



A SOCIOLOGICAL ANALYTICAL STUDY OF HEALTH AND WELLNESS AMONG RURAL AND URBAN WOMEN IN VIJAYAPURA DISTRICT

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ABSTRACT

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This study compares the health and wellbeing of rural and urban women in the Vijayapura District of Karnataka. It examines the many facets of well-being, including physical and mental health, eating patterns, access to and utilization of medical services, and program knowledge. Using questionnaires, anthropometric measures, and qualitative interviews, the study employs a mixed-methods approach to gather comprehensive data from women in both environments.

Significant findings clearly distinguish between rural and urban locations. Urban women typically have better access to healthcare facilities, specialists, and health information, which is linked to higher rates of institutional deliveries and screens for non-communicable diseases. However, they are more likely to experience lifestyle-related issues like stress, obesity, and sedentary behavior. However, rural women face significant barriers to access, affordability, and availability of healthcare, which increases the risk of infectious diseases, maternal health problems, and nutritional deficiencies including anemia. Their health is additionally impacted by societal norms, occupational risks from agricultural work, and low health literacy, even though they often have larger informal community support networks.

The study concludes that whereas urban women in Vijayapura District deal with health issues related to contemporary lifestyles, rural women primarily suffer socioeconomic limitations and institutional disparities in access to basic healthcare. To attain holistic wellbeing, tailored, situation-specific treatments are required. The ideas include developing urban wellness programs focused on mental health and lifestyle diseases, establishing targeted nutrition and sanitation initiatives, and bolstering primary healthcare and outreach programs in rural areas. Closing this equality gap would require integrated policy actions that address both the growing public health challenges in urban settings and the infrastructure shortcomings in rural communities.

KEY WORDS: Health, Wellness, Comparative, Women, Disorders, Programs, Vijayapura, Impact, Rural and Urban.

INTRODUCTION

Despite being a fundamental human objective, attaining health and wellness is greatly influenced by one's environment. For women, who are often the backbone of family and community health, this quest is made more difficult by a complex interplay of biological, social, economic, and cultural elements. In a rapidly developing nation like India, the stark contrast between rural and urban environments creates different realities of well-being. Understanding these disparities is not merely an academic endeavor but is crucial for equitable public health planning and implementation. This study examines this specific contradiction by contrasting wellness and health in rural and urban environments, with an emphasis on women in the Vijayapura District of Karnataka.

In this context, "wellness" encompasses more than just the lack of disease. It encompasses a full range of physical, mental, and social well-being. This includes having access to preventative

and curative healthcare, mental health resilience, reproductive health, dietary status, and the ability to live an economically and socially engaged life. Crucially, access to these wellness pillars is mediated by geographic location. Even though urban areas typically have better healthcare infrastructure, expert access, and information distribution, they may also encourage lifestyle-related non-communicable diseases. The burden of infectious diseases and maternal health difficulties is increased in rural areas due to systemic issues of accessibility, affordability, and awareness, even though there may be stronger linkages to the community and traditional knowledge systems.

Although the already published literature highlights a nationwide pattern of urban-rural health disparity, the specifics of this split are rather localized. They are influenced by district-level governance, local cultural norms, and the effectiveness of governmental health missions. There is a glaring paucity of location-specific, nuanced research that details the lived

experiences and relative health indicators of women in a certain administrative district, like Vijayapura.

As a result, many crucial questions act as the study's compass: What physical health markers, such as nutritional status and the prevalence of common diseases, distinguish rural and urban women in Vijayapura? How do they use and access maternity care and other medical services differently? What is the difference between their health literacy and mental health? In the end, what are the main socio-environmental factors influencing these results in each situation?

By carefully analyzing these problems, this study aims to provide an evidence-based, comparative profile of women's health in the district, moving beyond generalizations. The findings are intended to provide information to community organizations, healthcare professionals, and politicians to successfully close the wellness gap and promote a healthier, more equitable future for all women in Vijayapura.

REVIEW OF LITERATURE

1.Priya Sharma, etal (2022): carried out research on infections and menstrual hygiene. Good menstrual hygiene is essential for women's health, education, and general well-being. Menstruation is a natural part of being human. Nonetheless, it has long been ignored on both a personal and global level. Menstruation is still viewed as taboo in many cultures, and it is still associated with negative cultural attitudes and beliefs. Menstruating women and girls are often stigmatized as "dirty," "filthy," "stink," and "impure," leading to social and dietary restrictions, forced seclusion, and limited mobility.

2.Prasanna Kumar Mudi, etal (2023): carried out research on Juang women's menstrual health and cleanliness. For this study, 360 women in all were selected. They used the Crosse sectional study approach for this investigation. The results showed that 85% of Juang women used their old clothes as absorbents during their periods. A number of factors contributed to the low level of sanitary napkin usage, including cost (15%), ignorance (31%), and distance from the market (36%). Although 71% of the Juang women experienced menstrual problems, just one-third of them sought medical help.

3.Amrita Namasivayam, etal (2022): investigates research on how gender disparities affect women's access to reproductive health care. The effect of gender disparity on women's access to reproductive healthcare was examined in four different countries. Differences in women's status and autonomy, as well as cultural practices and gender norms, all contribute to the degree of gender inequality, which varies between and within countries. They used information from the Demographic and Health Survey for this study. The results showed that many dimensions of gender equity were strongly correlated with reported use of maternal reproductive health care services. Furthermore, many pathways of influence between the outcome and exposure variables were discovered. The results emphasize the significance of patriarchal and discriminatory traditional value systems and practices that place women and girls below men and boys in a variety of social contexts, as well

as the pressing need for concerted and ongoing efforts to alter these detrimental traditional values if several of these nations are to meet MDG-5.

4.Güç, Çağla (2024): conducted study on women's lifestyle and wellness visibilities on Instagram: a critical analysis from a feminist perspective. Wellness influencers and Instagram accounts have amassed significant followings, predominantly made up of women, by curating captivating content that appeals to users looking for advice on a range of topics and enhancing their lifestyles. This study focuses on the themes within the latest 200 posts from 20 wellness and lifestyle Instagram accounts, analyzing the messages, communication tactics, and foundational feminist values conveyed to their audience. Findings suggest that the content creates a sense of inadequacy among women, particularly as it encourages them to continuously pursue self-improvement. While these accounts profess to promote empowerment, they frequently reflect media-endorsed feminist viewpoints defined by post-feminism, neoliberal feminism, and popular feminism. They use the term feminism as a fashionable and inspiring idea, which dilutes its significance and does not genuinely adhere to feminist principles.

