aspects of women's health are thematically presented as a matter of presentation and the themes are not to be construed as mutually exclusive and water tight compartments. The conditions of women's lives shape their health in more ways than one. Given this backdrop, the present study reviews the recent literatures in the health status of the rural women in the India.

STUDY AREA:

Rohtak district is one of the 22 districts of Haryana state in Northern India. It is located in the southeast of Haryana and northwest of Delhi, bounded by Jind and Sonipat districts to the north, Jhajjar and Sonipat districts to the east, and Hissar, Sirsa, and Bhiwani districts to the west. Rohtak city is the district headquarters.

DEMOGRAPHIC PROFILE OF ROHTAK DISTRICT

Total Area : 1668 Km² (644 Sq mi)
Population : 1058683
Population Density : 607/Km²

Sr. No.	**Detail**	**%**
1	Literacy	80.4
2	Sex Ratio	868
3	Urban Population	42.01
4	Male Literacy	87.65
5	Female Literacy	71.72

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As of the 2011 census figures, Rohtak District had a population of 1058683. The District had a sex ratio of 868 females per 1,000 males. Effective literacy was 84.4%; male literacy was 87.65% and female literacy was 71.72%. Rohtak District is one among 22 Districts of Haryana State,India. Rohtak District Administrative head quarter is Rohtak. It is is Located 235 KM North towards State capital Chandigarh. Rohtak District population is 1058683. It is 14 th Largest District in the State by population. It is Located at Latitude-28.9, Longitude-76.5. Rohtak District is sharing border with Bhiwani District to the west, Jhajjar District to the South, Sonipat District to the East. Rohtak District occupies an area of approximately 1668 square kilometres. . It's in the 222 meters to 221 meters elevation range.This District belongs to Hindi Belt India

Objective of Study:

Main objective of our study for the status of rural women in Rohtak district are fallowing:

1. To find out the marriage and age related information of Rural Women.
2. To find out the Mortality related information of Rural Women.
3. To find out the Family Planning information of Rural Women.
4. To analysis the how many women are aware about the infect disease.
5. To analysis the environment of rural household.

Data sources and Methodology:

Present study will be based on data drawn from both primary and secondary sources. Census will be the main secondary source of data. For the study of status of rural women primarily we prepared a questionnaire in which five indicators and more than twenty question. Primary data are collected by sample survey of randomly selected 50 villages out of 244 villages of Rohtak district. The paper begins with an overview of Mortality and marriages related information of rural women and also highlight the family planning, awareness about disease by infection and conditions of household.

Status of Rural Women:

Age and Marriage index

Table-1

Sr.No.	Details	%
1.	Age on Marriage: 18>	10.32
2.	18-20	33.83
3.	20<	55.63
4.	Age on first child born: 20>	16.54
5.	20<	83.45
6.	Number of children: 1-2	33.08
7.	2<	66.91
8.	Gap between child born: 1>	24.06
9.	2<	75.93

Table-1 Showing Age and marriage related information of rural women in which more than 10 % rural women get early marriage and 33% rural women get marriage between 18 to 20 Age and approximate 55% rural women get marriage after 20 ages. Approximate 16% rural women not cross the age 20 she made mother and 67% rural women have more than two children.

Mortality index

Table-2

Sr.No.	Details	%
1.	How many women meet to Doctor after pregnancy:	27.06

2.	How many women take iron tablet during pregnancy:	43.60
3.	How many women take help to nurse during delivery time:	83.43
4.	How many women have blood deficiency:	39.09

Table-2 Showing mortality related information of rural women in which only 27% rural women meet to doctor after pregnancy and only 43% rural women take iron tablet after pregnancy. More than 80% rural women take help to nurse during delivery time. Approximate 40% rural women have blood deficiency.

