Health Maintenance Among Women in Ernakulam – A Sociological Study

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Health Maintenance Among Women in Ernakulam – A Sociological Study

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CERTIFICATE

I certify that the thesis entitled **"Health Maintenance Among Women in Ernakulam – A Sociological Study"** is a record of bonafide research work carried out by Anjali Baburaj, under my guidance and supervision. The thesis is worth submitting in fulfillment of the requirements for the award of the degree of Master of Arts in Sociology.

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DECLARATION

I, Anjali Baburaj, hereby declare that the thesis entitled "Health Maintenance Among Women in Ernakulam- A Sociological Study" is a bonafide record of independent research work carried out by me under the supervision and guidance of Georgia Ann Benny. I further declare that this thesis has not been previously submitted for the award of any degree, diploma, associateship or other similar title.

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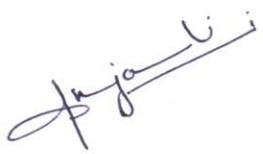

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INTRODUCTION

In accordance with Dunn's idea, there is a dynamic shift in health where we can be at our best health with no disease (as when we were young and healthy) and we can get a disease through our genetics, environment, food, injury, or age where our health can become bad. In the Hindu religion, "health" refers to the maintenance of the human body's optimal functioning under typical, and occasionally even unnatural, environmental conditions.

A healthy state is defined as "a condition in which the temperament is in a balanced state and the structures of the human body are such that their activities are carried out in a right and entire manner" by unani physicians. This definition is very comprehensive and practical. In homoeopathy, healthiness of the mind, body, and spirit is referred to as health. Disease is a dynamic disturbance of the equilibrium between the physical body's material components and the vital force that keeps the body healthy.

The management of symptoms and sickness is not the primary focus of health maintenance, which places more emphasis on disease prevention and promotion of good health. Screening techniques, risk assessment, early intervention, and primary, secondary, and anticipatory prevention are all parts of maintaining good health. For some age groups, especially for the younger ones, there are relatively well-established guidelines for maintaining health. Paying a fee to an organisation that only lets you utilise its own doctors and facilities is known as a Health Maintenance Organization (HMO).

Drugs called "maintenance" are those that are administered regularly and repeatedly to treat chronic, long-term diseases. Drugs used to treat diabetes, high blood pressure, heart disease, and asthma are examples of maintenance medications. Assistance with daily activities of living, such as getting in and out of bed, a wheelchair, or a car, assistance with regular bodily functions, such as bathing and personal hygiene, dressing, and grooming, and feeding, including preparation and clean-up, are all included in health maintenance services. Maintaining your general health offers several advantages in addition to helping you prevent disease. You are more likely to feel energised and content

when your health is in good shape. In addition, you'll feel much better because your body will be in better form and you might sleep better.

To improve your health, practise safe sex, protect your skin, eat a nutritious diet—your health is highly correlated with what you eat—get regular exercise, quit smoking and using nicotine, consume alcohol in moderation, and ask your doctor the right questions.

Examining asymptomatic people and checking Preoperative Care for potential occult diseases is health care maintenance. The procedure offers a chance for early disease detection, disease prevention, and the potential to stop disease progression and consequences. Breast cancer screening, colorectal cancer screening, cervical cancer screening, diabetes eye exam, and advanced care plan are the five commonly tracked things under the category of "Health Maintenance" at the moment. Lack of exercise, a poor diet, environmental problems, and congenital flaws all contribute to ill health.

The socially constructed qualities of women, men, girls, and boys are referred to as gender. This covers interpersonal connections as well as the standards, mannerisms, and roles associated with being a woman, man, girl, or boy. Men and women are not treated equally, which is a societal phenomenon known as gender inequality. The differences in genetics, psychology, or prevailing cultural norms in the society may be the cause of the treatment. While some of these divisions have empirical support, others seem to be social constructs.

The main problems with gender discrimination include child marriage, other forms of gender-based violence, the gender wage gap, gender inequality in agriculture, low access to healthcare, excessive water prices, and a lack of representation for women and girls in policy. Almost all human rights treaties forbid gender-based discrimination. Despite significant advancements in the protection of women's rights worldwide, millions of women and girls still face violence and discrimination, losing their equality, dignity, and even their lives.

As a result of their conditioning to follow existing gender norms, men and women are likely to see health and illness differently, as well as define it differently and act differently while seeking it out. In contrast to men, women behave differently when seeking healthcare in different contexts. According to a number of South Asian studies,

women often fail to recognise the signs of a health issue, fail to treat it seriously enough to seek medical attention, or fail to see themselves as entitled to make investments in their own health. Contrarily, most studies on men reveal that they are less likely to use preventative care, and those who do tend to seek treatment later and at a greater level than women for conditions like tuberculosis and mental health issues.

Women frequently put off obtaining health care due to their limited time and financial resources as well as physical mobility restrictions, which are prevalent in many traditional civilizations. According to the National Family Health Survey-3 (2005-06), 52% of women were not permitted to visit a medical facility alone, and 47% of women reported experiencing one or more of the following issues when trying to access care: worry that there were no female providers available, reluctance to travel alone, needing to take public transportation, lack of permission, and having to ask for money from the household. A nation will be unable to meet the best health goals and its people won't be able to realise their right to health unless health systems pay attention to gender-based obstacles to health-seeking and use of health services.

A health system is made up of all institutions, individuals, and activities whose principal goal is to advance, preserve, or restore health. Consequently, a health system is more than just a network of public hospitals and health centres that provide medical care. It encompasses the public and commercial sectors, laws governing workplace safety, preventing traffic accidents, and controlling pollution, as well as medical schools and paramedical training facilities and even families who are taking care of a sick relative at home. A concept of the health system with such a broad scope is beneficial because it acknowledges the role that all facets of society play in enhancing population health.

However, the health system appears too amorphous when characterised in this way, and it may be challenging to imagine how to intervene to strengthen the health system so that it produces better health outcomes. The WHO created a framework consisting of six health-system building blocks in order to support efforts to strengthen health systems: service delivery, health workforce, information, medical products, vaccines and technology, financing, and leadership and governance.

Every government would work to improve its health system so that it could provide everyone with inexpensive, timely, and safe healthcare; The country's health personnel

is adequately staffed and fairly spread across all regions, as well as in urban and rural areas; this workforce is skilled, productive, and sensitive to the requirements of the populace; The health system is financed by methods that generate sufficient funds without placing financial restrictions on any segment of the population's access to care or leading to unsustainable health spending; Drugs, vaccines, and technologies that are safe, effective, and affordable are readily available to all segments of the population; the health system is effectively governed, with a strategic policy framework, effective oversight, and regulation to ensure quality; and health information systems collect, analyse, disseminate, and use reliable information for further planning.

The ultimate objective of a robust health system is to achieve enhanced health for all individuals Equitably, without placing an undue burden on anyone's finances, by implementing a service delivery system that meets needs and makes effective use of resources. If the health system does not pay attention to gender-specific requirements of women and men and gender-power inequities in society, it may not be able to strengthen the health system to fulfil these health goals.

Much more work must be done in addition to focusing on maternal health in order to take sex and gender differences into consideration when addressing the demands of a population in terms of health. For instance, as women often outlive males in most nations, treatments for elderly women's health issues should be included in the scope of services offered at the primary care level.

Several health disorders have differing effects on men and women and may require different management strategies: Although malaria is more common in men, it can have serious and even deadly health repercussions for pregnant women. Women who have had strokes are more likely than men to experience pre- and post-stroke disability, as well as greater mental damage.

In terms of conditions that only affect women or men, are more prevalent, manifest differently, are more severe or have more significant implications, and have different risk factors, the scope and substance of services offered must take into account the disparities between women and men. Additionally, it's important to address the health needs of traditionally underserved groups, such as older people, teenagers, and transgender communities.

Gender differences in duties and responsibilities, access to resources and authority, and service delivery methods must also be recognised and addressed. More people are likely to use services that are closer to their homes or places of employment and sometimes suitable for women or men, which could significantly improve the ability to identify morbidity and provide effective treatment and cure. Studies from Bangladesh and Vietnam, for instance, suggest that women with tuberculosis may not be properly diagnosed or informed, which could result in a reported prevalence of tuberculosis in women that is lower than it actually is. Other studies from Nepal and Peru, where case-finding was carried out at the community level, support this. To make services more "acceptable" to these various groups, another dimension is to provide exclusive areas and timings within service delivery settings for women, men, and young people of both sexes.

Most patients view healthcare professionals as a strong authoritative figure who is distant from their own lives and realities due to their training and social standing. Lack of assertiveness is caused by women reduced social position, particularly among those from low-income and socially excluded regions. They could find it difficult to voice their thoughts or make decisions, as well as to communicate with the provider about their health issues. Patients should be encouraged to ask questions, seek answers, and express their opinions by their healthcare providers. This is especially important for women who may not feel comfortable doing so. The current quo fosters power disparities between men and women, which can be changed consciously.

Health professionals need a work atmosphere that fosters these same values and is supportive of them in order to deal with patients in a respectful, non-biased, and empowering way. Gender inequality in society places restrictions on women working in health care at all levels, from doctors to community health workers. Women doctors who must balance their dual responsibilities as carers and professionals frequently find a solution by selecting specialties or occupations that require less of their time. Discontinuity in service to have children and raise them, men-oriented workplace cultures with long hours, meetings outside of regular working hours, the need to travel, and transfers or relocations may limit their capacity to advance to leadership roles.

The twin disadvantage of being female and being at the bottom of the entrenched medical hierarchy appears to be felt by nurses and community health workers. Nursing has a reputation for being a profession that is secondary to the doctor's function in healing

and curing patients and that focuses mostly on mundane, nurturing, and caring chores. According to research from Pakistan, women who work in health care encounter a number of challenges, including hierarchical management, disdain from male co-workers, a lack of family support, and antagonism from the public. They claimed that their interactions with patients were negatively impacted by these difficulties.

Making health services more gender-responsive requires training health professionals. However, efforts are dispersed and underfunded since this crucial issue has not received the legislative and political backing it deserves. Pre-service and in-service training for health managers and workers at all levels must be made with a focus on those who deal with patients on a daily basis.

Unpaid health labour is the informal care given by a friend, family member, or member of the same household or community to a person who is ill or disabled without receiving payment. Low-income households that cannot afford hired home care are likely to bear the brunt of unpaid health work, and they may also experience a higher incidence of disease and long-term disability. The amount of household work required by women increases significantly when they must care for long-term diseases.

Up to 24 more buckets of water may be needed to bathe an HIV patient at home, clean soiled bedding, wash dishes, and prepare food. Despite the fact that nursing needs of care receivers did not significantly differ by care-giver sex in Japan, women carers reported being in worse emotional health than male carers. This was most likely caused by the fact that female carers took care of patients with more severe cognitive problems, spent more time providing care, completed a considerably greater variety of care tasks, and used house assistance less frequently than male carers. Older women in Botswana who were providing care for HIV patients at home described feeling overburdened with their duties as well as fatigued, undernourished, and despondent.

To identify and lessen the disproportionate burden of unpaid health care borne by women, action is required on a number of fronts. There is a need for specific therapies that cater to the emotional and social support requirements of carers. In order to provide such emotional and social support, a specific project for carers in one county of Wales, UK, asks carers to identify themselves. The organisation also hosts a monthly carer support group where carers can connect with others going through similar experiences.

Day homes are another option for caregiving when the carers themselves require medical attention.

The quest of gender equity in all sectors, including health, is made possible by information, which is a crucial instrument. Gender-responsive planning and policy-making have been significantly hampered by the scarcity of high-quality health statistics that are broken down by sex and age. There is no way to start addressing gender or other health inequities without knowledge of whether and in which health-related dimensions disadvantages exist, as well as within which demographic subgroups. One cannot overstate the importance of gathering, analysing, and publishing data that has been broken down by sex and age. The WHO launched its Action Programme on Essential Drugs in 1981 as a project to encourage the accessibility of medicines and supplies that address the population's top health needs. Generic medications that cost between 50 and 70% less than name-brand medications are included on the Essential Drugs List.

The majority of developing nations use a variety of funding sources to support their health systems. Typically, there is a baseline package of services that are free at the time-of-service delivery and are paid for by tax income. Other healthcare expenses must be covered through out-of-pocket (OOP) spending or by using a variety of health insurance plans. Additionally, there are Social Protection Schemes in some nations, which offer low-income groups, indigenous populations, women with young children, and others who are considered to be "vulnerable" populations free services or even financial incentives for using specific health services.

The capacity of people without access to money, the majority of whom are women, to seek medical attention is badly impacted by a health system that is financed mostly through out-of-pocket expenses, as is the case in India. Reduced out-of-pocket spending on healthcare would be a first step towards gender mainstreaming health funding. Where insurance is a significant source of funding for healthcare systems, special consideration should be given to how women are covered. It would be necessary to recognise that women, even when they belong to better-off homes, may fall under this category and to partially or entirely subsidise premium payments for those who cannot pay. Making homes the unit of enrolment in insurance programmes would aid in extending insurance coverage to women and other household members with limited financial and decision-making capabilities.

Inadvertently, a lack of attention to women's unique health issues and a lack of understanding of the unique issues and challenges faced by women in the health workforce may emerge from the underrepresentation of women in leadership. Through policy advocacy, research on gender-issues in health, and support for integrating gender and women's health in the curricula of health professionals, women leaders in academic medicine have been at the forefront of advancing gender equity in health in many parts of the world. The Association of American Medical Colleges (AAMC), a non-profit organisation of medical colleges, teaching hospitals, and academic societies in the US and Canada dedicated to the advancement of academic medicine, places a high priority on gender equality in leadership positions.

In addition to top-level leadership changes, pressure from below is also significant. The people who will be affected by the policy change must be involved in creating the agenda for change. To hold the health industry and the government as a whole responsible for reducing the gender gap in health, accountability systems must be put in place. Longwe makes the case that policies promoting gender equality go against the interests of bureaucracies, which are intrinsically patriarchal, in an article titled "The Evaporation of Policies for Women's Advancement." She discusses the bureaucracy's limitless ability to destroy laws promoting women's equality. Not only is it crucial to ensure that policies are engendered, but also that the women's movement and civil society institutions are actively involved. Without their ongoing support and impartial oversight, there is a good danger that gender equality measures would never be taken seriously and quietly put to rest.

While our attention has so far been on how social norms in a society affect women's health, it is crucial to acknowledge that many nations lack gender-integrated national policies and programmes, as well as sex-disaggregated data necessary to understand how gender differences in health risks, health information, and access to health services exist. Following the (ICPD) in 1994 and the Fourth World Conference on Women in Beijing in 1995, the notion of "gender mainstreaming" originated in this setting.

In order to "mainstream," or integrate, gender into the mainstream in all industries, the goal is to primarily focus on women. All interventions should become more comprehensive, effective, and efficient as a result of this strategy. Additionally, it seeks to advance equity and equality for both genders throughout the lifespan and, at the very

least, to ensure that interventions do not support or maintain unfair gender roles and relationships (WHO 2002).

Operational mainstreaming is the process of incorporating equality issues into the content of policies, programme interventions, and projects in order to ensure that they benefit women and lessen gender inequality. This entails mainstreaming within government agencies, where internal workshops for gender sensitization are implemented in addition to other initiatives.

Additionally, it suggests introducing gender sensitization into the medical school curricula for health professionals. Furthermore, gender is taken into account at all phases of the research process, from defining the research to disseminating results, as part of mainstreaming in health research. Structures, techniques, and procedures that will catalyse, launch, and maintain gender-mainstreaming efforts are required for operational gender mainstreaming to succeed.

In order to support and advance gender equality, institutional mainstreaming requires addressing the internal dynamics of formal (and informal) institutions, such as their objectives, method of creating agendas, governance structures, and operational procedures (UN 2000). Gender considerations in health and within the organisations in charge of administering and providing health care services are one part of this mainstreaming that must be identified and addressed. This aims to end gender-based discrimination in hiring practises, change institutional policies and cultures to foster an environment that supports gender equity and equality, and improve staff and senior management's capacity to mainstream gender issues in health policies, programmes, research, and training. Gender issues have been incorporated into all studies, policies, programmes, projects, and activities at the worldwide mainstreaming level. The goal is to establish a solid evidence basis for gender and health and to create and improve tools and policies for including gender into research.

It is possible to address gender-based disparities and inequalities across all health programmes using these two methods. Additionally, it highlights programmes designed to meet the unique health requirements of women, which are caused either by biological differences between men and women or by social discrimination on the basis of gender. However, mainstreaming continues to face difficulties. Top-down strategies that don't

allow for democratic participation, both inside international organisations and national government institutions, have been one of the difficulties.

Furthermore, community-based service provision and training initiatives tend to concentrate on the unique needs of women without questioning gender roles and conventions. The attempts to include gender concerns in the training of health professionals have mostly been on a modest scale. The main cause of these difficulties is attributed to the objectives for social justice and human rights not taking gender into account. However, due to a number of factors, mainstreaming gender continues to be difficult in the health industry.

First of all, because gender concerns aren't looked at when it comes to any health issues or how medical services are provided, instead attributing all male and female disparities to biology. Second, despite the need for gender mainstreaming, policymakers and programme managers are not persuaded that there exist gender-based disparities in health. This is due to the fact that, in the majority of nations around the world, women outlive men and that, for many diseases, male mortality is higher than female mortality. Finally, the biological approach-driven health sector does not recognise the importance of comprehending the social determinants and aspects of health.

Women's physiology necessitates different energy needs than men's do. Girls begin losing blood and micronutrients like iron due to menstruation at a young age. In some circumstances, women have greater nutritional needs than males; for instance, women require twice as much calcium as men do. Therefore, it is essential that women's dietary needs are met beginning at a young age. Women's reproductive systems continue to develop up until the age of 17 to 18 years, and during pregnancy, the body goes through a number of physiological changes to accommodate the needs of the developing foetus.

