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RURAL WOMEN AND HEALTH CARE ACCESS: A CASE STUDY OF KARVEER TAHSIL

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ABSTRACT

The present paper examines the health care facilities available to rural women who are working in the agricultural sector as a labourer. Women's health is a critical component of rural development in India, as women play a central role in sustaining households, agricultural activities, and community life. Despite their vital role, rural women face multiple health disadvantages due to poverty, limited education, nutritional deprivation, frequent pregnancies and inadequate access to health care services. The present study examines the availability, accessibility and utilization of health care services among rural women in Karveer Tahasil. The present study is based on primary data collected through structured interview schedule. The finding reveal that although public health facilities such as Primary health centres and ASHA services are available, rural women face multiple barriers in accessing timely and adequate health care.

INTRODUCTION

India is the second most populous country of the world and has changing socio-political demographic and morbidity patterns that have been drawing global attention in recent years. Despite several growth orientated policies adopted by the government, the widening economic, regional and gender disparities are posing challenges for the health sector. About 75% of health infrastructure, medical man power and other health resources are concentrated in urban areas where 27% of the population live. Contagious, infectious and waterborne diseases such as diarrhoea, amoebiasis, typhoid, infectious hepatitis, worm infestations, measles, malaria, tuberculosis, whooping cough, respiratory infections, pneumonia and reproductive tract infections dominate the morbidity pattern, especially in rural areas. However, non-communicable diseases such as cancer, blindness, mental illness, hypertension, diabetes, HIV/AIDS, accidents and injuries are also on the rise. The health status of Indians, is still a cause for grave concern, especially that of the rural population. This is reflected in the life expectancy (63 years), infant mortality rate (80/1000 live births), maternal mortality rate (438/100 000 live births); however, over a period of time some progress has been made. (Ashok Vikhe Patil, Somasudaram, Goyal 2002). Although there has been an overall improvement in the health conditions of both males and females, but women still get differentiated from men when it comes to providing medical care and this shows comparative low status of women in our society.

According to UNICEF, 12 million girls are born in India every year, out of which 25 percent do not survive beyond the 15th year. The reason behind this is that the mortality rate of 0-5 years age group is about 20 times greater than any other age group. Female mortality rate up to the age of 40 years is higher than the rate for mortality as a whole. Although an increase in the life expectancy for women has been recorded in absolute numbers, but in comparison to the life expectancy of males, it is still lower. Strikingly, maternal mortality rates are particularly high. Even the number of years they stay healthy is much lesser (Madhu Nagla 2013). Agricultural labourers who are mostly landless and form a significant section of rural society mainly depend on wage employment in agriculture. Majority of them belong to the category of Scheduled Castes and Scheduled Tribes and are among the worst exploited section of the society. Their income has always been meagre, resulting in poor living and heavy indebtedness. Much worse are those who get casual agricultural work merely exist and do not live. Their morning holds no promise for the evening and they can never sleep without tensions for they have no stocks left for the morning. Struggling for their morning and evenings they pass their whole life.

Concept of Agricultural Labourers: Though the term 'agricultural labourer' is extensively used in many studies there is no unanimity in defining the term. It is generally said that an agricultural labourer is one who works on farm for wages. The first agricultural labour Enquiry Committee (1950-51) ' defined the agricultural labourers as those people who are engaged in raising crops on payment of wages. The Second Agricultural Labour Enquiry Committee (1956-57)

enlarged the definition of the agricultural labour to include those who are engaged in other agricultural occupations like dairy, poultry, farming and horticulture, etc (Mamoria, 1976. 371). However in the overall context of Indian agriculture the definition is not adequate because it is not possible to see separately those working on wages from others. According to the National Commission on Labour, an agricultural labourer is one who is basically unskilled and unorganised and wholly depends for his livelihood on his personal labour (ibid).

Concept of Health: Health is one of the essentials of life without which nothing can be achieved. The most commonly quoted definition of health is that formalized by World Health Organization (WHO, 1946) over a half century ago, 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. (Thamilarasan 2016. 41). While WHO views health as an absence of disease, injury or distress, most studies suggests that lay persons tend to view health as the capacity to carry out one's daily activities. Many individuals consider health to be a state of functional fitness and apply this definition to their everyday lives (ibid. 41). As Rene DuBos (1981) explains, 'health can be defined as the ability to function'. This does not mean that healthy people are free from all health problems; it means that they can function to the point that they can do what they want to do.