Family Planning index

Table-3

Sr.No.	Details	%
1.	How many women using family planning recourses:	65.41
2.	How many women adopted vasectomy technique:	19.54
3.	How many women aware about family planning:	40.08

Family planning is organized action with regard to the reproductive function of the family, both by society and the family itself. However, this action is not performed on an institutional level, rather it is done on a family level. Its basic purpose is to achieve greater humanization of the family function, where the family-planning process is associated with "demographic neutrality". Within the family, the husband and wife should decide freely number of births, having in mind not only their own but also broader societal capacities and needs. This objective could be reached by greater democratization of family relations, those of the husband and wife in primarily, which assumes enhancing their knowledge in the field of biological reproduction. Through family planning, as a principal human right, the society treats the family unit as a "human society", recognizing the uniqueness of the family as the primary societal unit.

Table-3 Showing family planning related information of rural women in which approximate 65% rural women using resource for family planning and only 40% rural women aware about family planning. Only 19% rural women have adopted vasectomy technique.

Level of information about disease by infection

Table-4

Sr.No.	Details	%
1.	How many women aware about HIV:	75.09
2.	How many women aware about T.B& Dots:	80.08
3.	How many women aware about disease by Physical relation & Delivery:	84.96
4.	How many women share above mentions disease to other:	42.10

Table-4 Showing the information about disease by infection. In which approximate 75% rural women know about HIV and 100% rural women aware about T.B and Dots technique. More than 80% rural women know about disease by physical relation or delivery. Only 40% rural women share information to other people about his disease.

Households Facility of rural women

Table-5

Sr.No.	Details	%
1.	Availability of fresh water:	100

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2.	Availability of Had pump:		18.04
3.	Availability of toilet with flesh:		24.06
4.	Availability of bathroom:		100
5.	No of Rooms:	2>	5.2
6.		2-4	15
7.		4<	76

Table-5 Showing the Households Facility of rural women. In which 100% household have fresh drinking water and approximate 18% have hand pump facility. Approximate 24% have flush toilet facility and 100% have bathroom facility. More than 76% household have four or more than room.

Major finding of study:

1. More than 10 % rural women get early marriage.
2. Approximate 16% rural women not cross the age 20 she made mother and 67% rural women have more than two children.
3. Only 27% rural women meet to doctor after pregnancy.
4. Approximate 40% rural women have blood deficiency.
5. Only 40% rural women aware about family planning.
6. Approximate 75% rural women know about HIV.
7. 100% rural women aware about T.B and Dots technique.
8. Only 40% rural women share information to other people about his disease.
9. 100% household has fresh drinking water facility.
10. Approximate 24% have flush toilet facility.
11. More than 76% household have four or more than room.

Conclusion:

The status of rural women is discussed and found that the women health remains to be a challenging issue. There is a need of strong interrelationships between women health and development underscores the need to address the women reproductive health and its status. Epidemiological transition in India has led to double burden of diseases with surging prevalence of non-communicable diseases. However, there is need a wide scope for research to bring a holistic view of rural women status. Since women faces various unique health issues as compared to male, there is a need for more specific and combined research on women health status. Thus, the present study suggests the researchers in the field of women health to bring various researches for safeguarding the women health status as whole. The study presents an impressive research on the status of rural women tackling numerous policy issues from delivery of public services in the rural areas, to how certain policies such as employment, social inclusion, gender equality and rural development address rural women's needs. The reforms in the education policy area (especially the introduction of the compulsory secondary schooling) improve this situation and increase the potentials of the younger generation of rural women. They are however, the most vulnerable to unemployment because of the limited offer of jobs in the rural regions and the tradition patriarchal expectations to fulfill the prescribed role of mothers and housewives, bearing the bulk of the unpaid home-work and be

exploited as unpaid family agricultural worker or low paid seasonal worker again in agriculture. Having limited public services offered in the rural areas and being faced with the above mentioned challenges rural women have little incentive to spend their lives in the villages and would rather move to the cities where they get married. Finally for all this to happen we need politics to change to allow for more women to voice their needs and meaningfully participate in local decision making, but also on central level. The policies that are being adopted need to be based on analysis of the current situation and the policy options to reflect the needs of rural women. Participatory mechanisms on local level need particular strengthening, as rural women and men showed little awareness of as well as limited trust in having their voices being heard, let alone considered in local planning and decision making.

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