Original Article
ISSN (Online): 2582-7472

ShodhKosh: Journal of Visual and Performing Arts
January-June 2023 4(1), 4380–4389

A SOCIOLOGICAL STUDY OF EDUCATIONAL LEVEL AND ITS EFFECT ON WOMENS' HEALTH: A STUDY OF S.A.S NAGAR, MOHALI, PUNJAB

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DOI
10.29121/shodhkosh.v4.i1.2023.5374

Funding: This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

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ABSTRACT

Education is the most powerful tool for improving the status of women in society. Women who receive mindfulness training see a noticeable difference in their conceptual and child welfare as compared to unskilled women. The prevalence of social problems pertaining to women is higher in rural areas. These include dowry practices, selling female infants, female infanticide, female feticide, gender inequity, and more. Therefore, it is imperative to regulate these social problems. Enhancing the quality of life for rural women is crucial for this reason. A higher standard of living and education contribute to a reduction in the social ills connected to women's status. Therefore, it is crucial to look into the socio-cultural connection between women's health and educational achievement. The goal of this study is to determine rural women level of education, to evaluate the health of rural women and to understand the relationship between education and health of rural women.

Keywords: Education, Health, Rural women

1. INTRODUCTION

[1]In India, where men predominate in all spheres of life, women are compelled to solely take care of their families and labor in the home due to several social and familial constraints. In terms of national development, women play a less role while making up 50% of the population. Despite the fact that many women have gained recognition and reputation for their contributions to a variety of fields and concerns, gender inequality still exists. The causes of this gender imbalance include male dominance and poverty. After our country gained its independence, many women are still subjected to male oppression. It is really concerning that the sex proportion is dropping and that violence against women is increasing. [2]The sex ratio in India has been steadily decreasing over the past century, falling from 972 in 1901 to 927 in 1991, a 45-point decrease, according to the Department of Women and Child Development's Annual Report 2001-2002, Ministry of Human Resources Development, Government of India. However, there has been a six-point improvement during the past ten years. According to the 2011 Census, there were 940 females for every 1000 males[3]. The fall in sex ratio at birth is due to the practice of female feticide (identifying the sex of the fetus and killing) and

[1] Women in India. www.google.com
[2] Census of India 2011
[3] Padia, Chandrakala, (2007). Feminist Challenges to Political Theory, Proceeding of the 8th Orientation Course in Women's Study, P.1.

practice of female infanticide that killing of a child because it is a female. There are more male children than female children, despite the fact that a female fetus is naturally stronger than a male fetus. Rural areas have seen a significant increase in female infanticide. It is impossible to address the issue of female infanticide in a vacuum. According to Raju (2014), it is a particularly severe and heinous type of violence against women in our culture. All of these issues demonstrate that females are less aware of reproductive health, nutrition, cleanliness, and numerous diseases since they are illiterate and have low levels of education. For females to maintain their health and well-being, they must be aware of these challenges and have the necessary knowledge. In order for females to have equal status, respect, employment prospects outside the home, financial independence, etc., gender equality is also necessary. Females must receive an education for this reason. [4]According to census 2011 only 65.46 percent of women are literate as compared to 82.14 percent of man. The development of women as a whole depends on education. Education increases knowledge and understanding of a wide range of topics, including healthcare, nutrition, cleanliness, legislation, lifestyle, economic issues, political awareness, and other topics that are crucial for women to preserve their health and live with dignity and respect. According to Victoria and Adlakh (1998), the majority of Indian women's deaths occur between adolescence and the early stages of pregnancy. Indian women's health is largely correlated with their status; visual weakening is very important to both the ladies and their families. Unwanted pregnancies that result in risky preterm births also have a detrimental impact on women's health.

