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**Ill-Health Experience  
of Women: A Gender  
Perspective**

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# ILL-HEALTH EXPERIENCE OF WOMEN: A GENDER PERSPECTIVE

**Annapuranam Karuppanan\***

## **Abstract**

*This review paper examines the ill-health experience of women, and whether it has been adequately explored in a socio-cultural context from a gender perspective. A deeper understanding of the wide range of literature about the ill-health of women highlights three issues. Firstly, in spite of the increasing concern over women's health in India, their exposure to illness is greater due to various social conditions in which gender is a predominant phenomenon. Secondly, women living in a rigid system of cultural norms and lacking strong economic background are exposed to extremely poor health. Thirdly, the ill-health experience of women increases in a relative context but disparities continue to persist between caste and class groups. These issues are explored by using gender as a category to understand the health differences across social groups, but not in the context of the changing pattern of gender relations between the agency and social structure.*

## **I. Introduction**

Gender is the most significant social phenomenon which shapes the multiple dimensions of women's social life. Fikree and Pasha (2004) argued that the status of women in Asia is much lower than that of men when compared to developed nations in the West. In fact, the rigid customary practices pertaining to families keep them inferior despite various movements against such practices and affirmative action by the State. If they want to achieve something they face challenges from cultural forces of gender norms and rapid socio-economic changes. Often, conventional social structure dictates their functions rather than legitimate reasons, handing men control of most of the functions of reproduction, production and household activities. The conventional practices not only determine their position, but also govern the relationship between men and women and enables men to retain their 'superiority' over women. In India, deep-rooted societal gender attitudes put women in a lower position than men in the whole social set-up though they play significant roles in different realms of life.

With respect to health, we find that despite an increasing concern for women's health in India, their exposure to illness<sup>1</sup> continues to be high (National Sample Survey Organisation, 2014) due to the prevalence and operation of various social conditions in which gender is an extremely important factor, framing their ill-health experience<sup>2</sup> and understanding of social realities. This is very much evident when we look at the global gender gap reports that portray the continued decline in the health performance of women in India. The latest report on gender gap reveals that India was ranked at 143 out of 149 countries though in other parameters like education, economy and politics, there has been good

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progress (Global Gender Gap Report, 2015). It clearly indicates that the health performance of the country's women stays at the bottom of the gender development index.

In this context, we may consider gender as a social construct and sex as a biological principle is evident in gender discourse. In contrast, Lober (2002) argues that human body itself is a social construct because of the bodily process of women transforming themselves through social practices. However, the literature on the gender aspect of health points to disparities occurring on the basis of age, caste, class, and space. Most of the literature used gender as a category to understand the proposed phenomenon to be studied, but the dimension of gender relations and gender performance are the recent work of gender theorists, which are given less attention in the context of ill-health. This review paper is divided into seven sections including an introduction, a conceptual framework, the multi-dimensional aspects of illness, the magnitude of illness in India, and the socio-cultural determinants of health and illness, followed by a discussion and conclusion.

## **II. Conceptual Framework**

In India, traditionally, the interaction patterns and the various dimensions of household and societal relations subjugate women in a patriarchal society. The male members of the family are considered superior, while women are treated as inferior in all spheres of life. This is because of tradition, where a woman is treated as dependent on her father in childhood, husband after marriage, and son in old age if her husband dies; for any adverse events, the blame is placed on women. These hierarchical relations are governed by culturally sanctioned social norms, and controlled by social institutions (Jejeebhoy, 1998; Subadra, 1999; Mathur, 2007, Inhorn, 2008). In this way, they reinforce gender identity, which is maintained by the socially constructed role of men and women, and draws the primary boundary of relationships between them. This produces different kinds of relationships between members of the family, and conditions women to operate within certain boundaries with either positive or negative effects on their relations and family well-being.

These relations can be categorised into three dimensions: vertical, horizontal and intimate. Vertical relations are those where one person has more power and controls the entire family's functions. Such a household comprises of three or more generations, including grandparents, parents and children living together. Under horizontal relations, people enjoy equal power and status, such as intra-generational relations living together as a family. And finally, intimate relations involve relations between husband and wife living together as a family. The various forms of gender relations are influenced by structural changes in institutions along with other socio-economic and cultural factors. As a consequence, the boundaries of gender relations are more likely to be altered when changes occur in the traditional roles of men and women at the household level. In fact, such changes have occurred through affirmative actions of the State by providing reservations for women, for example, in panchayat elections. Further, a World Bank (2014) report says that economic reforms have brought about structural changes in the economy, increasing job opportunities for women, especially for the poor in the informal sector. Indeed, among the low income groups, women have become the breadwinners in large numbers, despite hindrances in the form of caste and gender.

