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Women's Health: a Critical Approach to Gender Issues, Ideas and Practices in India

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Abstract
Women's health status is an emerging subject-matter of study revealing diverse inequalities in causes and outcomes of it in both industrialized and developing countries. Various socio-cultural and socio-economic determinants ranging from diverse ideology, beliefs, taboos and practices shape the manifestations, conceptualisation, consequences, appropriate treatment, treatment-seeking behaviour and treatment response. The entire gamut of discussion of this paper revolves around some of these socio-cultural and socio-economic determinants of women's health issues .

Keywords: women's health, determinants, beliefs, practices, issues

Introduction

"Cradle of life; that's the WOMEN." Though it was long since identified that women represent one half of the world's population, supporting an increasing numbering of families; living longer than their male counterparts for biological reasons; are also the one, who often suffer the greater burdens of illness and disability .The recognition of this ground reality has invoke the Government of India to reiterate ,rethink and reallocate and consistently increase the budget outlay for programmes on family planning and women's health with every Five-Year Plan .However, this has had little impact on the overall scenario ; resulting in contrasting and divulging inequalities in both developed and developing societies. Health concerns of women are often neglected if not unmet; and their lies the importance of emphasising this basic need of women; as health is something to be nurtured , in order to , prevent illness and diseases.

Illness and diseases and its perception, treatment form a common experiences process and is part and parcel of human life in every society. Every community has its own way of dealing with the illness based on certain preconceived knowledge, beliefs and practices build around health and illness, which invariably varies with the members of different communities, as well as, within the members of the same communities .The notion of health is related to the concept "healthy" which simply means living well despite, any inescapable illnesses and diseases. Thereby, health is the balance and integration of physical, mental, intellectual, emotional, occupational and environmental aspects of human condition.

The women's health movement that started in the United States of America and spread worldwide has been successful in shifting the preconceived notion of women's health from sex neutrality to gender specificity, from a biomedical model to a social model and to a holistic model, from dependency of the patient to self – determination of the patient, and from doctor – centred care to client–centred care (Richters, 2002). It is being recognised that everywhere women's experiences, and presentations of their health problems are misunderstood (Chhabra, 2002). The concerns of women's therapies, preventive and curative in various parts of the world have also

been perceived differently (Richters 1992; Zaidi 1996; Vlassof & Manderson 1998).According to Richter (2002), while in some parts of the world the concerns and priorities may be clean water, malaria control, or safe childbirth, in the industrialized world activists charge that scientists have neglected to include women in the epidemiological studies and clinical trials, arguing that researchers mistakenly assumed that data from middle-aged white males apply equally well to women, minorities and the elderly .Partly because of these accusations, the field of gender-based medicine has come into existence, concentrating on the fundamental male-female differences in the incidences and prevalence of specific diseases, specific diseases risks, the response to risk factors, etiology, symptoms, manifestations, the presentation of complaints, the experience of disease and complaints and the dealing with the complaints, the course of the disease, the psycho-social consequences of diseases, the appropriate treatment, treatment responsivity, the kind of health education needed, etc. (Kolk et al; the Journal of Women's Health and Gender-Based Medicine). Despite, all the jargons in the Family Planning Programme and Reproductive and Child Health Programmes, India has failed to achieve the desired goals. In India, women have high mortality rate particularly, in their childhood and in reproductive years. Maternal mortality rates is high in the rural areas accounting for, 19% of still births and 27% of all maternal deaths from a global perspective .The health of Indian women is linked to their societal background and status .The United Nations ranks India as a middle-incomed country. The United Nations Development Programme's Human Development Report (2011) ranked India 132 out of 187 in terms of gender inequality. Gender Inequality Index (GII) is a multidimensional indicator determined by numerous factors including maternity mortality rate, adolescent fertility rate, educational achievement and labour force participation rate. India exemplifies many of these multidimensional indicators.

The term gender as used often to distinguish the differences between men and women that are socially construed from those that are biologically acquired is more a recent concept. A gender approach to a particular health aspect or a disease probes both the differential impact of it on women and men and the social, cultural and economic contexts within which the person live and work. According to Dr A martya Sen, "Burden of hardships fall disproportionately on women" due to inequalities like: mortality (due to gender bias in health care and nutrition), natality (Sex Selective Abortion and female infanticide), basic facilities (education and skills development), special opportunities (higher education and professional training),employment (promotion) and ownership (home, land and property).

