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Women's Health And Wellness: A Comparative Analysis Of Rural And Urban Women In Vijayapura District

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Abstract: The health and welfare of rural and urban women in Karnataka's Vijayapura District are compared in this study. It looks into the various aspects of well-being, such as mental and physical health, dietary habits, access to and use of healthcare services, and knowledge of health programs. The study uses a mixed-methods approach, collecting detailed data from women in both contexts using surveys, anthropometric measurements, and qualitative interviews.

Important results show a clear difference between urban and rural areas. Higher rates of institutional deliveries and non-communicable disease screenings are associated with urban women's usually better access to healthcare facilities, specialists, and health information. On the other hand, lifestyle-related problems like obesity, stress, and sedentary behavior are more common among them. On the other hand, rural women have substantial obstacles concerning healthcare accessibility, affordability, and availability, which leads to a higher prevalence of infectious diseases, maternal health issues, and nutritional deficiencies such as anemia. Despite frequently having greater informal community support networks, their health is further impacted by sociocultural norms, occupational dangers from agricultural work, and lesser health literacy.

The study comes to the conclusion that rural women in Vijayapura District mostly struggle with socioeconomic constraints and systemic gaps in basic healthcare access, whereas urban women face health concerns associated with modern lifestyles. Customized, context-specific therapies are necessary to achieve holistic wellness. Strengthening primary healthcare and outreach programs in rural regions, launching focused nutrition and sanitation campaigns, and creating urban wellness programs centered on mental health and lifestyle disorders are among the recommendations. Integrated policy initiatives that address the infrastructure deficiencies in rural areas as well as the new public health issues in urban settings are required to close this equality gap.

Key words: Health, Wellness, Comparative, Women, Disorders, Programs, Vijayapura, Impact, Rural and Urban.

Introduction:

Although achieving health and wellness is a basic human goal, one's surroundings have a significant impact on how this goal is realized. A complex mix of biological, social, economic, and cultural factors further complicates this pursuit for women, who are frequently the cornerstones of family and community health. Different realities of well-being are produced by the striking contrast between rural and urban settings in a country like India that is quickly developing. Comprehending these discrepancies is essential for fair public health planning and action, not just an academic endeavour. This study explores this particular paradox by comparing health and wellness in rural and urban settings with a focus on women in Karnataka's Vijayapura District.

In this sense, "wellness" refers to more than just the absence of illness. It includes a comprehensive state of social, mental, and physical health. This comprises the capacity to lead a socially and economically active life, access to preventative and curative healthcare, mental health resilience, reproductive health, and nutritional status. Importantly, geographic location acts as a mediator for access to these wellness pillars. Urban environments may promote lifestyle-related non-communicable diseases even though they usually have greater healthcare infrastructure, specialist availability, and information distribution. Despite possibly better ties to the community and traditional knowledge systems, rural areas frequently struggle with systemic problems of accessibility, affordability, and awareness, which increases the burden of infectious diseases and maternal health issues.

A national pattern of an urban-rural health difference is highlighted in the literature now under publication, however the precise details of this divide are highly localized. The success of state health missions, local cultural customs, and district-level administration all have an impact on them. Nuanced, location-specific research that document the lived experiences and comparative health indicators of women in a particular administrative district such as Vijayapura are conspicuously lacking.

Thus, a number of important questions serve as the study's compass: What differences exist between rural and urban women in Vijayapura in terms of physical health indicators like dietary status and the occurrence of common ailments? What differences exist in their use of and access to maternity care and other healthcare services? What is the difference between their health literacy and mental health? In the end, what are the main socio-environmental factors influencing these results in each situation?

This study attempts to go beyond generalizations and offer an evidence-based, comparative profile of women's health in the district by methodically examining these issues. In order to effectively close the wellness gap and advance a healthier, more equitable future for all women in Vijayapura, the findings are meant to give policymakers, healthcare professionals, and community organizations with information.

Review of Literature:

1. **Priya Sharma, etal (2022):** conducted a study on Menstrual hygiene and infections. The health, education, and well-being of women worldwide depend on good menstrual hygiene. Menstruation is a normal aspect of being a human. However, it has long been disregarded on a global and personal scale. Many civilizations still see menstruation as taboo, and there are still many unfavorable cultural attitudes and ideas attached to it. Menstruating women and girls are frequently labelled as "dirty," "filthy," "stink," and "impure," which results in forced isolation, restricted movement, and food and social limitations.

2. **Prasanna Kumar Mudi, etal (2023):** conducted a study on Menstrual health and hygiene among Juang women. A total of 360 women were chosen for this investigation. For this investigation, they employed the Crosse sectional study approach. According to the findings, 85% of Juang women utilized old clothing as absorbents when they were menstruating. The low level of sanitary napkin

usage was attributed to several issues, including distance from the market (36%), lack of knowledge (31%), and expensive cost (15%). Only one-third of the Juang women, who had menstruation issues in 71% of cases, sought medical attention.

