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HEALTH AND HYGIENE OF WOMEN IN TAMILNADU WITH SPECIAL REFERENCE TO SALEM DISTRICT AFTER INDIAN INDEPENDENCE

Ms. M. GEJALAKSHMI

Ph.D Research Scholar (Part-Time), Guest Lecturer,

Thiruvalluvar Government Arts College, Rasipuram, Namakkal Dt.,

Affiliated with Periyar University, Salem, Tamil Nadu.

&

Dr. S. SWAMINATHAN

Assistant Professor, Department of History,

Thiruvalluvar Government Arts College, Rasipuram, Namakkal Dt.,

Affiliated with Periyar University, Salem, Tamil Nadu.

ABSTRACT

Indian society has always recognized the need for special consideration for women in its traditional health sciences. It contains special sections on women's Nutrition, health and hygiene and how to treat their specific medical problems. Importance of Women's education plays special role in health care while comparing other social factors. The National Rural Health Mission seeks to provide effective healthcare to rural population throughout the country with special focus on affected states, which have weak public health indicators and weak infrastructure. It aims at affective integration of health concern with determinants health like sanitation and hygiene, nutrition, and safe drinking water through a District Plan for Health. The present study deals with the status of health and hygiene of women in Salem district after Indian independence.

Keywords: Women's Maternity Health, Children Health Care System, Nutrition, Hygiene, Health Education, Tamil Nadu Health and Family Welfare Department, Health and Preventive Medicine Department, Salem District.

Introduction

Today the position of women is not an enviable one. Several social reformers fought against the oppression of females in India. The contribution of women to nutrition, health, and hygiene is countless. Women take a lot of effort to improve the health and hygiene of the community. Population diet and psychological condition are crucial indicators of a country's progress. Unquestionably, women have a critical role in sanitation and safety measures. Some rural areas are particularly challenging for women since they are ill-prepared and unaware of the need for proper cleanliness, health, and nutrition. Inadequate nutrition is a major component of the high mortality rate that may be related to a variety of factors, including poverty, ignorance, traditional beliefs and rituals, poor feeding practices, poor cleanliness, filthy living conditions, and a lack of basic nutritional understanding. Malnutrition is mostly caused by a lack of food. This study aims to analyse the contribution of women to nutrition, health, and hygiene in the Salem district. The effects of nutrition on the national economy are also addressed in this survey. Women's ability to contribute to health, hygiene, and their different leadership styles are also discussed in this study. The study examines the problem faced by women and their contribution. The attendance of women seems to boost enter efficiency by dropping the rank of variance and ensuring the elevated superiority of the National Economy.

Objectives

1. To assess the impact of maternal factors such as socio-economic background fertility record and their awareness on health practices in promoting the children health.

2. To study the Influence of prenatal healthcare practices on the lactating women and their children.

3. To identify the respondent's mode of identifying child health status for hospital treatment.

4. To suggest some policy measures to improve the child health awareness among women.

Health care in rural areas poses a challenge to health care providers and these providers of health care have a developing partnership that could potentially address the challenge of provision to this rural area. Maternal and Child Health care. Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women, it is associated with suffering, ill health and even death. Most maternal deaths and pregnancy complications can be prevented by quality ante-natal, care during delivery period and post-natal care. Ante-natal care is the "care before birth" to promote the well-being of mother and fetes, and

is essential to reduce maternal morbidity and mortality, low-weight births and peri-natal mortality. However, the content and quality of ante-natal care and the availability of effective referral and essential obstetric care are important for ante-natal care to be effective (WHO, 2005). Ante-natal care is generally aimed at producing healthy mother and baby at the end of any pregnancy. It presents important opportunities for reaching pregnant women with a number of interventions that may be vital to their health and wellbeing and that of their infants.[1]

Health is a fundamental aspect to the human progress. It is not a concern of the body alone but sound health can accelerate the pace of social and economic development. This study is an attempt to examine Public Health in Tamil Nadu with special reference to the Women's Health for the period of 1900-1970. An analysis of the various preventive, curative and rehabilitative measures and health family planning programmes under taken by the Government of Tamil Nadu to control communicable and non-communicable diseases is attempted.[2]