The multiple roles of women such as care giver, homemaker, wife, parent, and breadwinner of the family sometimes cause a strain in their relationship with the family. Such stress and strains on their relationships increase the vulnerability of women to health risks (Swaminathan, 2014). The chronic stress and conflict lead to poor appetite, hypertension, and heart diseases. As Foucault (1994) argues, when a man uses his strategy of relations to assert what he thinks a woman should do, as is the case when men seek to enforce an advantage over women, and when he imposes his thinking on a woman, it may lead to a relationship confrontation between the partners. The consequences of various kinds of violence against women not only affect their physical health, but also, as the literature indicates, adversely impact their quality of life. Thus, when one exercises one's power over others, the freedom of the other is restricted. An example would be, as Mathur (2007) points out, the lack of freedom restricting women from access to information related to her body, menarche, sexuality and reproductive health in the family as well as in the social world. The lack of sources to access information results in a low level of awareness about health and illness. This is because the rigid system of socio-cultural norms and identity crisis are major constraints on women living in a society, which is highly patriarchal in nature or by structure. This continues to restrict their ability to respond to their needs, and it also affects their choices and decision-making ability on their own health.

On the other side, there are issues of governance in health care service delivery, despite India having the largest health care network in the world (Dalal and Ray, 2005). The accessibility and availability of health service remain distant for low income groups, particularly in rural areas. This is because of various forms of discriminatory practices based on the identity they belong to, resulting in negative implications for accessing health care services. A study by George (2015) presents the stark differences between scheduled and non-scheduled castes in accessing health care services. This is because of the relatively lower representation of health personnel from scheduled castes in all the sections of health care delivery system, which is thus unfavourable to their health outcome. Scheduled castes are most deprived also due to institutionalized discrimination especially in Bihar, which fares poorly compared to Tamil Nadu, though both the states have high inter-group disparities. This is not only due to the attitude and high representation of non-scheduled caste service providers, as the study emphasised, but also due to lack of health care facilities. For example, India is one of the countries with the lowest public health expenditure in the world, which leads to a shortage of doctors. As per the Twelfth Five Year Plan, there were only 45 doctors for one lakh population whereas the desirable number is 85. The number of nurses, auxiliary nurses and midwives available was only 75 per one lakh population whereas the desirable number is 255. This situation expands the scope of public private partnership, but the lack of regulatory mechanism there increases the financial burden on the poor, which in turn restricts them from accessing health services. Simultaneously, the private sector presents a scenario where many doctors are not qualified and skilled practitioners are in short supply (Planning Commission, 2013). Even as a transition is taking place from the public to the private sector, the quality of health service has not been adequately defined. Other issues such as supply side factors also force the poor to buy medicines outside and go to private health services, which further worsens their situation. Marmot, *et al* (2010) observe that this situation drives many families towards poverty, pushing

them deeper into what is known as a 'medical poverty trap. 'Consequently, it restricts their upward social mobility in the class hierarchy.

This state of affairs makes the family's role very crucial. A 'family' is a basic unit of society providing great social security against health risks, freedom of choice on health, and support in terms of emotional care, information, finance, and so on. These elements vary, depending on the influence of various aspects of gender relations based on the norms, roles and responsibilities recognised by society and how they operate at different levels within a family. The boundaries of relationships depend on the degree of value placed on women, which again depends on their religion, caste, age, marital status, income, and occupational status. If these place a high value on women, then they lead to a more equal treatment and also better protection of their health. However, when the gender relations from each dimension intersect with the other identities of women such as caste, class and religion, they make women more vulnerable to health risks. Besides influencing women's agency, their effects may vary depending on the society they live in.

Due to these multiple social forces, the poorer sections often do not give adequate attention to their own health needs, resulting in untreated illness being high among women. As a consequence, illnesses are experienced by women for a longer period, weakening their physical condition which, in turn, affects or jeopardises their functions in various areas. Ravindranath (2013) has brought out the other implications of long-term illness, such as the exacerbation of poverty, deprivation of quality of life, and health exclusion which marginalises the affected from mainstream society. Hence, it is important to study the socio-cultural aspects of the ill-health experience of women from a gender perspective. In particular, the dimension of gender relations, which is a fundamental element, frames the society in a larger context. For example, norms regulate the interactive relationship pattern of men and women and can exemplify their health behaviour. An understanding of this can lead to the identification of the core issues regarding the health behaviour of women, and contribute to new intervention strategies to reduce health risks by encouraging better health behaviour.

### **III. Multi-Dimensional Aspects of Illness**

A discussion about health, that too in a socio-cultural context, has to take note of conceptualising, and provide an understanding of the distribution and explanation of patterns of health and illnesses across various social groups. It should also include a fairly detailed discussion about health care givers as well as institutions that provide health care. A sociological perspective on the above aspects of health is given by Talcott Parsons (in Filho, 2001), who states that the health of a person can be defined as a state of optimum capacity that enables individuals to effectively perform socially valued tasks. Parsons observes that a sick person is a victim of forces beyond his/her control. Such persons are exempted from taking up daily activities; they don't hold any responsibility and cannot perform their normal duties and are forced to seek help from others for overcoming their sickness (Parsons, 1975). However, even if sick, some of them do work, as their ability to do so depends on the severity of illness. Their behaviour is identified by examining the social constructs of health and illness that varies across population groups. The differences mentioned by Graham (2004) and Max Weber (in Bendix, 1974) can be understood through unequal positions occupied by people in the social hierarchy based on class, status, power,

gender and space. The magnitude of these differences can be explained through a range of health indicators, such as the higher incidence of morbidity among disadvantaged groups, as against affluent groups (Kawachi, *et al* 2002). These variations can be described in terms of absolute and relative differences. Bartley (2004) felt that absolute differences are indications of the actual number of people who fall sick across various groups, while relative differences refer to the percentage of differences in morbidity between groups.