3. **Amrita Namasivayam, etal (2022):** Examines study on the role of gender inequities in women's access to reproductive health care. In four nations, the impact of gender inequality on women's access to reproductive healthcare was investigated. The degree of gender inequality varies between and within nations, and it is a result of disparities in women's status and autonomy as well as cultural behaviors and gender norms. For this investigation, they used data from the Demographic and Health Survey. The findings revealed a strong correlation between reported usage of maternal reproductive health care services and numerous gender equity aspects. Additionally, several routes of effect between the exposure and outcome variables were found. Findings highlight the importance of patriarchal and discriminatory traditional value systems and practices that put women and girls in inferior positions to men and boys in various social contexts, as well as the urgent need for coordinated and sustained efforts to change these harmful traditional values if several of these countries are to achieve MDG-5.

4. **Ragini Kulkarni, etal (2022) :** conducted study on Assessing the potential of self-help group women for improving reproductive health of women in a tribal block of Maharashtra, India. This study aimed to evaluate how self-help groups (SHGs) could improve the way indigenous women sought reproductive health services and how often they used them. Focus groups with SHG women were held both before and after the intervention, and in-depth interviews were done with them. Findings from this investigation are The public health facilities provided services to sixty-five percent of the women with reproductive morbidities who were referred. When comparing the study block to the control block, there was a notable improvement in the intent of the women seeking services for reproductive health issues, according to an analysis of their data. Results from Focus Group Discussions prior to Intervention FGDs involved fifty-seven SHG women (10–12 women in each FGD). The majority (68.4%) had completed higher secondary education, and 77% worked as farmers. The findings imply that this paradigm might be expanded to meet women's unmet requirements for reproductive health without adding to the strain on the available staff.

5. **Vaneeta Chandna, etal (2022):** conducted study on Status of Reproductive Health of Women in Himalaya. Examining the reproductive health status of Uttarakhand women is the main goal of this paper. With an emphasis on women's participation in the workforce in their daily lives, the current study demonstrates the relationship between socioeconomic services and health-related issues pertaining to women. The general health problems and their impact on the maternal health of the rural women are comparable to the lack of medical services already in place. The age gap between men and women is concerning because women work harder and longer hours than men do. Hill women have experienced weakness, stress, back discomfort, muscle soreness, and hypertension as a result of lengthy workdays and a demanding job. They are unaware of the pressures of daily employment that have negatively impacted their reproductive health as well. The purpose of this study is to describe the housing amenities, the amount of work that women must do, the working hours, the availability of medical services, and the transportation infrastructure in four villages located in Uttarakhand's Chamoli district. The Himalayas' marginalization, fragility, and accessibility characteristics increase the likelihood of substandard living conditions, which furthers the disregard for women's reproductive health issues. According to research, women from the mountains are the most engaged members of society. They work extremely hard and exhausting physical jobs even while pregnant. They experience a range of health problems as a result, which makes their pregnancy more difficult.

Objectives of the study:

1. To understand the socio-economic status of rural and urban respondents in the study area.
2. To examine the present health status health practices of rural and urban women.
3. To explore the wellness among rural and urban women.

Research Methodology:

This is the study on 'Health And Wellness Among Women: A Comparative Study Of Rural And Urban Women In Vijayapura District'. For the present study Descriptive research design has been used to explain the causative relationships in between the independent and dependent variables. It helped to Comparative study of Rural and Urban Women.

Sample of the study:

For the present study Vijayapura District is selected for the purpose of data collection. Women's were the respondents who provided information regarding women's health and wellness status of rural and urban communities in Vijayapura district.

400 women's have been selected based on random sampling method. For comparative study 200 are selected from rural community and 200 are selected from urban community of 2 talukas in Vijayapura district. These are Indi and Vijayapura talukas of Vijayapura district. 400 samples are drawn from Vijayapura, Toravi, Horti, and Indi based on random sampling method in both rural and urban communities.

Data Collection:

Data collection is an important stage of the whole research. There are two types of data collection method namely, Primary data and another one is secondary data. The present study is based both the primary and secondary data. **Variables of the study:** For the study variables are divided into two parts, independent and dependent variables. **Independent variables:** Caste, Education, Age, place. **Dependent variables:** Health and wellness, health problems, knowledge of health, utilization of health facilities, sanitization. Health and wellness among women: A Comparative study of Rural and Urban Women in Vijayapura District" Karnataka State Akkamahadevi Women's University, Vijayapura.

Data analysis and Interpretation :

Table 1: Education of the respondents

Education	Frequency	Percent
Illiteratre	26	6.5
Primary	59	14.7
Secondary	87	21.7
PUC	142	35.5
Graduate and above	86	21.5
Total	**400**	**100**

Graph 1 : Education of the respondents

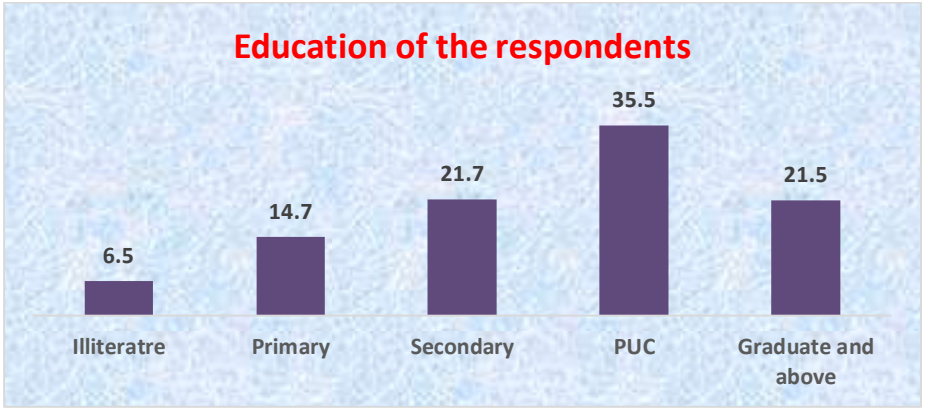

Table No. 4.1 is discussing the details respondents Education. Education is a lifetime process that include formal education, informal encounters, and self-directed learning to promote personal development and society engagement. It involves gaining knowledge, skills, beliefs, and habits, developing potential, and preparing for life. Majority of 35.5 percent of the respondents education is PUC and least of 6.5 percent of the respondents are illiterate.