[5]Some Government Schemes for Women Education

- **Beti Bacho, Beti Padhao:** *T*he program began operations on January 22, 2015. This scheme aims to prevent one-sided sex-related disposal based on sexual orientation, ensure the survival and safety of girls, and ensure their education.
- **[6]CBSE Udaan Scheme:** A well-known welfare program for girls in India, CBSE Udaan was introduced in 2014 with the goal of increasing the number of females enrolled in school. In addition to assisting impoverished Indian women students' study for several engineering admission examinations, this program offers them mentorship support, which can help them advance in life.
- **Saakshar Bharat:** In India, Saakshar Bharat was a nationwide literacy initiative that operated from 2009 to 2018. To lower India's illiteracy rate, particularly for women. Under the Department of School Education and Literacy (DSEL), the program was administered. The plan had central sponsorship. Rural areas, where illiteracy is frequently higher, were the program's primary focus. It provided skill development, basic education, and vocational education. The program's objectives were to minimize the gender gap in literacy by 10 percentage points and raise India's literacy rate to 80%.
- **Kasturaba Gandhi Balika Vidyalaya Yojana:** This plan was propelled in 2004. The goal of this initiative is specifically to improve the education of young girls. This plan's goal is to improve education for girls who belong to SC, ST, OBC, and minority groups.
- **National Programe for Education of Girls at the Elementary Level (NPEGEL):** The goal of NPEGEL is to increase the accessibility of education for young girls, foster their connections, and ensure that women and young girls are more interested in the field of education.

2. REVIEW OF LITERATURE

In order to improve society, education is essential. The most effective way to improve the status of women in society at large is through education.

[7]According to India's National Family Health Survey, educational fulfillments have shown a positive correlation with important aspects such as marriage age, fertility, desired number of children, and so on. According to Pandya (2007) Women's education leads to improved hygiene, better eating habits, more significant adequacy in considering family health, and the pursuit of fortunate therapeutic engagement. In addition to improving the women's health, this also

[4] Government of India: "Census of India, (2001)", http://www.censusindia.net/data/apd.pdf, (2001).
[5] www.google.com
[6] https://ipbindia.com/top-10-government-schemes-for-girl-child-education/
[7] National Family Health Survey, 3. 2005-06 vol. 3

improves their maternal skills and lowers infant mortality. Education can help them become more knowledgeable about contraception, which will help them make decisions about how many children to have and how to raise them. Offspring of educated women are less likely to die as newborns, and their long-term children are better off and more educated. According to Geertz (2016), millions of women nationwide continue to encounter major obstacles to having a dignified and comfortable menstrual experience. Education about menstrual health and puberty is not always available to girls. 71% of Indian females said they had no idea what a menstruation was before they got their first period. There are insufficient facilities for proper sanitation available to women and girls. Women and girls lack the necessary resources and social support to safely and privately manage their periods, even in the face of governmental attempts to increase sanitation. According to Ross and Mirowsky (1999), the positive effects of education is that it ultimately impact health, financial success, a person's ability to manage their own life and seek out social support, and a healthy lifestyle.

Tiwari (2018) aims to draw attention to the problems that women, particularly in rural India, face because of menstruation. In order to accomplish the stated goals, the researcher tried to concentrate on preventing negative outcomes that affect women's confidence and self-esteem as well as their overall well-being, taking into account pertinent literature in the field. When it comes to equality, obtaining an education, providing for their families, and other aspects of daily life, Indian rural women face numerous challenges. However, the days that girls get their period are equally difficult for them. Due to a lack of information of their social rights, knowledge, safety, and dignity free from social taboos, they endure numerous inhumane and unsanitary treatment. Mitra (2004) examined the relationship between women's literacy rates and their access to health care and excellent health. He made the important discovery that women will undoubtedly receive medical care from highly competent medical experts if the literacy rate among this demographic is raised by highly trained professionals. Ross and Wu (1995) draw attention to the fact that those with less education face greater challenges than those with more education, even at comparable income levels. In terms of money, the effects of poverty and illiteracy are complementary. Accordingly, the evidence suggests that a lack of education may really be harmful to one's health.