The term morbidity refers to a multiplicity of social phenomenon largely used in the analysis of health systems. Further, terms such as illness, sickness and morbidity are often used interchangeably. As defined by Duraisamy (1998), morbidity<sup>3</sup> is a state of being ill. Illness refers to any form of deviation from the state of physical well-being (National Sample Survey Organisation, 2006). Illness originates in a body due to external factors (Sujatha, 2003). It can be explained by the ill-health experience of an individual based on the model he/she has constructed. Illnesses can be classified into various groups, on the basis of duration of suffering, the way in which body gets infected, the severity of illness, and so on. According to Ministry of Health and Family Welfare (2011), illnesses fall into three broad areas: communicable diseases,<sup>4</sup> non-communicable diseases<sup>5</sup> and injuries.

Communicable diseases are responsible for 38 per cent of all deaths, and are the cause for major health issues in a country. This could be attributed to certain demographic factors, socio-economic conditions and micro-organisms that are rapidly evolving due to the vulnerability of social conditions. Meanwhile, a shift from infectious diseases to degenerative diseases is taking place in what is being called the 'health transition'. As evidence of this shift, 'diseases of affluence' including diabetes, hypertension and heart diseases are becoming more common among the poor altering the diseases' social distribution (Krishnaji and James, 2002; Taylor, 2010; Mohan and Reddy, 2013). For instance, it was found that non-communicable diseases such as hypertension and diabetes are now more common among low income than high income groups in Royapuram, Chennai (Ramachandran, *et al* 2002). These diseases, according to Ministry of Health and Family Welfare (2011), accounted for 53 per cent of all deaths in India in 2008. Although the increase in non-communicable diseases is a recognised threat to the socio-economic development of the country, it has not been dealt with under the Millennium Development Goals. The third category of illness is injury, which covers all types of physical injuries such as cuts, wounds, haemorrhage, fractures, burns, and bites to any part of the body. This category also covers both natural and accident-related physical disability. Deaths due to injuries constitute ten percent of all deaths; the proportion is the same for both rural and urban areas.

#### **IV. Magnitude of Illness in India**

Globally, over sixty percent of mortality is attributed to non-communicable rather than communicable diseases. Of this, it is women who suffer more due to both the diseases<sup>6</sup> and also untreated illness for a long period as compared to men. Among them, the poor happen to be the high risk group because of socio-economic deprivation, high risk behaviour including tobacco consumption, low intake of fruits and vegetables, environmental factors, unhealthy lifestyle and food habits, and lack of sanitation and housing facilities (World Health Organisation, 2011; Ravindranath, 2013). In fact, life expectancy is relatively higher for women than men. Even then, as life expectancy increases, certain kinds of illnesses

also increase. Available data from National Sample Survey Organisation indicates that the overall illness rate (morbidity) increased significantly from 54 to 91 from 1996 to 2004 and further increased to 103 (per1000 persons) in 2014 in the country as a whole. While the proportion of ailing persons among women from all the age groups has increased from 57 in 1996 to 93 in 2004, and 99 in 2014 in rural areas, the corresponding numbers were 58, 108 and 135 in urban areas. In the case of men, the increase was from 54, 83 and 80 in rural areas and 51, 91 and 101 in urban areas. It shows that the proportion of ailing persons is higher in urban areas as compared to rural areas. The report also says that this is because of an increase in the health consciousness among people and better reporting of ailments during the survey period. If people are health conscious, the prevalence rate<sup>7</sup> of illness can be reduced by taking preventive measures, but the data show a dramatic increase in the illness rate in the country over the years.

**Table 1: Sex Differences in Illness in India**

<b>Selected States</b>	<b>Male</b>	<b>Female</b>	<b>Total</b>
Andhra Pradesh	91	102	96
Goa	117	131	124
Kerala	240	261	251
Maharashtra	97	110	103
Punjab	109	146	127
Tamil Nadu	86	104	95
Tripura	118	126	122
Uttar Pradesh	95	109	102
West Bengal	120	128	124
Bihar	54	54	54
Rajasthan	56	64	60
Madhya Pradesh	58	67	62
Karnataka	60	63	62
Jharkhand	27	45	36
Delhi	13	15	14