Table 2 : Type of Family

Type of Family	Frequency	Percent
Joint Family	169	42.2
Nuclear Family	231	57.7
Total	**400**	**100**

Graph 2 : Type of Family

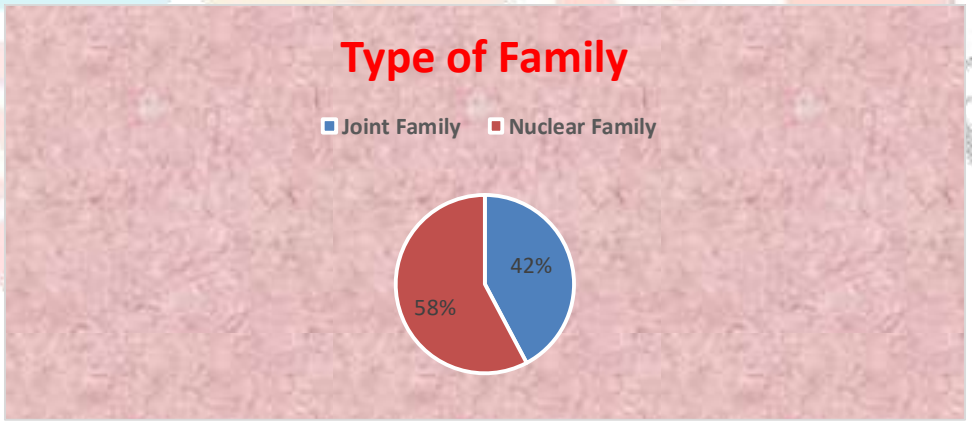

Table No. 4.2 showing the respondents type of family details. There are many different types of families, the main categories Nuclear (parents and children), Extended (adding grandparents, aunts, etc.), Single Parent, Blended (step families), Same Sex, Adoptive, and Childless families describe structure and members and reflect a variety of contemporary societal structures that go beyond conventional models. 42.2 percent of the respondents are staying Joint Family and 57.7 percent of the respondents are staying Nuclear Family.

Table 4.3 Respondent Occupation

Respondent Occupation	Frequency	Percent
Home maker	188	47
Agriculture Labor	22	5.5
Farming	30	7.5
Petty business	55	13.7
Govt Services	10	2.5
T-stall	10	2.5
Coolie	35	8.7
Others	50	12.5
Total	**400**	**100**

Graph 4.3 Respondent Occupation

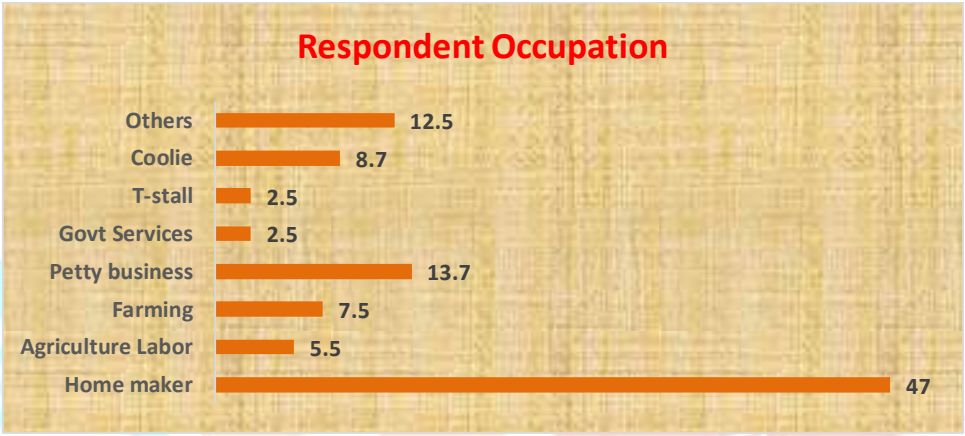

Table No. 4.3 is discussing the respondents Occupation details. Financial stability, the provision of necessities for society (food, health, and safety), and personal development which gives us a sense of purpose, identity, skills, and social connection and makes life more meaningful, structured, and satisfying than simply getting money all depend on jobs. In this regard Majority of 47 percent of the respondents are home maker means house wives and least of 2.5 percent of the respondents are having T-Stall shop and some of 2.5 percent are having Government Job.