A woman's body experiences stress during delivery because she loses a lot of blood and fluids and the body requires time to recover. Long nursing periods and frequent pregnancies with little time between them increase the nutritional burden. Women need much more protein, calories, vitamins, and minerals during pregnancy and breastfeeding because they need to consume enough nourishment for both themselves and their child.

Girls throughout their adolescence are more at risk for malnutrition since they are developing more quickly than at any other point after birth. To support the adolescent

growth surge and satisfy the body's increased requirement for iron during menstruation, they need protein, iron, and other micronutrients. Teenagers who become pregnant run the risk of developing a variety of issues since they may still be maturing. So it can be seen that women at all phases of life require more food and food that is nutritious. Social neglect, poverty, ignorance brought on by a lack of education, early marriage, early and recurrent pregnancies, and other factors all have a negative impact on women, especially in developing nations like India.

Many underweight women are also stunted, or have heights below the average for their age. Stunting is a known risk factor for obstetric difficulties, such as obstructed labour, and raises the need for skilful intervention during delivery; otherwise, mothers and their new-borns may sustain injuries or lose their lives. Girls who are married off at a young age, before their bodies have fully matured, face serious risks because they will be battling malnutrition at the same time. Because they may still be growing, adolescents who become pregnant have a high risk of different difficulties. Competition for nutrition between an infant and a still-growing adolescent mother increases the infant's risk of low birth weight (defined as a birth weight of less than 2,500 grammes) and early mortality. It is also linked to moms' decreased ability to work.

The onset of anaemia is a significant and frequently ignored consequence of undernutrition and malnutrition in women. Lack of awareness of the early signs of anaemia, such as the fatigue and depression brought on by iron deficiency, may be brushed off as "normal" or inconsequential, aggravating the situation. The most prevalent micronutrient deficiency in the world, iron deficiency is the primary cause of anaemia in women. When haemoglobin levels are below the median for an individual's age, physiological status, location, race, etc., anaemia in women is indicated.

The World Health Organization has established 11–12 mg/dl as the cutoff level for haemoglobin in females 15 years of age and older. Women who have mild to moderate anaemia experience negative effects like diminished defences, less productivity, impaired cognitive function, and a lower quality of life. Increased maternal morbidity and mortality, preterm births, low birth weight newborns, perinatal death, impaired cognitive development, and intellectual disabilities in children are all consequences of severe anaemia. According to a 2001 UN assessment, iron deficiency affected 43% of mothers in underdeveloped nations and raised the risk of maternal death. In less

developed nations, the majority of anaemic women are either eating too few foods high in iron or foods that prevent the body from absorbing iron.

The decrease of immunity and poor health are further effects of this ongoing lack of sufficient nourishment in women. Women's susceptibility to severe chronic illnesses like HIV and tuberculosis rises as body immunity declines, accelerating the downward trend in their health and nutrition. A woman who is chronically malnourished frequently tries to quell her hunger in other ways, and it is common for these women to develop smoking or chewing tobacco habits. Although these practises temporarily suppress their appetites, they have a much greater negative impact on their health, endangering their respiratory systems and increasing their risk of developing cancers like lung, mouth, and tongue cancer. These illnesses and behaviours have an impact on more than just these women; they also have an impact on the next generation.

Both prenatal and postnatal transmission of diseases, including tuberculosis and HIV, is possible. These infants have low birth weights, are stunted, have less developed brains, and have weaker immune systems, rendering them more prone to illnesses and early mortality. Smoking during pregnancy harms the foetus' growth and has a negative impact, which can result in genetic problems. Such infants may be continuously exposed to second-hand smoke after birth, which also has an impact on their development.

Babies with low birth weights are born from women who are malnourished. Additionally, many kids are malnourished from birth. More than 20 million infants in less developed nations experience low birth weight each year, and it is the single biggest predictor of a child's survival. The majority of new-born deaths in the first week of life occur in low-birth-weight babies, who also have a higher mortality risk during the remainder of infancy. Those who do survive are frequently lighter and shorter than their contemporaries, which hinders their capacity to work as adults. Low birthweight babies frequently experience cognitive impairment, developmental issues, and heightened vulnerability to illness, which is linked to a higher burden of illness and lower life expectancy.

These moms' offspring are also prone to micronutrient deficiencies, including those in iron, calcium, iodine, vitamins, and folates. These kids are more likely to experience physical and neurological abnormalities, decreased cognitive growth, stunting, lower

working ability, and, in the worst situations, increased susceptibility to several illnesses and early mortality. Thus, there is a direct link between mothers' poor nutritional condition and childhood malnutrition.

As a result, the populace is less able to work, which hinders the societies' ability to flourish and progress economically. Such a community and nation must also deal with extremely expensive health care expenses that could have been easily avoided by ensuring the nutritional quality of its ladies. Due to the reduced ability of women to work and the potential for generational impacts, malnutrition among women causes economic costs for families, communities, and nations.

Anaemia-related issues, such as those that affect children's cognition and adults' productivity, cost US$5 billion annually in South Asia alone. Women's productivity in less developed nations has been considerably decreased by illnesses linked to dietary inadequacies. According to a recent analysis from Asia, malnutrition lowers gross domestic product by 5% to 10% and human productivity by 10% to 15%. Nations can save health care expenditures, boost intellectual ability, and increase adult output by improving the nutrition of adolescent girls and women.

Education is a planned activity with certain goals in mind, such as knowledge transmission or the development of skills and character. These objectives might include the growth of comprehension, reason, kindness, and honesty. Health and wellbeing are built on a foundation of high-quality education. People need to know how to prevent illness and disease if they want to live long, healthy lives. Children and adolescents must be fed properly and in good health in order to learn.

Students' knowledge, abilities, and positive attitudes about health all increase as a result of health education. Mental, emotional, physical, and social health are all included in health education. Students are motivated to improve and maintain their health, avoid illness, and cut back on harmful activities. Education plays a significant impact in health through influencing opportunities, employment, and income. Education is highly connected with life expectancy, morbidity, and health behaviours. Health education improves physical, mental, emotional, and social health by expanding people's knowledge and changing their attitudes towards taking care of their well-being. This empowers people and enables communities to live healthier lifestyles.

Learning is enhanced and school attendance is increased by good health. Improved maternal education, in particular, benefits children's health and can have long-lasting impacts. It is important to create and implement policies that make the most of the linkages between health and education. Four more years of schooling cut the risk of diabetes by 1.3 percentage points, heart disease by 2.16 percentage points, and five-year death by 1.8 percentage points.

Numerous studies have shown that engaging in activities with others improves relationships, well-being, and can help lessen the detrimental impacts on health of stressful life events. The goal of occupational health is to develop and maintain the highest level of physical, mental, and social wellbeing for workers across all occupations. Occupation can have a direct impact on health through factors like physical job requirements (such as manual labour, exposure to noise, and heat), psychological job demands, stress, and social support. The primary goal of occupational health and safety (OHS) is to shield workers from mishaps, injury, and exposure to dangerous substances. Biological, ergonomic, chemical, and physical hazards are the four types of workplace health risks.

Health and income are closely correlated. For all health factors analyzed, the connection between income and health is observed to be skewed in the same direction, with more income being associated with better health both before and after social controls. A person with a high salary may afford the highest standard of medical care. He can take better safety measures to avoid getting sick. Better health does, however, correlate with increased income in the opposite direction as well.

Adults living in poverty are more likely to experience negative health outcomes from obesity, smoking, substance use, and chronic stress, in addition to the long-lasting effects of childhood poverty. Finally, mortality and disability rates are higher among older persons with lower earnings. Health risks decline, access to high-quality healthcare improves, and health outcomes—such as life expectancy—get better as earnings rise. An someone with poor health would have significantly reduced or even compromised income because they frequently couldn't go to work. Longevity is increased by good health. Workers who are in good health are more productive than those who aren't.

A person's search for meaning and purpose in life is one way that spirituality has been defined broadly across a variety of contexts. In that it doesn't necessarily require a religious context, spirituality differs from organised religion. That is to say, while organised religions frequently have a combination of these in place, one need not adhere to all of them in order to be spiritual. Serious mental illness sufferers sometimes find solace in religion. People who identify as spiritual may not follow any particular religious customs or practises. It's crucial to define spirituality broadly in order to choose the optimal approach for further investigation and study.

More than 3000 empirical studies, including more than 1200 in the 20th century and more than 2000 additional studies between 2000 and 2009, have looked at the connections between religion and health. There have been numerous more assessments of the literature on religion/spirituality and health published. These include two evaluations from an NIH-organized expert panel that were published in an American Psychologist special section with four other articles.

Additionally, the empirical literature has been evaluated in a number of chapters in edited academic volumes. The literature has also been thoroughly examined from the viewpoint of public health and its different subfields, including infectious illnesses, vaccination, and health policy and management. The relationship between religious or spiritual elements and health outcomes has been the subject of more than 30 meta-analyses and 100 systematic reviews.

Some research suggest that religion and physical health are favourably correlated, according to Ellison & Levin (1998). People who frequently attend religious events and regard themselves to be both religious and spiritual, for example, have lower death rates. Seybold & Hill (2001) state that practically all research on how religion affects a person's physical health has shown that their way of life plays a favourable role. These studies have involved people of all ages, genders, and religious backgrounds. These are founded on the idea that religious experience is good in and of itself.

It's possible that religion indirectly improves physical health. Attendees at churches report decreased rates of alcohol use and improved moods, both of which are linked to greater physical health. Kenneth Pargament has made significant contributions to the understanding of how people can utilise religion as a stress-relieving tool. His work

appears to be influenced by the attribution theory. More evidence points to a causal association between religion and physical health. Certain diseases may be less likely as a result of religion.

According to studies, it enhances immune system health and prevents cardiovascular disease by lowering blood pressure. Similar research on religious feelings and health has been conducted. It is uncertain whether religious persons cultivate and experience those feelings more frequently than non-religious peoples, despite the fact that religious emotions like humility, forgiveness, and thankfulness have positive health effects.

The World Health Organization (WHO) distinguishes four aspects of wellbeing: bodily, social, mental, and spiritual health. Health was defined as a state of "physical, mental and social well-being and not merely the absence of disease or infirmity" in the preamble to the World Health Organization (WHO) Constitution, which was adopted by the International Health Conference held in New York from 19 June to 22 July 1946 and signed on that date by representatives of 61 States. This definition has not been changed.

However, a lot of spiritual people also have happy times. To add a reference to spiritual health to this preamble, however, 22 WHO member nations from the Eastern Mediterranean Region proposed a draught resolution in 1983. This resolution would have redefined health as a state of "physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity."

The Thirty-seventh World Health Assembly's resolution WHA31.13, which recognised that "the spiritual dimension plays a great role in motivating people's achievements in all aspects of life," urged Member States to consider including a spiritual dimension as defined in that resolution in accordance with their own social and cultural patterns in their Health for All strategies. Despite the fact that WHO did not amend the preamble to its constitution, this resolution did call for Member States to consider doing so.

A family is any two or more people who live together and are connected by blood, marriage, or adoption; all of these people are regarded as belonging to the same family. Family is crucial because they can provide unconditional love, support, and stability. They constantly strive to see and bring out the best in you, even when you are unable to do so for yourself. Generally speaking, there are three different types of families: a

nuclear family is a unit of family made up of two adults and one or more children who live together; Grandparents, aunts, uncles, and cousins who reside close by or in the same home are referred to as "extended family"; and Another name for a reconstituted family is a blended family or step family. Families have a key role in social development as the fundamental and indispensable building blocks of societies. They are primarily responsible for the upbringing, education, and socialisation of children as well as for teaching civic virtues and a sense of community.

Families offer the encouragement and surroundings necessary for healthy living, disease prevention, and chances for early detection and treatment to avoid or delay problems. The socioeconomic determinants of health must always be taken into account for interventions to improve health to be effective. For support and solace through both happy and sad times, it's critical to surround oneself with family and friends. According to studies, having supportive relationships both makes us feel better mentally and acts as a powerful barrier against mental diseases. Good mental and emotional health may be supported by a supportive family environment, which may in turn promote improved physical health. Your mental and emotional health may be improved by having close family ties that are characterised by open communication, candour, humour, and assurance.

REVIEW OF LITERATURE

CHAPTER 2

REVIEW OF LITERATURE

A literature review is the writing process of summarizing, synthesizing and/or critiquing the literature found as a result of a literature search. It may be used as background or context for a primary research project. There are several reasons to review the literature: Identify the developments in the field of study. The purpose of a literature review is to gain an understanding of the existing research and debates relevant to a particular topic or area of study, and to present that knowledge in the form of a written report. **According to World Health Organization (WHO)**, "health is a state of complete physical, mental, and social well-being and not m**erely the absence of disease or infirmity".** Merriam-Webster **online dictionary defines health as** "the condition of being sound in body, mind, or spirit".

Good health is commonly defined as a "state of complete physical, mental and social-wellbeing and not merely absence of disease or infirmity" (WHO, 1948 p 1). It is now widely recognised that health is not only influenced by biological and physiological factors, but also a broad range of 'political, social, economic, and cultural forces' (CSDH, 2008). Referred to as the 'social determinants of health', these influences have been defined as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life" (WHO, 2017b p 1). They include a broad range of social factors, such as wealth, gender, race, political power and social inclusion (Figure 1). Significantly, the social determinants of health have been shown to contribute to health inequities between and within countries, as well as directly impact individual health outcomes (CSDH, 2008). Evidence suggests a social gradient in health has emerged, in which an individual's socioeconomic status often correlates with their experience of health or ill health (Marmot, 2007).

As Marmot observes, "[w]ith few exceptions, the evidence shows that the lower an individual's socioeconomic position the worse their health" (Marmot, 2007 p 10) In March 2005, the former Director General of WHO, Dr JW Lee, established the Commission on the Social Determinants of Health (CSDH). The CSDH was endowed

with the task of drawing attention to the social determinants of health and the 'pragmatic ways' that health outcomes could be improved by focusing on the social conditions required for good health (CSDH, 2006 p 6). This framing of health as a social phenomenon was seen to reveal the complexity of health and its importance as a matter of social justice. As a direct result, the CSDH's work was grounded in a focus on health equity, which it defined as the "absence of unfair and avoidable or remediable differences in health among social groups" (WHO, 2010 p 4). One of the key implications of this framing is that efforts to improve health outcomes must rely on "more complex forms of intersectoral policy action" (WHO, 2010 p 4), as distinct from an exclusive focus on "technology-based medical care and public health interventions" (WHO, 2010 p 4).

That is, services targeted at improving the health status of vulnerable target populations, including women, must not only consider the individual's biological and physiological traits, but also the social context in which health and illness occur (Germov, 2014). While a large body of literature has focused on the impact of income inequality in influencing individuals' health outcomes (Sen & Östlin, 2008), it is important to recognise that health disparities occur along several complex and often intersecting "axes of social stratification" (Marmot, 2007 p 10). That is, a broad range of social factors impact an individual's health, for example housing, health literacy, access to services and social inclusion. This is also highlighted in the differential health status of men and women across the globe, which has been described by the WHO as "perhaps the single most pervasive and entrenched inequity" (Marmot, 2007 p 15).

Importantly, when considering the role of the social determinants of health it is important to draw a distinction between health inequality and health inequity. While health inequality refers to "the differences, variations and disparities" (I. Kawachi et al., 2002) in health outcomes of individuals and specific cohorts, health inequities are "are avoidable inequalities in health between groups of people" (WHO). That is, inequalities in health outcomes which "are deemed to be unfair or stemming from some form of injustice" (I. Kawachi et al., 2002).

It is now widely recognised that gender is a social determinant of health (DiGiacomo et al., 2015; Hills & Mullett, 2005; Phillips, 2005). In contrast to the term sex, which refers to the 'different biological and physiological characteristics of males and females,' gender refers to the 'economic, social, political and cultural attributes and opportunities ascribed with being either female or male' (AWHN, 2012; WHO, 2013). These socially

constructed characteristics influence the health status of men and women through a range of pathways, such as an individual's vulnerability to ill health, their capacity to access health services, their experience of care and ability to exert control over their health and healthcare decisions (Sen & Östlin, 2008).

The role of gender as a social determinant of health was central to the work of the Women and Gender Equity Knowledge Network (WGE KN), which reported to the WHO CSDH. In their final report to the CSDH, WGE KN presented a conceptual framework for understanding the structural and intermediary factors that contribute to health inequity (Figure 2). The structural determinants were seen to include the gender systems and relations of power that "govern how people live, and what they believe, and claim to know, about what it means to be a girl or a man" (Sen & Östlin, 2008). Importantly, gender has "meaning for both men and women" (AWHN, 2012 p 7) and contributes to health inequity and inequality in all societies to a varying degree (WHO, 2013). Sen and Östlin observe that despite men commonly experiencing greater 'resources, power, authority and control,' these social benefits can also have detrimental impacts on their overall health and wellbeing. Specifically, the social benefits can be "translated into risky and unhealthy behaviours, and reduced longevity" (Sen & Östlin, 2008 p 1). At the same time, these 'gender relations of power' (Sen & Östlin, 2008 p 2) also influence women's experience of health.

Despite women having a longer life expectancy than men in a number of countries, including Australia, women fall behind on a number of key health indicators. As an example, globally, women are more likely to experience depression (5.1 per cent) than men (3.6 per cent) (WHO, 2017a). Rates of hospitalisation for self-harm in Australia are also higher in women (154.4 per 100,000 population in 2010-11) than men (101.1 per 100,000 population in 2010-11) (NSW Ministry of Health, 2013). As DiGiacomo et al observe, "Women continue to experience inferior health outcomes across a number of conditions, despite human rights advances and average longevity in many developed countries as surpassing men by several years" (DiGiacomo et al., 2015 p 106). These health inequalities will be explored in depth below.