Srivatsa (2016) Due to dietary deficiencies, Indian girls do not reach their maximum potential in terms of height and weight. Adolescents in rural areas lag behind their urban counterparts in every aspect of physical development. Compared to their metropolitan counterparts from higher socioeconomic groups, the rural girls are shorter. The denial of a girl child's right to life during pregnancy is the first instance of discrimination against her. Census data indicates that having a male child is a deeply ingrained societal requirement. Child marriage and other wicked customs that negatively impact girls' health include female feticide and female infanticide. It causes a number of detrimental outcomes for the girls, including early pregnancy, sexual exploitation, lack of educational opportunities, and violence, in addition to violating their human rights. The inferior status of women in rural life is a result of their mistreatment, discrimination, and violence. Early marriage pushes them to drop out of school, which results in a lack of understanding about reproductive health and other health-related topics. As a result, she continues to experience significant health problems. Women are the most disadvantaged group in the globe, especially when it comes to health, in rural societies, especially in India. They lack access to reasonably priced health-related services and information (Racheral, 2006). Cutler and Lleras (2007) find that even after adjusting for family background, income, and work characteristics, those with higher levels of education have more positive health outcomes. Similarly, the present study aims to understand the relationship between education and health. Is there a connection between education and the health of rural women?

3. THEORETICAL FRAMEWORK

Patriarchal theory: Women's health issues, as well as their access to healthcare and education, are viewed from a gender bias perspective by the patriarchal approach, which means that men's health issues and education are given more priority than women's. Whether from husbands or lawmakers, women encounter gender discrimination as well as male-centered social attitudes and practices (Germain, 1995).

Socio-Economic theory: This theory mostly depends on the effects of socioeconomic factors on health and education. Additionally, it has the drawback of examining those characteristics in a social vacuum, treating people as distinct entities with predetermined income and educational levels (Sundari, Ravindran, 1995). As a result, it disregards the social milieu, which includes the society's resource base, caste and class-based social stratification, and health culture (beliefs and practices that impact health). It states that those who have income have the opportunity to study. People with high family incomes tend to be well educated. This study looks at women's health and educational attainment from the perspectives of personal socioeconomic traits, community health culture, accessibility, and scope of health services.

It is anticipated that development and education will provide women with a secure and healthful environment. Women who receive an education not only lead healthier lives for themselves, but they also produce healthy offspring, which in turn leads to a healthy family. In light of the aforementioned facts, the current study attempts to determine rural women level of education, to evaluate the health of rural women and to understand the relationship between education and health of rural women.

3.1. OBJECTIVES

- To assess Socio-demographic profile of rural women
- To assess rural women level of education
- To evaluate the health of rural women
- To understand the relationship between education and health of rural women

4. RESEARCH METHODOLOGY

The sample for this study was the villages of Nadiali and Saidpur of S.A.S Nagar, Mohali, Punjab. 200 respondents in total served as the basis for the sample size. 100 respondents from each village. The following age categories were examined: Below 20, 21–30, 31–40, 41–50, and 51+. 20 respondents from each age categories from each village making a total of 200 respondents.

4.1. AREA OF STUDY

The primary focus of the present study on rural women was their level of education and health-related concerns. For this purpose, Nadiali village, and Saidpur village of S.A.S Nagar, Mohali, Punjab were taken as the area of research.

4.2. SAMPLING TECHNIQUES OF DATA COLLECTION

The data was gathered using both quantitative and qualitative techniques. The quantitative method has been applied using an interview schedule. To find out about the health and educational attainment of rural women, the researcher visited Nadiali village and Saidpur village in Mohali, Punjab, on multiple occasions. The following elements make up the interview schedule: sociodemographic profile, educational attainment, health status, and disease profile. secondary sources of information, such as books, articles, policy documents, committee reports, working papers, proceedings from conferences and seminars, census records from newspapers, and official websites of different ministries were also consulted. There were both open-ended and closed-ended questions. The questions have been manually tabulated. By applying percentage analysis, a conclusion has been drawn.

4.3. SIGNIFICANCE OF STUDY

It has been observed that, historically, there have been only few social science researches on women's health in India, especially from an educational standpoint particularly in rural areas of India. Numerous aspects need to be investigated in this field of study. Upon reviewing all of the literature on the topic of women's health, it appears that not much work has been done in this area. Understanding education levels and their impact on women's health may therefore be made easier with the help of this study.

