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Women's Health in Rural Tamil Nadu

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Abstract

Rural women are the most marginalized communities in Indian society. They have been denied from mainstream social and economic development which affects overall economic growth. Many welfare policies are being launched and executed in favor of rural people and women, who have been historically marginalized. They continue to be plagued by various issues such as unemployment, poverty, poor health and so on. Rural women, in particular, have poor health status, despite its links to their productivity and human capital. In this aspect, WHO defines that "better health is central to human happiness and well-being. It also makes an important contribution to economic progress, as the healthy population lives longer, is more productive, and save more". Rural women have limited access and opportunities to make use of health care policies. Rural women face various kinds of problems such as maternity, mother feeding, reproduction, malnutrition and sanitation which are directly affecting GDP. The major objectives of this study are to identify the awareness of key health issues related to women and children in rural areas and to find out the perception of women about the various government schemes and initiatives for tackling health issues in rural areas.

Keywords: Women; Health; Rural; Government schemes

Abbreviations: ST: Scheduled Tribes; OC: Open Categories; PCOS: Polycystic Ovary Syndrome; POI: Primary Ovarian Insufficiency; IC: Interstitial Cystitis; PMJJBY: Pradhan Mantri Jeevan Jyoti Bima Yojana; PMSBY: Pradhan Mantri Suraksha Bima Yojana; APY: Atal Pension Yojana.

Introduction

According to the total rural women population of India is 405,967,794. Of these Utter Pradesh (18.3%) has a top position followed by Bihar (10.9%), West Bengal (7.5%) Maharashtra (7.4%), Andhra Pradesh (6.9%), Madhya Pradesh (6.3%), Rajasthan (6.1%), Tamil Nadu (4.6%), Karnataka (4.6%), Odisha (4.3%), Gujarat (4.2%), Assam (3.2%), Jharkhand (3%), Chhattisgarh (2.4%), Kerala (2.2%), Punjab (2%), Haryana (1.9%), Jammu & Kashmir (1.1%) and remaining states/UTs are below 1% of the rural women population. Citizens in rural India make up a major part of its population but are often neglected and ignored by the union and state governments. The major victims of the issues that are present in rural India are women. Rural Indian women often have no access to education, face gender discrimination, child marriage, domestic violence, and dowry, do not enter the labor force, and do not have access to safe drinking water, face severe health risks.

Jawaharlal Nehru, the first Prime Minister of India, said that "you can tell the condition of a nation by looking at the status of its women". He rightly pointed out that women are the more privileged people in this country. Women in rural areas face some different health problems than people who live in towns and cities. Rural Women are the key factors to the contribution of national income and they can produce huge amounts of food products. In India, rural women are among the most disadvantaged people in terms of their health status and access to accurate and appropriate health information and comprehensive, adequate and affordable health services. The accesses to health knowledge like sex education and reproductive health are very weak among rural women. Rural women's health is being affected all over

India, due to the traditional food chain is shifted to fast food. People belong to below the poverty line, children, women, aged and displaced suffer more from health problems [1]. Mortality and morbidity determine the health status of women in rural areas.

Review of Literature

Following the reviews have been collected and summarized such as Bishakha Datta, et al. [2]: Advocacy for Sexual and Reproductive Health: The challenge in India, Ajit K Dalal, et al. [1]: Social Dimensions of Health, Fabio Leonardi [3]: The Definition of Health: Towards New Perspectives, Jothy K, et al. [4]: Reproductive Health Status of Women in Tamil Nadu, Krishnammal S, et al. [5]: Health Status of Women In Tamil Nadu, Selvam V [6]: Awareness and Perception of Health Issues among Rural Women, Thanuskodi S, et al. [7]: Information Needs on Rural Women: a Study of Tamil Nadu, India, Mini Elizabeth Jaco, et al. [8]: A Community Health Programme in Rural Tamil Nadu, India: The Need for Gender Justice for Women, Sujatha P, et al. [9]: Issue and Challenges of Reproductive Health Status of Rural Women in Kanchipuram District, Tamil Nadu, and Cyril Kanmony J [10]: Public Healthcare Sector: Is Losing Its Importance in Rural Tamil Nadu? All the above reviews describe the health status of rural women from different perspectives. The Present Study are; To study the demography profile of the rural women in Tamil Nadu, To find out the health problems of rural women in Tamil Nadu, and To investigate the correlations between food habits and health problems among rural women [11-15].