While gender is often positioned as a distinct determinant, when considering health outcomes, Phillips (2005) suggests that sex and gender cannot adequately be examined independent of each other (Phillips, 2005). The 'interconnectedness' of biology and gender is said to be demonstrated in men and women's varying experiences of

myocardial infarcts (MI), commonly referred to as heart attacks. Despite MIs being a leading cause of death among both men and women in developing countries, Phillips observes that heart disease is typically presented as a 'male affliction' (Phillips, 2005 p 13). This includes the presentation of chest pain, the most common symptom experienced by men but not women, as the "most important diagnostic clue to the presence of angina" (Phillips, 2005 p 13).

Phillip's suggests that in such a case there "is no practical advantage to disentangling where sex ends and gender takes over" (Phillips, 2005 p 13) as a proper diagnosis will require health professionals to both recognise the unique symptoms experienced by women, as well as reject the dominant gender narrative that men are "the bearers" of coronary heart disease (Phillips, 2005 p 13). In response, Philips concludes "it might prove pragmatic to consider that gender encompasses both sex differences and the social constructs that give rise gender differences (Phillips, 2005 p 13).

Similar interplays are observed in the Health Foundation's Women and Heart Disease Forum Report (2011). The report points to research that indicates "women mistakenly believe that heart disease is only a male problem, with women tending to dismiss their symptoms or not seek help until their condition becomes 5 WOMEN'S HEALTH NSW WOMEN'S HEALTH CENTRES - LITERATURE REVIEW serious" (Heart Foundation, 2011 p 6). Additionally, focus groups undertaken with women aged 45-64, revealed a range of social determinants directly impact women's experience of cardiovascular health, including their "socioeconomic status, cultural background, health literacy, and rurality" (Heart Foundation, 2011 p 7). These social influences were seen to be a particular concern given that while men experience greater incidences of heart disease, women experience inferior health outcomes, including higher mortality rates (Heart Foundation, 2011 p 6). Coronary heart disease is the leading cause of death in women in Australia (AIHW, 2013; Heart Foundation, 2011).

The term 'women's health' has traditionally been associated with women's reproductive functions, which were seen to control women's overall health and mental wellbeing (Weisman, 1997). This focus is grounded in the "medical conceptions of women's health that emerged in the second half of the 19th century, when ideas about biological determinism and fundamental differences between the sexes were becoming prominent" (Weisman, 1997 p 180). The modern Women's Health Movement in Australia, which occurred at a similar time to movements in other countries such as the

United States, challenged this view (Jamieson, 2012; Weisman, 1997) Subsequently, a feminist critique of the male-dominated medical profession surfaced, with many individuals advocating for women to be informed and empowered to make their own healthcare decisions (Jamieson, 2012 p 30).

During the 20th century there was a growing emphasis on the impact of gender on a broad range of social issues, including gender equity, women's reproductive rights, gender bias in medical research, practice and treatment, and women's access to accessible and appropriate healthcare (Jamieson, 2012). Drawing on the earlier work of Broom (1991), Jamieson observes "… women were dissatisfied with medical services, critical of many of the professionals who delivered them and had a vision of a radically different society, in which women would be no longer subordinate, would be proud of their bodies and would enjoy life conditions that would enable them to be responsible for their own health and health care" (Jamieson, 2012 p 30). The WHO has identified some of the sociocultural barriers that prevent women from accessing health services and attaining quality health outcomes, including "unequal power relationships between men and women, social norms that decrease education and paid employment opportunities, an exclusive focus on women's reproductive roles, and potential or actual experience of physical, sexual and emotional violence" (WHO, 2017). These overarching barriers are reflected in the existing literature, which demonstrates the effects of a broad range of social determinants on women's health outcomes.

In recent years, women's health has been more broadly defined as the "social conditions, illnesses and disorders unique to, more prevalent among, or more serious in women for which there are different risk factors, interventions, or strategies for women than for men" (NSW Health Department, 2000 p 11). This expanded view has implications for the models of care that are likely to be most effective for women, as services must reflect the unique experiences that derive from women's biological differences, as well as their distinct gender roles (WHO, 2001). Of particular significance to this review, one of the notable outcomes of the Women's Health Movement in Australia was the establishment of Women's Health Centres across Australia during the 1970s (Mackey & Social Policy Group, 1997).

METHODOLOGY

CHAPTER 3

METHODOLOGY

GENERAL OBJECTIVE

To study the health wellness maintenance among women in rural and urban area.

SPECIFIC OBJECTIVES

- To examine the socio- economic status of the respondents.
- To analyse the pattern of health maintenance among the respondents.
- To examine the approach of the respondents towards taking medical aid for health maintenance.
- To find out the awareness of the respondents about health programmes.

CLARIFICATIONS OF CONCEPTS

Health: Not just the absence of illness or disability, but also total physical, mental, and social well-being, is referred to as being in good health. This term has a crucial implication: mental health encompasses more than just the absence of mental diseases or disabilities.

Health maintenance: It is a way of those activities that preserve a person's current state of health and that prevents future diseases or injuries from occurring.

VARIABLES:

Independent variables

- Age
- Education
- Occupation

- Income
- Religion
- Type of family
- Marital status

Dependent variables

- Health wellness maintenance

UNIVERSE

- The universe of the study consists of women in the age between 20-60 in Ernakulam (rural & urban).

SAMPLE SIZE: 100

SAMPLING METHOD

- Simple random sampling method.

TOOL OF DATA

- In this study questionnaire method is used as the tool of data collection.

DATA ANALYSIS AND INTERPRETATION

CHAPTER 4

DATA ANALYSIS AND INTERPRETATION

Table 4.1: DISTRIBUTION OF RESPONDENT ON THE BASIS OF LOCALITY

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	RURAL	49	49.0	49.0	49.0
	URBAN	51	51.0	51.0	100.0
	Total	100	100.0	100.0	

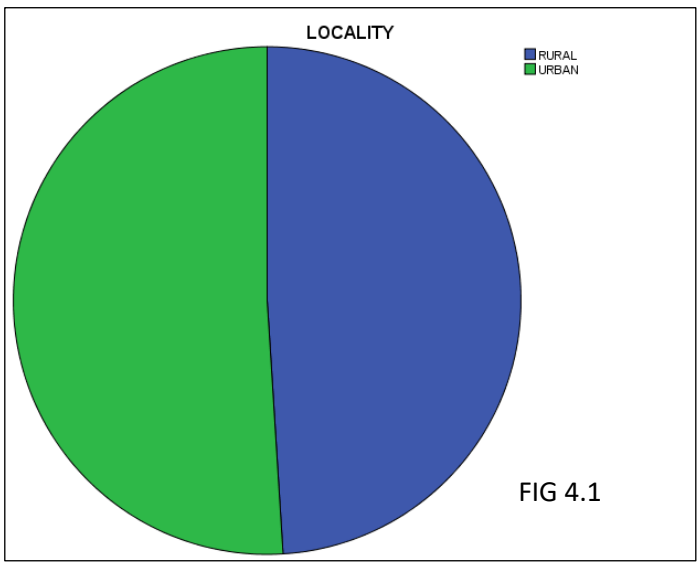

FIG 4.1

49% of the respondents are from rural areas, and 51% are from urban areas.

Table 4.2: DISTRIBUTION OF RESPONDENT ON THE BASIS OF AGE

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	20-30	20	20.0	20.0	20.0
	30-40	21	21.0	21.0	41.0
	40-50	34	34.0	34.0	75.0
	50-60	25	25.0	25.0	100.0
	Total	100	100.0	100.0	

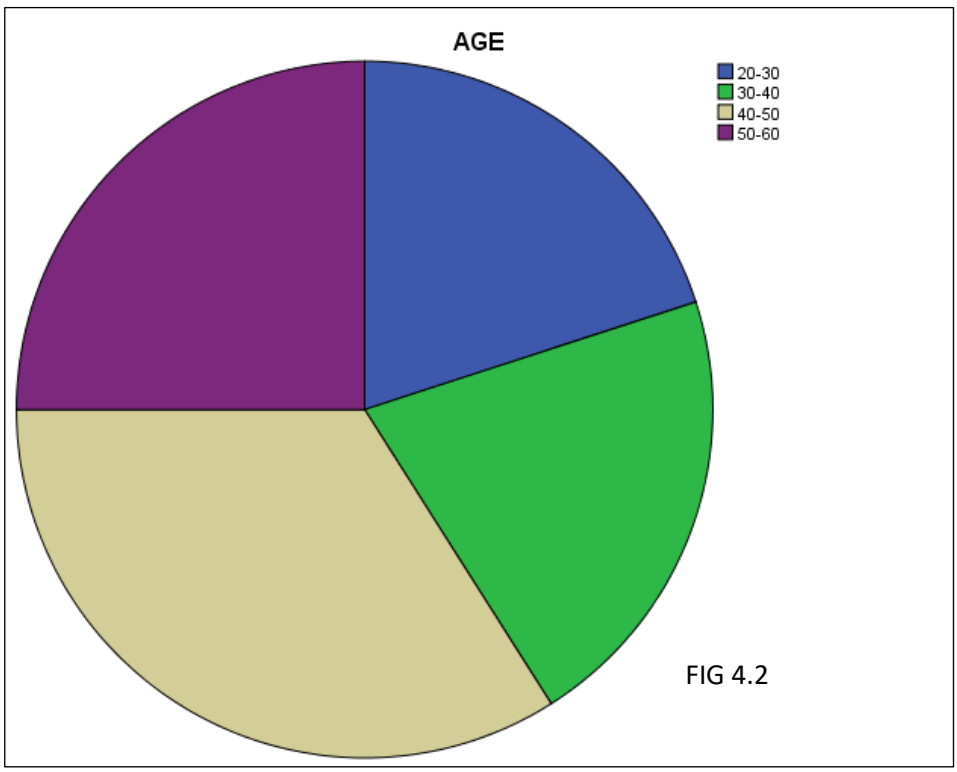

FIG 4.2

In this study 20% of the respondent is in the age group 20-30, 21% are in the group of 30-40 age group, 34% are belongs to the age group 30-50, 34% are in the 40-50 age group and 25% of the respondent are from the age group of 50-60.

Table 4.3: DISTRIBUTION OF RESPONDENT ON THE BASIS OF RELIGION

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	HINDU	51	51.0	51.0	51.0
	CHRISTIAN	45	45.0	45.0	96.0
	MUSLIM	4	4.0	4.0	100.0
	Total	100	100.0	100.0	

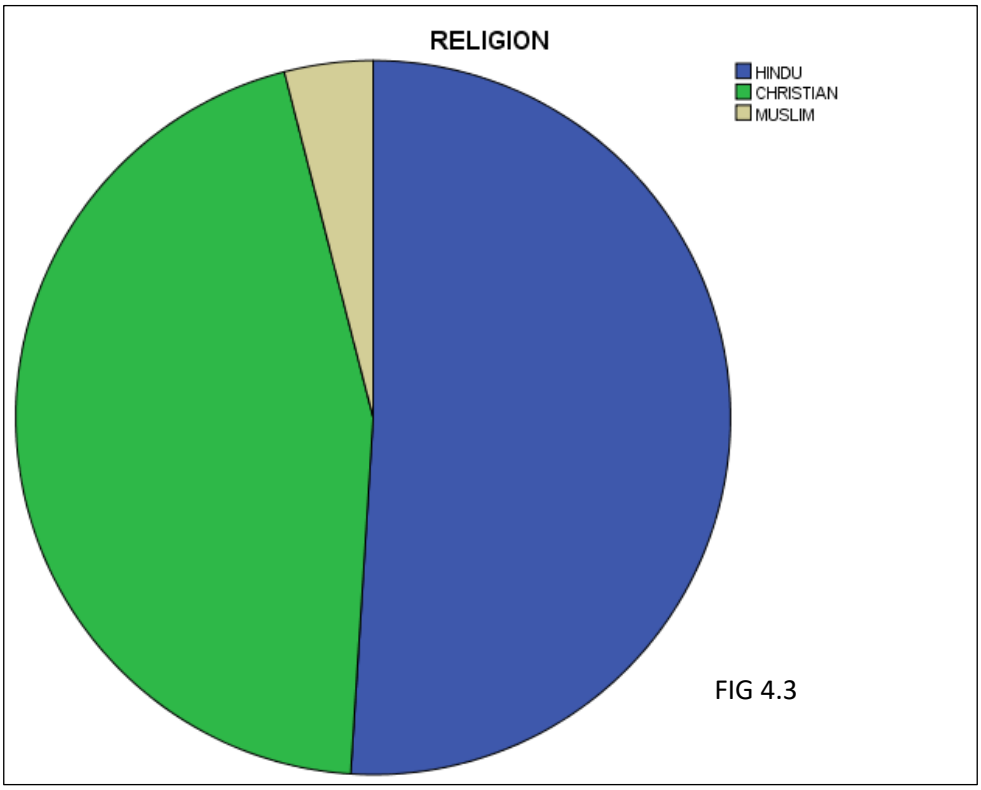

FIG 4.3

51% of those polled are Hindu, 45% are Christian, and 4% are Muslim.

Table 4.4: DISTRIBUTION OF RESPONDENT ON THE BASIS OF MARITAL STATUS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	MARRIED	78	78.0	78.0	78.0
	UNMARRIED	22	22.0	22.0	100.0
	Total	100	100.0	100.0	

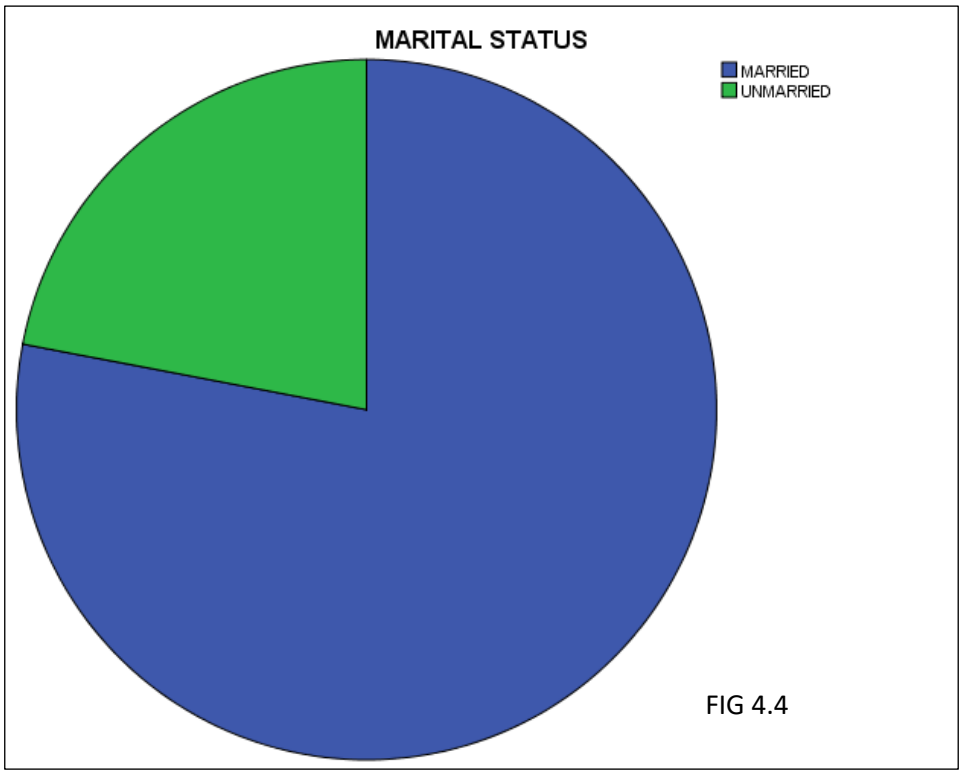

FIG 4.4

78% of the respondent is married, and only 22% of the respondent is unmarried.

Table 4.5: DISTRIBUTION OF RESPONDENT ON THE BASIS OF LIVING IN

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	OWN HOUSE	74	74.0	74.0	74.0
	RENTED HOUSE	6	6.0	6.0	80.0
	OWN APARTMENT/ FLAT	17	17.0	17.0	97.0
	RENTED APARTMENT/ FLAT	3	3.0	3.0	100.0
	Total	100	100.0	100.0	

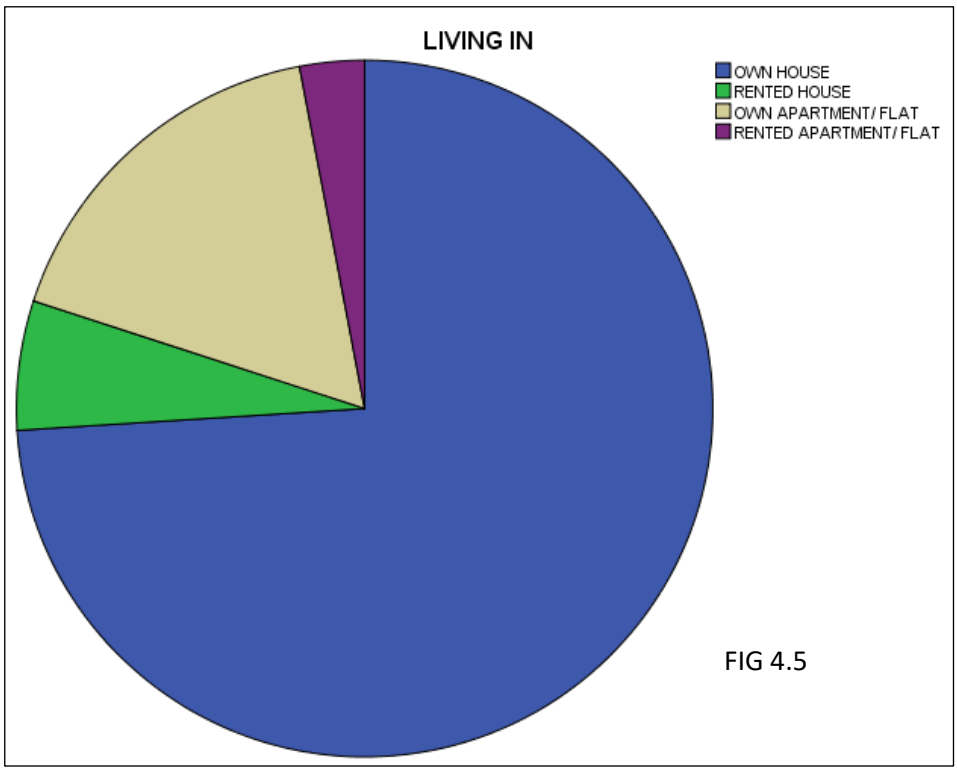

FIG 4.5

74% of those polled live in their own home, 6% in rented homes, 17% in their own apartment or flat, and 3% in a rented apartment or flat.