**Note:** Number per 1,000 of persons reporting ailments during last 15 days of survey by sex.

**Source:** NSSO 60<sup>th</sup> Round, Morbidity, Health Care and the Condition of the Aged (2006)

Table 1 shows that inter-state differences in illness are relatively higher among both sexes in Kerala, Punjab, West Bengal, Maharashtra, Andhra Pradesh, Tamil Nadu and Uttar Pradesh, while states like Bihar, Rajasthan, Madhya Pradesh, Karnataka, Jharkhand, and Delhi reported very low morbidity. On the other hand, sex differences in morbidity are greater in Punjab, Himachal Pradesh, Tamil Nadu, Haryana, and Uttar Pradesh (National Sample Survey Organisation, 2006). A greater variation is seen due to various socio-economic and cultural conditions, and gender is specifically seen as one of the

major reasons for differences in morbidity across the States (Ghosh and Arockiasamy, 2009). Further, the data also show that the proportion of ailing persons on the basis of age, monthly per capita consumption expenditure,<sup>8</sup> and social categories as follows:

- i) The prevalence of illness increases with age. The level of morbidity is higher for children (0-14) and those aged over 60 years, though their composition is relatively low in the total population, i.e., only 30 per cent of the population is between 0-14 years, 60 per cent between 15-59 years, and around nine percent 60 years and above in the country.
- ii) The illness reporting and monthly per capita consumption expenditure are highly important for the general health of family members. The reporting of morbidity is likely to increase when expenditure increases towards improving their standard of living. Besides, the range of variations between consumption expenditure and reporting of morbidity is larger in rural areas than urban areas.
- iii) The proportion of persons reporting ailments is highest among general categories as compared to SCs, followed by OBCs and STs in both rural and urban areas.

In spite of an overall improvement in the health status of the country, it is still far from the target expected by the state. Health surveys have repeatedly shown that the major reason for the increase in ailments lies in not seeking any effective treatment, as people generally do not consider their ailments as being serious. Another reason is financial problems. Consequently, untreated minor ailments often become acute leading to chronic illness<sup>9</sup> over a period of time. Sundar and Sharma (2002), in a study, reveal that the monthly prevalence rate of morbidity in Chennai slums is 86 per 1000 population and it is 109 per 1000 population in Delhi slums. Although municipal dispensaries are available within two kilometers, the utilisation of health facilities is lower mainly because of lack of knowledge, financial constraints, lack of time, prolonged waiting for treatment and familial reasons. It is important to note here that, as Singh, *et al* (2004) observed, the utilisation of health care services is often based on the cultural conception of health and illness. In rural areas, mostly based on previous experiences, people continue to follow indigenous practices or traditional folk medicine, or whichever is available, in the absence of bio-medical clinics. The relative cultural preference for indigenous systems of medicine over allopathy is higher in rural areas. Perhaps this is because they have relatively less side effects, are cheap and effective, and doctors practising these systems are easily available.

As Ravindranath (2013) and Ministry of Health and Family Welfare (2011) state, if the rate of morbidity increases, then i) The country's burden of illness is likely to increase substantially in future since the non-communicable disease burden is forecast to go up by seventeen per cent during 2011-2020 globally; ii) at the micro level, considering the high cost of medicines and longer duration of treatment for non-communicable diseases, this will constitute a greater financial burden for low income groups and possible loss of more man-days; and iii) it could also slow down the reduction of poverty ratio.

## V. Socio-Cultural Determinants of Health and Illness

In a social context, Peacock and Bissell (2011) argue that societies with greater inequality have poorer health status than societies that are less unequal. An unequal society is characterised by a social hierarchy based on wealth, with graded health differences from the top to the bottom of the socio-economic spectrum. According to Mohan and Reddy (2013), people who are at the top of the wealth hierarchy enjoy relatively better health than those at the bottom. However, some of the ailments like obesity are more common among women who belong to the upper strata than those from the lower strata. They can lead to hypertension, diabetes and heart disease. Marmot, *et al* (2010) observed that the gradient health difference is more pronounced among people who are at the bottom of the hierarchical order, which is closely associated with a variety of diseases. This could be attributed to the existing conditions and other factors such as deprivation of nutritious food, poor living conditions, congested places, material deprivation and risk of infectious diseases, which lead to poor health outcomes. However, in the social gradient of health, while focusing on the specific causes of illness, the degrees of intensity vary across groups, not only in terms of absolute difference, but also in terms of relative difference with regard to income, education, employment and wealth.

One of the yardsticks to rank individuals or groups in the class hierarchy is their income. That is why per capita income and monthly household consumption expenditure form the basis for defining poverty line in India. In Sen's (2006:109) view, "poverty is the lack of capability to meet basic needs of specified commodities." When one is not capable of meeting basic needs, becoming sick results in poverty, low productivity, and poor performance in education and employment. The population living below the poverty line constitutes 21.9 per cent in the country, and among them 25.7 per cent and 13.7 per cent live in rural and urban areas respectively. Poverty is highly concentrated among Dalits and Adivasis, followed by OBCs and Muslims (Government of India, 2011; Desai, *et al* 2010). This disparity is widening due to a high degree of differences in the income profiles of people, particularly women, who have a low profile as compared to men. Krishna and Ananthapur (2013) point out that this is one of the major factors restricting their ability to access institutional health care services.