Methodology

Viluppuram district has been selected for this study. Viluppuram district has the highest rural women population among the Tamil Nadu districts. The distribution of rural women population is 7.2 percent in the 2001 census and 8 percent of total TN population in the 2011 census shows that the rural population is increasing. Both primary and secondary data were collected. Primary data collected from the Viluppuram district of Tamil Nadu through the interview schedule. Secondary data collected from the Census of India, government reports, documents, journals, and books.

Sample Size

The total sample size is 384 which were collected through power scale analyze methods. Based on the below formula sample size has been fixed.

$$SS=\frac{Z^2*(p)*(1-p)}{c^2}$$

Z = Z value (e.g. 1.96 for 95% confidence level)
p= percentage picking a choice expressed as a decimal (.5 used for sample size needed)
c = confidence interval, expressed as decimal(e.g., .04 = ±4)

Demographic Profile of the Respondents

Demographic variables are essential to understand the socio-economic status of respondents. Demographic variables include age group, community, religion, marital status, type of house, type of family, and monthly income.

Age Group	No. of Respondents	% of Respondents
18-25	30	8
26-32	78	20
33-39	61	16
40-46	77	20
47-53	92	24
54-60	31	8
Above 61	15	4
Total	**384**	**100**

Table 1: Distribution of the respondents based on their age group.

Above Table 1 shows that 24 percent of the respondents are in the age group of 47 -53 years followed by 20 percent of the respondents are in the age group of 26-32, 20 percent of the respondents are in the age group of 40-46, 16 percent of the respondents are in the age group of 33-39, 8 percent of the respondents are in the age group of 54-60, another 8 percent of the respondents are in the age group of 18-25, and 4 percent of the respondents are in the age group of above 61. It is observed that the sample populations are among the rural women population. Thus, the majority (80%) of the respondents agreed to participate in this study and they belong to the age group of 26-53.

Community	No. of Respondents	% of Respondents
BC	156	41
MBC	83	22
SC	124	32
ST	21	5
Total	**384**	**100**

Table 2: Distribution of the respondents based on their community.

Caste in TN can be created based on their traditional occupation (Table 2). Tamil Nadu Government has notified

five categories of communities namely; open category, Backward Class, Most Backward Class, Scheduled Cates, and Scheduled Tribes (ST), those who are not included in these categories come under the open categories (OC). Divisions of the community have greater control over the health and well-being of human being and the caste system affects the educational development and career progress of an individual and there is a close relationship between educational development and individual. Higher education leads to a higher level of awareness related to health and well-being. The poor health of people from the lower castes, *Dalits/Adivasi* and they have restricted access to clean water, sanitation, nutrition, and health care. The structural determinants of everyday life are thus perceived to contribute to the social determinants of health. Viewing health in general as an individual or medical issue, reducing population health to a biomedical perspective and suggesting individual medical interventions reflect a poor understanding of issues. Social interventions should form the core of all health and prevention programs as individual medical interventions have little impact on population indices, which require population interventions. The present study observed that caste is a major contribution to poor health among rural women which affects the health care system.

Religion	No. of Respondents	% of Respondents
Hindu	308	80
Christian	46	12
Muslim	15	4
Others	15	4
Total	**384**	**100**

Table 3: Distribution of the respondents based on their Religion.