4.4. SOCIO DEMOGRAPHIC PROFILE OF RURAL WOMEN

In sociological study, social profile is regarded as the most significant variable. The respondents' social and economic circumstances are depicted in the social profile. In a society such as India, social profiles determine life situations, resources, and other aspects. Therefore, the social profile of the women in the rural society that is being studied is crucial to the current research. The socioeconomic standing of people in society has a significant impact on their health as well.

4.5. CASTE AND MARITAL STATUS OF RESPONDENTS

Caste is one of the most significant social variables in Indian society that affects a person's other facets of life. In rural societies, this is especially true. It was impossible to overlook the caste backdrop in concerns such as health-related ones. For a variety of causes with numerous biological, psychological, and social foundations, marriage is a worldwide social institution. Marriage age is particularly significant because it typically signifies the end of some educational opportunities. Numerous factors that appear to affect the date of marriage have been identified by various research. Major socio-structural changes including urbanization, higher educational attainment, the introduction of new roles for women, and the number of children they bore are all linked to older marriage ages. In light of this, the current study aims to determine how caste, marriage, and age at marriage affect women's health and health care practices in rural society.

Table 1 showing distribution of respondents based on their "Caste and marital status"

Caste	**Below 20 years**	**21–30 years**	**31-40 years**	**41-50 years**	**51+ years**	**Total**
General	22(55)	16(40)	16(40)	17(42.5)	20(50)	91(45.5)
O.B.C	4(10)	5(12.5)	2(5)	3(7.5)	5(12.5)	19(9.5)
S.C	14(35)	19(47.5)	22(55)	20(50)	15(37.5)	90(45)
Total	**40(100)**	**40(100)**	**40(100)**	**40(100)**	**40(100)**	**200(100)**
Marital status	**Below 20 years**	**21–30 years**	**31-40 years**	**41-50 years**	**51+ years**	**Total**
Married	10(25)	33(82.5)	35(87.5)	34(85)	22(55)	134(67)
Unmarried	28(70)	2(5)	0(0)	0(0)	0(0)	30(15)
Widow	0(0)	2(5)	3(7.5)	5(12.5)	15(37.5)	25(12.5)
Divorced	2(5)	3(7.5)	2(5)	1(2.5)	3(7.5)	11(5.5)
Total	**40(100)**	**40(100)**	**40(100)**	**40(100)**	**40(100)**	**200(100)**
Age at the time of marriage	**Below 20 years**	**21–30 years**	**31-40 years**	**41-50 years**	**51+ years**	**Total**
10-15	0(0)	0(0)	0(0)	5(12.5)	19(47.5)	24(14)
15-20	8(20)	20(50)	27(67.5)	19(47.5)	15(37.5)	89(52)
20-30	2(5)	5(12.5)	3(7.5)	8(20)	1(2.5)	19(11)
No Response	2(5)	13(32.5)	10(25)	8(20)	5(12.5)	38(22)
Total	**12(100)**	**38(100)**	**40(100)**	**40(100)**	**40(100)**	**170(100)**

Figures in parentheses column wise indicate percentages

From Table 1 it could be summarized that there were 45.5 percent of respondents who belongs to general category. 9.5 percent of O.B.C. 45 percent of respondents belongs to S.C category. There were 67 percent of respondents who were married, 15 percent unmarried, 12.5 were widow, and 5.5 percent were divorced. It was found that there were 14 percent of respondents who were between 10-15 years when they got married. 52 percent got married between the age of 15-20 years. 11 percent got married between the age of 20-30 years. There were 22 percent of respondents who gave no response to their age at the time of their marriage. It is possible to draw the conclusion that many of the respondents married between the ages of 15 and 20, which is a youthful and vulnerable time. Where they rely on others and lack the

maturity to make their own decisions. The study supports the findings of Srivatsa (2016) who states that child marriage and other wicked customs that negatively impact girls' health. The study also supports the findings of Racheral (2006) who states that early marriage pushes women to drop out of school, which results in a lack of understanding about reproductive health and other health-related topics.