Health Care Facility: The success of any health care delivery system to meet health needs of society is depending upon the extent of people's participation or utilization of services by the people. According to WHO health care facilities are hospitals, primary health-care centres, isolation Camps, burn patient units, feeding centres and others.

Socio-Cultural Factors Bearing on Health in India: Health is multifactorial. The factors which influence health lie both within the individual and externally in the society in which he or she lives. It is true to say that what man is and to what disease he may fall victim depends on a combination of two sets of factors- his genetic factor and the environment factors to which he is exposed. According to the WHO (1946), 'Health is state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. Providing conditions for achieving normal health for all is the duty of the state and society. Health is one of the essentials of life without which nothing can be achieved. The sick and hungry child cannot learn and the sick and hungry adult cannot produce (Thamilarasan. 2016.165). Various factors social, economic and psychological have important significance in Health Care Service. On the basis of some of the studies by sociologists, anthropologists, social workers and medical scientists it has been advocated that health and diseases are not merely biological phenomena. The socio-cultural and economic environment, faith in supernatural powers and other related belief style, nature of medical profession and services, and their utilization also affect the health and disease profile of a community (ibid. 166).

Social Factors: There are several social factors which determine the health and health disease profile in a community. The social factors are various, like religion, caste, education, occupation, family, lifestyle, income and living conditions. The health status of a social group cannot really be maintained and safeguarded unless the importance and interrelationship of these factors with health and disease s understood. The study of religion and caste in a community is relevant to ensure people's participation in comprehensive community health care programmes. Muslims, for example, are reluctant to accept family planning for obvious religious reasons. Similarly, there are certain occupations which are still caste specific. The unhygienic conditions related with these castes. Education is supposed to generate understanding which facilitates utilization of health and social welfare facilities and accomplishes people's accessibility and participation in such programmes. Education again prepares individual to make proper choices of therapeutic alternatives, appropriate medical technologies, physicians and institution (ibid. 166).

Economic Factors: Economic conditions have long been known to influence human health. For the majority of the world's people, health status is determined primarily by their level of economic development. No doubt that in many developing countries, it is the economic progress that has been the major factor in reducing morbidity, increasing life expectancy and improving the quality of life. The economic status determines the purchasing power, standard of living, quality of life, family size along with the pattern of disease and deviant behaviour in our community. It is also important factor in seeking health care. Family income is the prime determinant of social status and there

Psychological Factors: Various psychological factors play an important role in one's health. The living conditions, hectic lifestyle, lack of rest and sleep, lack of recreation and entertainment leads to mental stress, anxiety and depression- thus it leads to mental illness (ibid. 167).

In 1977, the government of India launched a Rural Health Scheme, based on the principle of , 'Placing people's health in people's hands. It is three-tier system of health care delivery in rural areas based on the recommendation of the Srivastav Committee in 1975. The government of India is committed to achieving the goal of health for all, through primary health care approach which seeks to provide universal comprehensive health care at a cost which is affordable. In 1983, India evolved a National Health Policy based on Primary health care approach. Steps are already underway to implement the National Health Policy objectives towards achieving 'Health for All' (ibid.168).

Objectives of the study: The Objectives of the Study were

1) To understand Socio-economic profile of the landless agricultural labourers in rural Kolhapur
2) To understand the health care access to a landless agricultural labourer in rural Kolhapur.

Sources of Data: The present study was based on the primary as well as secondary data. Primary data is collected through field work and secondary data is obtained with help of unpublished and published literature concerned with the topic.

Methodology of Study: The present study is undertaken to understand the health care facilities available to female landless agricultural labourers in Karveer tahsil. The study has been conducted in six villages of Karveer tahsil. The present study is based on primary as well as secondary data. The primary data were collected by using interview schedule and observation. A sample of 120 female landless agricultural labourers as a respondents of four villages of Karveer Tahsil were selected by using purposive sampling technique for the study.

Research Design: Descriptive as well as empirical research design is adopted for the present study.

Study Area: The present study has been carried out in one of the taluka of the Kolhapur districts. Kolhapur city is situated in Karveer tahsil. It has a rich social-cultural and historical background. The tahsil is famous for the production of jaggary.

Universe and Sampling: Universe for the present study constituted all female landless agricultural labourers in Karveer Tahsil of Kolhapur district. The comprehensive lists of female landless agricultural labourers were not readily available.