India has secular States and the Government of India has classified into Hindu, Muslim, Christian, Sikh, Buddhist, Jain, and other religions and persuasions (Table 3). The majority (80%) of the respondents belongs to the Hindu religion, 12 percent of the respondents belong to the Christian religion, and the remaining 4percent of the respondents belong to Muslim and other religions are also the same 4 percent. It is observed that the majority (80.2%) of the respondent belong to the Hindu religions. The present study raises the question is that how religion has affected health among rural women? Religions are an important aspect of mental health and create the mental health of every human to make perfection in everyday life. Mental health has two dimensions such as the absence of mental illness and the presence of a well-adjusted personality that contributes effectively to the life of the individual. Hence rural women are enthusiastically involving all religious functions which indirectly promote the mental health of rural women and they can take decision with peace of mind. Most of the rural women can take fasting for their religious function, but it can indirectly help to promote blood sugar control by reducing insulin resistance, and enhances heart by improving blood pressure and so on.

The community and religions are closely associated with physical health as well as mental health. The divisions of Community behavior tell upon health, SCs/STs populations had worse health as compared to other sections of the population. The poor health of these disadvantaged groups is evident in the higher levels of morbidity and under nutrition, higher rates of mortality and early onset of death. They also have relatively lower utilization of both preventive and curative services, and receiving poor quality of services when they do access to services.

Marital Status	No. of Respondents	% of Respondents
Unmarried	32	8
Married	337	88
Separated	15	4
Total	384	100

Table 4: Distribution of the respondents based on their marital status.

The above Table 4 reveals that the distribution of the respondents based on their marital status and majority (88%) of the respondents are married, 8 percent of the respondents are unmarried, and 4 percent of the respondents live separately. It is observed that the majority (88%) of the respondents are married in this survey. Marriage and health are closely related. It gives commitment and responsibility to the individual to plan for a family. It gives confidence in the minds of the spouse; and also ensures that caregiving is an added dimension to social life. When there is a perfect understanding between the couples there is less chance of becoming depressive and other related diseases.

Type of House	No. of Respondents	% of Respondents
Rent	138	36
Own	246	64
Total	**384**	**100**

Table 5: Distribution of the respondents based on their Type of House.

Need-based Hierarchy theory rightly points out that shelter is one of the primary physiological needs. The above Table 5 shows the distribution of the respondents based on their type of house. The majority (64%) of the respondents

are having own house and 36 percent of the respondents are living in a rented house. How does the house influence rural women's health? Types of houses are directly associated with health and residence of house renters have to pay money to house owners in a month which is an additional burden of household income. The quality of housing has major implications for people's health. Raising housing standards is a key pathway for providing healthy housing conditions and improving health and well-being. It is clear that housing conditions can influence physical health, mental health, and well-being of humanity. It is observed that the house owner gets money, house renters get poor health.

Type of Family	No. of Respondents	% of Respondents
Nuclear	200	52
Joint	184	48
Total	**384**	**100**

Table 6: Distribution of the respondents based on their Type of family.

Family is one of the major social institutions and family is a social unit created by blood, marriage, adoption and can be described as nuclear or extended and data shows that 52 percent of the respondents are living in a nuclear family and 48 percent of the respondents are living in a joint family (Table 6). It is observed that from the data rural communities are partially living in nuclear and joint family structures. In the technological world, many of the families are interested to live in a nuclear family system and they are unable to live with their parents. The impact of the technological world on the joint family system does not affect the rural areas. The study is found that the majority (52%) of the respondents are living in a nuclear family system. Family structure promotes mental health among the family members and mostly elder people give guidance to family members with high-level moral principles. The moral principles are the best way to mold humans which can control crime. At the same time, most of the nuclear family does not have elder people and nuclear family children do not get any moral guidance from grandmother or grandfather. We observed that a joint family promotes ethical principles that create good psychological health and those who live in the joint family are psychologically well, at the same time those who live in the nuclear family are not psychologically well which may lead the wrong way.