If a nation has to develop them half of its population which consists of women and girls must also develop, educated, become healthy and develop positive self-image. If the so-called better half continues to be neglected, discriminated and explored in the matters of nutrition, education, health and legal rights, how can she be expected to give her 'best' for the health and development of her child, family, society and nation. The Government as well as voluntary organization have been providing welfare services for women such as education, health, vocational training in tailoring and handicrafts, shelter and protection for widows and destitute. Womens are however seen only as beneficiaries and not as active participants in the developmental policies and Programmes. The women are the key to the provision of health services for the family and society. The mother is central figure who provides childcare, hygiene, nutrition and even primary health care. Without good mental and physical health care for the mother herself, health programmes are doomed to failure. It is therefore essential that women's health is given primary importance. To review the various epidemics and important diseases of women that were prevalent in Tamil Nadu during the period 1900-1970 and the various health policies and programmes of the Government of Tamil Nadu on the various health indicators such as birth rate, death rate and infant mortality rate.[3]

In 1943, the Government of India appointed the Health Survey and Development Committee to make a survey of the existing position in regard to health conditions and health organizations in the British rule and make recommendations for the future developments. The committee made wide ranging recommendations. Some of recommendations are: to provide among other things, free medical care for those who cannot afford to pay. Emphasis was given on preventive. Women's ability to contribute to health, hygiene, and their different leadership styles are also discussed in this study. The study examines the problem faced by women and their contribution. The attendance

of women seems to boost enter efficiency by dropping the rank of variance and ensuring the elevated superiority of the National Economy.

The committee felt that[4]

a) Health consciousness should be stimulated among the people by providing Health Education.

b) The training of the doctor should be designed to equip him as a social physician

c) For a healthy life suitable housing, sanitary surrounding and a safe drinking water supply are necessary.

d) The most satisfactory method of meeting the health situation in the rural areas is to post a whole-time salaried doctor.

e) Combined preventive and curative health work should be provided by the establishment of a number of primary, secondary and distance health units.

f) The smallest health unit i.e. primary health unit was expected to serve a population of about 10,000 to 20,000 people

g) Reduction of sickness and mortality among mothers and children must have the highest priority of the health development Programmes.

h) Suitable organization and methods for controlling communicable diseases etc., were also recommended by the committee. After the attainment of Independence of India, the Government of India appointed a Health Survey and Planning Committee namely Mudaliar Committee in 1959 and this committee also confirmed more or 6 less the same recommendations of the Bhore committee with suitable modification wherever necessary with reference to the conditions prevailing then. The rural health service and eradication of communicable diseases were given due importance in this report.

The government of India constituted the planning commission in 1950. The First Five Year plan of 1951-1956 provided a sum of Rs.140 crores for the health development schemes.6 The budget provisions of Rs.140 crores gave priority to water supply, sanitation, primary health units, control of Communicable diseases, medical education, training and research work on indigenous systems of medicine, family planning etc.

An Analysis of Women's Health in Tamil Nadu, Measures taken by the Government, Works of Voluntary Organization, Diseases of Women, Causes for Maternal Mortality (Family Planning, Nutrition) Women and Literacy, Education of Women on Health and Hygiene makes the study in detail about Women's Health problems and preventions.[5]

Tamil Nadu consists of 32 districts in which 72 million subjects or 7.21 crores of people lives in the region. It is an increase from 6.24 crore in 2001 census. As per the 2011 census, the total population of the state is 72,14,730 of which male and female are 36,137,975 and 36,009,055 respectively. This forms 5.96% of the entire population in Indian Nation. Literacy rate in Tamil Nadu is 80.09% of which male literacy stands at 86.77% and for female it is 73.14%[2]. In actual numbers total literates in Tamil Nadu stands at 51,837,507 of which males were 28,040,491 and female literates are 23,797,016. The states are divided into 30 administrative districts and 385 community Development Blocks. The urban part of the state comprises 6 corporation,104Municipalities and cantonments,611 Town Panchayats,111 Census Towns. The rural part comprises 385 Panchayat Unions and 12,618 Village Panchayats. Sixty-one per cent of the village Panchayats have a Population of 1000 to 2000and 10% of the Village Panchayats have population below thousands.[6]

The status of women in Tamil Nadu evolved down centuries with ups and downs and a lot more remains to be done in enhancing the same. All along the history of Tamil Nadu, women are considered as goddesses but the patriarchal society sustained the male chauvinistic attitude in their families. There are more goddesses in the state comparing with male one. As of now, there are institutional arrangements aimed at promoting gender equality for women in the state. The important institutions are Tamil Nadu State Commission for women. Tamil Nadu Corporation for Development of Women and Department of Social Welfare. It is through these agencies that the Government implement policies and programmes relating to women development. Tamil Nadu State Commission for Women is one among the two State Commissions that do not enjoy statutory powers. The State had to move from the concept of welfare to development of women. Since 1956 it they started Service home to take care of destitute and other women in need11,300 Mahila Mandals were formed in the community development period. It has pioneered many of the gender related schemes.[7]

Important Targets for Tenth Tamil Nadu's Five-Year Plan

1.To reduce poverty ratio from 21.12 per cent in 1999-2000 to 10 per cent by 2000 and aiming at near elimination by 2012

2. To bring down unemployment rate as measured by current daily status from 12.05 per cent in 1999-2000 to 6 per cent by 2007 and to near Zero by 2012.