Karveer Tahsil is having 117 villages. It was not possible to include all the villages in the sample for time and money purpose. Out of 117 villages six villages were selected, keeping in view time and money constraints. Three villages nearby Kolhapur city of karveer tahsil and three villages far away from Kolhapur city in karveer tahsil were given preference for selection. Koge, Padali, Sadle-Madle, Ganeshwadi, Bhuyewadi, Nigave these six villages from Karveer

taluka were selected for the present study. These villages were selected by using purposive sampling technique. In short, due to the non-availability of readymade lists of female landless agricultural labourers in Karveer tahsil of Kolhapur district, the researcher had purposively selected 20 female landless agricultural labourers from all the six villages. Those female landless agricultural labourers were selected who were easily available for the study and were willing to respond to the questions concerned with the study. From each village 20 respondents were selected by using convenient sampling method. By resorting to Puposive Sampling Technique, the researcher has actually selected six villages from Karveer Tahsil. From these six villages 120 female landless agricultural labourers in Karveer Tahsil of Kolhapur district were selected by using convenient sampling method.

Sources of Data: The present study was based on the primary as well as secondary data.

Tools of Data Collection: Interview schedule and observation were the techniques of data collection for the present empirical study.

Data Collection: Primary data were collected with help of interview schedule.Fieldwork was carried out in six villages where these female landless agricultural labourers live and do their activity. Secondary data were collected from various Reports, Books and Journals and Websites.

Data Processing: The quantifiable data were coded and codebooks were prepared. The coded data were entered into the computer and have been processed with the help of SPSS software, andmade ready for interpretation. The computer generated out-put is used for tabulation, analysis and interpretation.

Statistical Techniques: Descriptive statistics is used. Single frequency tables are used for data analysis and interpretation:

Data Analysis and Interpretation

Section-I

Socio-Economic Profile of the Female landless Agricultural Labourers in Rural Kolhapur: Women in rural India are involved in various stages of agricultural operations starting from sowing of seeds to hand weeding, harvesting and post harvest activities. So it is necessary to through light on socio- economic profile of female landless agricultural labourers in the present study. Socio-economic profile of the respondents has been analysed in terms of age, religion, caste, education, types of family, marital status,age at marriage, monthly income of family, nature of family occupation etc.

Age of Respondents: Let us now look at the age of the respondents. The distribution of the respondents according to the age group categories to which they belong at present has been presented in the table no.1.1 below.

Table 1. Distribution of the respondents according to their Age-Group

	Age Group	Frequency	Percentage
1	18-30	31	25.83
2	31-45	53	44.16
3	46-60	29	24.16
4	Above 60	7	5.83
	Total	120	100.0

The present age-group wise distribution of the sample respondents in the table no 1.1 shows that, majority 44.16 percent of the respondents belong to the age group of 31-45, followed by 25.83 percent of the respondents belong to the age-group of 18-30, another 24.16 percent of the respondents belong to age-group of 46-60, and only 5.83 percent of women belong to the above 60 age-group. The above analysis reveals that relatively majority of the women respondents (70 percent) belong to younger age-group. Agricultural work requires lots

of physical energy and good health. This physical energy and good health maintained at a relatively young age.So the study clearly revealed that comparatively young women engaged in agricultural activity.

Religion: Let us now look at the religious background of the respondents of the present study. The data regarding the religious background of the respondents are presented in the table no.1.2 below.

Table 2. Distribution of the Respondents According to their Religion

No	Religion	Frequency	Percentage
1	Hindu	117	97.5
3	Muslim	3	2.5
	Total	120	100.0

The data presented in the table no.1.2 indicate that an overwhelming majority of the respondents i.e. 97.5 percent were found to belong to Hindu religion, only 2.5 percent of the respondents were found to belong to Muslim religion. It is revealed from the above table no.1.2 that, an overwhelming majority (97.5 percent) of the respondents were found to belong to Hindu religion in the context of the present study.

Caste Category: It is important to understand the caste background of the respondents under study.So the data regarding the caste category of the respondents were collected and it is presented in the table no 1.3 below.