Income disparity is related to caste hierarchy, and it is important to consider how it influences the health of women. In this respect, Deshpande (2000) argues that even if caste inequality is relatively less in Kerala, as compared to other parts of the country, inter-group disparity is higher between SCs/STs and other backward or poor categories in terms of consumption expenditure on basic needs such as food and clothing. As a result, when the intake of food comes down, they become more vulnerable to illness. Particularly, women from scheduled castes, scheduled tribes, and Muslims are more malnourished than other sections of society in India. Borooah, *et al* (2012) observe that malnourished women are more susceptible to illnesses as compared to other sections, and this is also reflected in mortality rates. The mean age at death is lower for Dalits, Adivasis, and Muslims as compared to Sikhs, Christians, and non-Scheduled Caste and non-Scheduled Tribe Hindus. Adivasis and Scheduled Tribe Christians are also less likely to receive medical attention than Dalits and Muslims if they fall sick before their death. Since rural women from low income groups mostly depend on agricultural labour and small landholdings, they often suffer from hunger due to inadequate income and material deprivation like housing and sanitation. Also, due to agricultural distress, some of them migrate

to urban centres in search of employment and to improve their standard of living. Of the total migrants, the number of those who are unskilled is high, comprising of workers from different sectors, pavement and street vendors, and domestic workers who constitute a sizeable population of the urban poor. Even though they earned a reasonable amount, most of them ended up spending the money rather than improving their standard of living.

Another significant dimension of health in this context is the wealth-based disparity between men and women. The possession of wealth is much lower for women than men in both urban and rural India (Jose, 2011). This is the result of a patriarchal culture, as argued by Friedrich Engels (in Keister and Southgate, 2012), where male domination is more prominent in economic relationships. Although the Hindu Succession Act 2005 provides for equal inheritance rights, the distribution of inherited wealth remains severely biased against women. This greater wealth disparity puts women at a disadvantage, and may be at the bottom of broader patterns of inequality in India, through lack of assets. It is indisputable that land is a key asset besides being an essential source of livelihood for millions of poor people. A World Bank (2010) report says that an increase in asset ownership may increase women's bargaining power, opportunities to earn their livelihood, and an intra-household allocation of resources towards consumption and expenditure, besides enabling them to make favourable reproductive decisions and significantly impacting their educational attainments. The legal framework of gender-equal inheritance rights can lead to positive effects on women, but it does not fully eliminate the underlying gender inequality. Where the legal mechanism fails to operate, and the customary practice of distribution of wealth prevails, it affects women's harmonious relationship with their family, in addition to inducing violence within the family. This discrimination and violence easily translate into morbidity. Empirical evidence (Jejeebhoy, 1998) shows that the violent behaviour of the husband towards his wife during pregnancy can become a causal factor of maternal morbidity, and it sometimes affects the infant as well. Studies from various parts of the country (Subadra, 1999; Go, *et al* 2003; Kramer, 2004; Visaria, 2008; National Family Health Survey, Round 3 - 2005-06) have found that women are more likely to experience various forms of violence, and are living within a rigid system of socio-cultural setting without any strong socio-economic support. This vulnerability, which is deeply rooted in the idea of male domination, enables men to act against women in the form of physical assaults.

Physical violence is a controlling strategy of men, which has adverse effects on the health of women. According to National Family Health Survey 2005-06, the experience of violence varies greatly across states. The prevalence of physical violence is high in Bihar (38.9 per cent) and Madhya Pradesh (37 per cent), followed by Tamil Nadu (36.1 per cent). A micro level study by Anandhi (2007) has found domestic violence related to alcoholism, suspicion about women's fidelity, and son preference as the prominent reasons for women frequently opting for abortion. Most of those subjected to physical violence are from the lower stratum; and in Tamil Nadu, it seems to be more prevalent in rural than urban areas. Men justify such actions claiming that their wives disobey their orders. It reflects, in fact, how women are conditioned by the patriarchal familial structure which increases their vulnerability to various forms of violence. Go, *et al* (2003) observed that in Chennai slums such violent behaviour became accepted by the women over a period of time. As a result, according to Ontai, *et al* (2008),

women face frequent health problems that hinder their ability to find and sustain stable employment, which leads to stress and affects their parenting roles as well.

An additional aspect of gender dimension is marriage. As Sen *et al* (2007), Santhya and Jejeebhoy (2007) and Mathur (2008) observe, as soon as women get married, they are expected to bear children, and so they face enormous pressure from the family and the community to have a child as early as possible. A large majority of women marry at a young age, generally below eighteen years, and as such are more susceptible to high reproductive morbidity risk, caused by multiple factors: poor knowledge about their body and sexual relationship, low perception about what is at risk, lack of awareness, lack of safe sex, and unhygienic practices that aggravate the prevalence of reproductive tract infection, and sexually transmitted infections, which are observed to be prevalent more among women than men. Although studies show that women are biologically vulnerable to acquiring these diseases, they are more likely to lack the freedom to negotiate their sexual relations with their husbands and may not be able to access the appropriate information due to cultural constraints.