3. Universalization of primary education up to class V by the year 2005, with Special efforts for girls and disadvantaged groups.

4.100 per cent retention of all enrolled children till age 14 by 2007.

5. 100 per cent access to a school within a km by 2007

6.To reduce Infant Mortality Rate (IMR) from 52 per 1000 live births in 1999 to 28 per 1000 live births by 2007.

7. To reduce Maternal Mortality Rate (MMR) from 150 per 100000 births to

100 by 2007 and 50 by 2012.

8. Reduction by 2007 of all rural-urban and female-male disparities in wages, health, education by 50 percent.

Tamil Nadu has a comparatively streamlined health services comprising Modern systems and Indian Medicine and Homeopathy. It is estimates that there is a doctor to serve 8230 patients (in – Patients and outpatients) and a nurse for 6,586 patients in the health system. Major concentration of the infrastructures is int the State capital followed by other urban areas. Women in rural areas often it difficult to access medical help in emergencies due to limitation of ambulatory services. In clusters of villages, the nearest primary health care is 5 to 30 kms away.[8] Given Women's health status is low during her optimal reproductive years, it is useful to understand how the institution of marriage affects this status. It is important to remember that through our cultural history, marriage has been considered as essential and even obligatory for women. India has built up a vast health infrastructure and manpower. However, the extent of access to and utilization of health care service varied substantially between states, regions and society. The demography and vital statistics provide the base information on the health status of any region or community. Life Expectancy at British, Infant Mortality Rate, Crude Birth Rate and Crude Death Rate are the important indicators that reflect the health status and human development. The comparison of these health indicators for Tamil Nadu and All India average reveals the advantageous position of the State. The achievements of Tamil Nadu are being extolled as remarkable and consider as a model that could be achieved by other states.[9]

Tamil Nadu witnessed significant advancement without accompanying progress in literacy and gender equality. The period between 1971 and 2004 such decline in the Death, Birth and Infant Mortality Rates could be attributed to better health status of the people, technology and its adoption, health care delivery and utilization, and health awareness and attitudes of the people. Health status in Tamil Nadu is made possible partly due to the health infrastructure available and its utilization.[10]According to the Nineth Five Year Plan of Tamil Nadu, "Health Care for All" was the main objective of the plan. It focused on the improvement in the general health status of population, better access to the health care services, improved Maternity and Child Health care.

Dr. MGR Medical University is the first Medical University of India, functioning in Tamil Nadu from July 1988 onwards. This University aims at promoting academic excellence in the field of medical and paramedical education and strives to bridge the growing gap between the Indian and International standard of research in medical science.

The medical and rural health services are rendered through 42 teaching hospitals,29district headquarters hospitals 155 taluk hospitals,80 non-taluk hospitals 187 ESI hospitals,1417 primary health centers 8682 sub-centers and 12 government dispensaries and mobile units. All the Primary Health Centers have been equipped with basic facilities for surgeries and deliveries. The Directorate of Public Health and Preventive Medicine is also concerned with the implementation of programmes for immunization, school health maternal health and child health care, food adulteration and health education.[11]

Nutritional Status and Relationship to Health

Traditionally, in Indian society, the mother has always been revered as the giver of life, the nurturer of children, and maternal feelings are considered a force to be reckoned with in girls. It has always been considered essential for a women's growth, development and status in society that she should become a mother. The health of the mother during pregnancy and her safety during the child birth are very important criteria for determining her health status and the health of children born to her. The health of a women would depend very much on her nutritional status during adolescence and the general growth pattern of her body. Nutritional status of most Indians is inadequate in some essential nutrition requirements like energy, protein, iron, vitamins A and B complex.