Method and Materials

This paper concentrates on the socio-cultural and demographic determinants of women's health issues and shares the ideas, notions, concept, beliefs and practices and treatment seeking behaviour of patients visiting the District Hospital, Midnapur and the experiences and interactions of a Senior Doctor with them.

Socio-cultural vs Biomedical Aspects

It is a common belief that whenever, we talk of women's health, our narrow conceptualisation encompasses only the reproductive role of women as concerned with child-bearing; it is a part of the whole gamut of women's health issues. We often perceive these health issues to be rooted in the biomedical sphere but their origin lies in the human behaviour that is embedded in the socially and culturally constructed patterns of gender relation, which in their turns are influenced

by economic and political factors. The individual's behaviour and practices; choices available to them and the choice they can make; awareness of healthy practices and the perception of the acceptable behaviour of women determine the extent of the health problem. So, it is always best that women's health is approached form a multidisciplinary perspective which looks at the complex interactions between body, mind social context and culture and the economic contexts within which they live and work.

Culture, customs and traditions quite often remained the reasons of incompatabilities, misunderstandings and tensions between people, groups and individuals. Subjugative and oppressive situations for women are normal in the society and are accepted by all, even the women themselves. Women often internalize injustice as a part of their life. The all-pervasive cultural notion sanctions the apathy towards women's health priority. Lack of support, access to financial resources, shame, embarrassment, fear, apathy, restrictions on mobility and access to health facilities add to this. Majority of the women in India work more than their male counterparts and for longer periods but eat poor quality of left-over food, which is inadequate in quantity. Inadequate nutrition compromises with the immunological status of women, enhancing the susceptibility to many diseases. Nutritional anaemia is rampant among Indian women, especially among the rural women. It exacerbates fatigue and reduces the working capacity of women in the workplace and at home. India has the highest prevalence of iron-deficiency anaemia in the world; about 80% of pregnant women and 70% in the reproductive age-group and also adolescents. It may be due to iron deficiency anaemia, pregnancy anaemia, general weakness and convalescence or childhood anaemia due to worm infestation. There are also traditional beliefs regarding food items and various myths and beliefs prevail in the society, which play an important role as to what is the proper amount of food desirable for the women. Most of these beliefs do not conform to the biomedical notions about proper food type. These nutritional taboos only ensure deprivation of essential nutrients, iron, calories and result in protein deficiency. For example, there is a concept of food being hot and cold – which varies from state to state and from community to community. For example, milk is considered to be hot in many states and cold in many states, which is a sheer belief and there is no relation to its physical and chemical characteristics of the food. These beliefs are the discriminations in food habits among the women in general and girls in particular. In Northern India, there is a belief that adolescent girls do not need to take milk; but, adolescent boys need to take milk as they are the ones who will study hard and bring name, fame and good luck to the family. After all, girls are "paraya dhan' and one day she will go to other house and so her food intake can be rationed and her requirement can be postponed to latter time. What a irony? If a girl child is born in a family it is considered auspicious to drown her to death in a bucket of milk; but as she grows up she is denied her intake of milk. Another, there is a common belief that a pregnant women should eat less, advocating a reduction in the already meagre daily food intake and discourage the consumption of certain nutritional food. There are instances when the in-laws discourage the intake of iron and folic acid tablets to the expecting mothers with the justification that they are given to induce caesarean deliveries.

The various socio cultural activities which the women perform do have a negative impact on the women's health. The long distances and the heavy head-loads of water from unstable sources that the women as traditional carriers of water for household purpose need to carry leads to chronic fatigue and other problems. This is a common problem in the hilly tracts, in the drier areas where the ground water-table is very low as in Kurukshetra and in the drought-prone areas; where women walk twice daily quite a few kilometres to fetch water. In such situations, osteo-arthritis, low back pain and head-ache are very common among the women. Recurrent child-bearing and

these heavy head load of water and fuel at times leads to uterine prolapse among women beyond the reproductive age-group. This a big problem in the rural areas among the widows and deserted women; where at times the victim cannot squat on the floor but at the same time she cannot reach out to any doctor for help or abstain from doing so; may be because of the social taboo associated with visiting a gynaecologist and obstetrics in such a situation. Society fails to understand that geriatrics and such underprivileged also have their distinctive health problems that need to be addressed. At times living with these problem may lead to other big health issues such as cancer. Lack of access to safe and adequate water for washing (and privacy in urban slums) has implications for RTIs (Reproductive Tract Infections) and UTIs (Urinary Tract Infections). For example in the ''sabji mandis" one will not find a toilet; and even, if one finds one there is no door, no water, no bucket, no mug or no light; and last but not the least, if everything is conforming to the requirement, in order to keep it very proper a very big lock in the toilet door will await you. It is often said that women are notorious for taking less water but many fail to internalize the problem that; at present, women has to travel a lot for their work or for their family work that needs to get accomplished which may be very urgent; and in such situation she has no other way but to resort to her own way of resolving the problems.