5.Collin c. Ceneciro and maryfe m. Dela cruz (2021): conducted study on women's mental wellness: coping and responding to covid -19. The COVID-19 pandemic has had a significant impact on women in the education sector, particularly concerning their mental health. This research, which is quantitative in nature, evaluated how 200 women—both teachers and students—responded and adapted to the various mental challenges brought on by the pandemic. To gain a deeper insight into the coping mechanisms and reactions of the participants, a detailed survey was utilized as a research instrument. The findings indicated that feelings of insecurity, lack of calmness, worry, apprehension, confusion due to information overload, and being in a heightened emotional state were the most prevalent mental challenges faced by the participants in the study. To deal with these mental challenges, the participants adhered to health guidelines, communicated openly, and participated in recreational activities, as well as actively campaigning against COVID-19. This study emphasizes the need for recognizing women's mental health conditions during a pandemic crisis so that academic institutions and the government can implement intervention programs aimed at addressing women's mental struggles during such emergencies.

OBJECTIVES OF THE STUDY

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

RESEARCH METHODOLOGY

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

variables. It helped to Comparative study of Rural and Urban Women.

Sample of the study

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

400 women's have been selected based on random sampling method. For comparative study 200 are selected from rural community and 200 are selected from urban community of 2 talukas in Vijayapura district. These are Talikoti and Vijayapura talukas of Vijayapura district. 400 samples are drawn from Vijayapura, Bekinal, Mukihal, Bommanahalli and Kodaganur based on random sampling methods in both rural

and urban communities.

Data Collection

Data collection is an important stage of the whole research. There are two types of data collection method, namely, Primary data and another one is secondary data. The present study is based on both primary and secondary data.

Variables of the study: For the study variables are divided into two parts, independent and dependent variables.

Independent variables: Caste, Education, Age, place.

Dependent variables: Health and wellness, health problems, knowledge of health, utilization of health facilities, sanitization. Health and wellness among women: A Comparative study of Rural and Urban Women in Vijayapura District" Karnataka State Akkamahadevi Women's University, Vijayapura.

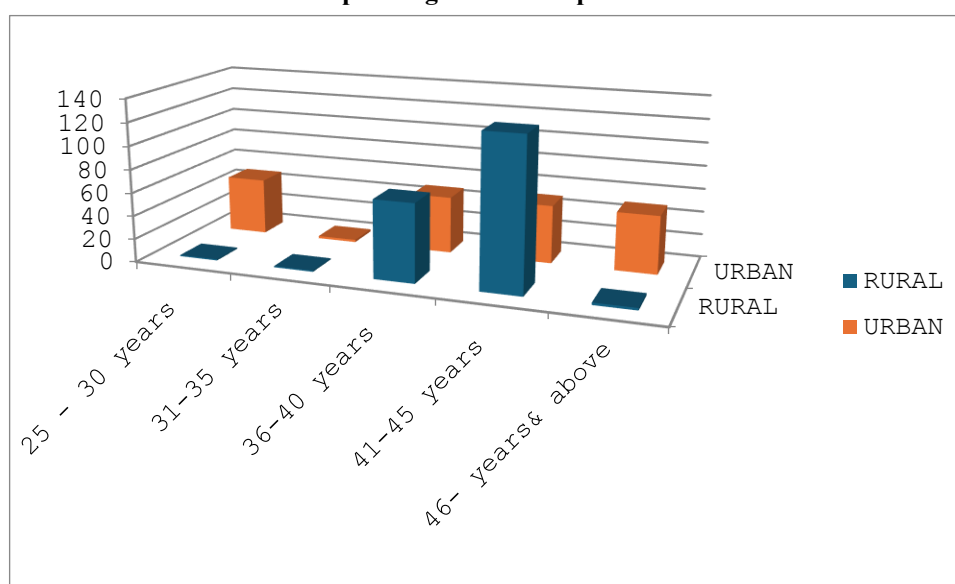
DATA ANALYSIS AND INTERPRETATION

Table 1: Age Of the Respondents

Age	RURAL	URBAN	Total
25 - 30 years	1	49	50
31-35 years	1	2	3
36-40 years	67	49	116
41-45 years	129	50	179
46- years& above	2	50	52
Total	200	200	400

Chi-square value=128.38 Df=4 P value=0.000 Remark= Significant

Graph 1: Age Of the Respondents



Above the table shows that Age of rural and Urban Community. The chi-Square value is 128.38. There is significant variation between rural and urban community. 25-30 years age of respondents are 0.5%(1) per cent in rural aria, 24.5%(49) year age of respondents in urban aria. 31-35 years age of respondents 0.5% (1) in rural aria. 1%(2) years age of respondents in urban

aria. 36-40 years age of respondents say that 33.5% (67) in rural aria. 24.5% (49) per cent age of respondents in urban aria. 46 years above age of respondents 1 % (2) per cent in rural aria and 25 % (50) per cent in urban aria. Finally researcher identify that 4-45 years old (64.5%) per cent respondents in rural aria.

Table 2: Caste of the Respondents

Caste	RURAL	URBAN	Total
Schedule cast	17	50	67
Schedule tribe	15	0	15
Backward caste	0	100	100
General merit	168	50	218
Total	200	200	400

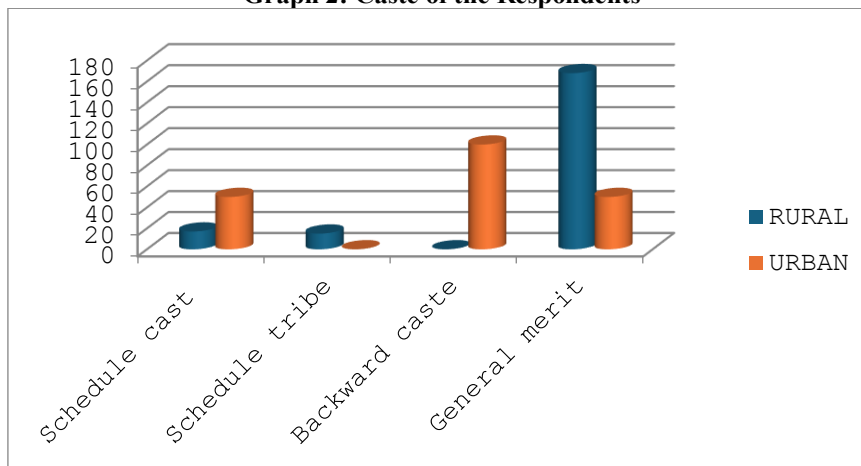
Chi-square value=195.125

Df=3

P value=0.000

Remark= Significant

Graph 2: Caste of the Respondents



Above the table shows that Caste in rural and Urban Community. The chi-Square value is 195.125. There is significant variation between rural and urban community. 8.5% (17) per cent respondents say that schedule caste in rural area, 25% (50) per cent respondents say that schedule caste in urban area. 7.5% (15) per cent respondents say that schedule tribe in

rural area than is no schedule tribe in urban area. 50% (100) per cent respondents say that backward caste in urban area, there is no backward caste in rural area. 84% (168) per cent respondents say that General merit in rural area and 25% (50) per cent respondents say that General merit in urban area.