Table 4.4: Media exposure

Media exposure	Frequency	Percent
Reading news paper	10	2.5
Watching T.V.	222	55.5
Listening to Radio	50	12.5
Visits Cinema	10	2.5
No regular expose to anu media	75	18.7
NA	33	8.2
Total	**400**	**100**

Graph 4.4 Media exposure

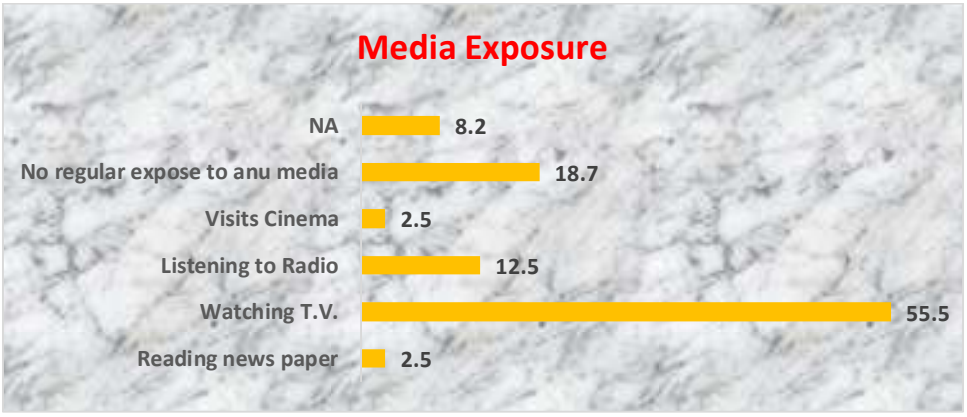

Table No. 4.4 is expressing the respondents media exposure details. The term "media" refers to the different channels (such as TV, radio, the internet, and print) and organizations that store, deliver, and distribute news, entertainment, data, and information to large audiences. They serve as effective tools for communication, influencing public opinion, and having an impact on culture, politics, and society. It includes everything from radio and conventional newspapers to contemporary digital platforms like social media and websites, with uses ranging from public discourse to education and advertising. Regarding this Majority of 55.5 percent of the respondents Watching Television and least of 2.5 percent of the respondents reading the News paper and Visits cinema hall for watching movie.

Table 4.5: Current state of health

Current state of health	Frequency	Percent
Always fine	55	13.7
Fine but occasionally ill	226	56.5
Consistently ill health	66	16.5
Not applicable	53	13.2
Total	**400**	**100**

Graph 4.5 : Current state of health

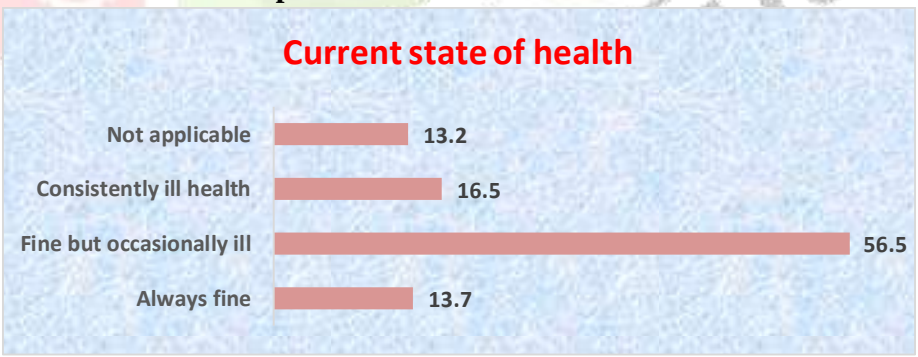

Table No. 4.5 is showing the respondents current state of health details. Health is a comprehensive state of total physical, mental, and social well-being, not merely the absence of illness or injury. It includes your body's ability to function, emotional stability, stress management, productive work, and community involvement, all of which are impacted by social, environmental, and lifestyle factors. Majority of 56.5 percent of the respondents current state of health is fine but occasionally ill and least of 13.7 percent of the respondents current state of health is always fine.

Table 4.6: Maturity details

Maturity details	Frequency	Percent

10-12	47	11.7
13-14	99	24.7
15-16	196	49
16 and above	58	14.5
Total	**400**	**100**

Table No. 4.6 is expressing the respondents maturity details. While maturity refers to the growth of one's emotions, intellect and behavior, age is a measurement of the amount of time spent. In this regard 49 percent of the respondents matured in the age of 15 to 16 years and least of 11.7 percent of the respondents matured in the age of 10 to 12 years.

Table 4.7: Menstruation details

Menstruation details	Frequency	Percent
Regularly	286	71.5
Irregularly	114	28.5
Total	**400**	**100**

Graph 4.7: Menstruation details

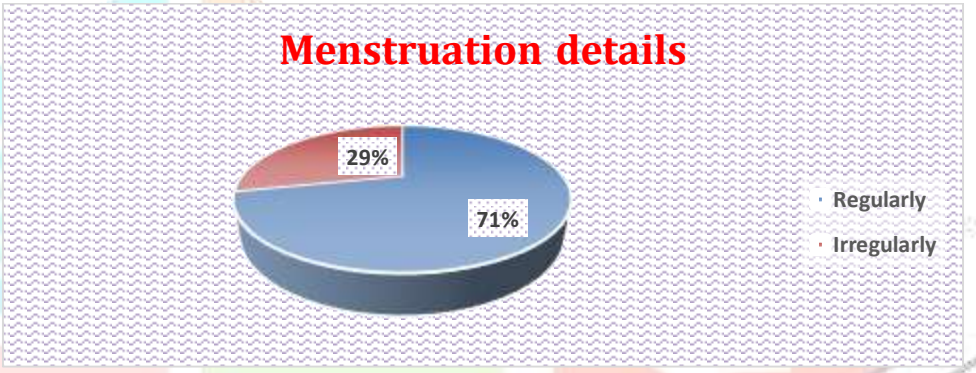

Table No. 4.7 is discussing the respondents Menstrual Cycle details. Menstruation, also known as a period, is the monthly shedding of the uterine lining (endometrium) as part of the reproductive cycle that happens when pregnancy does not occur. It is characterized by hormonal changes and vaginal bleeding, usually lasting a few days and occurring roughly every 21–35 days from puberty to menopause. 71.5 percent of the respondents having regular Menstrual Cycle and 28.5 percent of the respondents having Irregular Menstrual Cycle.

