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Cultural Dimension of Women's Health across Social Groups in Chennai

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CULTURAL DIMENSION OF WOMEN'S HEALTH ACROSS SOCIAL GROUPS IN CHENNAI

Annapuranam K∗ and Anand Inbanathan∗∗

Abstract

Illness and related problems are major issues for a substantial part of India's population, at any time. Comparatively, women appear to have more health problems than men, and this continues to increase across regions in the country. Variations occur to a considerable extent due to their conditions of life. Poorer people are not only more vulnerable to illnesses, but they suffer more often from illnesses, and also have more of related problems of economic wherewithal to support themselves when they are ill. The health belief model has been used to understand the perceptions of health, and health behaviour among women. 75 married women were interviewed, 43 from poor families, and 32 from middle class families, during June to October 2015 in Chennai. These women, by and large, had a weak perception of their illnesses, in the sense that they did not think they needed immediate health care. This also resulted in a longer time that they remained sick.

Key words: *women, illness, belief, behaviour, poverty*

Introduction

Culture as one of the social forces influencing many aspects of women's lives is embedded in the social structure, which in turn, is governed by social institutions. It is reinforced through social interactions that shape knowledge, beliefs, practices, capabilities, and behaviour of women at each stage of their life. In fact, the cultural landscape is central to understanding any particular aspect of women's lives, as it reflects the societal life as a whole. In reality, although women are expected to live longer than men, poor women are more vulnerable to health risks as compared to women in affluent sections of the society (Ramachandran *et al* 2002; Kawachi *et al* 2002) due to various factors, of which culture is considered the most significant factor. In particular, health related beliefs are more responsible for women's health promotive behaviour. From a global perspective, Karim *et al* (2011) noted that the prevalence of tuberculosis is perceived among rural Bangladeshi communities as due to sharing of beds, sexual intercourse, and hard work. For Circassian, an ethnic group which is not socially active in Israel, with a strong faith in Islam (in Haron *et al* 2004),and also among Saudi Arabian Primary Care Patients, supernatural beings, devils, sorcery and emotions are the important sources of illness (Alqahtani and Salmontha 2008). Studies, however, have found that such perceptions are unable to explain the causal relationships between peoples' perceptions and the severity of various illnesses.

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In India, Koya tribes in Andhra Pradesh attribute illnesses to supernatural beings (Kannuri 2005). Women from South India do not perceive that they are at risk of HIV (Rogers *et al* 2006). In Delhi, patients believe that cancer is due to karma and supernatural beings (Kishore *et al* 2007; Awasthi and Mishra 2010). Cervical cancer is attributed to inherited factors, as it is difficult to conceptualize the symptoms associated with the discharge of blood (Dein 2004). Women of Tamil Nadu believe that if one eats the best and most nutritious food, but does not work enough, the eaten food would be the underlying cause of illnesses (Sujatha 2002). These perceptions make them follow either the advice and instructions of professional health care givers, or non-professionals. Even if health services are available, many do not seek treatment for all illnesses due to various cultural constraints. This, in turn, can have a greater impact on the socioeconomic conditions of families (Sundar and Sharma 2002). Most of the studies have not given much attention to the transition of health beliefs to practices in terms of the factors which affect the health promotive behaviour of women.

The National Sample Survey Organization (2014) data have shown that the proportion of illnesses continues to increase across regions in the country. The illness rate significantly increased from 54 persons in 1996 to 91 persons in 2004 and further to 103 (per 1,000 persons) in 2014 for the country as a whole. The proportion of ailing persons reporting among women at any time during a 15-day reference period from all the age groups has increased from 57, 93 and 99 persons in rural areas (per 1000 persons), and in urban areas the corresponding numbers were 58, 108 and 135 persons respectively (per 1000 persons). In the case of men, the increase was from 54, 83 and 80 in rural areas and 51, 91 and 101 persons in urban areas. The illness rate among the male and female population is higher in urban areas than in rural areas. In this context, the main aim of the present paper is to understand health beliefs related to various illnesses, and health practices that are prevalent among women across income groups. This exercise also draws attention to the factors that tend to affect their health promoting behaviors. It would help us to understand the variations in their perceptions and the social reality grounded in them. The results are confined to the study groups only.