Table 3: Education of the respondents

Education of the respondents	RURAL	URBAN	Total
Illiterate	134	0	134
Primary	66	50	116
Secondary	0	50	50
PUC	0	50	50
Graduate and above	0	50	50
Total	200	200	400

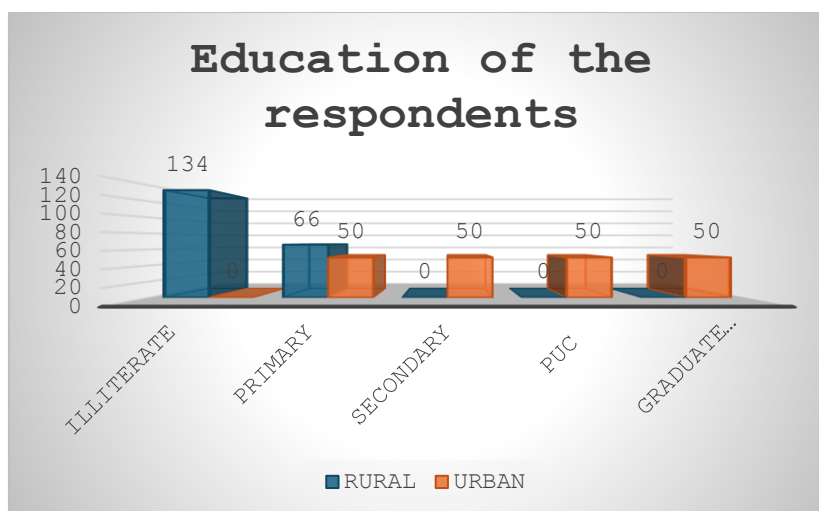
Chi-square value=286.20

Df=4

P value=0.000

Remark= Significant

Graph 3: Education of the respondents



Above the table shows that education of respondents rural and urban community. The Chi-Square value is 286.20. There is significant variation between rural and urban community. in urban area 76% (134) per cent of respondents say that illiterate in rural area and there is no illiterate in urban area. 33% (66) per cent of respondents say that primary education in rural area, 25% percent respondents say that primary education in urban

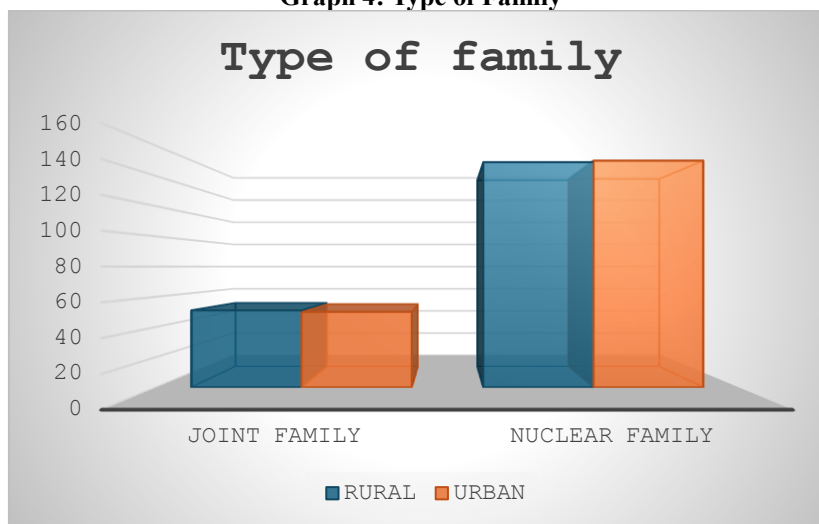
area. 25% (50) per cent of respondents say that completed secondary education in urban area there is no secondary education in rural area, 25% (50) per cent of respondents say that completed PUC in urban area, there is no completed PUC in rural area. 25% (50) per cent of respondents say that graduate and above in urban area and there is no graduate in rural area.

Table 4: Type of Family

Type of family	RURAL	URBAN	Total
Joint family	51	50	101
Nuclear family	149	150	299
Total	200	200	400

Chi-square value=.013 Df= 1 P value=0.908 Remark= non-significant

Graph 4: Type of Family



Above the table shows that type of family rural and urban community. The Chi-Square value is 0.30. There is no significant variation between rural and urban communities. 74.5% (149) per cent respondents replied that there is nuclear

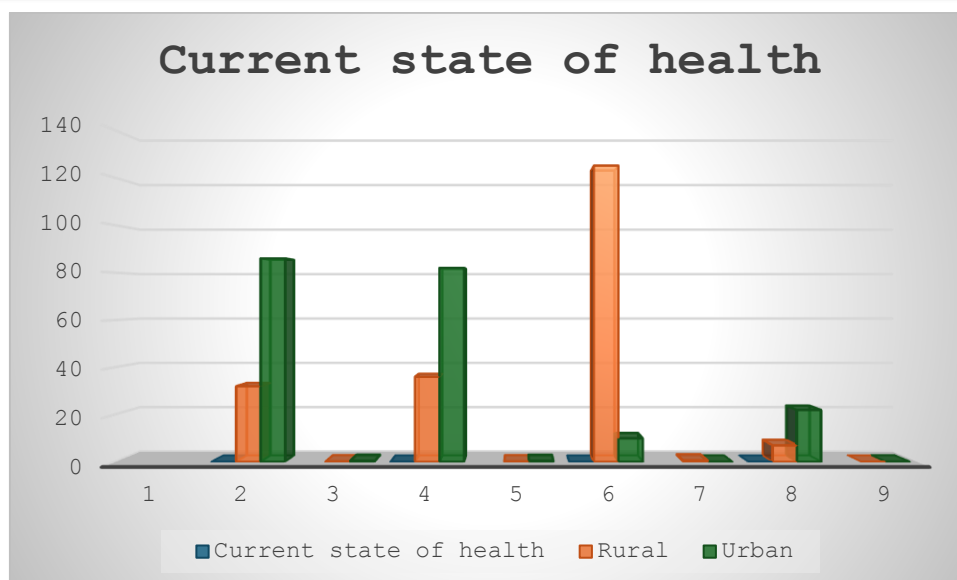
family in rural areas, 75% (150) nuclear family in urban area 25.5% (51) per cent respondent replied that there is joint family in rural area and 25% (50) per cent respondent replied that there is joint family in urban area.

