*International Journal of Humanities and Social Science Invention*
*ISSN (Online): 2319 – 7722, ISSN (Print): 2319 – 7714*
*www.ijhssi.org || Volume 3|| Issue 6 || June. 2014 || PP.55-58*

# Reproductive Health and Women Constructive Workers

Ruhi Gupta
*Research Scholar University of Jammu*

***ABSTRACT:*** *According to the World Health Organisation, health is a state of "complete physical, mental, and social well-being and not merely the absence of disease or infirmity". (1958). Reproductive health refers to a condition in which reproductive process is accomplished in a state of complete physical, mental and social well-being and is not merely the absence of any disease in the reproductive organs or in the reproductive system. The concept of women's reproductive health was developed by the World Health Organization, International Women's Health Movement Groups and International Family Planning Network in contrast to bio-medical approaches to women health.*

## I. INTRODUCTION:

"Women are not dying during pregnancy and child births because of conditions that are difficult to manage. They are dying because the societies in which they live do not see fit to invest what is needed to save their lives. It is a question of how much the life of a woman is considered to be worth."

Many factors affecting women's health are deeply rooted in our social structure (society) where women have secondary status resulting in low self-esteem. These factors are socio-cultural, economic and environmental factors which influence women's health status. Analysis of how these factors affect reproductive health of the women construction workers is undertaken in this chapter. This chapter also talks about the nature of work done by the female construction workers both at the construction sites and at the home.

Socio-cultural factors include looking into the background of the respondents consisting of a number of variables like age, income, education, religion, age at marriage, son preference etc. The study was conducted among 30 female construction workers and 30 were their husbands making a sample size of 60 respondents. In order to have a deeper understanding of these factors both the male and the female responses were taken into consideration.

The relationship between the reproductive health and its determinants is not a simple but a very complex phenomenon. There are not one but multiple factors which influence and account for fertility in varying ways under varying conditions. Sharma and Niranjna (2001) argued that women status is determined by the specific social and cultural conditions underlying the structure; women's work participation inside and outside the family is generally high with low recognition in a society based on the values of patriarchy; women's participation in decision-making process is also generally low in a social structure conditioned by patriarchal values. However, differentials in the participation in decision-making are caused by the relative social and economic status of women; the child-bearing practices are greatly influenced by the structure of social values conditioning marriage related practices; and the fertility behaviour differentials are caused by socio-economic and value variations and argued that how these factors affected the reproductive health and the fertility behaviour of women in their study.

Yadava and Mishra (2003) argued that women anywhere in the world have to suffer from some inbuilt advantages, compared to man because of certain biological reasons. They have to put up with menstruation, pregnancy, child-birth, lactation, child rearing and menopause and their various complications. Physically, they are less strong. They are also more vulnerable to sexual aggression and abuse. The different cultural, social and economic situations in India have given different focus to these biological disadvantages of women. These situations also influence the way these biological disadvantages affect the health of women and girl-child.

The relative neglect of the female child is evident from the fact of greater prevalence of growth retardation even in infancy, among girls, than in boys. It is such a nutritional neglect commencing right from infancy and continued through all stages of development, that eventually, results in maternal health/ nutritional status which harm not just the woman but the succeeding generation as well. (Yadava and Mishra, 2003).

Globally, about 8 million women suffer from pregnancy-related complications and more than half a million die from those complications. In developing countries, one woman in 16 may die due to pregnancy-related complications. (WHO, 2004).

**Education**

Education plays an important role on the matters related to health and reproductive health. Education contributes immensely to a person's awareness improving her/his chances of seeking timely medical treatment. Women need to be aware about their health and nutrition. They need to understand their reproductive health system and health care in a mature manner. Such understanding and awareness facilitated by education will have a positive influence on their health seeking behaviour.

Sandhu (1996) has argued that education especially of the women not only changes the outlook of the person regarding value of children and ideal number of children preferred, but also leads to greater acceptance of family planning. It also raises the age at marriage, thus cutting down the reproductive span of the women. Uneducated women are less likely to seek the help of professional health services because they are probably less aware of what is available and probably find the culture of health services more alienating and frightening.