Table 3. Caste Category of Respondents

No	Caste Category	Frequency	Percentage
1	Maratha	46	38.33
2	SC (Mahar, Mang, Chambhar)	42	35.00
3	NT (Dhanagar, Gosavi, Wadar, Dombari)	17	14.16
4	OBC (Kumbhar, Sutar, Lohar, Nahvi)	07	05.83
5	Muslim	05	04.16
6	Lingayat	03	2.5
	Total	120	100.00

The data presented in the table no.1.3 indicate that majority of the respondents 38 percent were found to belong to Maratha caste, another 35 percent of the respondents were found to belong schedule caste category which includesmahar, mang and chambhar castes, another 14.16 percent of respondents were found to belong to nomadic tribes category which includes dhangar, wadar, gosavi, dombari castes, 6 percent of the respondents were found to belong to OBC category which includes sutar, lohar, navhi and kumbhar, 4percent of the respondents were found to be muslims and only 3 percent of the respondents were found to belong to lingayat castes. It is revealed from the present study that, majority of the respondents 55 percent belongs to SC,NT and OBC caste category. Due to their economic backwardness these people are landless and found to be engaged in the labour activity. It was also revealed in a study that Maratha caste women (38 percent) also found to be landless in more numbers as they are more in numbers in total population and also engaged in agricultural activity as a labourer.

Educational Status: Your educational status determines your entry into the occupation. Therefore in a present study, respondent's educational status has been assed. Educational status of the respondents is presented in table no.1.4 below.

Table 4. Educational Status of Respondents

No	Educational Level	Frequency	Percentage
1	Up to 7th	50	41.6
2	Up to 10th	21	17.5
3	Up to 12th	4	3.3
4	Illiterate	45	37.5
	Total	**120**	**100.0**

The data presented in the table no.1.4 indicates that 47 percent of the respondents were found to be educated only upto 7th std, another 38 percent respondents were found to be illiterate and 18 percent of the respondents were found to be educated up to 10th std. Only 3 percent of the respondents were found to be educated up to 12th std. In the present study, it clearly reveals that overwhelming majority (79 percent Illiterate, up to 7th) of the respondents found to be less educated or illiterate which forced him to do agricultural work where no skill is required.

Type of Family: It is important to understand the family structure of the respondents while studying women labourers in agricultural sector. The data regarding the kind of family structure were collected in the present study and it is presented in the table no.1.5 below.

Table 5. Distribution of Respondents According to the Type of Family

No	Type of Family	Frequency	Percentage
1	Joint	61	50.83
2	Nuclear	59	49.16
	Total	120	100.0

The data regarding the type of respondent's family presented in the table no.1.5 reveals that an overwhelming majority 51 percent of the respondents were found to have hailed from joint family and remaining 49 percent of respondents was found to have hailed from nuclear family. It is clearly indicated in the present study that respondents belongs to both joint and nuclear family structure.

Marital Status: Let us now look at the marital status of the respondents**.** The data regarding the marital status of the respondents are presented in the table no.1.6 below.

Table 6. Distribution of Respondents According to Their Marital Status

No	Marital Status	Frequency	Percentage
1	Married	109	90.8
2	Divorcee	1	.8
3	Widow	10	8.4
	Total	120	100.0

The data presented in the table no.1.6 shows that an overwhelming majority 91 percent of respondents were found to be married. The number of widow and divorced women was found to be extremely insignificant. It clearly reveals that married women (91 percent) freely engaged in the agricultural activity as a labour force as compare to divorced or widow women.

Total Monthly Family Income: The economic status determines the purchasing power, standard of living, quality of life, family Size along with the pattern of disease and deviant behavior in our community. It is also important factor in seeking health care. To understand the monthly income of the respondents, three categories of income have been given to the respondents. The data regarding the total monthly family income of the respondents' family were collected and are presented in the table no.1.7 below.

Table 7. Total Monthly Family Income of Respondents

No	Monthly Family Income	Frequency	Percentage
1	Up to 5000	67	55.85
2	5001 to 10000	52	43.35
3	10001 to 15000	1	.8
	Total	120	100.0

It can be seen from the data in the table no.1.7 that, an overwhelming majority of the respondents' families were found to belong to the income group of upto 5000 rupees, another 43 percent were found to belong to the income group of 5001 to 10000 rupees and remaining 0.8 percent were found to belong to the income group of 10001 to 15000 rupees. The data regarding total monthly family income from all sources show that, an overwhelming majority of the respondents

(99percent) selected in the sample could be said to belong to Rs.10000 income groups against this background. It means they are economically poor.

Section-II: Health care access to female landless agricultutal labourers in rural Kolhapur

Health care covers not merely medical care but also all aspects of preventive care too. The health care delivery system in rural India relies on a combination of primary health care infrastructure and community outreach. So this section deals with the health care facilities available to these female landless agricultural labourers.

Health Care facility available to the Respondents: To understand the health care facility available to the female landless agricultural labourers in their respective villages in Karveer tahsil, the data were collected and it is presented in the table no.2.1below.