While education is seen as one of the determining factors of health, evidence shows that the years of schooling are considered a confounding variable of gradient, with those who are better educated able to perceive their illness and articulate their physical symptoms (McDaniel, 2013). But if the educated women do not have adequate knowledge of a specific illness, they may find it difficult to describe their illness. Further, studies done by Wilkinson and Marmot (2003) and Sharma (2012) found that higher levels of reporting of physical health are seen more among the unemployed. In particular, women working in the unorganised sectors and those holding temporary jobs can face as much harm as those in unemployment because of lack of job satisfaction or prevalence of job insecurity. Merely having a job may not always protect their health. The social organisation of work, job security, job satisfaction, organisational culture and social relations in the workplace also matter for health. Women can face health problems due to other factors also, such as lack of sanitation, and unhygienic working and living environments. The health risk is higher in regions where unemployment is widespread. Unemployment tends to reduce life satisfaction and the general well-being of an individual. The health effects of unemployment are also linked to psychological consequences, and financial problems. Psychological problems such as depression, frustration, and worry can adversely affect one's mental state and may also result in suicide, or cause physical ailments such as cardiovascular and gastrointestinal problems. In this respect, social and working environments are considered one of the primary determinants of health that contribute to the social gradient in ill-health, but it varies according to time and place.

The spatial differences in terms of income and access to health care among rural population is a recently emerging issue. Studies done by Krishnaji and James (2002), and Krishna and Ananthpur (2013) have observed better health among villagers who reside in urban fringes than those in remote areas. This is because of the demand side factor such as lack of transport facilities, lack of time, the distance to the health facilities, and supply side factors such as absenteeism among health workers like ASHAs and ANMs. A study by Banerjee, *et al* (2013) has found high incidence of maternal mortality among young poor women from two villages of Godda district, Jharkhand because of over-dependence on informal practitioners, who are more easily accessible and available near their locality, and also because of delay in seeking proper medical care. Further, health care delays in multiple referrals at

different levels by health facilities, absence of easily accessible and quality emergency obstetric care, lack of transport facilities, and high cost seem to be the non-medical factors for high maternal mortality rate. Also maternity expenses are not usually covered by insurance. Dror (2006) states that universal health insurance, comprehensive health insurance and other state insurance programmes are usually for hospitalisation and for more costly treatments like surgery. These insurance programmes are less likely to be accessible for the poor. Though relatively cheap for the poor, they do not cover minor illnesses.

The above issue is very much evident when we look at a study carried out in Aligarh City (Khan, *et al* 2012), which reveals that the utilisation of health care services is lower even among the urban poor due to financial constraints, lack of time, waiting for a long time to get the required treatment, and the rude behaviour of health workers, para-professionals and professionals. These factors restrict them from obtaining treatment from trained health professionals. As a result, they follow their own informal health practices such as home remedies, and traditional and folk medicine. Illnesses were cured in some cases while in others the period of ill-health increased. At times, illnesses also remained untreated. However, in case there was a severe illness and they had to choose allopathic treatment, their personal expenditure for health care services increased considerably. This has been clearly shown in a study by Narayan, *et al* (2009). For example, when they go for treatment as an out-patient, they had to buy medicines outside the hospital because of lack of stock of free medicines; also, the utilisation of private health care is increasing even among the poor. If patients pay for their health care it results in a very high financial burden on poor families in case of severe illness. Poor health also keeps the poor in poverty, and among those who are not poor, a serious health shock can trigger a fall into poverty. As a result, a better health outcome does not come easily in India. In spite of the efforts by states, literature has shown a consistent disparity in health status among different social groups. The variations in health status are found not only between the rich and poor, or between the deprived groups and everyone else. The theory of the fundamental causes of health inequality developed by Phelan and Link (2010) implies that the efforts towards improving the health status of the population through interventions still leave behind individual risks due to an unequal social structure and other conditions. Various social conditions, individual choices and cultural variability are some of the causes behind most health disparities being neglected by the social gradient approach rather than education, employment and income.

The cultural dimensions of health and illness refer to the variability of the boundaries of health and illness, pluralism in health concepts, evaluative nature of illness and treatment (Scott and Marshall, 2009). Doyal argues (in Scambler and Higgs, 1998) that cultural variations regarding concepts of health and illness lead to differential health status among different social groups. Illness has more than one meaning due to the strong influence of cultural changes over time and space in a multi-cultural society. DeMello (2014) argues that these cultural variations of illness are explained by various theories of illness. Some cultures explain illness as being caused by external forces such as bacteria and virus, and this is called the 'naturalistic disease theory'. Others may believe that illness is caused by the disruption of the body's natural imbalance as explained by the 'disharmony theory'. For example, meeting with an accident while travelling. Some others may see the cause of illness as supernatural beings, and this is called the 'personalistic disease theory'. For example, a study by Mathur (2005) found that smallpox is

attributed to goddess Mariyamma by South Indians, and to 'Sitala' by North Indians. Similarly, an ethnographic study by Kannuri (2005) found that when several people died due to Japanese encephalitis and viral fever, the Koyas in Andhra Pradesh believed that an evil spirit had killed them; so they performed a pooja and wore amulets on the upper part of the arm as a preventive measure. Such blind beliefs seem to be more common among women across different social categories severely impacting their health. A study by Sujatha (2007) has shown that some people in Tamil Nadu diagnose the nature of illness on the basis of urine, stool, blood, semen, spits etc., and that they have good knowledge about folk medicine and use a combination of herbs, stems, roots and dietary specifications to promote health.