Education delays marriage improves health and lowers fertility. In almost every setting-regardless of region culture or level of development –better educated women are more likely to:

- Marry later, use contraception, bear fewer children and raise healthier children.
- To make better decisions for themselves and their children.
- To make greater economic contributions to the household.

Better- educated women are also likely to have greater say in decisions such as when and whom they marry and to use family planning to bear only the children they can provide for.

The Committee on the Status of Women in India "The deep foundations of the inequality of the sexes are built in the minds of men and women through a socialisation process which continues to be extremely powerful. If education is to promote equality for women, it must take a deliberate planned and sustained effort so that the new value of quality can replace the traditional value system". (Kumar, 2006).

**Table 3.1 Educational Level of the Respondents**

| Educational Qualification | No. of Female Respondents | No. of Male Respondents | Total |
|---|---|---|---|
| **Illiterate** | 25(83.34%) | 12(40%) | 37(61.67%) |
| **Can Read and Write** | 4(13.33%) | 15(50%) | 19(31.67%) |
| **Primary** | 1(3.33%) | 3(10%) | 4(6.66%) |
| **Total** | **30** | **30** | **60** |

**Table 3.1** clearly depicts that 83.34 per cent female respondents were illiterate. 13.33 per cent female respondents were those who could read and write. Only 3.33 per cent respondents had the qualification up to primary level. This means that number of female respondents in the sample had low level of education. The data further shows that 40 per cent male respondents were illiterate, 50 per cent male respondents could read and write. Only 10 per cent male respondents were educated till primary level.

During the field work, it was found that that majority of the women were illiterate. Education affects the reproductive health of the women in general and the construction workers in particular. The low level of education among the respondents was responsible for the lack of awareness among them regarding various contraceptives and birth control technologies as well as their inability to make decisions about the number and spacing of children.

**Religion**

Sandhu(1996)[13] found that religiosity was positively related to fertility .In other words, the higher the religiosity, the bigger the family and lower the religiosity, the smaller the family. Besides, family size, religiosity was also related to preference of family size, son preference and fertility value index.

Religion is considered to be an important factor affecting fertility of the construction workers. Religiosity here means the disposition of the individual towards religion and religious way of life .Religious norms and values guide normative patterns of behaviour. In the Indian society children are viewed as God's gift and religious values stand in the way of acceptance of family planning.

Religiosity assumes special significance for the present study. Religion is responsible for the poor reproductive health of women. Religion continues to be the part of a society due to the fact that it provides a set of beliefs which to a considerable extent guide people's behavior and most people respond to the beliefs even if these are irrational. Since most of the construction workers are illiterate, so they have little knowledge over sexual behaviour and the sanctions against the contraceptive use. The desire to have more children i.e. daughters to help them at home when they are young and sons to bring in their wives' is the basic ideology of the construction workers. When asked why they give birth to so many children when they can't fulfill their basic requirements, the answer given was *"Bache to Upar Waale ki Dein Hain, Hum Kaise Inhe is Duniya Mein Aane se Rok Sakte Hain".* In the context of fertility and sex preference, one of the beliefs is that the birth of a son was a must.

**Table 3.2 Religion of the Respondents**

| Religion | No. of Respondents | Percentage |
|---|---|---|
| **Hindu** | 28 | 93.33 |
| **Muslim** | 2 | 6.67 |
| **Total** | **30** | **100** |

The information from the above table shows that 93.33 per cent respondents were Hindus and only 6.67 per cent respondents were Muslims. Religion was taken into consideration and it has been found during the field work whether the respondents were Hindus or Muslims the notion regarding to have more number of children was the same and the respondents of both the religion did not believe in aborting the child.

**Household Work and Child Rearing**

**Care for Children**

Women usually work longer than men. With their domestic hours on top, women work twice as many hours as men. Women continue to perform majority of household and childcare work even when they hold full-time labour market jobs. Women's performance of the majority of domestic work is justified as a 'natural extension of their biological capacity to bear children.' Housework is not considered as work, however even though it provides goods and services that add greatly to the comforts of life and often are crucial to its maintenance. Undervaluation of women's work either in the household or in the workplace leads to women being expected to work for longer hours than men (Ram et al, 2011).