Theoretical Construct

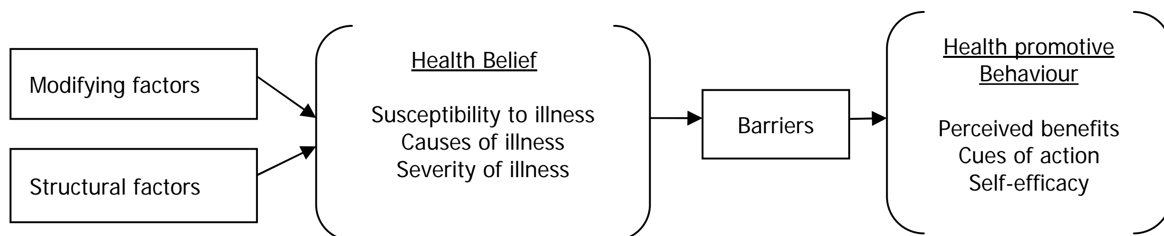
The terms 'illness', 'sickness' and 'morbidity' are often used interchangeably. In this study, 'illness' appears because it is commonly used by women in their day-to-day lives. Illnesses are considered as subjective experiences, suffered over a considerable time period, which cause pain, require a fairly regular kind of medication with a potential effect on their regular activities, and the circumstances that make them act on the condition of illness and their ability to recall the entire process. The National Sample Survey Organisation (2014) defines illness as any form of deviation from the state of physical well-being and is calculated as the number of ailing persons out of the total number of persons alive in the sample households x 1000. Kleinman *et al* (1978) situate illness in the domain of language as a social construct, which explains the way sick individuals perceive, experience, and deal with the process of becoming ill. It is a part of the cultural system that constitutes human experience, and can be understood through mutual social relations. As an abstract phenomenon, it is dealt with by more than one theory, in which health belief model is widely used for understanding the perception of people towards illness and behaviour. The belief generally refers to an individual merely accepting something

as being true. As such, every individual has his/her own beliefs about what causes illness, the severity of illnesses, therapeutic options, and evaluation of treatment.

Health belief arises out of perceptions, which are sensory experiences of illness by an individual, which is not only dependent on physical stimuli, but also stimuli in relation to the surroundings of the world. They give meanings based on a person's previous experience, beliefs, expectations, attitudes and personality (Sobti 2001; Russell 2009). It enables an individual to behave in a particular way that differs based on the situation. Health behaviour can be understood by comparing their situation or the condition in which they live. Each behaviour has its own meaning attached to it. This has been explicitly discussed in the health belief model (Taylor *et al* 2007) developed by Godfrey Hochbaum, Irwin Rosen Stock and Stephen Kegels in 1950, and updated in the 1980s. This model mainly focuses on six constructs: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues of action and self-efficacy in the promotion of health.

The study illustrates the transition of health beliefs into practices using this model (see figure 1). Redding *et al* (2000) and Taylor *et al* (2007) describe each component as follows. *Perceived susceptibility* is an individual's assessment of the chances of getting exposed to illness or vulnerability to the risk of illness. *Perceived severity* of illness is how an individual perceives the seriousness of illness, and its consequences. *Perceived barriers* mean an individual identifies the obstacles while taking health action in terms of reducing the severity of illness or threat to health.

Figure 1: Transition of Health Beliefs into Practices



Source: Health Belief Model – Taylor *et al* (2007).

The obstacles prevent the adoption of health promoting behaviour. It reflects the negative aspects of an individual, and how an individual can overcome those barriers. In this process, the *modifying factors* are age, sex, education, and occupation. These factors are more likely to be intertwined with the structural factors that include health knowledge and earlier experiences, which in turn, either directly or indirectly influence health beliefs, barriers and behaviour. *Perceived benefits* are the perception of a positive outcome of individuals' action to reduce health risks and what motivates an individual to exhibit a certain kind of behaviour or to adopt a treatment. *Cues of Action* explain the possible consistent action that promotes an individual to continue to engage in health promoting behaviour. It could be either *internal cues* (physical symptoms) *or external cues* (family members, health system or media), and *self-efficacy* which is the confidence in their own ability to follow a

suggested behaviour. It would be more capable of bringing about positive changes in improving health behaviour.