The variations in health culture, according to cultural theory, sometimes may be an advantage and sometimes a disadvantage for the health of different social groups (Keister and Southgate, 2012). The determining factors here centre around how they define illness; how they perceive and deal with it, and what steps they take, their healing practices, etc. This type of knowledge about where they are derived, how they are valued, and how they use it to diagnose the illness are most important to understand the illness in a particular cultural context. This process is entirely based on their perception. Russell (in Miah, 2006) said in his theory of perception that perception is a sensory process that enables us to obtain knowledge of health and illness from the social world and the self-experience of an individual in everyday life. This process is known as 'knowledge by description' and 'knowledge by acquaintance'. These two prominent elements play a major role in understanding the health experience of women. But acquaintance as a fundamental element of perception varies because sensory experience differs from acquaintance by providing knowledge of truth and knowledge acquired from the social world. Not surprisingly, as McDaniel (2013) says, this conceptual contrast between the objective and subjective views has drawn major criticisms on the ground that they fail to address the issues of illness and also that it is overestimated by medical professionals. Hence, the prevalence of morbidity among different social groups may not give a true picture because of the high influence of subjectivity.

To understand how subjective categories of differences begin, we need to examine the processes of constructing health and illness. Evidence shows that they are constructed on the basis of values and then transformed into social systems as customs and beliefs. In the process of illness construction, as the theory of social constructionism (Burr, 2015) argues, what we see is as real as the result of human interactions. So, we learn about these categories through social interactions and give or attach values and meanings linking these categories to our social institutions, peers and families. What we learn depends on the cultural domain in which we live, which determines what we experience in the social world. That is why Sen (2002) emphasises the need for scrutinising the statistics based on self-perception of illness by taking note of the level of education, availability of health facilities, information on illness and remedies within a given social context. In reality, even if one has a high level of education, one should have specific health knowledge. Even when one has such knowledge, it cannot be translated into practice as preventive, curative and promotive strategies due to the influence of gender relations because of the way it has been constructed in the private sphere.

In this regard, feminist thinkers (Agarwal, 2003; Krishnaraj, 2010; Swaminathan, 2014) have contributed much to the understanding of how a rigid system of socio-cultural processes and dynamics

of gender relations result in the unequal status of women. As Foucault (1994) argues, any social relationship evolves from a power structure. Power operates, for example, when men exercise their power over women, health practitioners over patients, and institutions over the way of life of the people. But, power also designates relationships between partners and influences how it operates in terms of health and illness at the household level. This equation is broadly termed as gender relations by feminists. They argue that gender relations arise out of the deep-rooted patriarchal societal attitude pervading the whole network of Indian society, which subordinates women in different contexts. It is defined by Agarwal (1994:51) "as the relations of power between men and women, in terms of a wide range of practices, ideas, and representations, including the division of labour, resources, abilities and behavioural patterns of men and women." These relations are often hierarchical in nature, and influence relations between individuals of the same sex as well within the household. As Foucault argues, moving one step beyond, one can view the relations of power not simply as plain oppression of the powerless by the powerful, but as a productive structure that brings about positive changes in human behaviour by disciplining them, subject to a certain code of conduct between individuals, groups and institutions.

The hypocrisy is that the society has already accepted women's mobility, education, and work but has not accepted the changing gender values. This mirrors the acceptance of tangible changes on the one hand, and on the other, reflects some aspects that have to do with culture, particularly relating to health, where there is still resistance. Obviously, weak health results in poor performance in routine activities and functions. Gender theorists (Walby, 2011) argue that mainstreaming of socially and economically marginalised groups can be done only through their own good performance, for which accommodating women's agency is extremely important where, at present, we are largely lagging behind. The point here is that only when they have sound health can it be translated into a productive asset; but even if their health is weak, many women end up doing hard manual work further depriving themselves of good health. This highlights the transition of traditional relations into a new social formation due to a paradigm shift from traditional to post-modern society, further exacerbating the situation. In this context, gender relations are crucial in the ill-health experience of women. There are no specific studies carried out on this aspect though a substantial amount of literature on gender addresses health seeking behaviour, violence, performance of health systems in delivery of service, the intersection of class, caste and gender in determining health, decision-making on reproductive health, and subordination of women.

## **VI. Discussion**

However, the studies draw attention to the social conditions that are more or less uniform across all the categories of people who live in a particular geographical and political region. But women are conditioned by norms and circumstances to react in particular way to a particular situation. For instance, women who are living in poverty face greater difficulties in the improvement of their health due to limitations of education, income, employment, social identities like caste, class and gender, the circumstances in which they are born and live, and the various systems within which they interact within the society. As Eapen (2004) stated, such difficulties would only worsen further when they also have to work more at home and work site, resulting in reduced consumption of nutritious food, less leisure, lack

of authority, and lack of access to resources. From the literature it would become clear that in the modern world, which puts considerable effort towards bringing about gender equality, the continued negative ill-health experiences of women are caused by a 'demand-supply' situation with the state and the household being parties to it. This is because of the continued societal attitude and practice of women being tied to the 'private' rather than the 'public' sphere, despite efforts being made to bring them into the 'open' in economic and political realms.