Table 5. Current state of health

Current state of health	Rural	Urban	Total
Always fine	32	86	118
Fine but occasionally ill	36	82	118
Consistently ill health	125	10	135
Not applicable	7	22	29
Total	200	200	400

Chi-Square Value=148.37 Df=3 P value=0.000 Remark= Significant

Graph 5: Current state of health



Current state of health of rural and urban communities. The chi square value is 148.37. There is significant variation between rural and urban community with regards to the Current state of health of the respondents. It reveals that above 62.5% (125) percent of the respondents reply that consistently ill health in rural community. Whereas only 5% (10) per cent of respondents reply that consistently ill health in urban community. Nearly

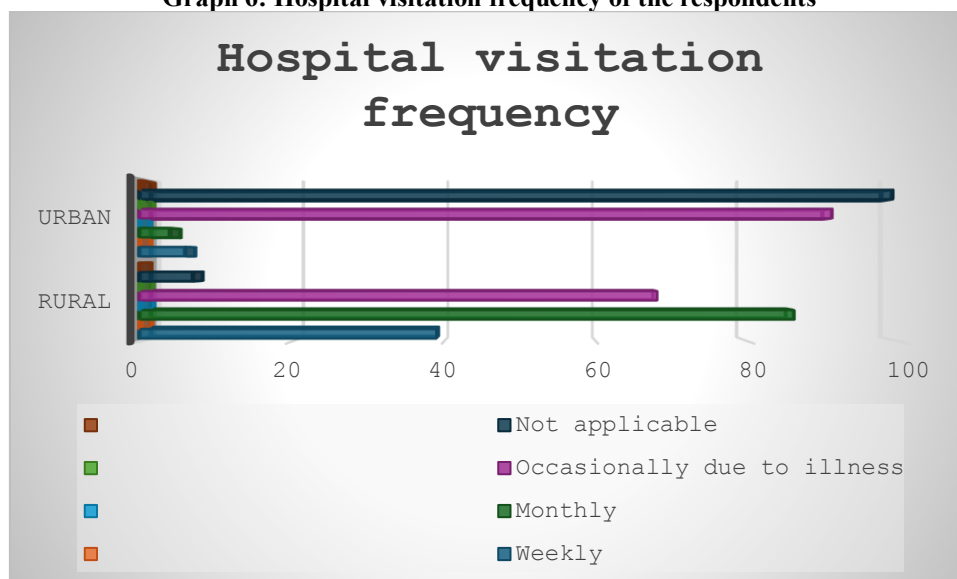
half of the respondents 43% (86) per cent of respondents reply that always fine in urban community and 41% per cent of a response reply that fine but occasionally ill in urban community but in rural area it very few percent 16% (32) per cent of response reply that always fine and 18% (36) per cent of response reply that fine but occasionally ill in rural community.

Table 6: Hospital visitation frequency of the respondents

Hospital Visitation Frequency	Rural	Urban	Total
Weekly	39	6	45
Monthly	86	4	90
Occasionally due to illness	68	91	159
Not Applicable	7	99	106
Total	200	200	400

Chi-square value=182.087 Df=3 P value=0.000 Remark= Significant

Graph 6: Hospital visitation frequency of the respondents



The chi square value is 182.087. There is significant variation between rural and urban communities. The researcher has identified that 19.5% (39) per cent of respondents say that they visits hospitals weakly for checkups in rural area and only 3% (6) per cent in urban area. 43% (86) per cent of respondents say

that they visit hospitals monthly for checkups in rural area and only 2%(4) per cent in urban area. 34% (68) per cent of respondents say that they visit to the hospital occasionally due to illness in rural area whereas 45.5% (91) per cent of respondents were in urban area visit for the hospital

occasionally due to illness. 3.5% (7) per cent of respondents say that not applicable in rural area and 49.5% (99) per cent of respondents are not applicable in urban area. The table shows

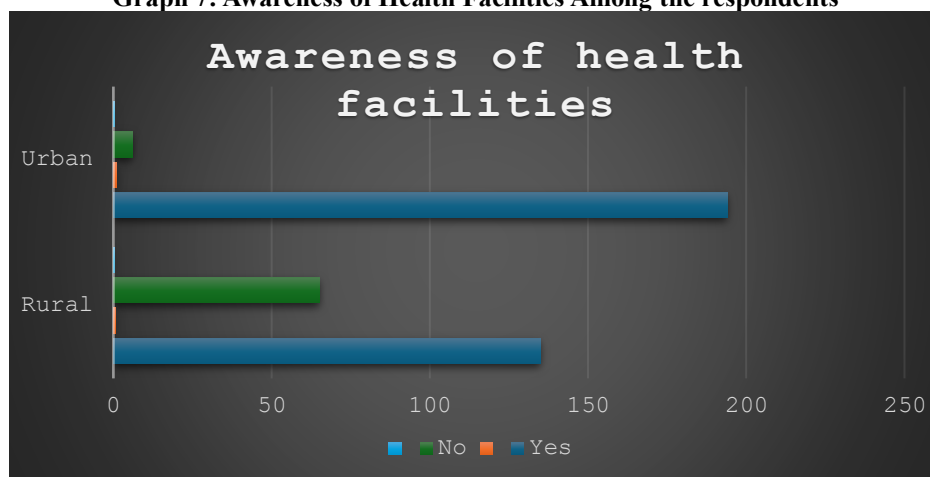
that health among the respondents in urban are much better than rural area.