Table 4.6: DISTRIBUTION OF RESPONDENT ON THE BASIS OF LIVING STATUS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	LIVING WITH FAMILY	99	99.0	99.0	99.0
	LIVING WITH HOME HELPER	1	1.0	1.0	100.0
	Total	100	100.0	100.0	

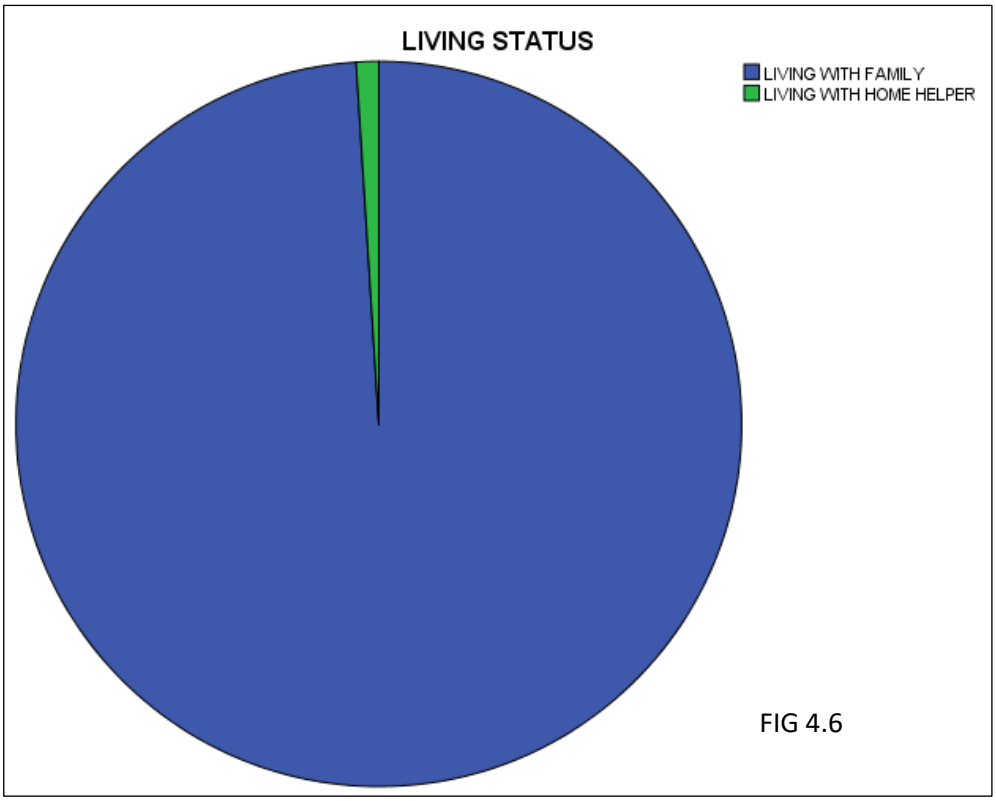

FIG 4.6

The living status of the respondent is distributed as follows: 99% are living with family, and only 1% are living with a home helper.

Table 4.7: DISTRIBUTION OF RESPONDENT ON THE BASIS OF TOTAL NUMBER OF PERSONS LIVING IN THE SAME HOUSE

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-5	74	74.0	74.0	74.0
	5-10	24	24.0	24.0	98.0
	10-15	2	2.0	2.0	100.0
	Total	100	100.0	100.0	

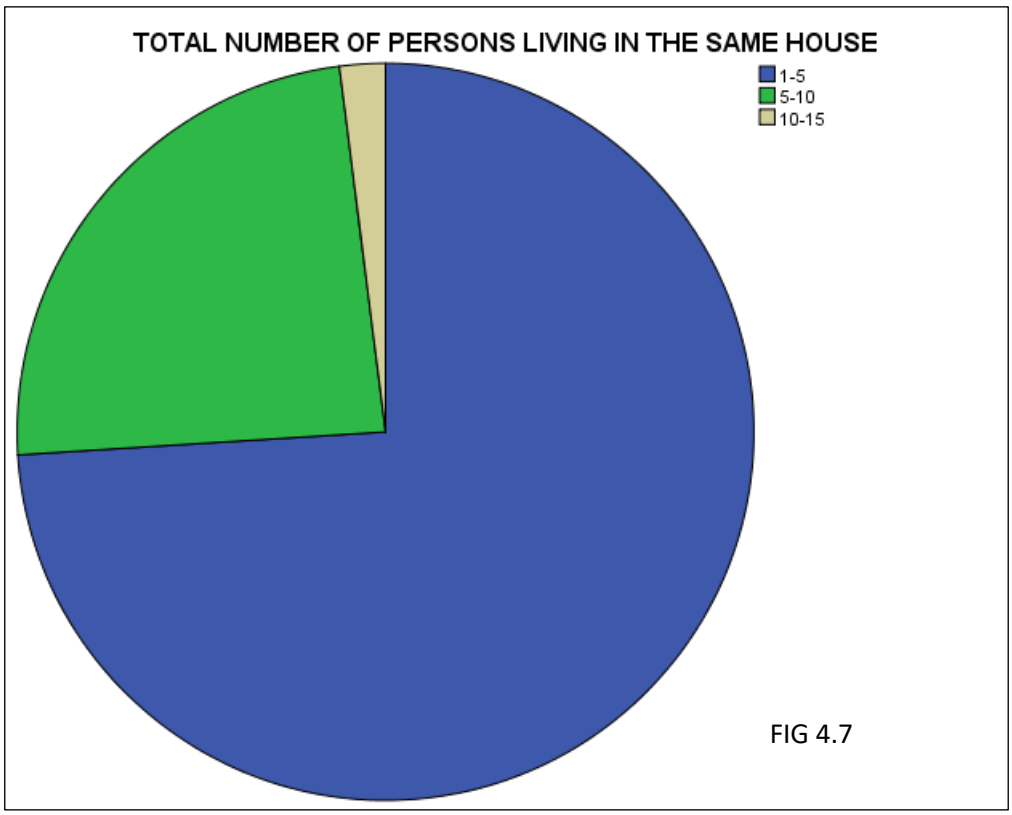

FIG 4.7

74% of the respondent belongs to the group of 1–5 persons living in the same house; 2% are in the group of 10–15; and only 2% are living with 10–15 persons in the same house.

Table 4.8: DISTRIBUTION OF RESPONDENT ON THE BASIS OF EDUCATION QUALIFICATION

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	BELOW SSLC	6	6.0	6.0	6.0
	SENIOR SECONDARY SCHOOL/ PREDEGREE	27	27.0	27.0	33.0
	UNDER GRADUATE	38	38.0	38.0	71.0
	POST - GRATUATE	29	29.0	29.0	100.0
	Total	100	100.0	100.0	

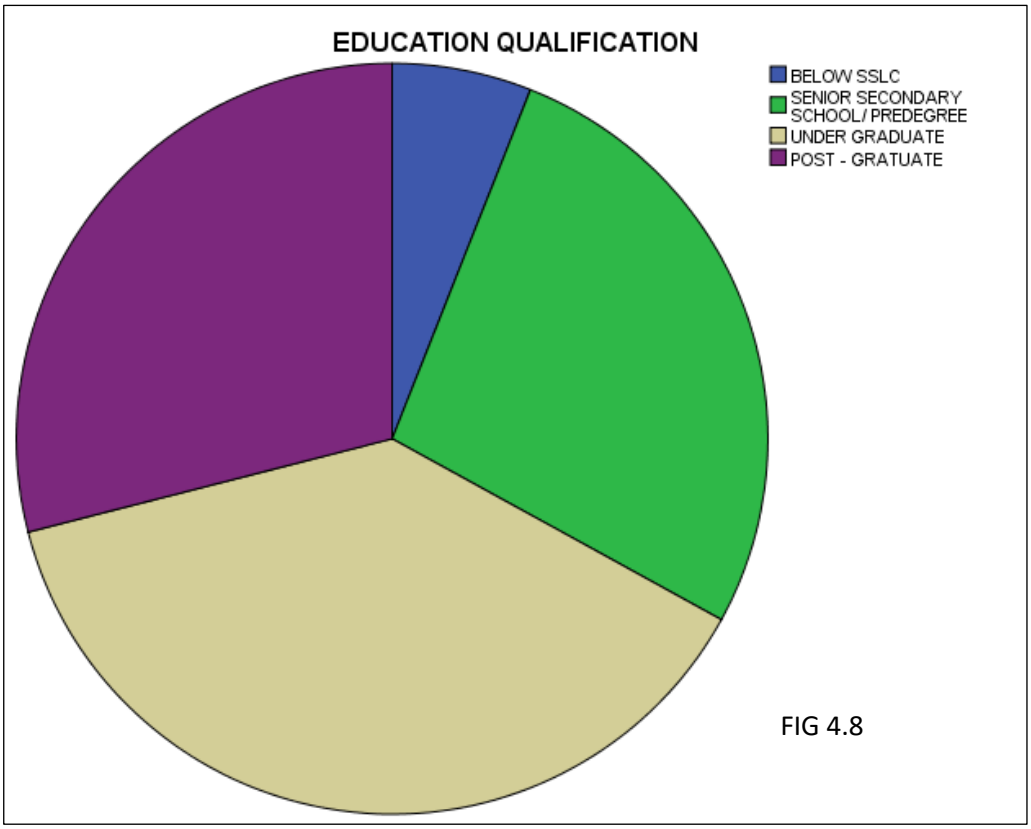

FIG 4.8

6% of responded have the education below SSLC. 27% of respondents have senior secondary school/ pre-degree. 29% of responded have qualified post-graduate. Among women, majority of them are post-graduated. This shows that, majority of the respondents are highly educated.

Table 4.9: DISTRIBUTION OF RESPONDENT ON THE BASIS OF OCCUPATION

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	UNEMPLOYED	52	52.0	52.0	52.0
	EMPLOYED	48	48.0	48.0	100.0
	Total	100	100.0	100.0	

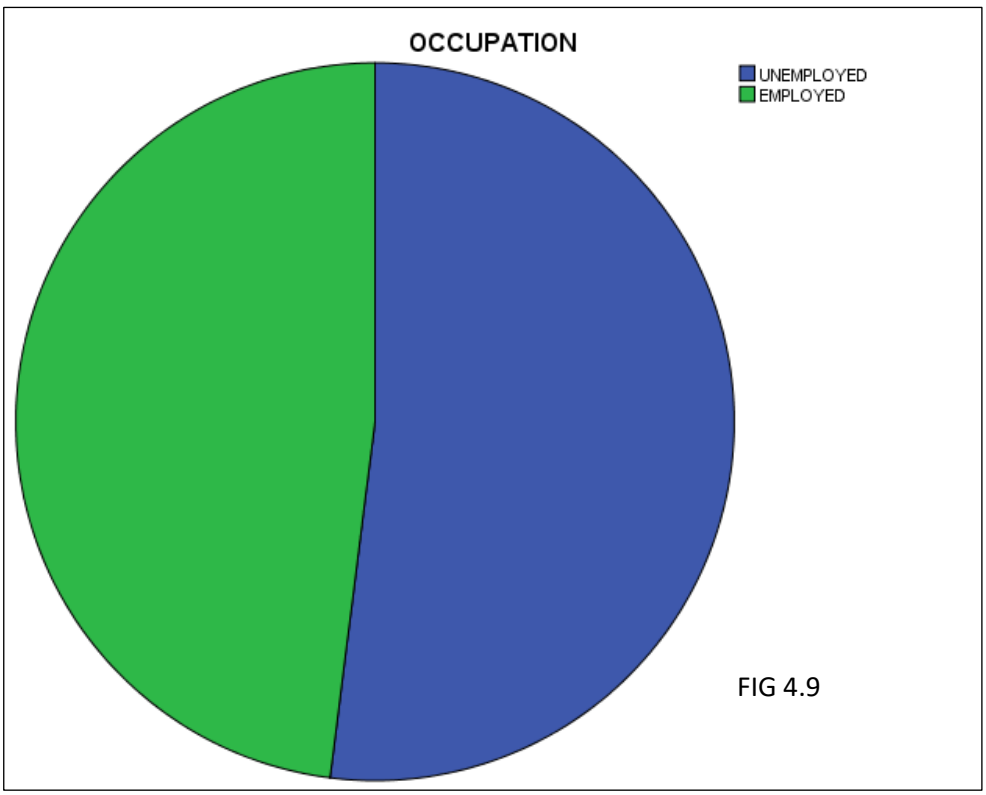

FIG 4.9

52% of respondents are unemployed, while 48% are employed. Among women, the majority of them are unemployed. This shows that the majority of the respondents are unemployed, even though they are highly educated.

Table 4.10: DISTRIBUTION OF RESPONDENT ON THE BASIS OF MAIN INCOME SOURCE OF FAMILY

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	PENSION OF HUSBAND	9	9.0	9.0	9.0
	PERSONAL WORK	19	19.0	19.0	28.0
	WORK OF HUSBAND	41	41.0	41.0	69.0
	FAMILY	25	25.0	25.0	94.0
	PERSONAL PROPERTY	2	2.0	2.0	96.0
	OTHER	4	4.0	4.0	100.0
	Total	100	100.0	100.0	

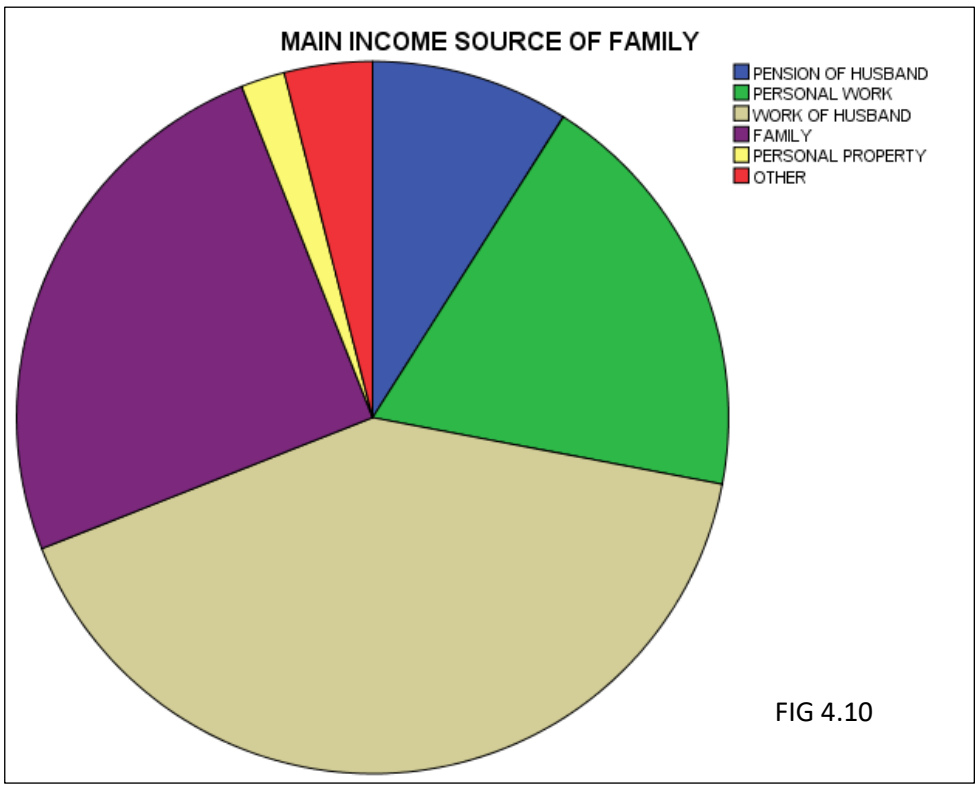

FIG 4.10

9% of respondents are reliant on their husband's pension. Personal work is relied on by 19% of respondents.41% of the respondents are dependent on the work of their husbands. 25% of respondents are financially dependent on their families. 2% of the respondents are dependent on their personal property. 4% of the respondents are dependent on each other. Among women, the majority of the respondents are dependent on the income of their husband. This shows that the majority of the respondents are dependent.

Table 4.11: DISTRIBUTION OF RESPONDENT ON THE BASIS OF ANNUAL INCOME

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	BELOW 3 LAKH	63	63.0	63.0	63.0
	3.50 - 5.50 LAKH	25	25.0	25.0	88.0
	5.50 - 7.50 LAKH	8	8.0	8.0	96.0
	7.50 -10.50LAKH	4	4.0	4.0	100.0
	Total	100	100.0	100.0	

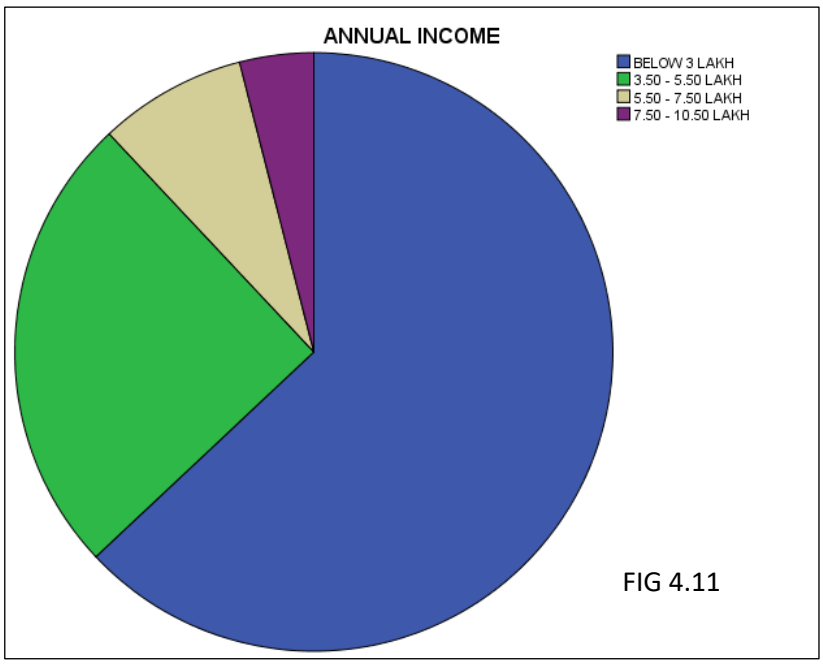

FIG 4.11

63% of the respondent's annual income is below Rs 3 lakh. 25% of the respondent's annual income is $3.50–5.50 lakh. 8% of the respondent's annual income is $5.50–7.50 lakh. 7.50-10.50 lakhs is 4% of the respondent's annual income. Among women, the majority of the respondent's annual income is below Rs 3 lakh.