Rural women's income is a key factor for the development of household expenditure; rural women are working as daily wage labor. Above Table 7 reveals that 40 percent of the respondents are earning monthly income between 2001 to 6000, 28 percent of the respondents are earning monthly income below 2000, 24 percent of the respondents are earning monthly income above 8001, and only 8 percent of the respondent are earning monthly income between 6001 – 8000. It is observed that nearly half of the respondents (40%) are earning monthly income between 2001 - 6000 per month. Income is related to health and it is strongly associated with morbidity and mortality across the income distribution, and income-related health disparities appear to be growing over time. Income influences health and longevity through various clinical, behavioral, social, and environmental mechanisms. Low income also contributes to reduced poor health and income inequality has grown substantially in recent decades, which may perpetuate or exacerbate health disparities.

Monthly Income (Rs.)	No. of Respondents	% of Respondents
Below 2000	107	28
2001- 6000	154	40
6001 - 8000	31	8
Above 8000	92	24
Total	**384**	**100**

Table 7: Distribution of the respondents based on their Monthly Income.

Health Problem of Rural Women

More recently, many rural women are facing a variety of healthcare issues, but often ignore it, on account of poverty, poor access to quality health care, and lack of awareness about health issues.

The present study categories twenty types of health problems among the rural women namely, Fever, Cold/ Cough, Headache, Toothache, Diarrhea, Skin disease, Body pain, Fracture, Typhoid, Cholera, Chest pain, Asthma, Bronchitis, Gynecology Problems, Heart diseases, BP problems, Diabetes, Knee/Joint Pain, Back/Neck Pain, and Chronic diseases (Table 8). Thirteen health problems have been found among the rural women such as Fever, Cold/ Cough, Headache, Toothache, Body Pain, Fracture, Typhoid, BP Problem, Diabetes, Knee/ Joint Pain, Back/Neck Pain, and Chronic Diseases. The above data illustrates that 21 percent of the respondents suffer from knee/joint pain and followed by 12 percent of the respondents suffer from high and low blood pressure, 12 percent of the respondents are suffering from toothache, 8 percent of the respondents suffer from Headache, Typhoid, Back/Neck Pain, Chronic Diseases, 4 percent of the respondents suffer from fever, cold/cough, 4 percent of the respondents suffer from body pain, fracture, diabetes, and 4percent respondents suffer from Asthma. This study found that sample respondents are being suffered from any illness either long term or short term.

Physical Health Problem	No. of Respondents	% of the Respondents
Short Term Health Problems		
Fever	16	4
Cold/Cough	16	4
Headache	30	8
Toothache	46	12
Body Pain	15	4
Typhoid	30	8
Total	**153**	**40**
Long Term Health Problems		
Fracture	15	4
BP Problem	47	12
Diabetes	15	4
Knee/ Joint Pain	79	20
Back/ Neck Pain	30	8
Chronic Diseases (TB, Cancer, etc.)	30	8
Asthma	15	4
Total	**231**	**60**

Table 8: Distribution of respondents based on their Health Problem.

The health problems of rural women are divided into two as short term health problems and long term health problems. As per the above data, nearly 50 percent of the respondents are having short term health problems such as fever, cold/cough, headache, toothache, body pain, and typhoid. More than 50 percent (231) of the respondents are above 40 years. Hence, they may be physically weak. That physical weakness results in different types of health issues. Moreover, when they are working in the field for the long term without proper food, exposing them to rain, hot sun, working in the wet soil for long hours will results in all types of temporary pain to the respondents. Further, when they come back from work, they have to do all households work at home such as cooking, cleaning, taking care of milk animals and other activities.

There are 13 health problems have been identified which is classified into two way such as short term and long term health problem. The long term health problems consist of Fracture, BP Problems, Diabetes, Knee/Joint Pain, Back/ Neck Pain, Chronic Diseases (TB, Cancer, etc.), and Asthma. The majority (60%) of the respondents is suffering long term health problems and 40 percent of the respondents are suffering short term health problems which consist of Fever, Cold/Cough, Headache, Toothache, Body Pain, and Typhoid.