This model is designed to explain how individuals can prevent illness through their perceptions, but here the model is reconstructed, factoring in not only perceptions, but also health promotive behaviour, even if they fall ill. Redding *et al* (2000) claim that both perceived susceptibility and severity help an individual to understand the vulnerability to illness, while perceived causes of illness are a missing aspect that has been added. The study argues that if women have a correct perception regarding their susceptibility to illness, it helps them to take preventive actions. Further, they can get an idea of the severity of illness and its consequences, for which it requires a specific knowledge of health. In this respect, Taylor *et al* (2007) observe that if we want to take preventive actions one should have the knowledge of illness as well as how to prevent it, in respect of which many are lagging behind. They may perceive the *benefits of taking preventive actions* as avoiding illness, which would be viewed as greater than *the perceived threat of illness*. This is because it would make them more likely to engage in risk reduction behaviour. On the other hand, these perceptions are influenced by their physical, social, economic, and cultural conditions in which they are born and live. Individuals wanting to modify their behaviour are more likely to feel constrained due to various socio-cultural conditions, which do not allow them to take any kind of action. Those barriers are viewed more negatively than the consequences of illness. However, it is important to observe the cultural landscape, which shapes their perceptions and provides space for a health promotive behaviour. In this process, it is imperative to understand their perceptions regarding illness, health-seeking practices, the factors that deprive them of a health promotive behavior, and its implications in the contemporary society.

Methods and Data

The data were gathered from Chennai city between June and October 2015. As part of a qualitative study, there were interactions with residents of a medical camp, prayer assemblies, and in school meetings, a night shelter home, and a municipal council office. As the first author was able to speak in the local language it enabled her to closely interact with school teachers, shelter home caretakers, municipal councillors and staff, *anganwadi* workers, and urban auxiliary midwives, for a better understanding of the lives of local residents. The daily formal and informal interactions enabled her to collect data through flexibly structured interviews with open-ended questions, and at the household level. The in-depth interviews were conducted with 43 women from poor families and 32 women from the middle class. The respondents were selected purposively based on the criteria of poverty, marital status, and caste, in order to capture each one's perceptions and to make a comparison across social groups. Those married and living with their husbands were chosen purposively because evidence shows that those married are more vulnerable to health risks, restricted as they have been by gender norms and the social structure (Bottorff, *et al* 2011).

Considering ethical issues[1], each interview was conducted with the informed consent of women, to whom the purpose of the study was explained. While the questions were related to their personal lives, the identities of the women, as well as all the collected information were kept confidential, and used only for the study. Each interview started with the persons who the first author

had interacted with earlier, and the interview went on for nearly an hour. The perceptions regarding illness, health promoting behavior, and challenges, which were then interpreted, mostly relied on qualitative information. The qualitative method was adopted because of the nature of the theme, and this method is more flexible, and provides rich and detailed information (Braun and Clarke 2006). The issues highlighted here were based on responses gathered during the fieldwork. From the voice transcription, there were two main themes to be analysed in relation to the objective: perceptions regarding illness, and health promotive behaviour with various sub-themes. Each theme was defined and interpreted based on the observed patterns and relationships.