Table 4.8: Food intake during pregnancy

Food intake	Frequency	Percent
Normal	212	53
More	137	34.2
Less	51	12.7
Total	**400**	**100**

Graph 4.8: Food intake during pregnancy

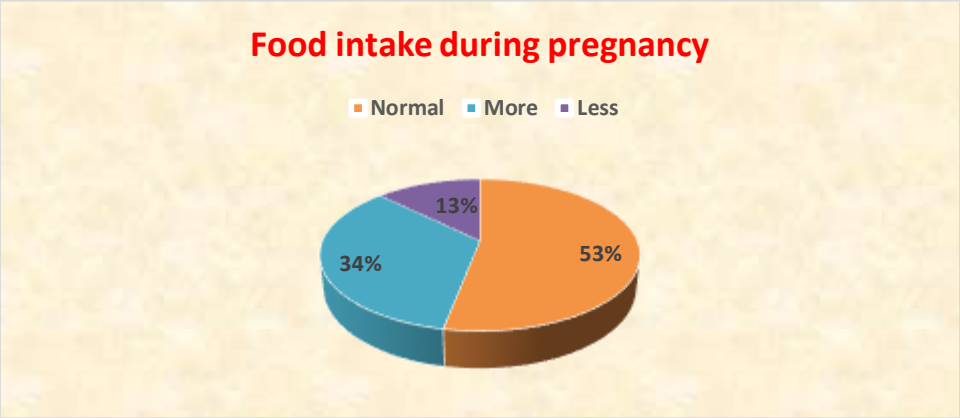

Table No. 4.8 is discussing the respondents food intake during pregnancy details. While pregnant, consume a varied diet abundant in fruits, vegetables, whole grains, lean proteins (meat, beans, eggs, fish), and dairy, emphasizing essential nutrients such as folic acid, iron, calcium, and Omega-3s for your baby's growth, while staying hydrated and steering clear of alcohol and excessive caffeine. Strive for a mix of vibrant fruits and vegetables, select whole-grain choices, make sure proteins are thoroughly cooked, and think about taking a prenatal vitamin to meet all nutritional needs. Majority of 53 percent of respondents having normal food in the pregnancy and 12.7 percent of respondents having less food intake during pregnancy.

Table 4.9: Health problems experienced immediately after delivery

Health problems	Frequency	Percent
No health problem	60	15
Bleeding	52	13
Smelling discharge	23	5.7
Abdominal pain	71	17.7
Backache	85	21.2
Anaemic condition	68	17
Others	41	10.2
Total	**400**	**100**

Graph 4.9: Health problems experienced immediately after delivery

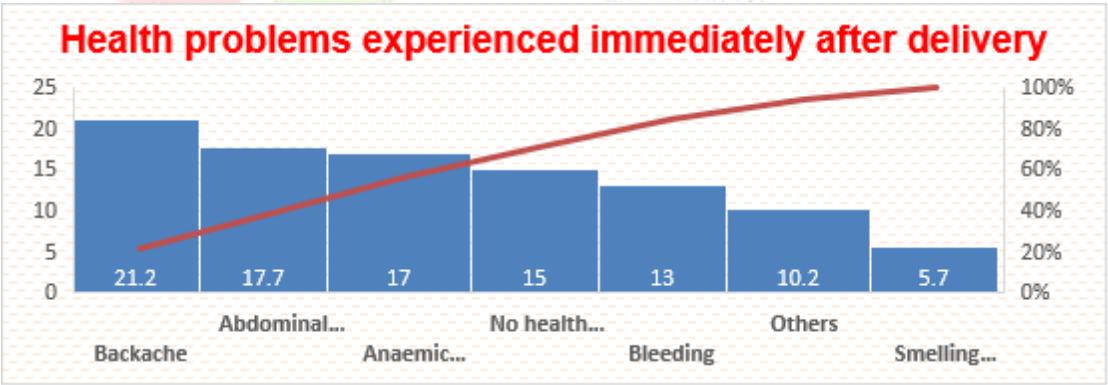

Table No. 4.9 is discussing the respondents health problems experienced immediately after delivery details. Majority of 21.2 percent of the respondents had Backache problem and least of 5.7 percent of the respondents had smelling discharges through vagina.