Child-related problems	No. of Respondents	% of Respondents
Infant death	32	8
Abortion	123	32
Miscarriage	108	28
Premature delivery	91	24
Not applicable	30	8
Total	**384**	**100**

Table 9: Distribution of the respondents based on their fertility-related problems.

Above Table 9 shows fertility-related problems among rural women and 32 percent of the respondents have faced abortion, 28 percent of the respondents (28%) had miscarriage, 24 percent of the respondents are affected due to premature delivery, 8 percent of the respondents are faced infant mortality and another 8 percent of the respondents do not have any child-related problems. It is worth noting that most of the rural women still face abortion problems.

Reproductive problem	No. of Respondents	% of Respondents
Menstrual health	169	44
Menopause	124	32
Pregnancy / delivery	76	20
Aging / geriatrics	15	4
Total	**384**	**100**

Table 10: Distribution of the respondents based on their reproductive health problems.

The above Table 10 shows that 44 percent of the respondents are having a menstrual health problem, 32 percent of the respondents are facing menopause, 20 percent of the respondents have faced pregnancy and delivery related problems, 4 percent of the respondents have aging and geriatrics problems.

Tables 9 & 10 shows that the child-related gynecology problems among rural women. due to following reasons, reproductive health is affected; male and female sexual dysfunction, endometriosis, cervical cancer, HIV, polycystic ovary syndrome (PCOS), primary ovarian insufficiency (POI), uterine fibroids, interstitial cystitis, (IC), excess body weight, not enough body weight, gonorrhea and chlamydia, environmental harms, lifestyle choices which include

smoking, excess alcohol use, stress, and poor diet which evidence that recently fertility centers have been increasing all over the nation to addressing fertility problems.

Medical Expenditure	No. of Respondents	% of Respondents
Self-Expenditure	262	68
Family Member's Expenditure	122	32
Total	**384**	**100**

Table 11: Distribution of respondents based on their Medical Expenditure.

Above Table 11 shows majority (68%) of the respondents manage their own expenditure from their pocket money or saving money, and 32 percent of the respondents are depending on their family member's expenditure (family member includes husband, son, daughter, son – in law, daughter – in – law and family relatives). It is observed that the majority of rural women are spending their own money when they are ill. Medical expenses can be related to medicines bought from medical shops or pharmacies or treatment of an ailment done at any clinic, medications, private hospital or public hospital.

Treatment in Medical Centre	No. of Respondents	% of Respondents
Primary Health Centre	152	40
Private Hospital	201	52
Government Hospital	31	8
Total	384	100

Table12: Distribution of respondents based on their Medication in health institutions.

The above Table 12 shows the distribution of the respondents based on their treatment in health institutions which includes primary health centers, private and government hospitals. The majority (52%) of the respondents visits private hospitals and the remaining 48 percent of the respondents attend government institutions that cover primary health centers and government hospitals. Out of 183 respondents, 152 respondents sought treatment from primary health centers and it is located in the village, and only 8 percent of the respondents are seeking health treatment in government hospitals.. The study identified three kinds of health institutions namely primary health centre, private hospital, and government hospital which have been admitted by rural women to take regular treatment. Rural women look at a private hospital for better quality treatment.

Postponing Medication	No. of Respondents	% of Respondents
Postpone	170	44
Not postpone	214	56
Total	**384**	**100**

Table 13: Distribution of respondents based on their Postponing Medication.

Above Table 13 shows 56 percent of the respondents are not postponing their medication and they can take the medication with the proper time, and 44 percent of the respondents are postponing their medication due to financial problems. It is found that majority of the respondents are taking medication on time when they are ill. It is evidenced that rural women are more aware of their health status and their impacts also.