Keeping these issues in mind, we would need to give the following areas specific attention to understand the social reality. In particular, the most deprived are women living in a rigid system of cultural norms without any strong socio-economic background and therefore experiencing an extremely poor state of health. The disparity in ill-health varies between different caste and class groups as well. The gender bias is perpetuated by the gender relations both within the family structure and the society at large. When this relationship becomes conflictual and intersects with the other identities of women, it increases women's vulnerability to health risks and influences women's agency as well. However, the reality of experience is socially constructed by different people and varies across cultural contexts. The review paper emphasizes the socio-cultural dimensions of the health behaviour of women, in addition to various dimensions of gender relations, i.e., how they percolate to women's health at the household level and their perception towards gender relations. At the same time, as Krishnaraj (2010) suggested, the study should take the view of men as well to explore the reality from a broader gender perspective. This would capture the changing pattern of gender relations between agency and structure. It is also important to understand how women articulate gendered illness, and the prevailing health related beliefs and practices of women in various social groups. While addressing the health issue of women it is important to consider not just the present conditions, but also the future generations as well.

## **VII. Conclusions**

The studies discussed above have drawn our attention to the fact that customary norms place less value on women in addition to creating circumstances that do not promote measures for the betterment of women's health. Further, lack of health knowledge specific to the illness leads to multiple health beliefs and practices, most of which prove disadvantageous to their health. Since they follow multiple practices, traditional folk medicines are dominant in rural areas. This is because of the 'constructive' notion of cultural norms regarding women's body that shapes our understanding of health practices. As it is not uniform, huge variations are seen between cultural groups. For example, the traditional health practices among villagers in Tamil society tend to promote health while among Koya tribes of Andhra Pradesh such practices tend to prove disadvantageous to improving their health. Also, variations in perception often conflict with professional systems. As suggested, we can scrutinize the variations of self-perception in the context of the personal traits of individuals and health facilities. High level of education, to be of advantage, would demand specific health knowledge. And even if one has such knowledge it cannot be put into practice easily due to inescapable norms, roles and responsibilities. In a relational context, the different forms of gender constructs are culture specific, contribute to health risks and create a larger impact on social structure. Thus, it is clear that the literature has not given much attention to exploring the socio-cultural dimensions of the ill-health experience of women from a gender

perspective. Particularly, the changing processes of gender relations between the sexes and within the same sex and how they affect the health of women in the current scenario have not been explored. In an interactive process, the way in which men and women interact with each other, how women perceive gender relations, recognition of agency, negotiation with the social structure, and gender performance are most significant. These aspects need greater attention with specific reference to inter-caste disparity in the budding literature on women in the context of their ill-health.

## End Notes

1. Kleinman (in Filho, 2001) situate illness in the domain of language as social constructs which explains the way sick individuals perceive, express, and deal with the process of becoming ill. It is part of the cultural system that constitutes human experience and that can be understood through mutual relations.
2. The disruption of the normal functions of the human body due to external factors and that affects their routine life denoted as ill-health. Such subjective experience known as ill-health experience and also termed as illness with a specific name once it is identified or diagnosed.
3. Morbidity = number of ailing persons/total number of persons alive in the sample households x 1000.
4. The communicable diseases are tuberculosis, leprosy; vector-borne diseases - malaria, kala-azar, dengue fever, chikungunya, filaria, Japanese encephalitis; water-borne diseases - cholera, diarrhoeal diseases, viral hepatitis A & E, typhoid fever etc.; zoonotic diseases - rabies, plague, leptospirosis, anthrax, brucellosis, salmonellosis etc.; and vaccine preventable diseases - measles, diphtheria, tetanus, pertussis, poliomyelitis, viral hepatitis B etc. that are seen in the country. In addition to these endemic diseases, there is always a threat of new emerging infectious diseases like nipah virus, avian influenza, SARS, pandemic H1N1 influenza, hanta virus etc. The outbreak of these diseases can't result in an adverse impact on health and morbidity levels.
5. Non-communicable diseases are cardiovascular diseases, cancer, diabetes, and chronic obstructive lung disease.
6. According to Kleinman (in Filho, 2001:757) disease refers to "alterations or dysfunction in biological processes."
7. World Health Organisation (in Ghosh and Arockiasamy, 2009:139) defines "prevalence rate as the ratio between the number of spells of ailment suffered at any time during the reference period and the population exposed to risk."
8. Household monthly consumer expenditure /household size = MPCE (National Sample Survey Organisation, 2011).
9. Ghosh and Arockiasamy (2009:139) viewed morbidity as composed broadly of acute and chronic types. Ailments of less than 30 days' duration are treated as 'acute' and those of more than 30 days' duration as 'chronic.'

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