According to Neelam (2011), men's work is judged to be productive and markets are seen as a way to judge the value of that work. Responsibilities in this reproductive arena limit women from participating in so-called 'productive' work. Although child care, care of the elderly, obtaining fuel, preparing meals, and maintaining the home are demanding tasks, deemed to be important to households and recognised as essential for society, they are usually unpaid. Another major reason for undervaluing women's work is that households are usually viewed as sites of consumption rather than producer of goods and services. Because women's work is undervalued and often invisible, insufficient attention has been given to the value of women's time and the time costs required to protect and promote women's health.

In addition to economic considerations, role expectations, gender identities, the meaning of sexual activities, meanings of health and disease, health seeking behaviour and the relationships among these and other factors impinge on reproductive health. Access to available health services may be constrained because women do not have the resources needed to attend. Women may have other responsibilities in the household which take precedence and thus do not seek out health care.

**Table 3.8 Child Care at Home**

| Care taken by | Ego's (Female) Response | Spouse (Male) Response | Total |
|---|---|---|---|
| **Husband** | 1(3.33 %) | 1(3.33%) | 2(3.33%) |
| **Ego** | 25 (83.34%) | 21(70%) | 46(76.67%) |
| **Both** | 4(13.33%) | 8 (26.67%) | 12(20%) |
| **Total** | **30(100%)** | **100** | **60** |

The above table shows that 83.34 per cent female respondents said that it was their duty to take care of the children. 13.34 per cent respondents said that their children were taken care by both of the parents and only 3.33 per cent respondents reported that their children were taken care by their husbands. On the other hand, 70 per cent husbands reported that it was their wives duty to take care of the children. But, 26.67 per cent.

**Objectives**

The study was under taken with the following objectives:-

- To look into the socio-economic profile of the respondents.
- To analyse the various factors i.e. social, cultural, religious and economic that affect the reproductive health of women.
- To look into the level of awareness among the women and her men regarding reproductive health matters.
- To explore the utilization of the reproductive health services by the women construction workers.
- To analyse the working hours of the women construction workers in order to view their dual role.

**Area of the study**

Jammu city has been selected as the area of the city from other states like U.P, Bihar, Odisha etc. have shifted in and they along with their wives are mostly seen in the construction work sites. Since the focus was on the reproductive health of the women construction workers working at the construction sites of the Jammu city and therefore the sample has been selected on the basis of purposive sampling method.

The area for field work has covered the Jammu city and its surrounding region. Because of the poor economic condition and meager income, the infrastructural developmental schemes have generated a greater demand for migrant labour in the city and therefore one finds a large influx of migrant labourers in the city. These construction workers men and women are working everywhere in the city in different spheres of economic activity and are unable to have access to various health facilities.

**Research Methodology**

Research methodology is a way to systematically solve the research problem. It may be understood as a science of studying how research is done scientifically. Various steps are adopted by the researcher in studying his research problem along with the logic behind them. Research methodology has many dimensions and research methods to constitute a part of the research methodology. The scope of research methodology is wider than that of research methods. Thus when research methodology is discussed, research methods as well as logic behind the methods are also discussed. Also it is discussed that why the researcher is using a particular method or technique.

For the present study the feminist perspective is used. Sherry B. Ortner attempts to provide a general explanation for the 'universal devaluation of women'. Ortner claims that it is not biology as such that ascribes women to their status in society but the way in which every culture defines and evaluates the female biology. Thus, if this universal evaluation changed, then the basis for female subordination would be removed. Ortner argues that in every society, a higher value is placed on culture than on nature.

The universal evaluation of culture as superior to nature is the basic reason for the devaluation of women. Women are seen as closer to nature than men and therefore seen as inferior to men. Ortner argues that women are universally defined as closer to nature because their bodies and physiological functions are more concerned with the 'natural processes surrounding the reproduction of the species'. These natural processes include menstruation, pregnancy, child birth and lactation, processes for which the body is 'naturally' equipped. They are primarily responsible for the socialization of the young. Finally, Ortner argues that 'women's psyche', her psychological make-up is defined as closer to nature. Because women are concerned with childcare and primary socialization, they develop more personal, intimate and particular relationships with others, especially their children. By comparison, men, by engaging in politics, warfare and religion have a wider range of contacts and less personal and particular relationships.

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