5. EDUCATIONAL LEVEL OF RURAL WOMEN

The study focuses on the health-related features of rural women, and it is thought that education level has a favorable impact on rural women's health care. Table 2 displays the data that the researcher gathered regarding the respondents' educational attainment while keeping this in mind.

Table 2 showing distribution of respondents based on their "Educational level"

Educational level	Below 20 years	21–30 years	31-40 years	41-50 years	51+ years	Total
Up to Class 5	2(5)	2(5)	2(5)	10(25)	9(22.5)	25(12.5)
Up to Class 8	7(17.5)	4(10)	4(10)	13(32.5)	16(40)	44(22)
Up to Matric	11(27.5)	8(20)	10(25)	10(25)	11(27.5)	50(25)
Up to Senior Secondary	20(50)	10(25)	19(47.5)	5(12.5)	3(7.5)	57(28.5)
Graduate	0(0)	13(32.5)	4(10)	2(5)	1(2.5)	20(10)
Post- Graduate and above	0(0)	3(7.5)	1(2.5)	0(0)	0(0)	4(2)
Total	**40(100)**	**40(100)**	**40(100)**	**40(100)**	**40(100)**	**200(100)**

Figures in parentheses column wise indicate percentages

From Table 2 it could be summarized that there were 12.5 percent of respondents completed their studies up to class 5. 22 percent of respondents had completed class eight. There were 25 percent of respondents who were matric pass. There were 28.5 percent of respondents who studied up to Senior Secondary level. There were 10 percent of Graduate respondents and 2 percent of respondents were qualified as post-graduate and above. As can be seen from table 1, many respondents married earlier, which limits their opportunities to further their education. From the narratives of the respondents, it could be said that those respondents who were less educated have brothers who were more educated than them, as their parents did not pay much attention to their daughters' education. Income plays a significant role in women education. Patriarchal theory fits in here, which means that men's health issues and education are given more priority than women's. It could be said that those respondents who were less educated suffers more and have more health problems. The study supports the findings of Ross and Wu (1995) who draw attention to the fact that those with less education face greater challenges than those with more education. Accordingly, the evidence suggests that a lack of education may really be harmful to one's health.

6. OCCUPATIONAL STATUS OF RURAL WOMEN

Table 3 showing distribution of respondents based on their "Occupational status"

Occupational status	Below 20 years	21–30 years	31-40 years	41-50 years	51+ years	Total
Working	5(12.5)	25(62.5)	22(55)	19(47.5)	6(15)	77(38.5)
Not Working	35(87.5)	15(37.5)	18(45)	21(52.5)	34(85)	123(61.5)
Total	**40(100)**	**40(100)**	**40(100)**	**40(100)**	**40(100)**	**200(100)**

Figures in parentheses column wise indicate percentages

From Table 3 it could be summarized that there were 38.5 percent of respondents who were working, have an occupation. While, 61.5 percent of respondents were found to be not working. A large number of respondents are not-working, one could argue that this could have a detrimental effect on their health rather than offering them adequate medical services.

7. INCOME OF THE FAMILY OF RURAL WOMEN (ON MONTHLY BASIS)

It is important to remember that a person's and their family's income and living standard are also correlated with their health. It is typically assumed that when living standards are lower, health status will also be lower, and vice versa.

Table 4 showing distribution of respondents based on their "Family income"

Income Range (in rupees)	Below 20 years	21–30 years	31-40 years	41-50 years	51+ years	Total
Lowest (Up to 10,000)	8(20)	4(10)	4(10)	10(25)	14(35)	40(20)
Lower (10,001-15,000)	15(37.5)	11(27.5)	12(30)	16(40)	15(37.5)	69(34.5)
Middle (15,001-25,000)	11(27.5)	12(30)	13(32.5)	9(22.5)	8(20)	53(26.5)
Higher (25, 001& above)	6(15)	13(32.5)	11(27.5)	5(12.5)	3(7.5)	38(19)
Total	**40(100)**	**40(100)**	**40(100)**	**40(100)**	**40(100)**	**200(100)**