Socio-economic vs Biomedical Issues

Women's subordinate economic and social status makes it difficult for them to make health decisions. Women's health is severely constrained by women's lack of authority to make health care decisions for themselves, seclusion practices that restrict their mobility, socialisation that leads them to underplay their own health problems and bear them in silence; and lack of control over economic resources with which to seek health care. Procrastination and unwillingness to invest in women's health rather than poverty , lack of women's will as for herself she is secondary and her family is her priority and her lack of knowledge to seek treatment has been the barrier to women's access to health service. Husbands and mother- in-laws still continues to be the real decision-makers; and even educated women cannot make decision when they are sick. Women's illness ranks low among family priorities, especially when the condition is perceived as non-threatening or self-limiting, thus delaying the decision to seek care. Poverty , ignorance , religious customs and traditional beliefs passed on for ages, respect for family structures ,social constraints and colonialism have helped to keep alive traditions , practiced with conviction and fidelity, as they have always formed part of society's everyday life. In India patriarchy, land ownership where land is passed from father to son, and caste, interact in striking ways to increase the vulnerability of women whereby the socialization ingrains and entails voicelessness as a virtue. Patrilocal inheritance patterns, women's low economic status and infrequent contact with the natal kin also tend to make Indian women powerless aggravates their situation and make them physically and socially secluded.

Education vs Biomedical Issues

Education is both a constituent and instrumental component of human development. Poverty of education creates a vicious circle of myth and information that perpetuates health damaging behaviours and harmful practices. Education increases women's ability to benefit from health information and to make good use of health care services. Education enhances women's self esteem, assertiveness and their decision making power; increases self respect and self-confidence in them. It increases their access to income and mobility and enables them to live a healthier live.

The impact of education extends beyond her to the attitudes of others around her, including, the health providers who treat her with more respect and consideration. Women with higher levels of formal education may have greater family decision making power on health and related matters. Dr. James Kwegyir Aggrey has rightly opined, "If you educate a man you educate an individual, but if you educate a women you educate a family (nation). Education is the only means to change in the society as is revealed from the following:

> "Equality of access to and attainment of educational qualifications is necessary if more women are to become agent of change... Investing in formal and non-formal education and training for girls and women, with its exceptionally high social and economic returns, has proved to be one of the best means of achieving development and economic growth that is both sustained and sustainable".(Beijing Platform of Action)

The impact of education is best evaluated from the stand-point of adolescents, as they are the ones who needs special mention as this age- group (10-14yrs) is different from the older age-groups as it is difficult for them to understand their problems, the consequences of their behaviour and effects of their actions. Within the gender-stratified social structure of India, adolescent girls are unlikely to have exposure or physical access to the outside world, due to the strict socio-cultural norms, and are caught in a web of ignorance. Adolescents tend to be extremely poorly informed regarding health and healthy practices. Above all, their knowledge is vague, erroneous, and incomplete. Ignorance compounded by reluctance among parents and teachers to impart relevant information often aggravates the health situations of them.

Social Media vs Biomedical Issues

In this age of ICT, the various modes of social media, especially the electronics ones have a far-fetched impact on the adolescents; while the proper use of it can be beneficial and advantageous with its positive information and social sustaining connections ; in its, untoward form it can be detrimental. Social media epitomises women as someone with looks and not just their actions, character , and brainpower. This notion is palpable from the childhood to maturity, whereby , the women is judged and ascertained by their appearance in most of the society. Media is flooded with information regarding the choice to be made in order to achieve these desired goals. The booming cosmetic and beauty products industry and fashion industry sets the parameters to be achieved ; and, in the bid to overcome the insecurity women fall easy prey to these products. It is so because, the self- esteem, self-complacency, self-confidence of many a women of today is boosted by the number of "likes" and "dislikes" posted on the Whatsapp and the Facebook. The beauty ideal embraced by our culture is a white ideal and the market is abound with anti-pigmentation creams, skin- whitening creams, skin- bleaching agents which are most profusely used by the women. Often, these products causes skin allergies and other dermatological problems and, some causes mercury poisoning , which may lead to neurological problems and kidney damage. The days are gone when makeovers were restricted to hair , makeup, and clothes; and ,today, many rely on cosmetic and plastic surgery to fix up any correction to be made on face or body without considering the health and psychological risks. Medico- professionals are ready with their scalpels to make changes but , very few of them aware, the participants that, at times such surgeries may go wrong. In our media- driven culture, our view of what women should look like are portrayed by models and there are preferences for thinness. No matter how hard it may seem average women try to achieve " curvaceously thin vital statistics " of that of a model