Table 7: Awareness of health facilities among the respondents

Awareness of health facilities	Rural	Urban	Total
Yes	135	194	329
No	65	6	71
Total	200	200	400

Chi-square value=59.609 Df=1 P value=0.000 Remark= Significant

Graph 7: Awareness of Health Facilities Among the respondents



Above the table describes the awareness of health facilities of both rural and urban communities. The chi square value is 59.609. There is significant variation between rural and urban communities. 67.5% (135) per cent of respondents say that they

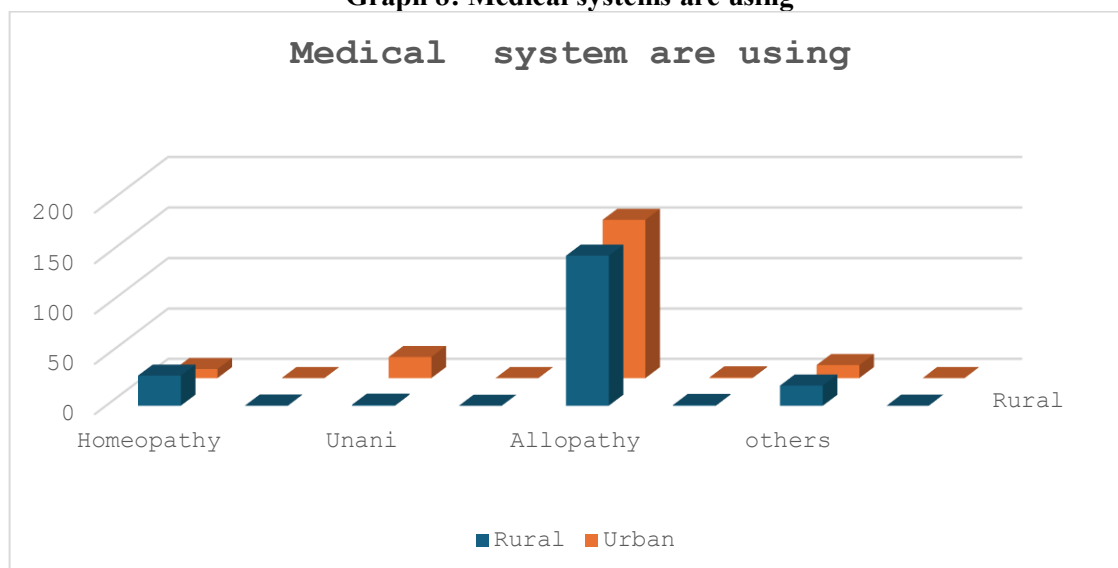
had awareness of health facilities in rural areas and 97% (194) per cent in urban areas. 32.5% (65) per cent of respondents say that there is no awareness of health facilities in rural area and 3% (6) in urban area.

Table 8: Medical system are using

Medical systems are using	Rural	Urban	total
Homeopathy	30	9	39
Unani	1	21	22
Allopathy	149	157	306
others	20	13	33
Total	200	200	400

Chi-square value=31.184 Df=3 P value=0.000 Remark= Significant

Graph 8: Medical systems are using



The table above shows that medical systems are used in rural and urban communities. The chi square value is 31.184. There is significant association between rural and urban communities. One third of the respondents in both rural (74.5%) and urban (78.5%) communities were using allopathic system for their health. 15% (30) per cent of respondents are using homeopathy,

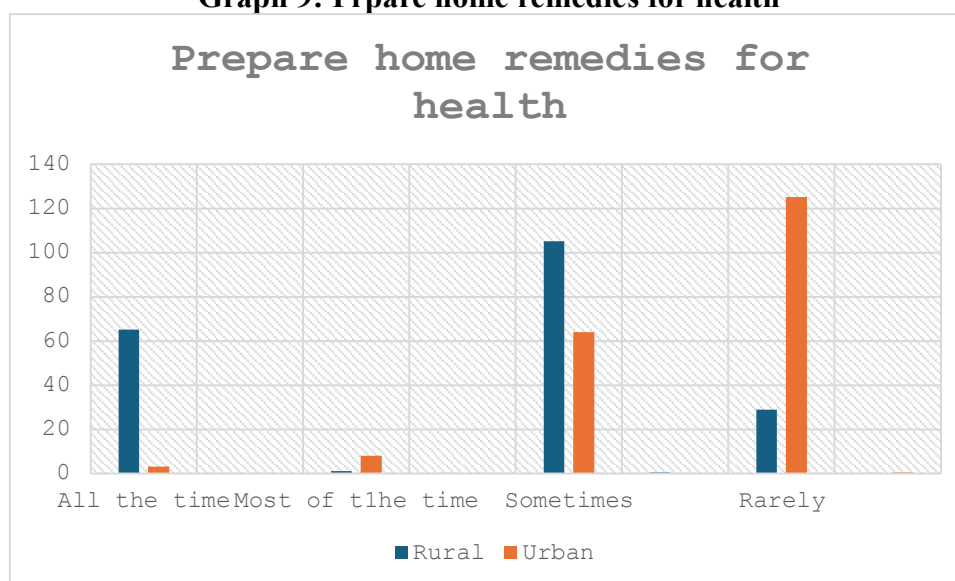
only 0.5% of respondents are using Unani and 10% (20) per cent of respondents are using other medical systems in rural areas. Whereas 4.5% (9) per cent of respondents are using homeopathy, 10.5% (21) per cent of respondents are using Unani and only 6.5% (13) per cent of respondents are using other medical systems in urban areas.

Table 9: Prepare home remedies for health

Prepare home remedies for health	Rural	Urban	Total
All the time	65	3	68
Most of t1he time	1	8	9
Sometimes	105	64	169
Rarely	29	125	154
Total	200	200	400

Chi-squre value=131.765 Df=3 P value=0.000 Remark= Significant

Graph 9: Prepare home remedies for health



Above the table shows that preparing home remedies for health in rural and urban communities. The chi square values is 131.765. There is significant variation between rural and urban communities. 32.5% (65) per cent of respondents replied that home remedies for health in rural areas, that is 1.5% (3) per cent in urban areas. 0.5% (1) per cent of respondents replied that most of one time prepare home remedies for health, 52.5% (105) per cent of respondents replied that sometimes they