Table 4.12: DISTRIBUTION OF RESPONDENT ON THE BASIS OF HEALTH PROBLEMS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	HYPERTENSION	11	11.0	11.0	11.0
	DIABETES	12	12.0	12.0	23.0
	VISUALLY IMPAIRED	3	3.0	3.0	26.0
	OTHERHEALTH PROBLEM	14	14.0	14.0	40.0
	NOHEALTH PROBLEM	60	60.0	60.0	100.0
	Total	100	100.0	100.0	

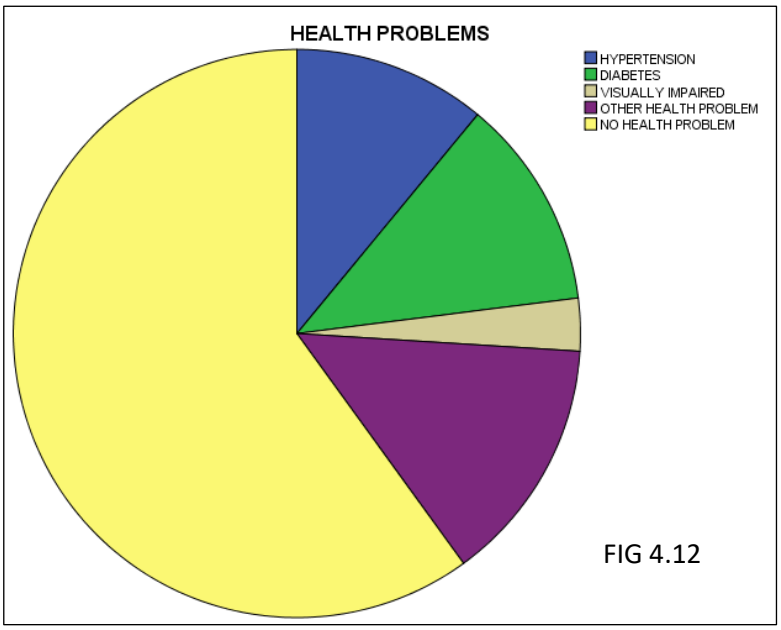

FIG 4.12

11% of the respondents have hypertension. 12% of the respondents have diabetes. 3% of the respondents are visually impaired. 14% of the respondents have other health problems. 60% of the respondents have no health problems. Among women, the majority of the respondents have no health problems. In this study, it was found that the women take part in many activities, so they are healthy.

Table 4.13: DISTRIBUTION OF RESPONDENT ON THE BASIS OF HEALTHY ENOUGH TO TAKE PART IN SEVERAL ACTIVITIES

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	I STRONGLY AGREE	31	31.0	31.0	31.0
	I AGREE	56	56.0	56.0	87.0
	NEITHER AGREE NOR DISAGREE	11	11.0	11.0	98.0
	I DISAGREE	2	2.0	2.0	100.0
	Total	100	100.0	100.0	

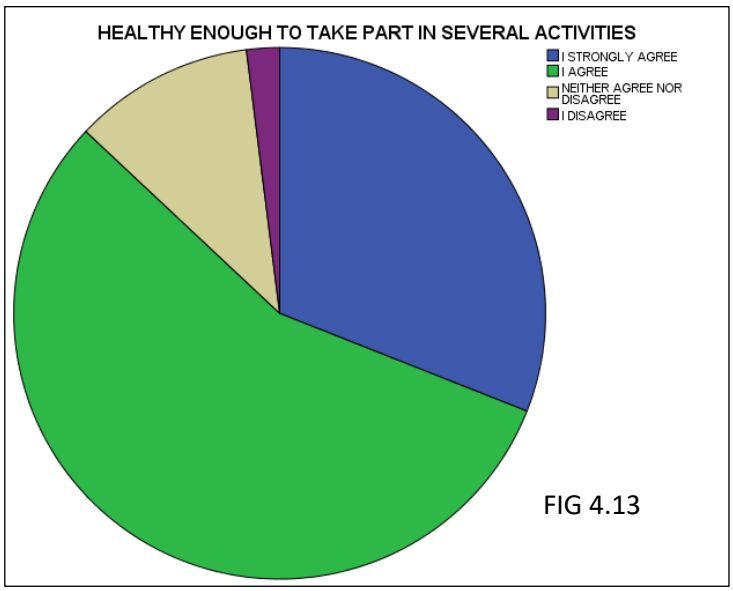

FIG 4.13

31% of the respondents strongly agree that they are healthy enough to take part in several activities. 56 percent of the respondents agree that they are healthy enough to take part in several activities. 11% of the respondents neither agree nor disagree that they are healthy enough to take part in several activities. 2% of the respondents disagree that they are healthy enough to take part in several activities. The majority of the respondents agree that they are healthy enough to take part in several activities. In this study, it was found that the women are healthy enough to take part in several activities, so they are healthy.

Table 4.14: DISTRIBUTION OF RESPONDENT ON THE BASIS OF SMOKING

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	NO	100	100.0	100.0	100.0

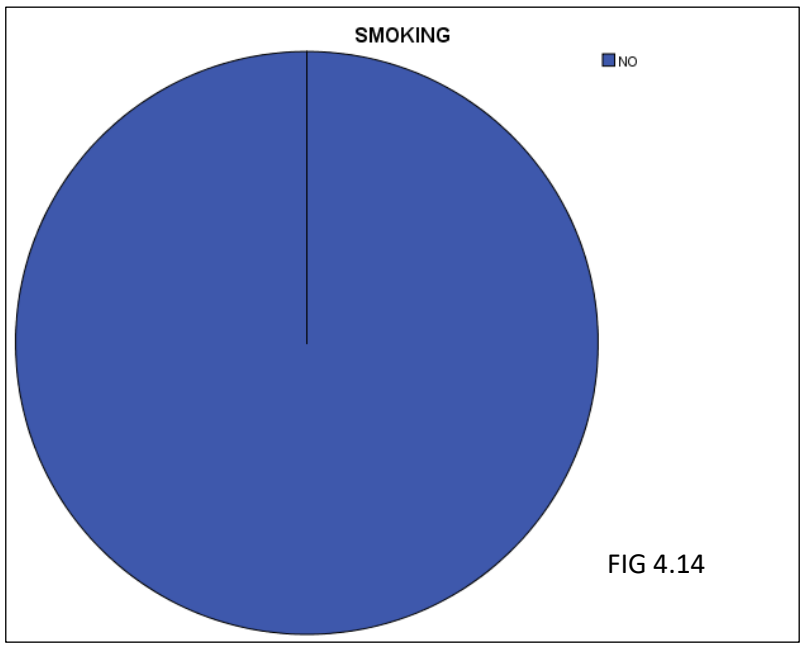

FIG 4.14

In this study, it was found that all the respondents don't smoke.

Table 4.15: DISTRIBUTION OF RESPONDENT ON THE BASIS OF CONSUPTION OF ALCOHOLIC DRINKS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	I NEVER USED ALCOHOLIC DRINKS	89	89.0	89.0	89.0
	I STOPPED USING ALCOHOLIC DRINKS	2	2.0	2.0	91.0
	STILL I USING ALCOHOL	9	9.0	9.0	100.0
	Total	100	100.0	100.0	

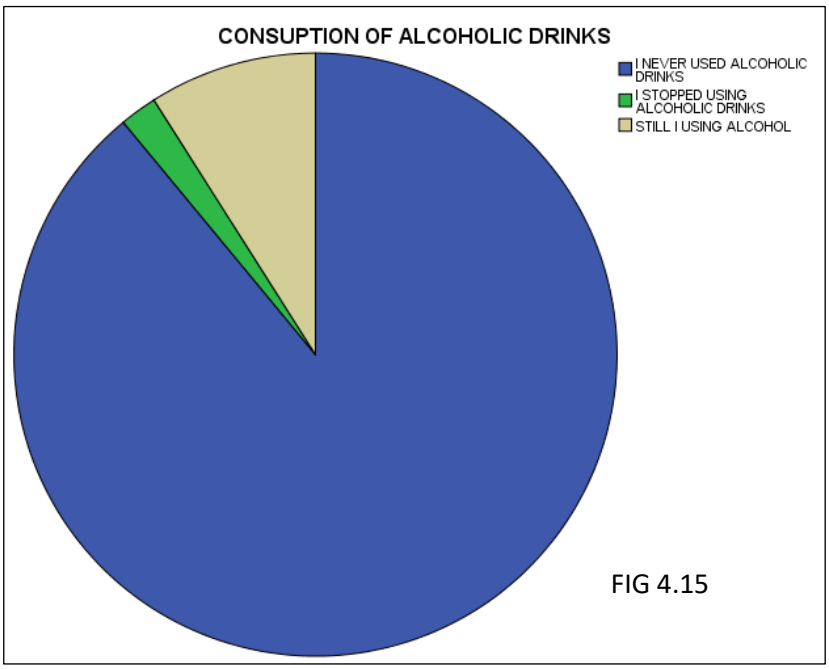

FIG 4.15

89% of the respondents never used alcoholic drinks. 2% of the respondents stopped using alcoholic drinks. 9% of the respondents are still using alcoholic drinks.

Table 4.16: DISTRIBUTION OF RESPONDENT ON THE BASIS OF EATING MEATS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	NEVER	7	7.0	7.0	7.0
	OCCATIONALLY	27	27.0	27.0	34.0
	SOMETIMES	53	53.0	53.0	87.0
	OFTEN	9	9.0	9.0	96.0
	ALWAYS	4	4.0	4.0	100.0
	Total	100	100.0	100.0	

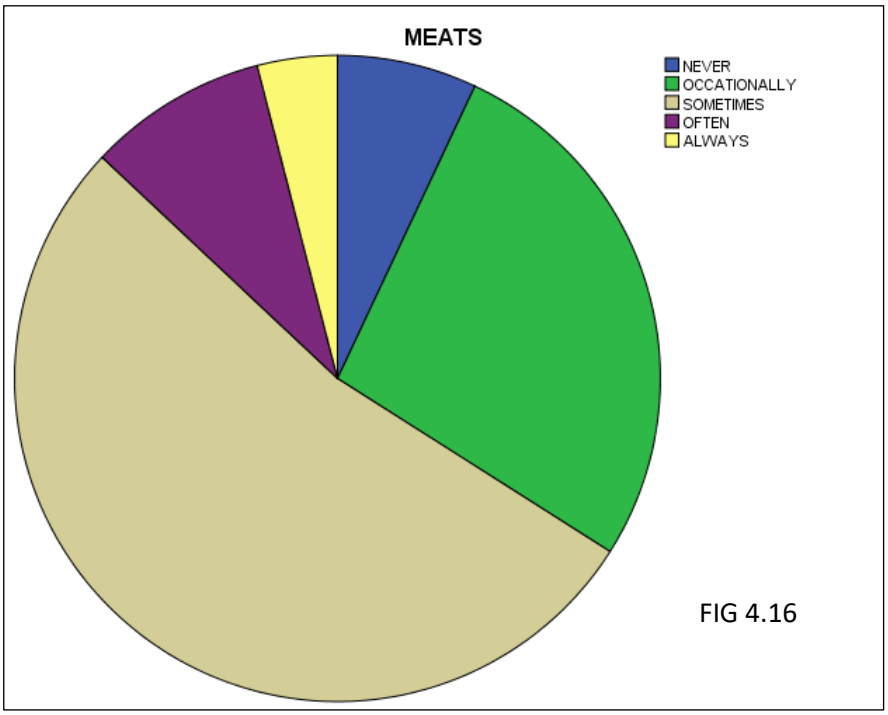

FIG 4.16

7% of the respondents never eat meat. 27% of the respondents occasionally eat meat. 53% of respondents eat meat on occasion.9% of the respondents often eat meat. 4% of the respondents always eat meat.

Table 4.17: DISTRIBUTION OF RESPONDENT ON THE BASIS OF EATING VEGETABLES

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	OCCATIONALLY	9	9.0	9.0	9.0
	SOMETIMES	10	10.0	10.0	19.0
	OFTEN	13	13.0	13.0	32.0
	ALWAYS	68	68.0	68.0	100.0
	Total	100	100.0	100.0	

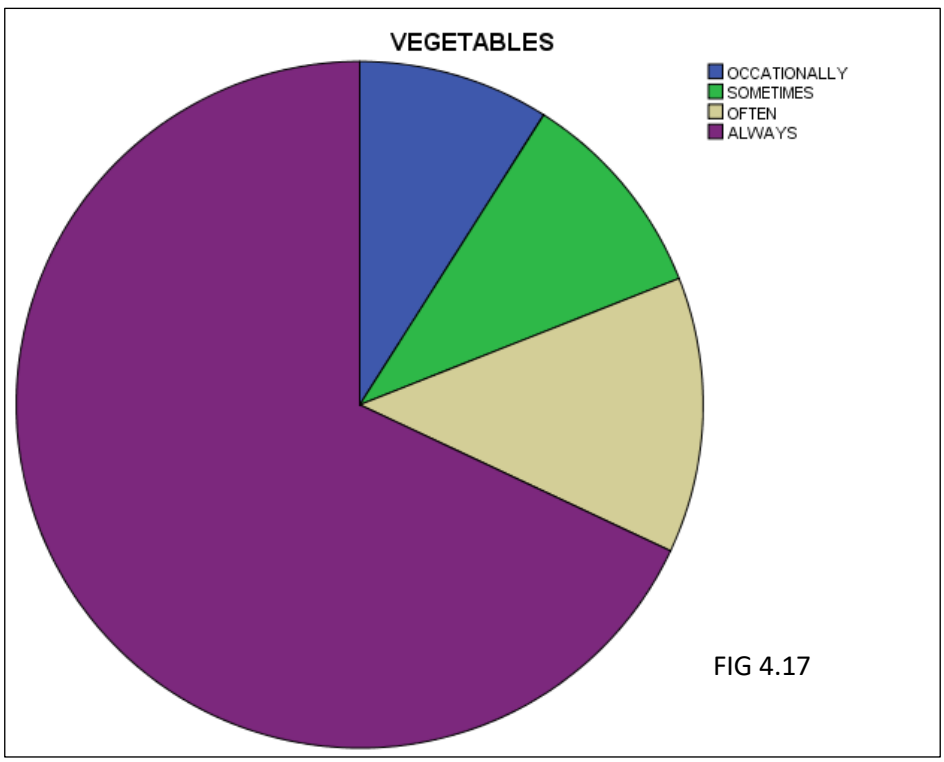

FIG 4.17

9% of the respondents occasionally eat meat. 10% of the respondents sometimes eat meat. 13% of the respondents often eat meat. 68% of the respondents always eat meat.

Table 4.18: DISTRIBUTION OF RESPONDENT ON THE BASIS OF SLEEPING QUALITY

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	SLEEP EASILY	75	75.0	75.0	75.0
	CAN'T SLEEP EASILY	25	25.0	25.0	100.0
	Total	100	100.0	100.0	

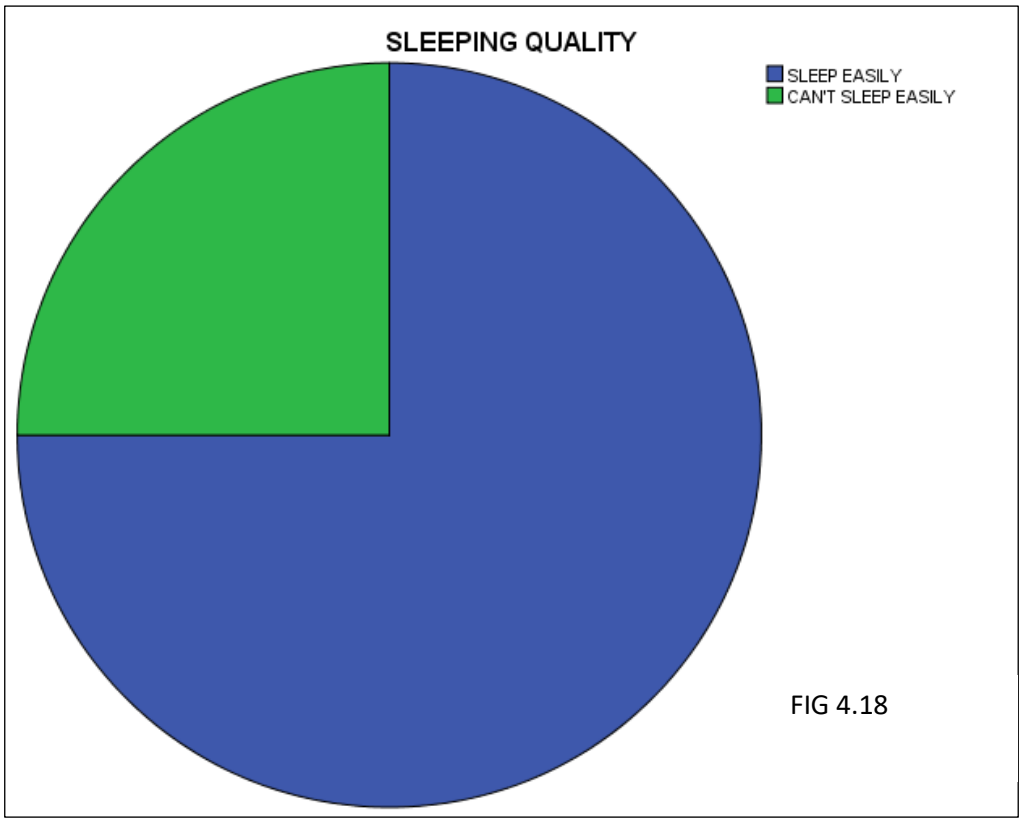

FIG 4.18

75% of the respondents can sleep easily. 25% of the respondents can't sleep easily.