In India nutrient absorption and utilization by the body is less efficiently carried out because of the presence of frequent infectious episodes. Even when mortality is controlled, the nutritional status may not improve. Education and communication regarding the importance's of nutrition can go long way in bringing about long-term changes in attitudes and recognition by parents of the importance of nutrition for their children. The Tamil Nadu Integrated Nutrition Programme show a high percentage of underweight children among the participants during the 1980s and 1990s. The education of both the father and mother seem to have an effect on the child's nutritional status as well. The district wise break up of programme data is once again confirms the importance of mother's educational status.[12]

Moving from Hunger to Nutrition

Providing food is not equivalent to providing nutrition. Nutrition is the outcome of interactions between a variety of factors and processes, including health care environmental hygiene etc. The government in Tamil Nadu has made serious attempts to combine provision of food under the Noon Meal Programme with other services such as health care, immunization, growth monitoring, pre- and post-natal care for women, and nutrition education. The state nutrition effort, however, does have a strong 'food bias'in1995, a state policy on nutrition was explicitly drafted with technical support from United Nation Children's Education Fund. Tamil Nadu is probably the first state to draft such a policy, following the 1993 National Nutritional Policy. This has been reformulated in 2002-2003 as Policy for

Malnutrition Free Tamil Nadu. The State policy, for the first time, explicitly recognizes that food alone eradicate malnutrition. Inter-sectoral coordination between the departments dealing with water, hygiene sanitation and health cruciform the prevention of diseases.[13]

Nutritional status is one of the indications of the overall wellbeing of population and human resources development. There has been significant improvement in the overall nutritional and health status of the population in Tamil Nadu over the last two decades with a steady reduction in the percentage of underweight children and severely malnourished children due to the better early childhood care for survival, growth and development and better status of pregnant and lactating women.[14]

In 1980, the Tamil Nadu Integrated Nutrition Project (TNP-I, 1980 to 1989) was started with World Bank aid with a focus on the nutritionally most vulnerable groups , children under three years along with pregnant and nursing women which eventually covered 174 blocks8. Starting with rural preschoolers, the scheme was expanded in phases to cover urban areas, school children up to 15 years of age, pregnant and lactating women and various categories of pensioners for social security. This finding is covered under the state budget.[15]

Supplementary Nutrition Programme

1. Year of Commencement: 1975 – 1976 – in Tamil Nadu 1989 – 1991 – in Salem District.
2. Objective of the Scheme: To improve nutrition and health status of children under 6 Years, pregnant and lactating mothers and adolescent girls. To achieve the status of Malnutrition. Free State and Universalisation of Integrated Child Development Services in the State under 'Mission Mode'.
3. Number of Units: At the rate of 100 Centres per project covering population of one lakh.
4. Norms for AWCs:

Pre-School Education to Children

1.Aim of the Scheme: To provide Early Childhood Care Education and Development (ECCED) to Children in the age group of 2 to 5+ years and thereby reduce the School drop outs.

2.Year of Commencement: 1975 to 1976

3.No. of Projects: 22 Projects **(20 RURAL, 2 URBAN)**

4.No. of Centres: 2696 (2543 Main Anganwadi Centres + 153 Mini Anganwadi Centres)[16]

MGR Noon Meal Programme

Tamil Nadu is the Pioneer State for implementing the massive programme of providing nutritious Midday Meal to lakhs and lakhs of school children. The Former Hon'ble Chief Minister Puratchi Thalaivar MGR has launched this scheme in Trichy District Pappakurichi Village on 01.07.1982. The scheme was implemented in entire rural areas on 01.07.1982 and it was extended in urban areas also from 15.09.1982. This scheme is being implemented successfully till date. 1. The main objective of the programme 1. To provide adequate nutrition to economically disadvantaged children. 2. To combat malnutrition among the children and to increase their literacy rate. 3. To act as a potent incentive for increasing the enrolment and reducing dropouts from schools. 2. The Department which implemented the programme since its inception in July 1982 1. Education Department From 1982 to May 1990 2. Rural Development Department from June 1990 to September 1992 3. Social Welfare Department from October 1992 to September 1997 4. Rural Development Department from October 1997 to 19th July 2006 5. Social Welfare Department From 20th July 2006 to till date (Rural) From 23rd August 2007 to till date (Urban) The scheme was implemented in throughout Tamil Nadu in all Government Schools, Local Body Schools, Government Aided Schools, ADW Schools and NCLP Schools. The allocation of funds to the scheme is given by the State and Central Governments.[17]

Salem District Feeding Strength & Centre Details:

Sl. No	Detail	1-5 Children	6-8 Children	9-10 Children	Children Total
1.	Elementary Schools	1120	69933	00	69933
2	Middle Schools	368	33137	25114	58251
3	High Schools	135	18824	12243	31067
4	Hr. Sec. School	154	32203	19746	51949