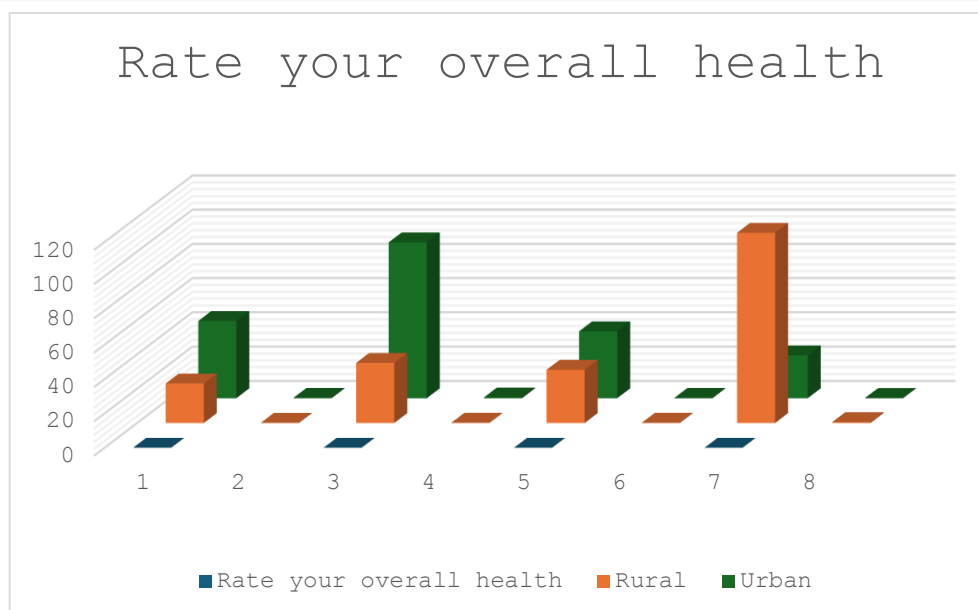
prepare home remedies for health in rural areas, 14.5% (29) per cent of respondents replied that they rarely prepare home remedies for health in rural areas. 4% (8) per cent of respondents replied that most of the time they prepare home remedies for health, 32% (64) per cent of respondents replied that sometimes they prepare home remedies for health in rural areas, 62.5%(125) per cent of respondents are replied that rarely prepare home remedies for health in rural area.

Table 10. Rate your overall wellness

Rate your overall health	Rural	Urban	Total
Excellent	23	45	68
Good	35	91	126
Average	31	39	70
Poor	111	25	136
Total	200	200	400

Chi-squre value=87.303 Df=3 P value=0.000 Remark= Significant

Graph 10: Rate Your Overall Wellness



Above shows the Rate of overall wellness of the respondent's details of rural and urban community. The chi square value is 87.303 there is significant variation between rural and urban communities. The current state of health of the respondents in rural communities is that more than half 55.5% (111) percent of respondents replied that poor health condition, whereas 45.5% (91) of response replied that good health condition in urban

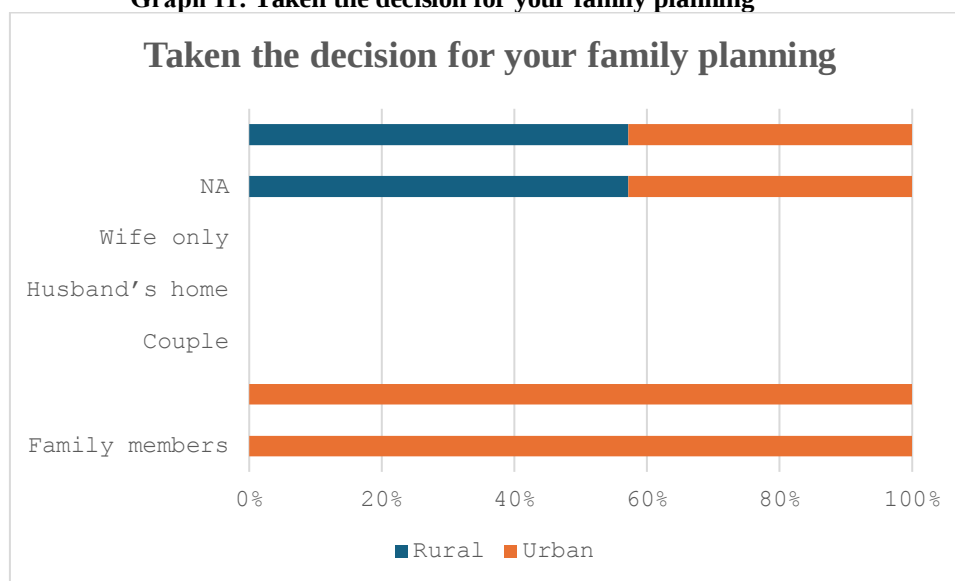
community. 17.5% (35) of response replied that good, 15.5% (31) were replied average and 11.5% (23) of respondents replied that excellent health condition in rural community. 22.5% (45) of respondents replied that excellent, 19.5% were said average and very few were replied 12.5% (25) that poor health condition in urban community.

Table 11: Taken the decision for your family planning

Taken the decision for your family planning	Rural	Urban	Total
Family Members	0	50	50
Couple	0	0	0
Husband's home	0	0	0
Wife only	0	0	0
NA	200	150	350
Total	200	200	400

Chi-square value=57.143 Df=1 P value=0.000 Remark= Significant

Graph 11: Taken the decision for your family planning



The table reflected that Who has taken the decision for your family planning in rural and urban area. The Chi-Square value is 57.143. There is significant variation between rural and urban area. 100% (200) per cent of respondents say that not applicable

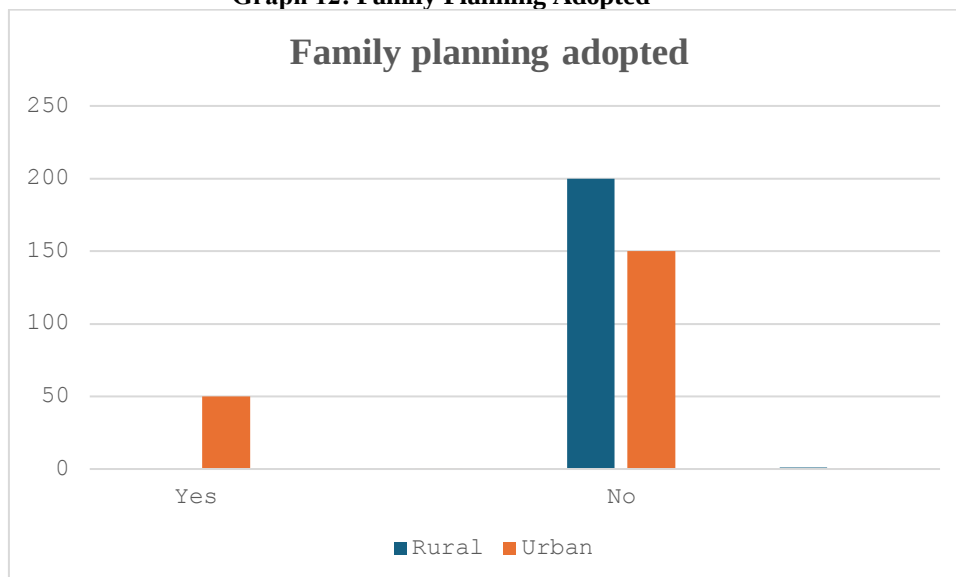
in rural area, 75% (150) per cent of respondents say that not applicable in urban area, 25% (50) per cent of respondents say that family members in urban area whereas no respondents in rural area.