Table 4.10: Knowledge of colostrum's

Colostrum's	Frequency	Percent
Don't know	175	43.7
Known	225	56.2
Total	**400**	**100**

Graph 4.10: Knowledge of colostrum's

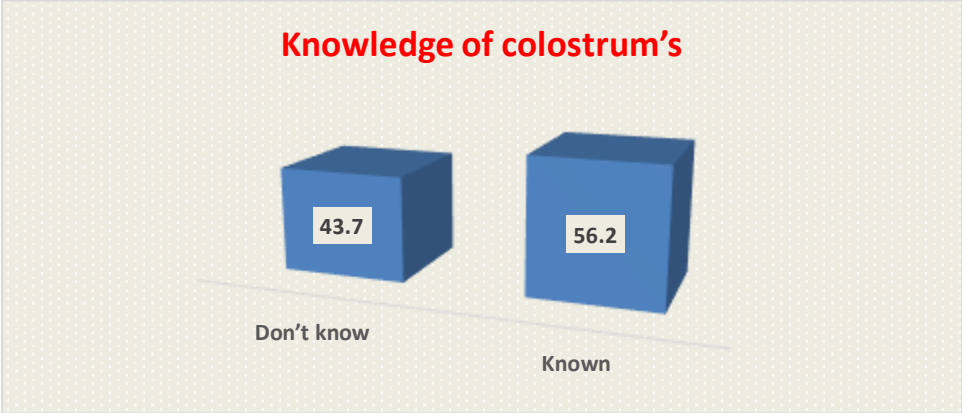

Table No. 4.10 shows the respondents knowledge of colostrum's details. Colostrum is the initial type of breastmilk produced by the mammary glands following childbirth. It is rich in nutrients and contains a high level of antibodies and antioxidants to strengthen a newborn's immune system. It transforms into breast milk within two to four days after your infant is born. 43.7 percent of the respondents don't know the Colostrum's knowledge and 56.2 percent of the respondents known about the Colostrum.

Table 4.11: Initiate breastfeeding

Breastfeeding	Frequency	Percent
After 24 hours	86	21.5
Within 3 hours	88	22
Within half an hour	226	56.5
Total	**400**	**100**

Graph 4.11: Initiate breastfeeding

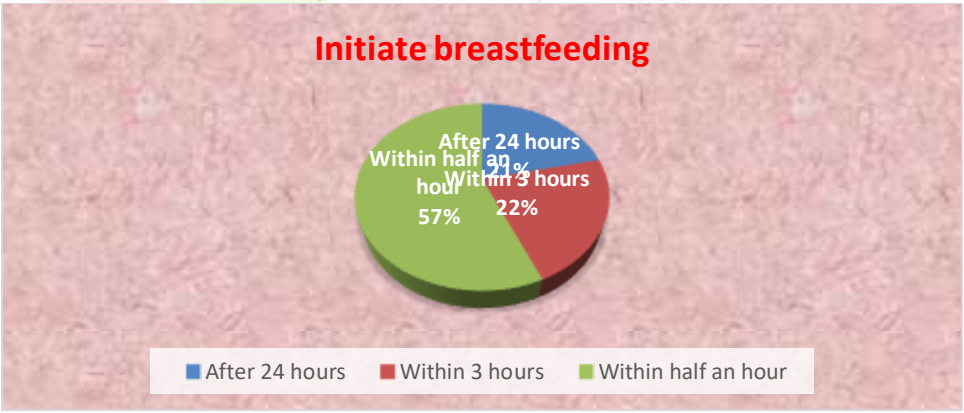

Table No. 4.11 is showing the respondents initiate breastfeeding details. Breastfeeding, also known as nursing, involves feeding an infant breast milk, either straight from the breast or via expressed milk, delivering optimal nutrition, antibodies, and health advantages for both the mother and baby, with guidelines to initiate within the first hour after birth and exclusively for six months, then in conjunction with solid foods, as it helps prevent illnesses, supports cognitive advancement, and lowers the risk of certain cancers in mothers. In this regard majority of 56.5 percent of the respondents breastfeed their baby within half an hour and least of 21.5 percent of the respondents breastfeed the baby after 24 hours.

Table 4.12: Reasons for non-adaption of contraceptive methods

Reasons for non-adaption	Frequency	Percent
Fear of side effects	41	10.2
Lack of awareness	82	20.5
Waiting for male child	57	14.2
Elders are not willing	65	16.2
Need for more children	12	3
Husband is not willing	53	13.2
Lack of faith in contraceptives	25	6.2
Waiting for female child	10	2.5
NA	55	13.7
Total	**400**	**100**

Graph 4.12: Reasons for non-adaption of contraceptive methods

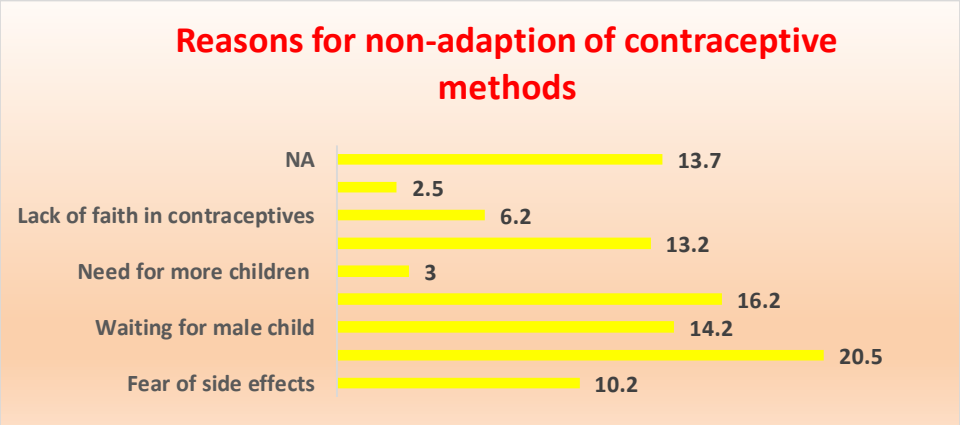

Table No. 4.12 is discussing the reasons for non-adaption of contraceptive methods details. Majority of 20.5 percent of the respondents had lack of awareness about contraceptive pills and least of 2.5 percent of the respondents waiting for female child.