Figures in parentheses column wise indicate percentages

From Table 4 it could be summarized that there were 20 percent of respondents whose family income were lowest i.e., up to Rs. 10,000. There were 34.5 percent of respondents whose family income was lowest i.e., between Rs. 10,001-15,000. The respondents with middle family income i.e., Rs. 15,001- 25,000 were 26.5 percent. There were 19 percent of respondents who had higher family income i.e., between Rs. 25,0001 & above. From the narratives of the respondents, it may be concluded that respondents with higher family incomes have fewer health problems. Compared to people with lower incomes, they are more likely to eat a healthy diet and take better care of their health. The study supports the findings of Cutler and Lleras (2007) who states that even after adjusting for family background, income, and work characteristics, those with higher levels of education have more positive health outcomes.

8. HEALTH PROBLEMS FACED BY RURAL WOMEN

Table 5 showing health problems faced by rural women

Health problems	Below 20 years	21–30 years	31-40 years	41-50 years	51+ years	Total
Anemia	10(25)	18(45)	22(55)	23(57.5)	28(70)	101(50.5)
Hormonal problem	18(45)	20(50)	29(72.5)	35(87.5)	22(55)	124(62)
Reproductive health problem	17(42.5)	22(55)	25(62.5)	38(95)	33(82.5)	135(67.5)
Weakness	15(37.5)	24(60)	28(70)	26(65)	33(82.5)	126(63)
Cardiovascular problems	0(0)	3(7.5)	8(20)	18(45)	24(60)	53(26.5)
Joint/knee problem	4(10)	12(30)	22(55)	26(65)	31(77.5)	95(47.5)
Diabetes	0(0)	0(0)	6(15)	19(47.5)	29(72.5)	54(27)
Urinary problem	3(7.5)	27(67.5)	32(80)	16(40)	12(30)	90(45)
Low/high BP (hypertension)	17(42.5)	29(72.5)	25(62.5)	22(55)	28(70)	121(60.5)

Anxiety	29(72.5)	25(62.5)	22(55)	33(82.5)	38(95)	147(73.5)
Feel Depressed	16(40)	20(50)	15(37.5)	22(55)	29(72.5)	102(51)
Insomnia	12(30)	17(42.5)	10(25)	15(37.5)	33(82.5)	87(43.5)
Total	**40(100)**	**40(100)**	**40(100)**	**40(100)**	**40(100)**	**200(100)**

Figures in parentheses column wise indicate percentages

****The respondents have given multiple answers. Total percentage was calculated from the total number of respondents separately (i.e., 40 each).***

From table 5 it could be summarized that there were 50.5 percent of respondents who suffers anemia. 62 percent of respondents have hormonal problems. There were 67.5 percent of respondents who have reproductive health problems. 63 percent suffers weakness. 26.5 percent of respondents have cardiovascular problems. There were 47.5 percent of respondents who suffers joint/knee problems. 27 percent suffers diabetes. 45 percent have urinary problems. There were 60.5 percent of respondents who suffers low/high BP. 73.5 percent of respondents suffers anxiety. There were 51 percent of respondents who feels depressed. While, there were 43.5 percent of respondents who complained about insomnia. It is possible to draw the conclusion that among the common health issues that respondents experience is anxiety, reproductive health issues, weakness, and hormone issues.

Do you take treatment for your health problem?

Table 6 Showing the response of respondents on the statement "Do you regularly take treatment for your health problem?"

Response	Below 20 years	21–30 years	31-40 years	41-50 years	51+ years	Total
Yes	15(37.5)	16(40)	18(45)	7(17.5)	4(10)	60(30)
No	18(45)	19(47.5)	14(35)	28(70)	30(75)	109(54.5)
Sometimes	7(17.5)	5(12.5)	8(20)	5(12.5)	6(15)	31(15.5)
Total	**40(100)**	**40(100)**	**40(100)**	**40(100)**	**40(100)**	**200(100)**

Figures in parentheses column wise indicate percentages

From Table 6 it could be summarized that there were 30 percent of respondents who regularly take treatment for their health problem. While, there were 54.5 percent of respondents who 'do not' take treatment for their health problem. There were 15.5 percent of respondents who 'sometimes' take treatment for their health problem. It could be said that a greater number of respondents do not regularly take treatment for their health problem. The study supports the findings of Mitra (2004) discovered that women will undoubtedly receive medical care from highly competent medical experts if the literacy rate among this demographic is raised by highly trained professionals.