Study Area

The available data with the National Sample Survey Organisation (2014) show that Tamil Nadu is one of the states experiencing a steady increase in the proportion of persons who were ill in a particular period of time. The proportion of ailing persons among men of all age groups has increased from 86 out of 1000 persons in 2004 to 133 persons in 2014 in rural areas, and in urban areas the corresponding number went up from 87 to 148 persons per 1000 persons. In the case of women, the increase was from 103 to 158 persons per 1000 persons in the rural areas, and 106 to 221 persons per 1000 persons in the urban areas respectively. Evidence shows that reported illnesses were relatively high in urban areas, and more among the poor than the middle class, or in rural areas. In the city of Chennai (also Tamil Nadu's capital), the proportion of the poor is increasing as compared to other parts of Tamil Nadu. The concentration of poor is for obvious reasons higher in the slums than in non-slum areas of the city. Out of the total city population, 27.11 per cent lives in slums (Census of India 2011). These slums are located near riverbanks, railway lines, drains and open places. The residents of these slums are prone to severe health problems, and face poor living conditions (Unite for Sight 2013). While Chennai is endowed with several institutional health facilities, the health status of the poor in slums remains vulnerable. One of the two areas identified for this study is Rajarathinam Nagar located in Kodungaiyur ward-37, in the northern part of Chennai. It is a low-income colony consisting of more than 7,000 people, comprising 1,500 households (A Fact Finding Report 2007), of which the observed results show that 83 per cent live in independent houses, and 17 per cent in tenement houses. They are *pucca* and *semi-pucca* houses with a few *kutcha* houses[2] without toilet facilities. Of the total population, 66 per cent belong to the Scheduled Castes and 34 per cent belong to the middle and upper caste groups. The religious composition indicates that 92 per cent are Hindus, 5 per cent are Christians, and 3 per cent are Muslims[3].

Rajarathinam Nagar was selected because the majority of families is below the poverty line, with the residents being even more susceptible to illness due to the presence of a dump yard. The dump yard, which is more than 300 acres across, is situated opposite the slum, surrounded by highly polluted canals and a drain. Apart from the precarious condition of the slum, there is also the problem of insufficient water supply while the household sewage lines are mostly open despite being connected to the main outlet. In this condition, women are the most deprived of basic needs, and they continue to remain socially and culturally marginalized. Social forces have kept them outside the mainstream of productive and socially reproductive activities, such as the production of goods and services. They are

also restricted by their own characteristics like social location, behaviour and lack of self-motivation towards changing their condition. However, despite the fact that women are more vulnerable, dependent, and with a lower quality of life, they are always concerned with family commitments and others' well-being.

The second place in Chennai that was selected for this study, Krishnamoorthy Nagar, is where middle class families live, and is located close to the slum settlement (Rajarathinam Nagar). These families live in *pucca* houses, maintain a comparatively high standard of living, each house is linked to the corporation water supply, has its own toilet facilities, the colony has a good infrastructure and a residents' association. The status of women in terms of education, employment, and income is better than that of the economically poor women. They both enjoy an advantage in terms of proximity to hospitals, better transportation, educational institutions, employment opportunities and commercial shops, but the actual use of these facilities is much less among the poor. Only a few poor households utilize these facilities due to personal and social constraints and their poverty. These two social groups live in extremely unequal social conditions within the city, and at the start of the study, we had assumed that these conditions would shape their health perceptions and health promotive behaviour.

Socio-Economic Status of Women

The characteristics of the study groups enable us to understand their condition, on the assumption that it would bring to the fore differences and similarities in these study groups. The caste composition of the respondents is 59 per cent from non-Scheduled Castes (43 per cent poor, and 57 per cent middle class), and 41 per cent of them from Scheduled Castes (77 per cent poor, and 33 per cent middle class). The mean age of the women in the study, and belonging to poor families is 33 years, and for the middle class it is 41 years. The mean age at marriage is 20 years and 23 years, and the average family size is 4.7 persons and 4.2 persons respectively. The family size is viewed as one of the determining factors of health behaviour in terms of resource allocation. The poor perceive that it is difficult for them to manage their family expenses with a low income, and an income that is also not regular. They manage with an average monthly income of Rs 7,349, and the middle class does so with Rs 40,421 per family. There exists a wide range of income disparities across groups. The economic activity of poor women is relatively higher (51 per cent), and they earn low wages from the informal sector as daily wage labourers, domestic workers, rag pickers and vendors. Their concentration in the informal sector is due to the lack of education, and lack of skills. There is also a significant proportion of the poor women whose husbands do not allow them to go to work. There are a few illiterate women (26 per cent), and many others have stopped with school education (74 per cent).