Table 4.13: Decision for your family planning

Decision	Frequency	Percent
Family members	65	16.2
Couple	121	30.2
Husband's home	95	23.7
Wife only	64	16
NA	55	13.7
Total	**400**	**100**

Graph 4.13: Decision for your family planning

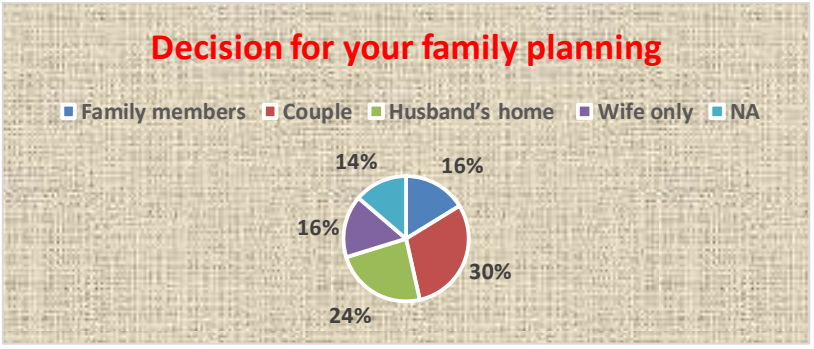

Table No. 4.13 shows the respondents decision for family planning details. Majority of 30.2 percent of the couples are planning to take family planning and least of 16.2 percent of the respondents family members took decision for family planning adoption.

Table 4.14: Hours do you sleep per night

Hours do you sleep per night	Frequency	Percent
Less than 4 hours	41	10.2
4 to 5 hours	80	20
6 to 7 hours	145	36.2
8 to 9 hours	78	19.5
10 or more hours	56	14
Total	**400**	**100**

Graph 4.14: Hours do you sleep per night

Table No. 4.14 is discussing the respondents sleep hours details. Majority of 36.2 percent of the respondents sleep for 6 to 7 hours and least of 10.2 percent of the respondents sleep for less than 4 hours.

Table 4.15: Consume fortified foods

Consume fortified foods	Frequency	Percent
Daily	86	21.5
Weekly	122	30.5
Rarely	176	19
No	16	4
Total	**400**	**100**

Graph 4.15: Consume fortified foods

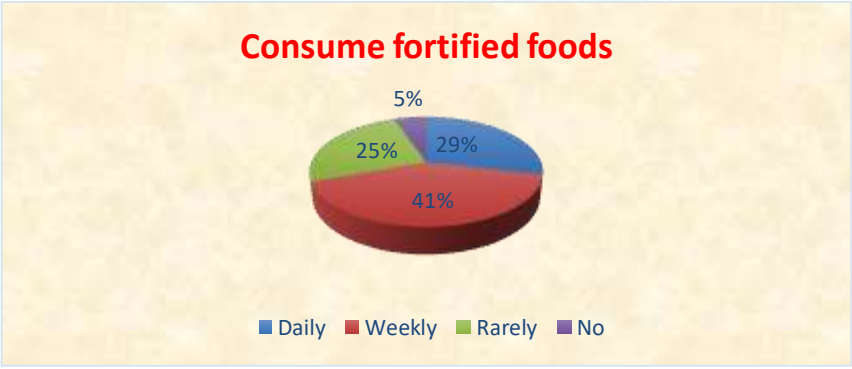

Table No. 4.15 is expressing the respondents consume fortified foods details. Majority of 30.5 percent of the respondents consume fortified foods weekly and least of 19 percent of the respondents consume fortified foods rarely.

Table 4.16: Clinically diagnosed with anaemia

Anaemia	Frequency	Percent
Yes	249	62.2
No	151	37.7
Total	**400**	**100**

Table No. 4.16 discussing the respondents clinically diagnosed anaemia details. 62.2 percent of the respondents clinically diagnosed with anaemia and 37.7 percent of the respondents not clinically diagnosed with anaemia.

Table 4.17: Most common cause of anaemia among women

Common cause of anaemia among women	Frequency	Percent
Vitamin B12 deficiency	176	44
Iron deficiency	109	27.2
Genetic deficiency	91	22.7
High protein intake	24	6
Total	**400**	**100**