restoring to crash dieting and starving themselves to death, undergoing dangerous weight loss surgeries or consuming untested dietary supplements. Eating disorder is widespread among the adolescent girls leading to anorexia, bulimia and binge eating disorder, night eating syndrome, pica which often lead to extreme emotional and physical problems that have life threatening consequences.

Conclusion

So, gender equality and women's empowerment are two sides of the same coin but are integral part in bringing positive changes in the health scenario of the society. There exist a wide gap between the goals enunciated for development and the related mechanisms for its implementation, on one hand, and the situational reality of the status of women on the other. Again, from the stand point of medical science, as health is something to be nurtured to prevent illness and diseases, there are three common types of health actions that are prevalent. They are- proactive care which emphasises on reduction of risks by lifestyle; health care maintenance which in fact, is a continual process; and, reactive care which involves treatment of illness. The greatest emphasis in health promotion is placed on proactive care. So, women health requires not just favourable health policies and its prompt and strict implementation ; strengthening and expanding of health services to include maximum possible women ; a long term policy ensuring improvement in nutrition , education and employment opportunities for women for positive impact on health but, a positive behavioural and attitudinal change in the immediate (family and friends) and on the larger society towards the women and a positive approach on behalf of the care-givers and care-seekers or "WE, THE WOMEN".

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References

Basu, S.K. 2003. "Cultural belief and practices affecting health-seeking behaviour of pregnant women ",Rural Surgery ,Official Publication of The Association of Rural Surgeons in India, 10(1): 16-22.

Chhabra, S. 2002. "Women's Health Issues, Review & Views", Rural Surgery , Official Publication of The Association of Rural Surgeons of India,9(3): 58-64.

Das, T. and S. Chakraborty. 2014. "Geriatrics: the great awakening ", JIMA, Journal of the Indian Medical Association ,112 (01): 12.

Gangopadhyay , B. and D. N. Das. 1997. "Quality of family planning services in India: The users' perspective ", The Journal of Family Welfare , 43(3): 5-12.

Jejeebhoy , S.J. 2000."Adolescent Sexual and Reproductive Behaviour : A Review of the Evidence from India", in R. Ramasubban and S. Jejeebhoy edited Women's Reproductive Health in India, Rawat Publication ,42-101.

Joshi , A. Dhapola, M. and P. J. Pelto. 2008. "Gynaecological Problems: Perceptions and Treatment-seeking Behaviour of Rural Gujrati Women " , in M.A. Koenig ,S. Jejeebhoy, Cleland and B. Ganatra edited Reproductive Health in India, New Evidences , Rawat Publication.

Joshi, B. N., Chauhan, S. L. Donde , U. M. , Tryambake , V. H., Gaikwad ,N. S.,and Bhadoria, V. 2006. "Reproductive Health Problems and Help seeking Behaviour Among Adolescents in Urban India , Indian Journal of Pediatrics ,73(6):509-513.

Richters, A. 2002. "The Evolution of Women-And-Health as a University Teaching Subject", rural Surgery , Official Journal of The Association of Rural Surgeons in India , 9(1):11-15.

Rishyasringa, B. 2000. "Social Policy and Reproductive Health ", in R . Ramasubban and S. Jejeebhoy edited Women's Reproductive Health in India , Rawat Publication, 418-446.

Sandhya, K. G. 2008. "Treatment-seeking for Reproductive Illness in Rural Tamil Nadu", in M. A. Koenig , S Jejeebhoy, Cleland and B .Ganatra edited Reproductive Health in India , New Evidences , Rawat Publication.

Touchstone, The Boston Women's Health Book Collective. 2008. "Our Bodies, Ourselves", Women Unlimited an associate for kali for women.