The economic activity of middle class women is relatively lower (44 per cent), but their economic contribution, which means their income contribution to their family is relatively higher than that of the poorer section i.e. from those who are employed. A majority of them are graduates (56 per cent) but many have stopped with high school education (44 per cent). Most of the graduates work in the formal sector as teachers, software engineers, clerks and police, with the Tamil Nadu government, who have the possibility of availing social security benefits. Some of the women work in the informal sector as sales women, in clerical jobs, and their own business such as textile shops, and an ice cream

shop, earning a moderately good income. A few are not working despite being graduates. The higher family income also determines their status, besides influencing other spheres of life such as the intake of food, and health care. Most of the middle-class women in this study are homemakers (56 per cent).

Perceived Illness

Russell (2009) and Sobti's (2001) view of perception is how we see the world around us. Perception as a sensory process enables us to obtain knowledge from the social world, and self-experience in everyday life, known as 'knowledge by description' and 'knowledge by acquaintance' respectively. The paradox between acquaintance and sense experience of illness is a basic issue in health behavior. In the context of health, the subjective experience of women in relation to illness and their existential condition is viewed as perception. Purola (1972) classified perception into two broad categories: i) the medical reality explicitly investigates each disease's characteristics, causes, diagnosis, disease condition, history, prognosis and appropriate treatment. These explanations are referred to as 'medical morbidity.' ii) the pathology of bodily processes, if they are explained by individuals, is referred to as 'perceived morbidity.' The present study considers illnesses as based on their own experiences, which cause pain, which requires a fairly regular medication, the length of suffering, potential effect on routine activities, the circumstances that make them react to it, and the recuperation process that they can recall.

Perceived Susceptibility to Illness

This section deals with the perception of women about their susceptibility to illness. The poor are often the victims of respiratory problems, tuberculosis, and fever. They also perceive that they are at risk of illness due to the presence of a garbage dump yard near their colony. Often waste matter is burnt during winter, sometimes fog and smoke emanating from the burning lead to road accidents. The women also remarked that those infected with tuberculosis sometimes look normal but many are thin in appearance. Informal interactions reveal that a resident's husband who worked as a construction labourer died due to tuberculosis. Because of social taboos around tuberculosis, many do not want to divulge details about their illness. They think it is not only contagious, but people keep to a distance from those with this disease, avoid touching each other, and do not share any material things. During the rainy season, fever and cold are very common. The lack of a proper drainage system, and the absence of cleanliness, lead to the formation of sludge. Sludge often leads to the breeding of mosquitoes and contamination of the supply of corporation water. Due to these, some of the residents suffer from typhoid, dengue, chikungunya and urinary infections.

Women perceive that the lack of proper drainage, absence of cleanliness, highly polluted environment, and contaminated drinking water make them fall ill often. Since they are connected to the public system, women are not in a position to take preventive measures, though they aware of the need for preventive measures. The municipal authorities are expected to ensure that the system functions effectively to protect the health of the people. A councillor (member of a local body) says that office bearers are making efforts to control the spread of mosquitoes by spraying mosquito anti-larva oil on wastewater wherever it has accumulated, with one labourer deployed for 80 houses to carry out this task. For protected water supply, they use bleaching powder, lime powder, and spray di-chloral wash

regularly, and they often check the PH value before supplying water to residents, in addition to organizing awareness programmes at schools. In the event of an outbreak of any disease, the system provides immediate health service. If all this was being done, the incidence of illness found among women should also have been reduced, but the study shows contradictory results, with a higher proportion of the poor women falling ill (93 per cent) than the middle class (72 per cent), in the past one year. In this context, the women of the middle-class do not perceive that they are vulnerable to illness, in view of their relatively comfortable life, while nearly half the poor women stated that they face a high risk of illness, whatever be the actual form that this illness takes.