Causes of illness

In order to determine the precise reason for the respondents' illness, the researcher also asked them a question. The following table displays the information related to the illness's causes.

Table 7 Showing Causes of illness faced by rural women

Causes of Illness	Below 20 years	21–30 years	31-40 years	41-50 years	51+ years	Total
Nutritional Deficiency	23(57.5)	33(82.5)	36(90)	33(82.5)	38(95)	163(81.5)
Family Tensions	15(37.5)	24(60)	32(80)	29(72.5)	33(82.5)	133(66.5)
Over Workload	8(20)	28(70)	30(75)	31(77.5)	34(85)	131(65.5)
Heredity Reasons	19(47.5)	17(42.5)	22(55)	24(60)	26(65)	108(54)
Negligence	24(60)	32(80)	35(87.5)	32(80)	36(900	159(79.5)
Do not have much knowledge about health/ health care	15(37.5)	17(42.5)	30(75)	37(92.5)	38(95)	137(68.5)

Total	**40(100)**	**40(100)**	**40(100)**	**40(100)**	**40(100)**	**200(100)**

Figures in parentheses column wise indicate percentages

****The respondents have given multiple answers. Total percentage was calculated from the total number of respondents separately (i.e., 40 each).***

From Table 7 it could be summarized that there were majority of respondents (81.5 percent) who mentioned that there cause of illness is nutritional deficiency. There were 66.5 percent of respondents who said that family tensions are the cause of their illness. 65.5 percent reasoned work overload to be the cause of their illness. There were 54 percent of respondents who said that heredity is their cause of illness. While, there were 79.5 percent of respondents who mentioned that their own negligence towards their health is the cause of their illness. Nutritional deficiency, negligence, not having much knowledge about health/ health care, family tensions are some of the causes of illness. The study supports the findings of Pandya (2007) who states that women's education leads to improved hygiene, better eating habits, more significant adequacy in considering family health, and the pursuit of fortunate therapeutic engagement. There were 68.5 percent of respondents who mentioned that they do not have much knowledge about health/ health care which is the reason of their illness. The study supports the findings of Ross and Mirowsky (1999), which states that education is that it ultimately impact health, financial success, a person's ability to manage their own life and seek out social support, and a healthy lifestyle.

9. VIEWPOINT OF RESPONDENTS

Table 8 Showing the viewpoint of respondents on the statement "Do you think that if you were more educated/ knowledgeable you would have lived a healthier life?"

Response	Below 20 years	21–30 years	31-40 years	41-50 years	51+ years	Total
Yes	23(57.5)	22(55)	34(85)	33(82.5)	38(95)	150(75)
No	2(5)	4(10)	1(2.5)	2(5)	1(2.5)	10(5)
Not sure	15(37.5)	14(35)	5(12.5)	5(12.5)	1(2.5)	40(20)
Total	**40(100)**	**40(100)**	**40(100)**	**40(100)**	**40(100)**	**200(100)**

Figures in parentheses column wise indicate percentages

From Table 8 it could be summarized that there were 75 percent of respondents who said that 'yes' they believe that if they were more educated/ knowledgeable they would have lived a healthier life. There were 5 percent of respondents who said 'no' to the mentioned statement. While, there were 20 percent of respondents who were 'not sure' about the same. It could be concluded that there were higher number of respondents who do believe that if they were more educated/ knowledgeable they would have lived a healthier life.

10. CONCLUSION

It is determined that education will give women a safe and healthy environment. In addition to leading healthier lives for themselves, educated women also have healthier children, which benefits the family as a whole. The socio-Economic theory fits in the study which states that those who have high family income will have the opportunity to pursue education. Therefore, it might be argued that improving financial standing and increasing educational opportunities are necessary to lower the number of medical problems among women.

CONFLICT OF INTERESTS

None.

ACKNOWLEDGMENTS

None.

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