Table 6. Health Care Facility Available to Respondents

No	Health Care Facility Available to Respondents	Frequency	Percentage
1	Yes	120	100
2	No	00	00
	Total	120	100.0

The data presented in the Table no.2.1 clearly reveals that, in case of an overwhelming majority of the respondents 100 percent opined that they receive health care facility in their villages where the percentage of the respondents who do not receive health care facility in their village were found to be zero. The present study clearly reveals that an overwhelming majority of the respondents (100 percent) receive primary health care facility for them.

Nature of Health Care Facility: In most of the villages' government primary health centres do not work properly. To understand this situation, a question was asked to respondents, from where you seek health care facility. The frequency distribution of the responses is presented in the table no.2.2 below.

Table 7. Nature of Health Care Facility

No	Nature of Health Care Facility	Frequency	Percentage
1	Primary Health Centre	77	64.17
2	Private Hospital	43	35.83
	Total	120	100.0

The data presented in the table no.2.2 clearly reveals that, in case of an overwhelming majority of the respondents 64 percent opined that they go to government health centre to avail health care facility while 36 percent of the respondents opined that they go to private hospital to avail health care facility. It is clearly revealed from the present study that government health centre facility is available to majority of the respondents (64 percent) in Karveer tahsil of Kolhapur district.

Do you always get available doctors in the Primary Health Centre: The infrastructural facilities are inadequate in public health organizations followed by their poor maintenance. Second, most of public health institutions are understaffed accompanied by a high absence rate among the personnel. So to understand the availability of the doctors in the primary health centres the data regarding the availability of doctors were collected and it is presented in the table no.2.3 below.

Table no.2.3. Availability of Doctors in the Primary Health Centre

No	Availability of Doctors in the Primary Health Centre	Frequency	Percentage
1	Yes	82	68.37
2	No	38	31.66
	Total	120	100.0

The data presented in the table no.2.3 clearly reveals that, in case of an overwhelming majority of the respondents 68 percent opined that the doctors are always available to them to avail primary health care facility but remaining 32 percent of the respondents opined that doctors are not available to them to avail health care facility at primary health care centres. In the present study it is revealed that still few respondents (32 percent) are not getting the availability of the doctors in public health care centres.

Did you always get medical facility and medicines in time: The constitution of India provides equality in all respect to men and women; therefore, each individual can make his or her own decision. However, in the patriarchal structure of Indian society, most of the women patients are either unable or unwilling to make decisions about their medical care, thus female patients autonomy is often questioned. So to understand the situation, information about getting of medical facility and medicines in time were collected and it is presented in the table no. 2.4 below.

Table 2.4. Always Get Medical Facility and Medicine in Time

No	Always get Medical Facility and Medicines in Time	Frequency	Percentage
1	Yes	100	83.34
2	No	20	16.66
	Total	120	100.0

The data presented in the table no.2.4 clearly reveals that,in case of an overwhelming majority of the respondents 83 percent opined that they always get medical facility and medicines in time but other 17 percent of the respondents opined that they do not get medical facility and medicines in time. It is revealed from the present study that an overwhelming majority 83 percent of the respondents get medical facility and medicines in time. But still 17 percent of women don't get the medical facility and medicines in time which adversely affects their health.

The Place of Your Delivery: Now-a-days delivery usually takes place at the medical institutions like hospitals, nursing homes, maternity centres. However, these are not accessible equally to all the people. People especially in rural areas are reluctant to use medical institutions or qualified professionals for delivery because of various social and ritual taboos. For this reason, there may be under-utilization of health services for delivery. Untrained professionals and relatives attend most of the deliveries in rural areas. Given the wide use of untrained personnel and the probable conditions under which babies are delivered at home, it is likely that a large number of babies and the mothers were affected with several infectious diseases, germs because of prevailing unhygienic and non-sterile conditions at home. Therefore, place of delivery is also an important factor in the reproductive health of women. In this context, an attempt has been made to find out the respondents place of delivery when they gave birth to their children. In the present study the data was collected about the place of delivery of the respondents and it is presented in the table no.2.5 below.

Table no.2.5. Place of Your Delivery

No	Place of Your Delivery	Frequency	Percentage
1	Home	45	37.5
2	Hospital	75	62.5
	Total	120	100.0

The data presented in the table no.2.5 clearly reveals that, an overwhelming majority of the respondents 62 percent opined that their delivery has taken place in the hospital where trained staff members were present but remaining 38 percent of the respondents opined that they delivered their babies at their home only. It is observed in a present study that women are using hospital facility for their deliveries but still 38 percent of women have selected to prefer to give birth of their babies at home, where unhygienic conditions and non-sterile conditions are present. It also negatively affects their health.