The burden of health expenditure	No. of Respondents	% of Respondents
Yes	124	32
No	260	68
Total	**384**	**100**

Table 14: Distribution of respondents based on their Burden of health expenditure.

The above Table 14 reveals that the majority (68%) of the respondents does not have any burden of their health expenditure and 32 percent of the respondents are facing the burden of health expenditure. Rural women have admitted that health expenditure has not affected their regular income. It is because most of them have only temporary physical problems.

Health Insurance Scheme	No. of Respondents	% of Respondents
Yes	170	44.3
No	214	55.7
Total	**384**	**100**

Table 15: Distribution of respondents based on their Health Insurance Scheme.

The majority (56%) of the respondents does not have any health insurance scheme and they are not benefited from any government or private health insurance, rural women are not willing to take any health insurance, 44 percent of the respondents have taken health insurance scheme (Table 15). It is observed that the majority (56%) of rural women are not willing to take health insurance policies. Even

Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY), Pradhan Mantri Suraksha Bima Yojana (PMSBY), Atal Pension Yojana (APY) has not reached to rural areas. It is highly noted that government health insurance schemes have not properly executed among rural women. Ultimately, what is inferred from the above table is 56 percent of rural women are not aware of the importance of health insurance schemes.

Food Habits	No. of Respondents	% of Respondents
Vegetable	139	36
Non - Vegetable	245	64
Total	**384**	**100**

Table 16: Distribution of respondents based on their Food Habits.

The above Table 16 shows that the majority (64%) of the respondents are taking non-vegetables, 36 percent of the respondents are taking only vegetable food. It is observed that food habits are changed to non–vegetables among rural women.

Eating fruits	No. of Respondents	% of Respondents
Regularly	324	84
Not regularly	60	16
Total	**384**	**100**

Table 17: Distribution of respondents based on their Eating fruits.

Above the Table 17 shows the majority of the respondents (84%) are eating fruits regularly, and 16 percent of the respondents are not eating fruits regularly. The rural women know the importance of taking fruits. When the researchers enquired them personally they revealed that they take fruits that are available at the backyard of their houses like banana, mango, guava, papaya and tender coconut.

Health Drinks	No. of Respondents	% of Respondents
Homemade Branded	140	36
Company Branded	244	64
Total	**384**	**100**

Table 18: Distribution of Respondents based on their habits of Health drinks.

Health drinks are classified into two namely homemade branded and company branded. The above Table 18 shows 64 percent of the respondents are taking company-branded health drinks. 36 percent of the respondents are taking homemade health drink. It is observed that the majority (64%) of the rural women are willing to buy health drinks from markets and drink branded products.

Tables 17 & 18 demonstrate the eating habits of fruits and healthy drinks. Food has a very significant place in our lives because it is our primary requirement and which promotes good nutrition. Food is a tool for good health and implying an instrumental relationship between *food and health*.

Availability of Staff	No. of Respondents	% of Respondents
Yes	293	76
No	91	24
Total	**384**	**100**

Table 19: Availability of Staff in Primary Health Centre.

The above Table 19 shows that the majority of the respondents (76%) agreed that there is sufficient staff is available in primary health care centers and 24 percent of the respondents said that there is insufficient staff in the primary health care centers. The reason behind this is the area where it in situated.

Availability Medicines	No. of Respondents	% of Respondents
Available	323	84
Not Available	61	16
Total	**384**	**100**

Table 20: Availability of adequate Medicines at the Primary health centers.

The above Table 20 shows that majority of the respondents (84%) told that adequate medicines are available at the primary health centers and 16 percent of the respondents told that no adequate medicines are available at the primary health center.

Tables 19 & 20 revivals that the availability of staff and medicines at PHCs, in rural health centers should be adequately available. So that every individual in the villages can access the basic health care benefit at possible cost. Health infrastructures are an important indicator to understand the health care delivery provisions and mechanisms in a region. PHC is the first contact point between the village community and the medical officer. The PHCs were envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive and promote aspects of health care.