Women are key in generating good nutrition and household food security. They have the greatest potential to make decisions that positively affect child survival. However, the position and status of women strongly influences their ability to make decision to realize that potential. Women's position and status is framed around a series of cultural and economic factors such as resources use, ownership, control, legal, ideological, structures, education, and information. Women are over represented in poor households this is a strike against nutrition. Poor women are likely to be poorly nourished, which has serious implications for the nutrition status of their yet to be born Children. If girls do not receive the same educational opportunities as boys, this has important negative consequences for their total fertility rate, their labor force participation, and their ability to provide child welfare.[18]

Salem District Geography

Salem District is one of the land locked District in Tamil Nadu. It is bounded on the North by Dharmapuri district on the south by Trichy and Namakkal District, east by Villupuram and Preambular District and West by erode District and Karnataka State. Salem is Geologists paradise, surrounded by hills and the landscape dotted with hillocks. Salem has a vibrant culture date back to the ancient Kongu Nadu. Now the district of Salem comprises of eight taluks; like Salem, Sangagiri, Omalur, Attur Idapadi, Mettur, Yercaud, and Vazhapadi.[19]

Area Profile

The study of total area is5,245 sq. kms, total population 34,82.056, male population17,81,571, female population17,00,485 population density 660/sq.km and the area is located between 11.14 and 12.53' N 77. 44' and 78.50 E in the western part of the southernmost state of India. The total population as per 2001 census is 3,016,346. The proportion of male and female in the total population is 51.83%, and 48.17% respectively. Out of total population nearly 68% live in rural areas and 32% live in urban areas.[20]

Sampling

The randomly selected villages are fort, Shevapet, Gugai, Police Line, Thadagapatti, Garrisons Mettu street, Namam hill, Sanyasi Gundu, Azhagapuram, Mitta Pudur, Kumarasamy Patti and Hasthampatty. From each village 50 respondents are selected as sample. The study comprises the age between 15 and 38 with 300 respondents. Various factors like literacy level, age at marriage, age at first conception, total conception, total abortion, prenatal checkup, health care breast feeding, aware food and child birth weight which are associated with women health status were analyzed.

Caste	**Total**	**Percentage**
No of respond	300	
Literary level		
Primary level	40	13.33
Below HSc	96	32.00
UG	86	28.66
PG	52	26
Above PG	26	8.67
Age at marriage		
Below 18	73	
18 – 19	103	
21 – 25	70	
Above 25	72	
Age at first conception		
Below 18	80	
18 -21	95	
21- 25	53	
Above 25	72	

Total conception		
One	164	
Two	59	
Three	41	
Above Three	36	
Total no of abortion		
Nil	106	35.33
1	113	37.67
2	81	27.00
Prenatal checkup		
3 time	93	31.00
4- 5 times	128	42.67
Above 5 times	79	26.33
Health care		
i.TT Immunization		
Yes	168	56.00
No	132	44.00
ii. IFA tablet		
Yes	123	41.00
No	177	59.00
iii. advices from HCP/Dr		
Yes	148	49.33
No	152	50.67
Less than 1.5h	110	36.67
1.5 -2h	75	25.00
2-6h	70	23.33
6-24h	45	15.00
FBF		
Hourly	88	29.33
Two hourly	132	44.00
On demand	80	26.67
Duration of Breast Feeding		
Below 6 months	50	16.67
6-12 months	109	36.33
1-2 years	94	31.33
Above 2years	47	15.67
Types of Weaning Food		
Liquid	73	24.33
Semi solid	90	30.00
Solid	137	45.67
Child Birth Weight		
Below 2.5 kg	65	
2.5 – kg	142	
Above 3kg	93	31.00

HSC-Higher Secondary, TT – Tetanus Toxoid, IFA – Iron Folic Acid, HCP – Health Care Personal, Dr-Doctor FBF – First Breast Feeding, PG-Post Graduate, UG – Under Graduate.

Conclusion

Women Health is important to all society. The basic proposition of this study is forward – looking interventions, what real matters is the vulnerability to see the status of mother and child. The study identifies the proposition of livelihood among the married women, in Salem district. In urban area, women's won education being high school and above and or possessing a sales/clerical professional job has tremendous impact on risk reductio. This illiterates and primary level educated women became pregnant before 20 years of their age in contrast to women with higher education, who conceived only after 20 years of age.

The overall statistical figure shows that as literacy level increases there is a good linear positive relationship between lactating women and child's health. The studies suggest that more awareness programmes like Child Health Care and hygiene, women Health care and Hygiene, Brest Feeding Awareness and Nutrition during pregnancy should be conducted by the health care personals periodically.

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