Table 12: Family planning adopted

Family planning adopted	Rural	Urban	Total
Yes	0	50	50
No	200	150	350
Total	200	200	400

Chi-square value=57.143 Df=1 P value=0.000 Remark= Significant

Graph 12: Family Planning Adopted



The table mention that Family planning adopted in rural and urban area. The Chi-Square value is 57.143. There is significant variation between rural land urban area. 100% (200) per cent of respondents say that they didn't adopted Family planning in

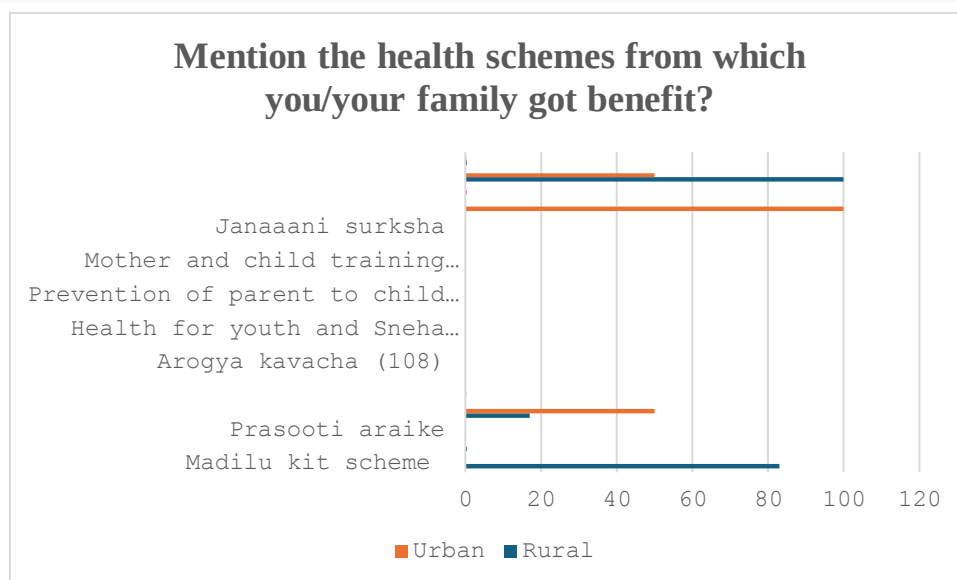
rural area and 75% (150) per cent of in urban area. 25% (50) per cent of respondents say that yes there is adopted Family planning in urban area.

Table 13: Mention the health schemes from which you/your family got benefit?

Mention the health schemes from which you/your family got benefit?	Rural	Urban	Total
Madilu kit scheme	83	0	83
Prasooti araike	0	0	0
Tayi bhagya	17	50	67
24X7 primary health services	0	0	0
Arogya kavacha (108)	0	0	0
Suvarna chaitany health programme	0	0	0
Health for youth and Sneha clinic	0	0	0
Mobile health service	0	0	0
Prevention of parent to child transmission	0	0	0
Health help line	0	0	0
Mother and child training system	0	0	0
National family welfare programme	0	0	0
Janaaani surksha	0	0	0
Polio vaccine programmes	0	100	100
Any others	100	50	150
Total	200	200	400

Chi-square value=215.92 Df=3 P value=0.000 Remark= Significant

Graph 13: Mention the Health Schemes from which you/your family got benefit?



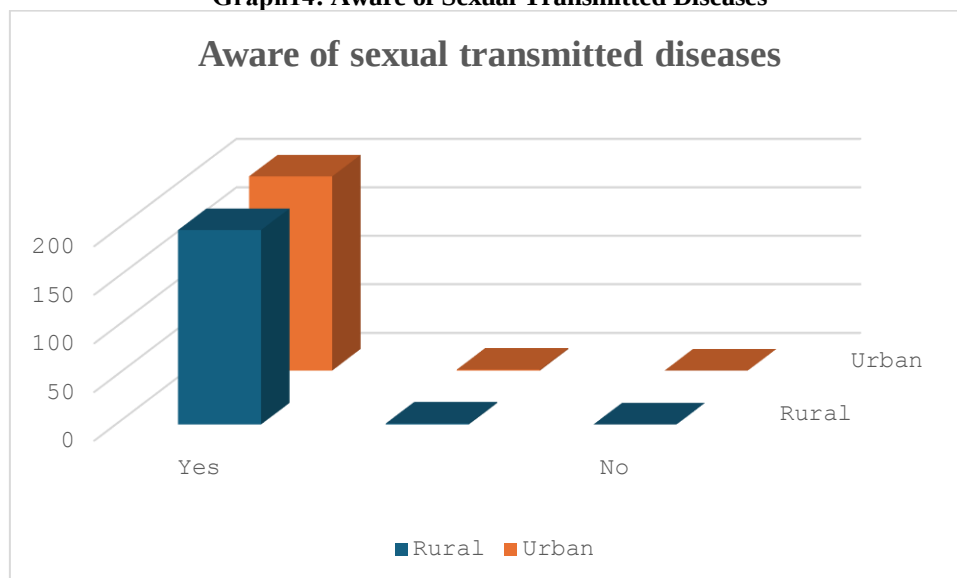
The above table shows that health schemes which family got benefit in rural and urban area. The Chi-square value is 215.92. there is a significant variation between rural and urban area. 50% of the respondents were get other schemes benefits, 41.5 % of the respondents get Madilu kit and 8.5 % of the

respondents get Tayi Bhagya in rural area. Whereas 50% of the respondents get Polio vaccine programmes, 25 % of the respondents get Tayi bhagya and 25% of the respondents get other schemes benefits in urban area.