		Food habit	Physical Health Problem
Food habit	Pearson Correlation	1	0.223
	Sig. (2-tailed)		0
	N	384	384
Physical health problem	Pearson Correlation	0.223	1
	Sig. (2-tailed)	0	
	N	384	384

Table 21: Correlations on Food habit and Physical Problem.
H_0 = There is no positive correlation between Food habits and Physical problems.
H_1 = There is a positive correlation between Food habits and Physical problems.

The correlation coefficient for Food habit and Physical problem is .223. The direction of the relationship is positive. Hence, Food habits and Physical problems are positively correlated (Table 21). The P-value for this correlation coefficient is .000. Hence the Null hypothesis is rejected and the alternative hypothesis is accepted. It is observed that there is a strong correlation between food habits and physical problems.

		Child-related problems	Physical health problem
Child-related problems	Pearson Correlation	1	-0.296
	Sig. (2-tailed)		0
	N	384	384
Physical health problem	Pearson Correlation	-0.296	1
	Sig. (2-tailed)	0	
	N	384	384

Table 22: Correlations on Food habit and fertility related problems.
H_0 = There is no negative correlation between Food habits and Child-related problems.
H_1 = There is a negative correlation between Food habits and Child-related problems.

The correlation coefficient for Food habit and Child-related problems is -.296. The direction of the relationship is negative. Hence, Food habits and Child-related problems are negatively correlated (Table 22). The P-value for this correlation coefficient is .000. Hence the Null hypothesis is rejected and the alternative hypothesis is accepted. It is observed that there is a negative correlation between food habits and Child-related problems.

Observation and Findings

It is widely recognized that the determinants of health are social and economic rather than purely medical. The poor health of people from the lower castes, their social exclusion, and the steep social gradient is due to the unequal distribution of power, income, goods, and services. Caste is inextricably linked to and is a proxy for socioeconomic status in India. The restricted access of those from the lower castes to clean water, sanitation, nutrition, housing, education, health care, and employment is due to a toxic combination of poor social policies and programs, unfair economic arrangement and bad politics. The structural determinants of daily life contribute to the social determinants of health and fuel the inequities in health between caste groups [15-20]. Viewing health in general as an individual or medical issue, reducing population health to a biomedical perspective and suggesting individual medical interventions reflect a poor understanding of issues. Social interventions should form the core of all health and prevention programs as individual medical interventions have little impact on population indices, which require population interventions. The study observes that there is a strong correlation between food habits and physical problem and there is a negative correlation between food habits and Child-related problems.

Conclusion

It concludes by saying that rural women are facing a lot of problems such as no access to education, gender discrimination, child marriage, domestic violence, dowry, women in labor force, collection of safe drinking water, health risks and so on. Among these, poor health is predominant problems among rural women in Tamil Nadu and India. The present study found that 44 percent of the

sample respondents are being faced with menstrual health problems and 32 percent of the sample respondents face abortion problems in rural women. It is noted, as per the 2011 census, the rural women literacy rate is 64.55 percent, the rural male literacy rate is 82.04 percent, and the literacy gap between men and women is 17.49 percent. The literacy rate is pivotal to the promotion of health care knowledge among rural women. The study recommends that the state shall be provided formal education to rural women with free education up to higher education. Once women are educated, rural women's health problems are slowly going down. Monthly once awareness campaigns should be organized in favor of women thorough medical experts. It is recommended that women's health campaign shall be organized in every village which promotes reproductive health. Village counseling centers should be created at the local level which provides counseling about women's health and reproduction health also. Presently women in rural areas are not willing to cook traditional food and they are purchasing food from outside. Hence, the behavior of food habits is shifted to the modern food chain system and due to globalization; traditional food habits are not practiced among rural women. Good food gives good health and poor food gives poor health, hence traditional food practices can be followed to avoid illness.

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