Table 4.19: DISTRIBUTION OF RESPONDENT ON THE BASIS OF TAKING DRUGS TO FACILITATE SLEEP

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	NO	100	100.0	100.0	100.0

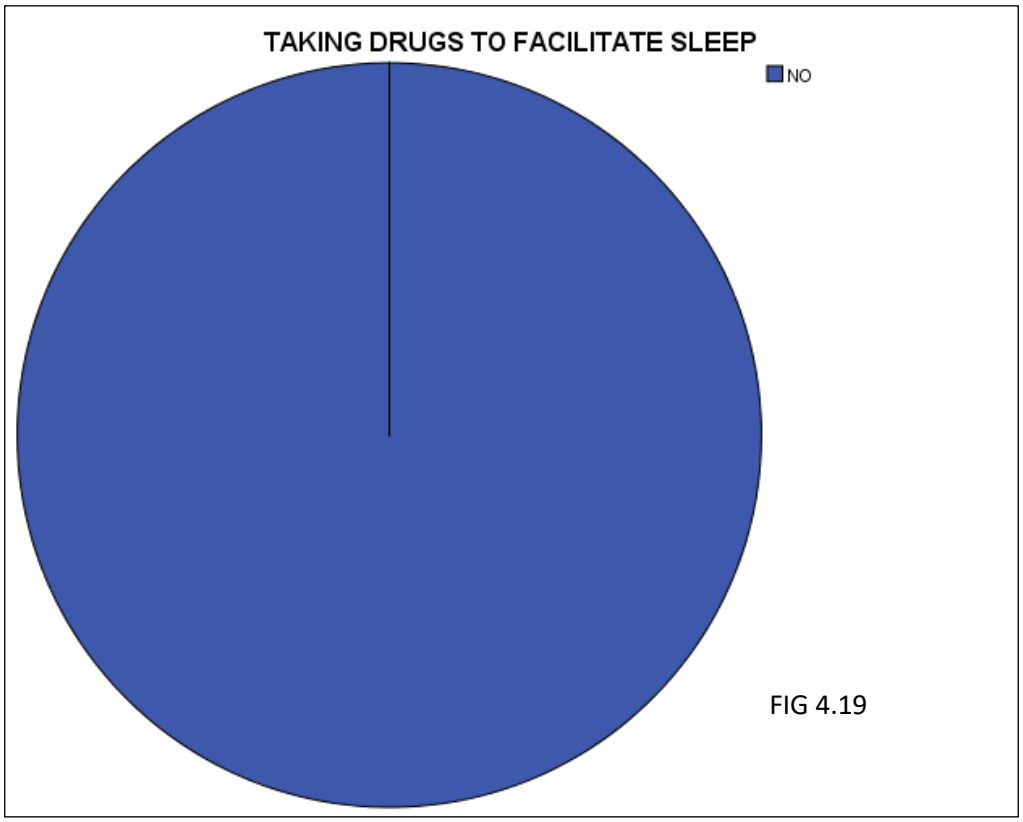

FIG 4.19

All respondents aren't taking any drugs to facilitate sleep.

Table 4.20: DISTRIBUTION OF RESPONDENT ON THE BASIS OF TIREDNESS WHEN WAKE-UP

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	NO	36	36.0	36.0	36.0
	SOMETIMES	60	60.0	60.0	96.0
	I DON'T KNOW	4	4.0	4.0	100.0
	Total	100	100.0	100.0	

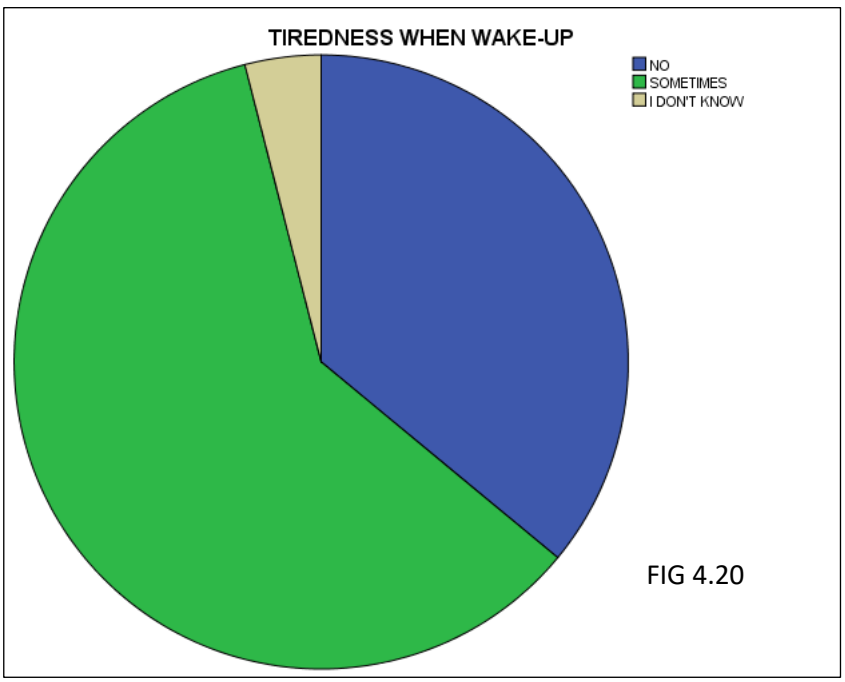

FIG 4.20

36% of respondents do not feel tired when they wake up.60% of the respondents sometimes feel tired when they wake up. 4% of the respondents don't know about it. The majority of the respondents agree that sometimes they are tired. In this study, it was found that they don't get enough sleep.

Table 4.21: DISTRIBUTION OF RESPONDENT ON THE BASIS OF PHYSICAL ENERGY

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	I STRONGLY AGREE	24	24.0	24.0	24.0
	I AGREE	47	47.0	47.0	71.0
	NEITHER AGREE NOR DISAGREE	21	21.0	21.0	92.0
	I DISAGREE	8	8.0	8.0	100.0
	Total	100	100.0	100.0	

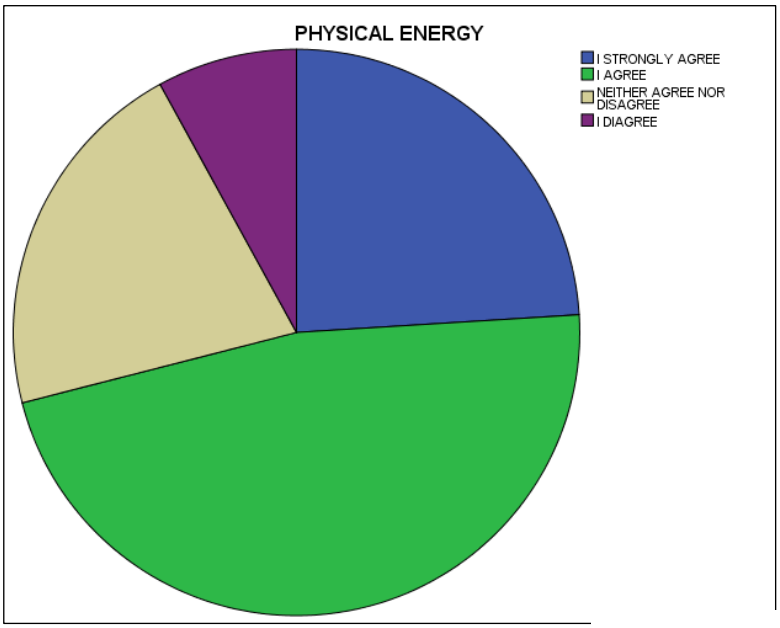

FIG 4.21

24 percent of the respondents strongly agree that they have good physical energy. 47 percent of the respondents agreed that they have good physical energy. 21 percent of the respondents neither agree nor disagree that they have good physical energy. 8% of the respondents disagree with that, saying they have good physical energy. The majority of the respondents agree that they have good physical energy. In this study, it was found that women have good physical energy.

Table 4.22: DISTRIBUTION OF RESPONDENT ON THE BASIS OF HEALTH CHEKUP

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	ONCE IN THREE MONTHS	2	2.0	2.0	2.0
	ONCE IN 6 MONTHS	9	9.0	9.0	11.0
	ONCE A YEAR	12	12.0	12.0	23.0
	ONLY WHEN NEEDED	67	67.0	67.0	90.0
	NEVER GET IT DONE	10	10.0	10.0	100.0
	Total	100	100.0	100.0	

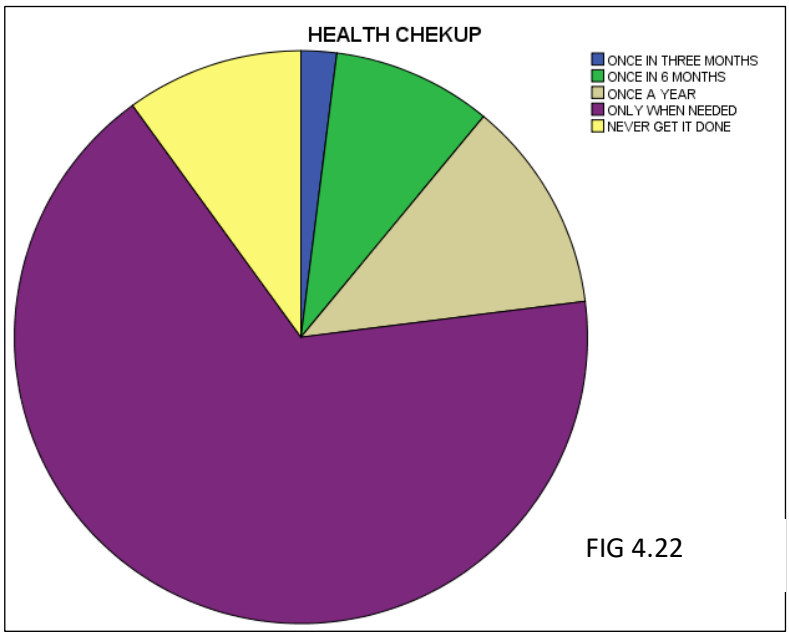

FIG 4.22

2% of the respondents do a health check-up once every 3 months. 9% of respondents get a health check-up every six months. 12% of the respondents do a health check-up once a year. 67% of the respondents do health check-ups only when needed. 10% of the respondents never get a health check-up. The majority of the respondents agree that they do health check-ups only when needed.

Table 4.23: DISTRIBUTION OF RESPONDENT ON THE BASIS OF ENGAGE IN MODERATE TO STRENUOUS EXERCISE

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0 DAY	28	28.0	28.0	28.0
	1 DAY	14	14.0	14.0	42.0
	2 DAYS	13	13.0	13.0	55.0
	3 DAYS	15	15.0	15.0	70.0
	4 DAYS	5	5.0	5.0	75.0
	5 DAYS	10	10.0	10.0	85.0
	6 DAYS	2	2.0	2.0	87.0
	7 DAYS	13	13.0	13.0	100.0
	Total	100	100.0	100.0	

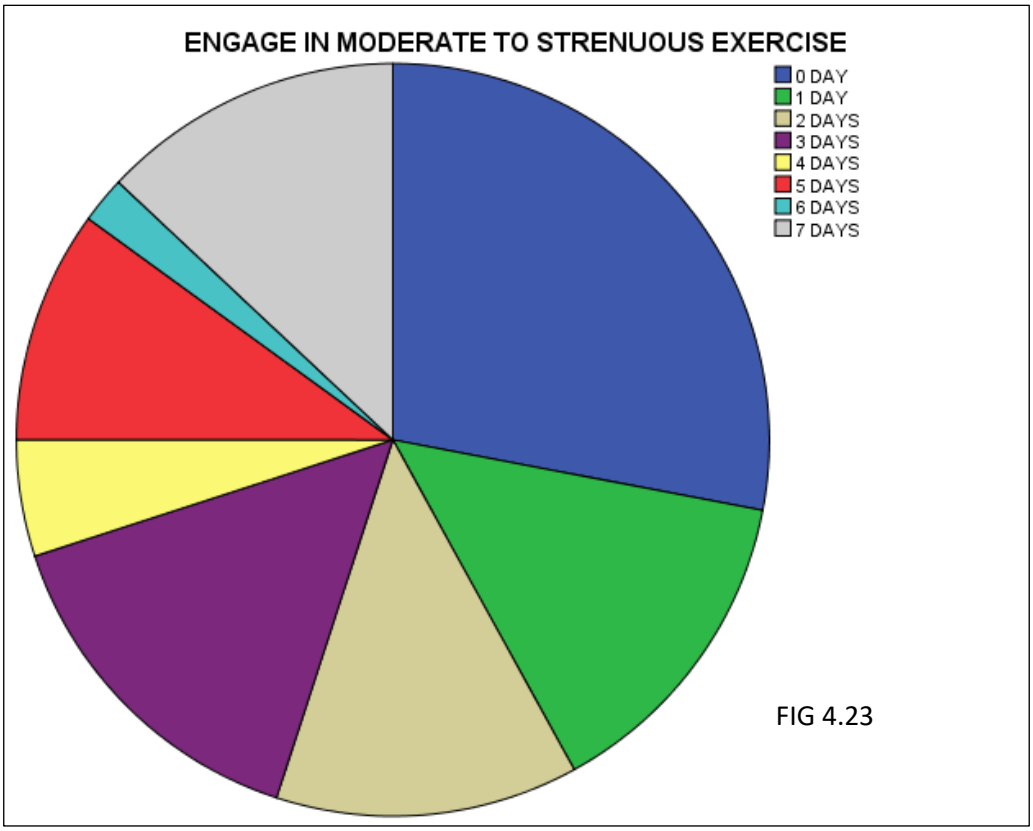

FIG 4.23

28% of the respondents didn’t engage in moderate-to-strength exercise. 14% of the respondents engage in moderate-to-strength exercise once a week. 13% of the respondents engage twice a week in moderate-to-strength exercise. 15% of respondents engage in moderate-to-strength exercise three times per week.5% of the respondents engage four times a week in moderate-to-strength exercise. 10% of respondents engage in moderate to strenuous exercise 5 times per week.2% of the respondents engage six times a week in moderate-to-strength exercise. 13% of respondents engage in moderate-to-strength exercise once a week. The vast majority of respondents do not engage in moderate-to-vigorous exercise.

Table 4.24: DISTRIBUTION OF RESPONDENT ON THE BASIS OF EATING FRUIT

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	I RARELY EAT FRUIT	64	64.0	64.0	64.0
	1 TIME A DAY	22	22.0	22.0	86.0
	2 TIMES A DAY	9	9.0	9.0	95.0
	4 OR MORE TIMES A DAY	5	5.0	5.0	100.0
	Total	100	100.0	100.0	

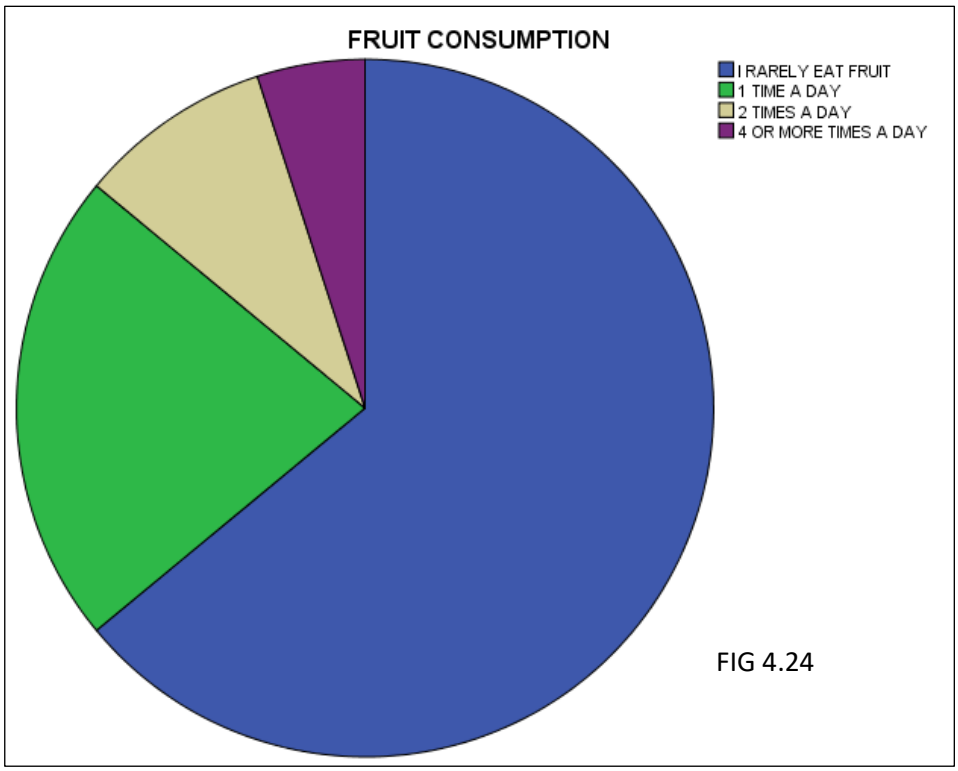

FIG 4.24

64% of the respondents said they rarely eat fruit. 22% of the respondents eat fruit once a day. 9% of the respondents eat fruit twice a day. 5% of the respondents eat fruit four or more times a day.