Do You Delivered in the presence of skilled and experienced doctor?

To understand the services and presence of skilled and experienced doctor at the time of delivery of the female landless agricultural labourers, a question asked was that, do you delivered in the presence of skilled and experienced doctor? The collected data were presented in the table no. 2.6 below.

Table no.2.6. Delivered in the presence of skilled and experienced doctor

No	Delivered in the Presence of skilled and experienced doctor	Frequency	Percentage
1	Yes	59	45
2	No	66	55
	Total	120	100.0

It is revealed from the above Table no. 2.6 that an overwhelming majority of the respondents did not delivered in the presence of skilled and experienced doctor and remaining 45 percent of the respondents delivered in the presence of skilled and experienced doctor. In the present study, it is revealed that an overwhelming majority of the respondents 55percent delivered in the presence of untrained professionals and relatives. It causes many serious infections to mothers and neonates due to unhygienic and non-sterile conditions. It also affect on the maternal mortality and neo-natal mortality also.

Do You have your health Insurance Policy?: The data regarding the health insurance policy of the female landless agricultural labourers were collected and it is presented in the table no 2.7 below.

Table No. 2.7. Do You Have Your Health Insurance Policy

No	Do You have your health Insurance Policy	Frequency	Percentage
1	Yes	10	8.34
2	No	110	91.66
	Total	120	100.0

It is revealed from the above table no 2.7 that an overwhelming majority of the respondents were opined that they do not have their health insurance policy and only 8 percent of the respondents opined that they have their health insurance policy. In a present study it is revealed that an over whelming majority of the respondents do not have their health insurance policy. It may be because they do not aware of such policies or may be because of their poor economic condition.

FINDINGS

Majority of the women respondents (70 percent) belong to younger age-group. Agricultural work requires lots of physical energy and good health. This physical energy and good health maintained at a relatively young age.So the study clearly revealed that comparatively young women engaged in agricultural activity. An overwhelming majority (97.5 percent) of the respondents were found to belong to Hindu religion in the context of the present study. It is revealed from the present study that, majority of the respondents 55 percent belongs to SC, NT and OBC caste category. Due to their economic backwardness these people are landless and found to be engaged in the labour activity. It was also revealed in a study that Maratha caste women (38 percent) also found to be landless in more numbers as they are more in numbers in total population and also engaged in agricultural activity as a labourer. It clearly reveals that overwhelming majority (79 percent Illiterate, up to 7th) of the respondents found to be less educated or illiterate which forced him to do agricultural work where no skill is required. It is clearly indicated in the present study that respondents belongs to both joint and nuclear family structure. It clearly reveals that married women (91 percent) freely engaged in the agricultural activity as a labour force as compare to divorced or widow women.

An overwhelming majority of the respondents (99 percent) selected in the sample could be said to belong to Rs.10000 income groups against this background. It means they are economically poor. It is clearly revealed from the present study that government health centre facility is available to majority of the respondents (64 percent) in Karveer tahsil of Kolhapur district. It is revealed that still few respondents (32 percent) are not getting the availability of the doctors in public health care centres. An overwhelming majority 83 percent of the respondents get medical facility and medicines in time. But still 17 percent of women don't get the medical facility and medicines in time which adversely affects their health. It is observed in a present study that women are using hospital facility for their deliveries but still 38 percent of women have selected to prefer to give birth of their babies at home, where unhygienic conditions and non-sterile conditions are present. It also negatively affects their health. In the present study, it is revealed that an overwhelming majority of the respondents 55 percent delivered in the presence of untrained professionals and relatives. It causes many serious infections to mothers and neonates due to unhygienic and non-sterile conditions. It also affect on the maternal mortality and neo-natal mortality also. In a present study it is revealed that an over whelming majority of the respondents do not have their health insurance policy. It may be because they do not aware of such policies or may be because of their poor economic condition.

CONCLUSIONS

In a nutshell it is clearly revealed from the study that due to lack of education these female landless agricultural labourersare forced in a unskilled agricultural activity which in turn pushes them in a lower economic position. Thus socio-economic and cultural factors such as caste, illiteracy, lower economic position affects on their health status and also to avail health care facilities.

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