Table 14: Aware of Sexual Transmitted Diseases

Aware of sexual transmitted diseases	Rural	Urban	Total
Yes	200	200	400
No	0	0	0
Total	200	200	400

Graph14: Aware of Sexual Transmitted Diseases



Above the table shows that awareness of sexual transmitted diseases of respondents in rural and urban area. 100% (200) per cent of respondents asked that Yes aware of sexual transmitted diseases in rural area and 100% (200) per cent of respondents

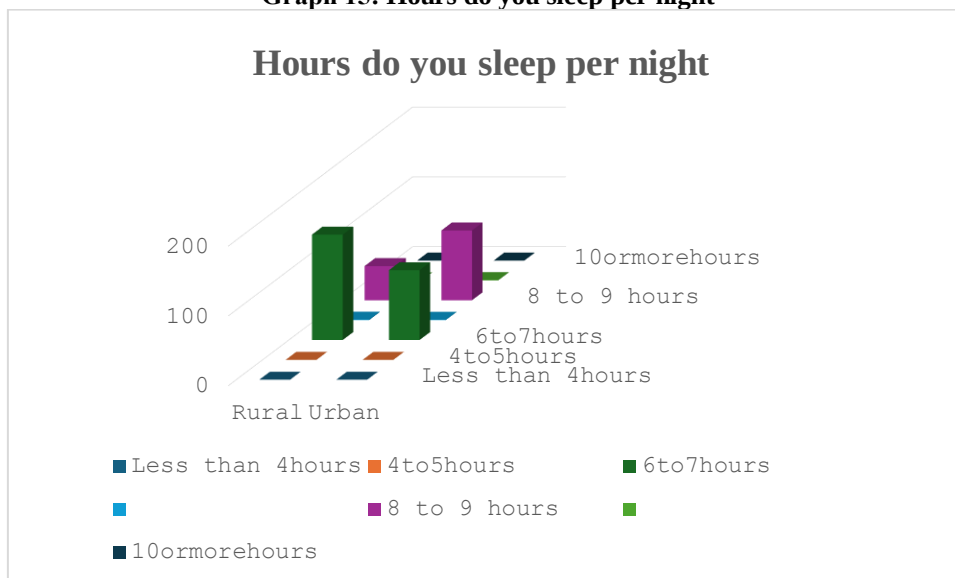
asked that Yes aware of sexual transmitted diseases in urban area.

Table 15: Hours do you sleep per night

Hours do you sleep per night	Rural	Urban	Total
Less than 4hours	0	0	0
4to5hours	0	0	0
6to7hours	151	100	251
8 to 9 hours	49	100	149
10ormorehours	0	0	0
Total	200	200	400

Chi-square value=27.81 Df=1 P value=0.000 Remark= Significant

Graph 15: Hours do you sleep per night



The table shows sleeping hours of the respondents per night in Rural and urban areas. Chi-square value is 27.81. There is significant association between sleeping hours of the respondents per night in rural and urban areas. 75.5% of the

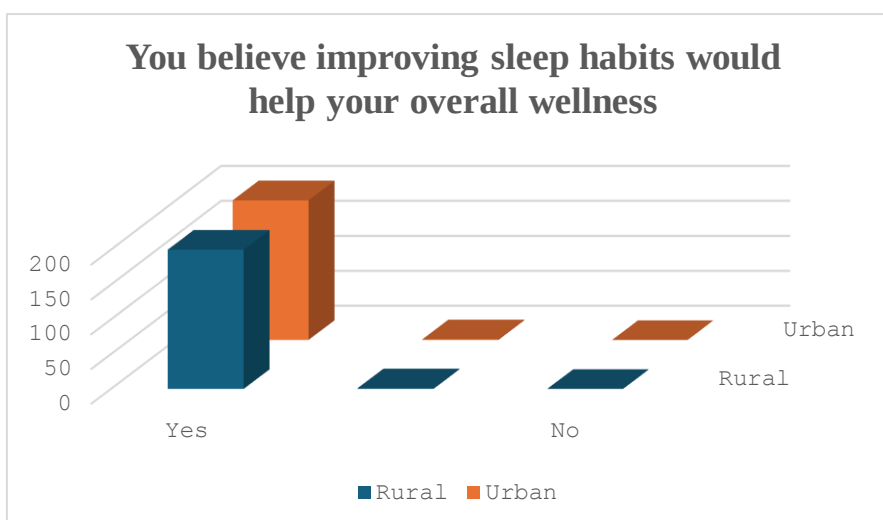
respondents sleep 6-7 hours and 24.5% of the respondents sleep 8-9 hours per night in rural area. Whereas in urban area 50% each and no respondents found who didn't sleep less than 4 hours, 4-5 hour and 10 or more hours in the both community.sss

Table 16: You believe improving sleep habits would help your overall wellness

You believe improving sleep habits would help your overall wellness	Rural	Urban	Total
Yes	200	200	400
No	0	0	0
Total	200	200	400

Chi-square value=71.014 Df=1 P value=0.000 Remark= Significant

Graph16: You believe improving sleep habits would help your overall wellness



The above table shows that respondents stress or anxiety level associated with their sleep quality in rural and urban area. Chi-square value is 71.014. There is a significant association between rural and urban community with regards respondents stress or anxiety level associated with their sleep quality. 75% of the respondents replied that were affected rarely and 25% were replied sometimes in urban area. Whereas 67% were said anxiety was affected sometimes and 33% were said rarely but no respondents found who replied anxiety was not affected.

CONCLUSION

The findings of this study, which compares the health and wellness of women in the Vijayapura district who live in rural and urban areas, show a landscape that is characterized by both similarities and differences, greatly influenced by the socioeconomic and environmental factors of each location. The results support the idea that geographic location has a big impact on wellbeing perceptions and health outcomes. Due to improved access to healthcare facilities, a bigger selection of medical treatments, and increased health knowledge, urban women typically have higher physical health indicators. However, they report greater levels of stress, anxiety, and lifestyle-related non-communicable diseases, highlighting the detrimental effects of urban living on wellness, such as social isolation, sedentary habits, and pollution.

On the other hand, rural women exhibit higher levels of social and community wellness resilience, which is bolstered by more robust kinship networks and conventional support systems. However, they have significant disadvantages in terms of the economic and physical aspects of health. Their health state is compromised by obstacles such financial limitations, reliance on unofficial treatment, distance to high-quality healthcare, and the tremendous burden of home and agricultural labor. Occupational dangers, reproductive health issues, and nutritional deficits are still common problems. Importantly, patriarchal systems and gendered norms continue to restrict women's autonomy over their health choices, access to resources, and self-care time in both groups. This universal component emphasizes how women's health in Vijayapura is inextricably related to more general concerns of gender parity and empowerment, which go beyond the rural-urban divide.

The study concludes by recommending a two-pronged, context-sensitive policy strategy. In metropolitan settings, the emphasis should be on encouraging healthy habits, preventive screening, and mental wellness. It is still crucial to improve community-based health education, transportation, nutritional security, and access to primary healthcare in rural areas. Crucially, district-wide improvements in health and wellness outcomes cannot be sustained without cross-cutting programs that strengthen women's socioeconomic autonomy, health literacy, and decision-making ability. In the end, improving the health and well-being of every woman in Vijayapura necessitates adopting a comprehensive, socio-ecological paradigm rather than just a biological one. Regardless of location, such a strategy must intentionally target the common structural disparities that impact women's well-being while addressing the difficulties of each context.

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