Table 4.25: DISTIBUTION OF RESPONDENT ON THE BASIS OF DRINKING REGULAR SODAS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	NEVER	78	78.0	78.0	78.0
	1 TO 3 TIMES A WEEK	20	20.0	20.0	98.0
	1 TIME A DAY	2	2.0	2.0	100.0
	Total	100	100.0	100.0	

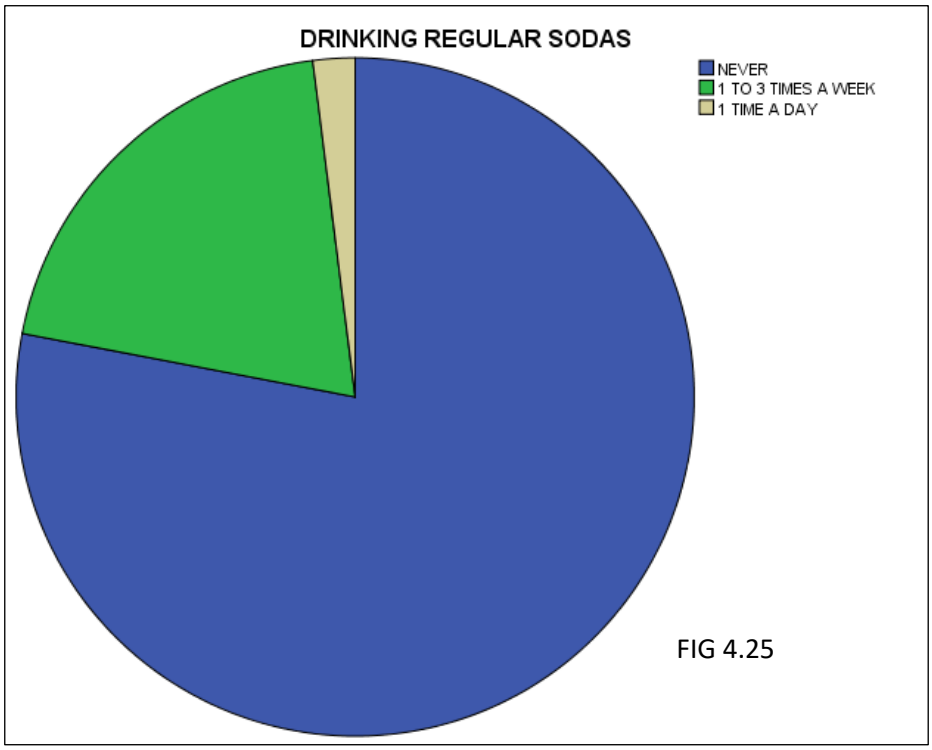

FIG 4.25

78% of the respondent's never drink regular sodas. 20% of the respondent's drink regular sodas 1 to 3 times a day. 2% of the respondent's drink regular sodas once a day.

Table 4.26: DISTRIBUTION OF RESPONDENT ON THE BASIS OF DRINKING WATER

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4 GLASSES	32	32.0	32.0	32.0
	8 GLASSES	40	40.0	40.0	72.0
	12 GLASSES	18	18.0	18.0	90.0
	MORE THAN 12 GLASSES	10	10.0	10.0	100.0
	Total	100	100.0	100.0	

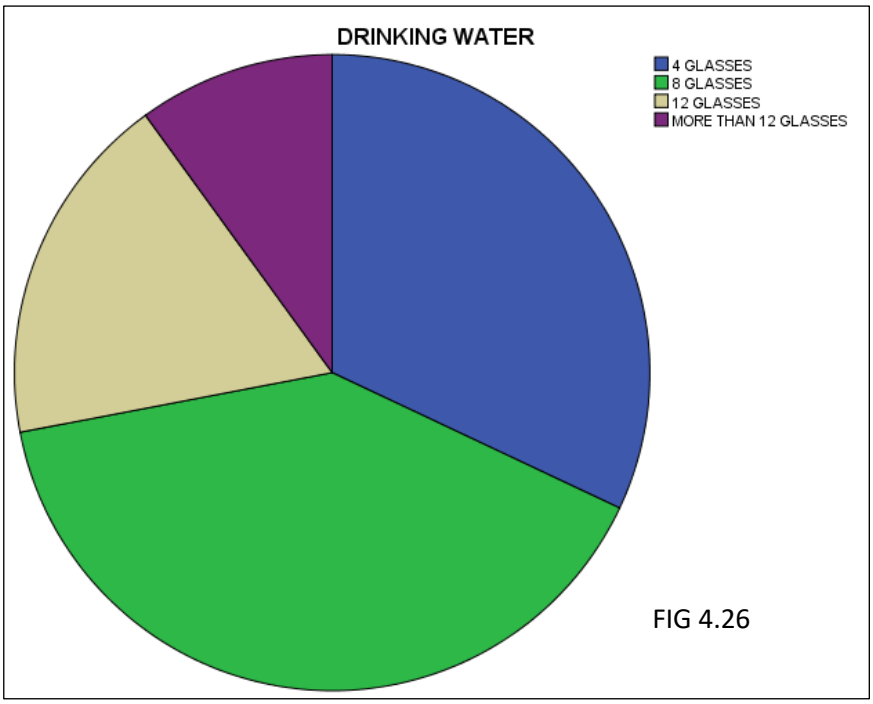

FIG 4.26

32% of the respondent's drink 4 glasses of water per day. 40% of the respondent's drink 8 glasses of water per day. 18% of the respondent's drink 12 glasses of water per day. 10% of the respondent's drink more than 12 glasses of water per day.

Table 4.27: DISTRIBUTION OF RESPONDENT ON THE BASIS OF DRINKING FRUIT PUNCH, FRUIT DRINKS, SWEET TEA OR SPORTS DRINKS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	NEVER	37	37.0	37.0	37.0
	1 TO 3 TIMES A DAY	40	40.0	40.0	77.0
	4 TO 6 TIMES A DAY	23	23.0	23.0	100.0
	Total	100	100.0	100.0	

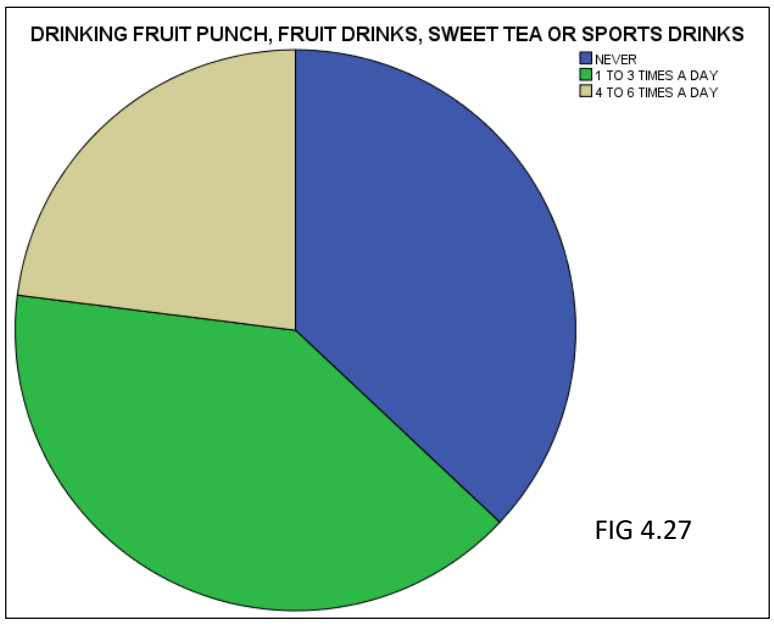

FIG 4.27

37% of the respondents said they never drink fruit punch, fruit drinks, sweet tea, or sports drinks. 40% of the respondents drink fruit punch, fruit drinks, sweet tea, or sports drinks 1–3 times a week. 23% of the respondents drink fruit punch, fruit drinks, sweet tea, or sports drinks four to six times a week.

Table 4.28: DISTRIBUTION OF RESPONDENT ON THE BASIS OF DRINKING MILK

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	NEVER	30	30.0	30.0	30.0
	1 TO 3 TIMES A DAY	54	54.0	54.0	84.0
	4 TO 6 TIMES A DAY	16	16.0	16.0	100.0
	Total	100	100.0	100.0	

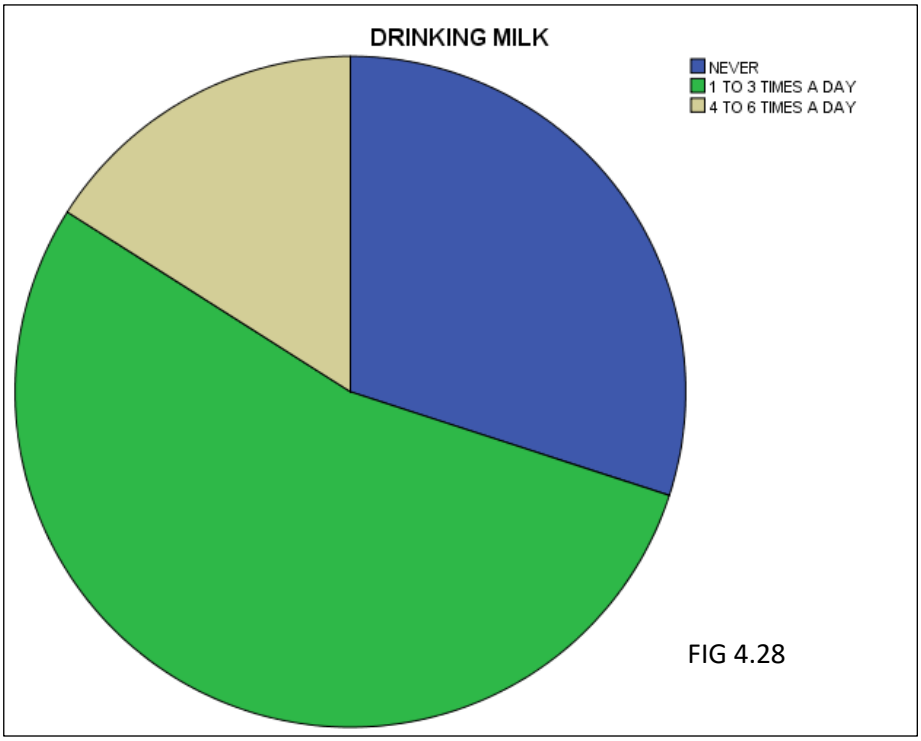

FIG 4.28

30 percent of those polled said they never drink milk on a daily basis.54% of the participants responded that they drink milk 1–3 times a day. 16% of the participants responded that they drink milk 4–6 times a day.

Table 4.29: DISTRIBUTION OF RESPONDENT ON THE BASIS OF EATING FAST FOOD

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0 DAY	67	67.0	67.0	67.0
	1 DAY	20	20.0	20.0	87.0
	2 DAYS	9	9.0	9.0	96.0
	7 DAYS	4	4.0	4.0	100.0
	Total	100	100.0	100.0	

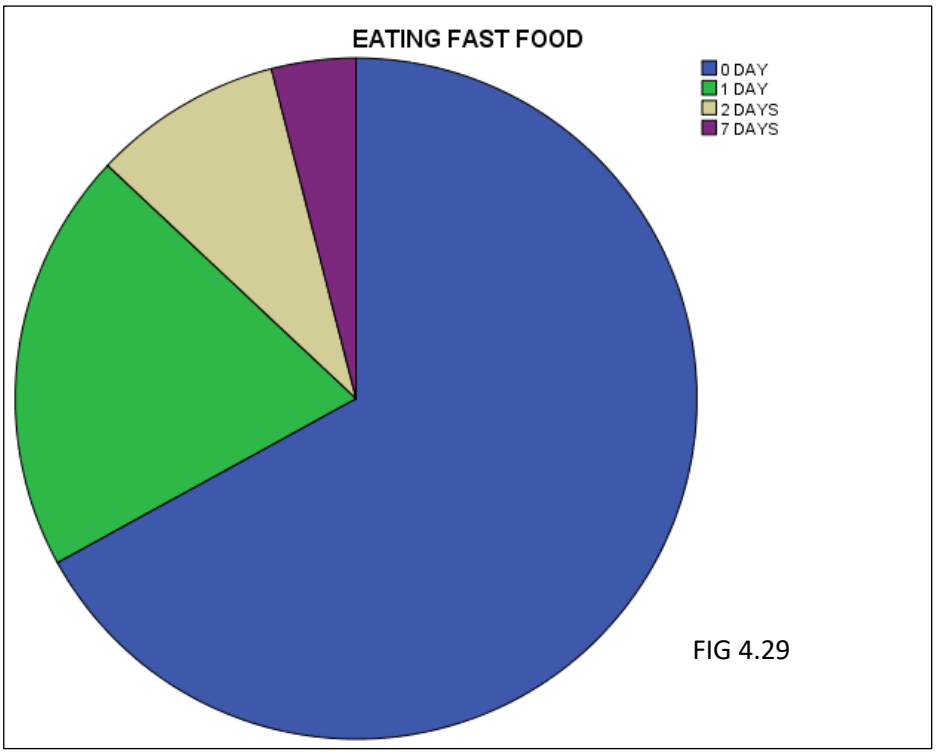

FIG 4.29

67% of the respondents never eat fast food. 20% of the respondents eat fast food once a week. 9% of the respondents eat fast food twice a week. 4% of the respondents eat fast food once a week.

Table 4.30: DISTRIBUTION OF RESPONDENT ON THE BASIS OF WASHING HANDS BEFORE EATING

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	NEVER	2	2.0	2.0	2.0
	SOMETIMES	6	6.0	6.0	8.0
	ALWAYS	92	92.0	92.0	100.0
	Total	100	100.0	100.0	

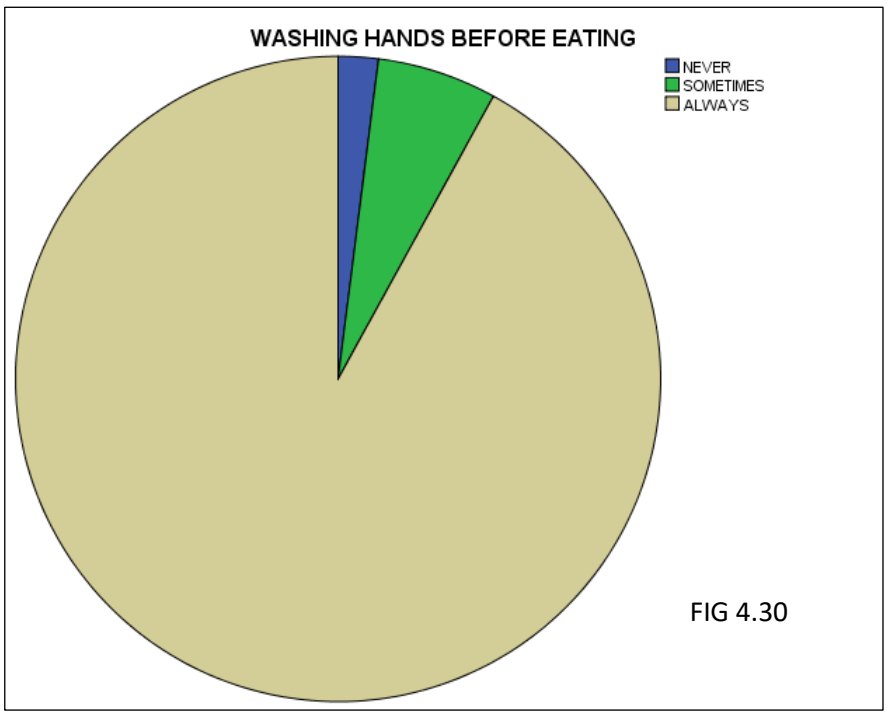

FIG 4.30

2% of the respondents never wash their hands before eating. 6% of the respondents sometimes wash their hands before eating. 92% of the respondents always wash their hands before eating.

Table 4.31: DISTRIBUTION OF RESPONDENT ON THE BASIS OF WASHING HANDS USING SOAP/HANDWASH

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	NEVER	2	2.0	2.0	2.0
	SOMETIMES	13	13.0	13.0	15.0
	ALWAYS	85	85.0	85.0	100.0
	Total	100	100.0	100.0	

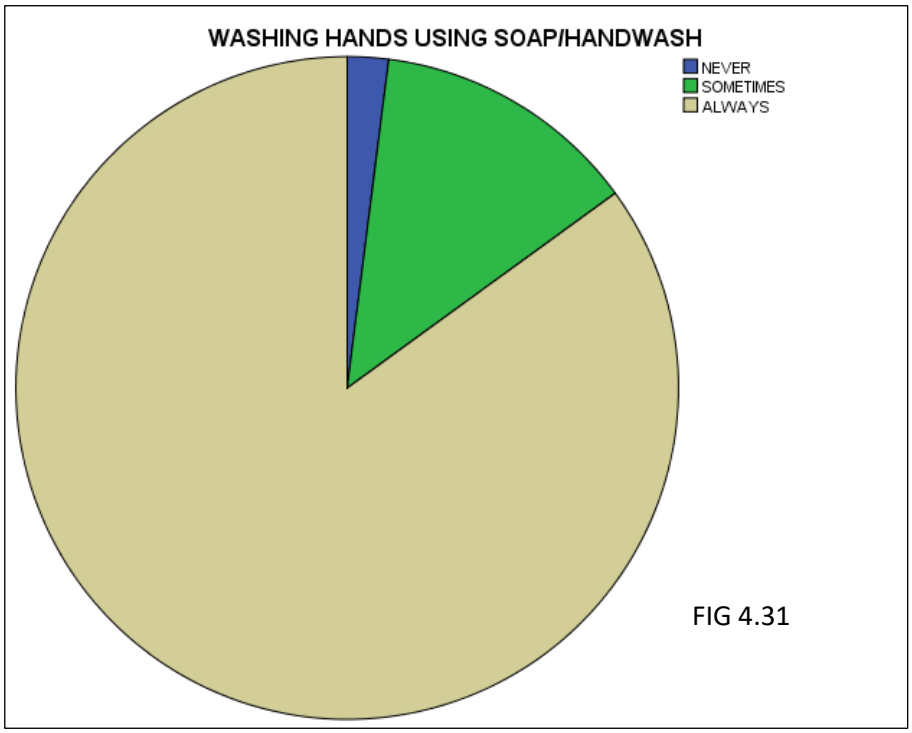

FIG 4.31

2% of the respondents never wash their hands using soap or handwash before eating. 13% of the respondents sometimes wash their hands using soap or handwash before eating. 85% of the respondents always wash their hands using soap or handwash before eating.