Graph 4.17: Most common cause of anaemia among women

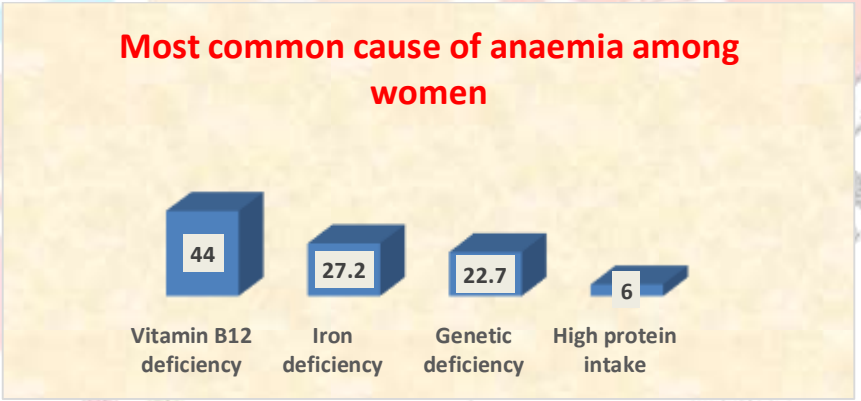

Table No. 4.17 discussing the respondents most common cause of anemia among women details. Majority of 44 percent of the respondents Vitamin B12 deficiency is cause of anaemia among women and least of 6 percent of the respondents said High protein intake is cause of anaemia among women.

Table 4.18: Engage in Physical Exercise

Engage in physical exercise	Frequency	Percent
Walking	108	27
Gym	45	11.2
Yoga	42	10.5
Others	205	51.2
Total	**400**	**100**

Graph 4.18: Engage in Physical Exercise

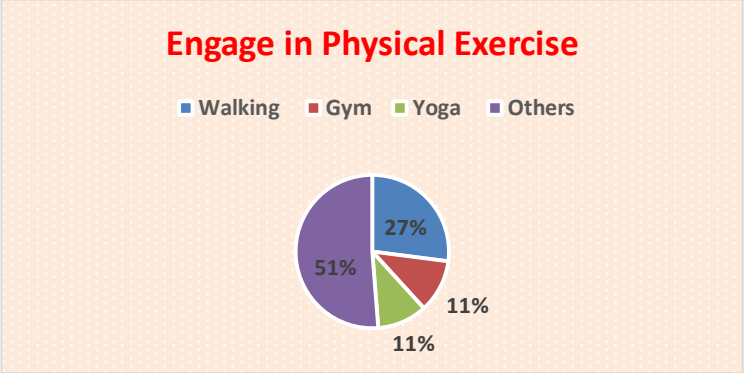

Table No. 4.18 is discussing the respondents engage in physical exercise details. Majority of 51.2 percent of the respondents in others work like home, office, agriculture and in small businesses and least of 10.5 percent of the respondents doing Yoga for Physical exercise.

Table 4.19: Experienced mental stress

Experienced mental stress	Frequency	Percent
Yes	385	96.2
No	15	3.7
Total	**400**	**100**

Table No. 4.19 shows the respondents experienced mental stress details. 96.2 percent of the respondents experienced mental stress and 3.7 percent of the respondents not experienced mental stress.

Table 4.20: Techniques employ to improve spiritual well-being

Techniques	Frequency	Percent
Mindfulness or meditation	89	22.2
Prayer or religious rites	146	36.5
Nature time	42	10.5
Spiritual literature	95	23.7
Others	28	7
Total	**400**	**100**

Graph 4.20: Techniques employ to improve spiritual well-being

Table No. 4.20 is elaborating the respondents techniques employ to improve spiritual well-being details. Majority of 36.5 percent of the respondents doing prayer or religious rites for improve spiritual well-being and least of 7 percent of the respondents doing other works to improve spiritual well-being.

Conclusion:

This comparative study of health and wellness among rural and urban women in the Vijayapura district reveals a landscape marked by both contrasts and shared challenges, shaped profoundly by the socio-economic and environmental determinants of their respective settings. The findings confirm the hypothesis that geographic location significantly influences health outcomes and wellness perceptions. Urban women generally benefit from better physical health indicators, facilitated by superior accessibility to healthcare infrastructure, a wider range of medical services, and greater health literacy. However, they report higher levels of stress, anxiety, and lifestyle-related non-communicable diseases, underscoring the negative wellness impacts of urban living including pollution, sedentary routines, and social isolation. Conversely, rural women demonstrate greater resilience in community and social wellness, supported by stronger kinship networks and traditional support systems. Yet, they face pronounced disadvantages in physical and economic dimensions of health. Barriers such as distance to quality healthcare, financial constraints, reliance on informal treatment, and the heavy burden of agricultural and household labor compromise their health status. Issues like nutritional deficiencies, reproductive health concerns, and occupational hazards remain prevalent. Crucially, across both demographics, gendered norms and patriarchal structures persistently limit women's autonomy over their health decisions, access to resources, and time for self-care. This universal factor underscores that beyond the rural-urban divide, women's health in Vijayapura is intrinsically linked to broader issues of gender equity and empowerment.

In conclusion, the study advocates for a dual-track, context-sensitive policy approach. For urban areas, the focus should shift towards promoting mental wellness, preventive screening, and healthy lifestyles. For rural areas, the imperative remains strengthening primary healthcare access, transportation, nutritional security, and community-based health education. Importantly, cross-cutting initiatives aimed at enhancing women’s socio-economic agency, health literacy, and decision-making power are essential for sustainable improvement in health and wellness outcomes district-wide. Ultimately, advancing the health and wellness of all women in Vijayapura requires moving beyond a purely biomedical model to embrace a holistic, socio-ecological framework. Such an approach must address the unique challenges of each setting while deliberately targeting the shared structural inequalities that affect women’s well-being, irrespective of geography.

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