Table 4.32: DISTRIBUTION OF RESPONDENT ON THE BASIS OF MEDICATION

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	I DO NOT HAVE TO TAKE MEDICINE	24	24.0	24.0	24.0
	I ALWAYS TAKE THEM AS PRESCRIBED	52	52.0	52.0	76.0
	SOMETIMES I TAKE THEM AS PRESCRIBED	18	18.0	18.0	94.0
	I SELDOM TAKE THEM AS PRESCRIBED	6	6.0	6.0	100.0
	Total	100	100.0	100.0	

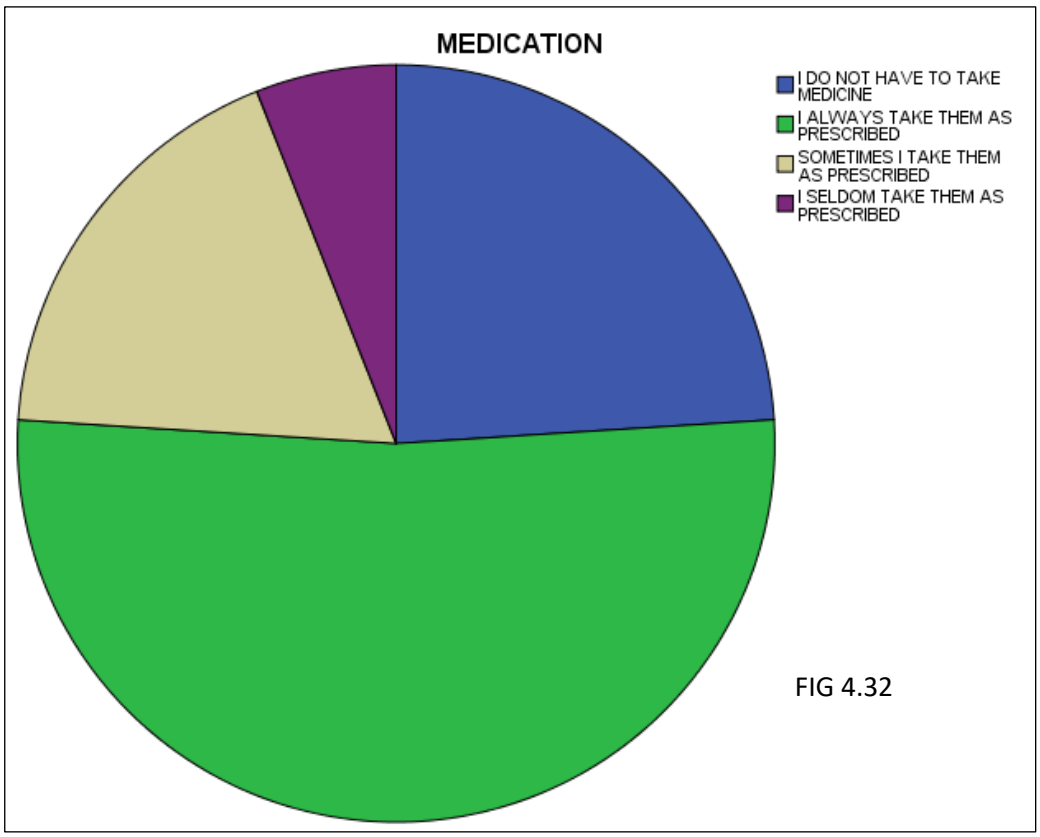

FIG 4.32

24 percent of respondents have no difficulty taking their medications as prescribed.52 percent of the respondents always take them as prescribed. 18% of the respondents sometimes take them as prescribed. 6% of respondents seldom take them as prescribed.

Table 4.33: DISTRIBUTION OF RESPONDENT ON THE BASIS OF HEALTH PROGRAMMES AWARENESS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	YES	100	100.0	100.0	100.0

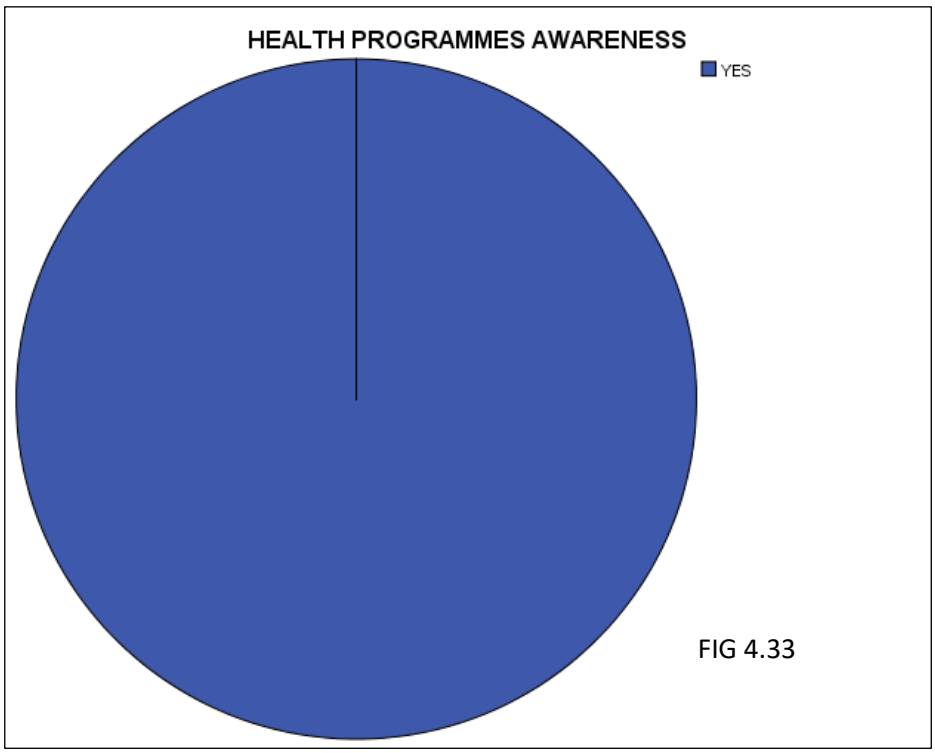

FIG 4.33

All the respondents are aware of the health programmes in India.

Table 4.34: DISTRIBUTION OF RESPONDENT ON THE BASIS OF HEALTH INSURANCE POLICY

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	YES	39	39.0	39.0	39.0
	NO	61	61.0	61.0	100.0
	Total	100	100.0	100.0	

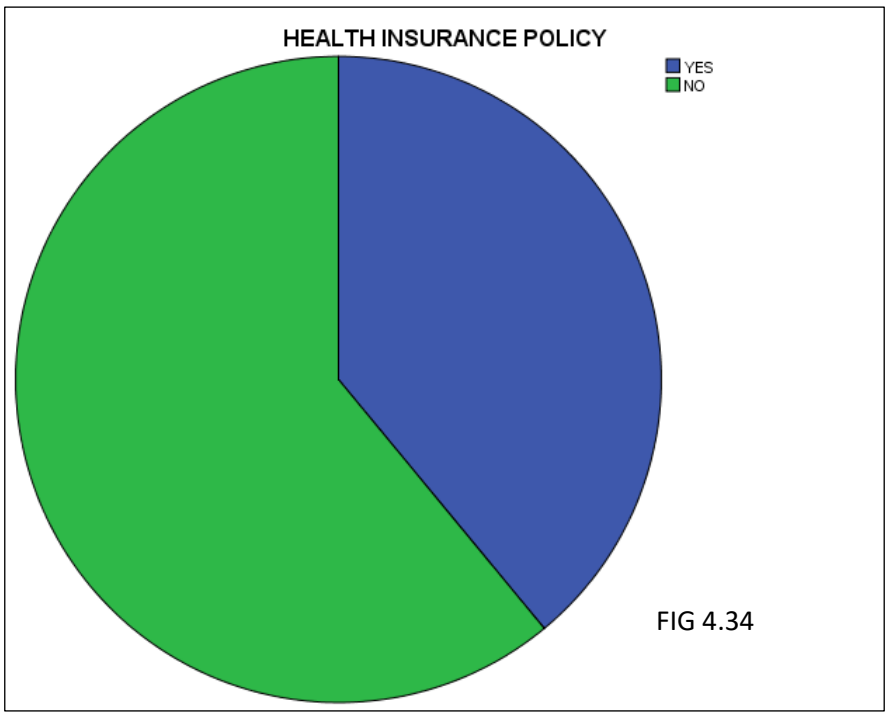

FIG 4.34

39% of the respondents have health insurance policy. 61% of the respondents have not health insurance policy.

FINDINGS AND CONCLUSION

CHAPTER 5

FINDINGS AND CONCLUSION

The study, entitled "Health Maintenance Among Women in Ernakulam- A Sociological Study " aims to investigate the health maintenance among women by analysing the data. The study provides the current state of women's health maintenance in Ernakulam.

In this study of health maintenance among women, an interview schedule was used to conduct the study, and a representative sample of the population under consideration was chosen. The district of Ernakulam was picked. For the purpose of evaluating the maintenance of women's health, a sample of 100 respondents was chosen.

49% of the 100 respondents are from rural areas, while 51% are from urban areas.20% of the respondents are between the ages of 20 and 30, 21% are between the ages of 30 and 40, 34% are between the ages of 30 and 50, and 25% are between the ages of 50 and 60. In terms of religion, 51% of respondents are Hindu, 45% are Christian, and only 4% are Muslim.

Respondents are highly educated, with 27% having senior secondary school/pre-degree and 29% post-graduate. The majority of respondents are unemployed, even though they are highly educated. They don't get much time to maintain their health because they are engaged in work at home. Same in the case of employed women. The majority of respondents are dependent on their husband even though they have personal income. The majority of respondents have low family incomes. They don't spend much money on their health maintenance.

The majority of the participants responded that they are more likely to have no health problems. The majority of respondents agree that they are healthy enough to take part in several activities. What I understand from interacting with them is that they believe themselves to be healthy. Women are more likely to take part in several activities, and the family is completely dependent on the women, especially the married women. So, even though women feel worse in health, they are forced to work because, according to

our cultural norms, women are the homemakers. The worst situation is that the family is not bothered about their health or health maintenance.

All respondents don't smoke. The majority of the respondents don't use alcohol. But a few young respondents use it occasionally. This shows that the participants are well aware of the health issues associated with smoking and drinking alcohol and tend to avoid them. The eating habits of women is a concern. Because they are not eating according to their health. The majority of the participants responded that they do not have any sleeping issues. What I understand is that the majority of the participants sleep for less than 6 hours, which is not healthy. They tend to sleep late at night, which may be the reason they sleep easily. All respondents are taking no drugs to facilitate sleep.

The majority of respondents engage in moderate-to-strength exercise but not vigorous exercise, and they also do not do it regularly. Drinking the water of women is not better, which is concerning because urine infection and other related diseases are becoming more common among women. In severe conditions, the woman does not identify, or even though she does, she is not bothered to consult the doctor. Majority of the respondents tend to wash their hands before eating using soap or handwash. COVID-19 has a great influence on the practise of this habit.

Participants responded that they are taking medications as prescribed, but sometimes they can't. They do health check-ups only when needed. But the issue is that the women are not ready to consult a doctor, and they tend to self-treat, which may lead to severe health issues. All respondents are aware of health programmes, and some of them are members of the health programmes. But, majority of the women are not taking part in any health programmes.

This study shows that the women are well aware of health maintenance and also know their health conditions. The outcomes for almost all the respondents are positive in nature. I've learned from my study that they are only constrained by social norms. For them, family always comes before themselves. So sometimes they consciously avoid their health maintenance for their family. Despite their education, the majority of families in our culture still have patriarchal values.

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APPENDIX

HEALTH MAINTENANCE AMONG WOMEN IN RURAL AND URBAN

1. Locality

   Mark only one oval.

   - o Rural
   - o Urban

2. Age

   Mark only one oval.

   - o 20 - 30
   - o 30 - 40
   - o 40 - 50
   - o 50 - 60

3. Religion

   Mark only one oval.

   - o Hindu
   - o Christian
   - o Muslim
   - o Other: _____

4. Marital Status

Mark only one oval.

- o Married
- o Unmarried
- o Widow
- o Divorced
- o Separated

5. Living in

Mark only one oval.

- o Own House
- o Rented House
- o Own Apartment / Flat
- o Rented Apartment / Flat

6. Living status

Mark only one oval.

- o Living alone
- o Living with husband
- o Living with children
- o Living with family
- o Living with other relatives
- o Living with home help
- o Living with professional caretaker (home nurse)
- o Other

7. Total number of persons living in the same house *

8. Educational Qualification

Mark only one oval.

- Below SSLC
- SSLC
- Senior Secondary School/Pre-degree
- Under Graduate
- Post- Graduate
- Doctorate Degree

9. Occupation

Mark only one oval.

- Unemployed
- Employed
- Retired

10. Main income source of family

Mark only one oval.

- Personal Pension
- Pension of Husband
- Personal work
- Work of Husband
- Family
- Personal property
- Other

11. Annual Income

Mark only one oval.

- Below 3 lakhs
- 3.50 - 5.50 Lakhs
- 5.50 - 7.50 Lakhs
- 7.50 - 10.50 Lakhs

12. Health problems:

Check all that apply.

- Trauma- Injury
- Hypertension Diabetes
- Musculoskeletal/ Mobility
- Neurological
- Psychiatric (e.g.: depression)
- Cardiovascular
- Visually impaired
- Hearing problems
- other health problem
- No health problem
- Other

13. I am healthy enough to take part in several activities

Mark only one oval.

- I strongly agree
- I agree
- Neither agree nor disagree
- I disagree
- I strongly disagree

14. Physical energy is very good.
Mark only one oval.

- o I strongly agree
- o I agree
- o Neither agree nor disagree
- o I disagree
- o I strongly disagree

15. I sleep well (sleeping quality)
Mark only one oval.

- o Yes (I sleep easily)
- o No (I can't sleep easily)

16. If the answer is NO, please specify if you are taking any drug to facilitate sleep.
Mark only one oval.

- o Yes
- o No

17. I feel tired when I wake-up
Mark only one oval.

- o Yes
- o No
- o Sometimes
- o I don't know

18. How often do you get a health checkup?

Mark only one oval.

- o Once in 3 months
- o Once in 6 months
- o Once a year
- o Only when needed
- o Never get it done

19. What do you say about your overall health?

Mark only one oval.

- o Having good physical health
- o Moderately physically impaired
- o Severely physically impaired
- o Totally physically impaired

20. On how many of the last 7 days did you engage in moderate to strenuous * exercise (like brisk walk?)

Mark only one oval.

0 day
1 day
2 days
3 days
4 days
5 days
6 days
7 days

21. Smoking

Mark only one oval.

- o Yes
- o No

22. Consumption of alcoholic drinks (Current situation)

Mark only one oval.

- o I never used alcoholic drinks
- o I stopped using alcoholic drinks
- o Still I using alcohol

23. Types of foods:

Mark only one oval.

A. Meats

- o Never
- o Occasionally
- o Sometimes
- o Often
- o Always

B. Vegetables:

- o Never
- o Occasionally
- o Sometimes
- o Often
- o Always

24. How many times a day do you eat fruit?
*Do not include juice

- I rarely eat fruit
- Less than 1 time a day
- 1 time a day
- 2 times day
- 4 or more times a day

25. During the past 7 days, on how many days did you eat food from a fast *
food restaurant, (such as McDonalds, Berger king)

- 0-day
- 1 day
- 2 days
- 3 days
- 4 days
- 5 days
- 6 days
- 7 days

26. How often do you drink regular water?
Mark only one oval.

- 4 glasses (1 liter)
- glasses (2 liter)
- 12 glasses (3 liter)
- More than 12 glasses.

27. How often do you drink regular sodas (not diet)

Mark only one oval.

- o Never
- o 1 to 3 times a week
- o 4 to 6 times a week
- o 1 time a day
- o 2 times a day
- o 3 times a day
- o 4 or more times a day

28. How often do you drink fruit punch, fruit drinks, sweet tea or sports

*

drinks?

Mark only one oval.

- o Never
- o 1 to 3 times a week
- o 4 to 6 times a week
- o 1 time a day
- o 2 times a day 3 times a day

29. How often do you drink milk?

Mark only one oval.

- o Never
- o 1 to 3 times a week
- o 4 to 6 times a week
- o 1 time a day
- o 2 times a day

30. During the past 30 days, how often did you wash your hands before *
eating?
Mark only one oval.

- Never
- Always
- Rarely
- Sometimes
- Most of the time

31. During the past 30 days, how often did you use soap when washing your* hands?

Mark only one oval.

- Never
- Rarely
- Sometimes
- Most of the time
- Always

32. How often do you have trouble taking medicines the way you have been* told to take them?
Mark only one oval.

- I do not have to take medicine

- I always take them as prescribed
- Sometimes I take them as prescribed
- I seldom take them as prescribed

33. Are you aware about health programmes in India?
Mark only one oval.

- Yes
- No

34. Do you have any health insurance policy?
Mark only one oval.

- Yes
- No

35. Which health insurance do you have?
Mark only one oval.

- Individual health insurance
- Family floater health insurance
- Group health insurance
- Other: _____