Perceived Causes of Illness

As soon as they fall ill, they try to identify an illness based on the symptoms. They go on to find reasons through their own experience, or when they go to doctors for treatment, for which multiple explanations are given with several meanings attached to a particular illness. However, these are not uniform, and vary from person to person, and these perceptional variations result in their actions towards illnesses. When it is a challenge for health professionals to establish clear connections between illnesses and their causes, women have perceived them through their subjective experiences. The perception of women has divided itself into two groups – class[4] and caste[5]. i) the class-based perceptions are listed in table 1. It explains that the poor women often tend to locate illness related to the present social landscape, i.e., the environment they live in, food habits, work they do, heredity, water, climatic conditions and infections. A difference was observed only in the case of a member of one poor family, who suffered with fever, and this was attributed to supernatural beings. In the case of the middle class, they attribute illness to diet, climate, heredity, polluted environment, and disruptions of the body. However, no greater class variations have been observed. In a disharmony system, it means sudden deviations are found in the normal functions of the body. Injury is viewed here as a disruption of the body's natural balance, occurring due to unexpected accidents, or intended violent behaviour of the spouse—causing injuries to the woman's body (in one case, teeth were broken), which has been observed to be comparatively common among poor families.

Many of the causal constructs are not directly connected to the systematic terms of naturalistic disease theory in terms of virus, bacteria, or imbalance of bodily elements, and to modern medical science, but are explained as being the result of natural forces and social conditions such as an unpleasant environment, imbalanced diet, cold, heat, and weather. Thus, therapeutic interventions identify causes of illness through clinical trials, but as many poor women observed, they did not acquire any such knowledge when they were under medication, except for uterus related issues. The uterus related ailments, kidney problems, and thyroid problems do not show symptoms until they become severe. Finally, out of six uterus cases, (two belong to poor families and four to the middle class) what is striking is that they had all undergone hysterectomy when they were less than 40 years old. Due to the reasons of fibroid, flesh growth, prolepses, and cervical issues, which were a symptomatic in nature, two women had abdominal pain and bleeding for a few months. Whether, or why, there was a definite requirement for a surgery was never explained to the poorer women patients, and they could easily fall prey to unscrupulous doctors whose sole aim was to increase their income. Especially the poorer

women, they tried to relate the causal factors to the perceived knowledge of bodily experience and advice of medical professionals. In the case of the middle class, many of them relied on private clinics, and were also able to access a detailed information of their own health.

Table 1: Perceived Causes of Illness according to Women at RRN and KMN, Chennai

Type of Illness	Poor	Middle class
Fever	Head bath, mosquitoes, scared	Cold, climate, dust, water
Jaundice	Body weakness	Do not know reason
Skin issue	Gas trouble	Air conditioner
Diabetes	Do not know reason, hereditary	Hereditary, depression
Thyroid	Work load, head bath	Dust, cold, white blood cells
Hypertension	Tension, work load	Nil
Joint pains	Over work, walk, weak	Weak, bone depreciation
Injury	During rain, fell down	Do not know reason
Teeth issue	Ate sweets, fought, wet	Nil
Ulcer	No proper food	Nil
Epilepsy	Over work related to water use, washing	Nil
Heart issue	Hereditary, tension	Nil
Stomach ailments	Lack of food, water, heat	Don't know reason
Anaemia	Work in dump yard	Nil
Migraine	Nil	Tension and unhappiness
Piles /Gallbladder	Nil	Heat body
Kidney issue	Nil	Anaemia, weakness, diet
Uterus	Asymptomatic nature	Body weakness
Asthma	Smoke, work, mosquitoes	Nil
Tuberculosis	Infection	Nil

Source: The information was drawn from the in-depth interviews conducted with women during June-October 2015

The perceived causal differences are because of two scenarios; one is, symptoms vary widely for the same illness, and the second is, similar symptoms for many illnesses. For example, headache, tiredness, and giddiness are common symptoms for illnesses such as migraine, menstrual issue, diabetes, uterus-related ailments and fever. These are extremely complex and perplexing variations in symptoms and are possibly responsible for discrepancies in identifying causes of illness. A Scheduled Caste woman, age 36, and was a domestic worker, narrated her experience:

> "I have ulcer and a diabetes problem. I did not know that these were tiring me. I often had giddiness and back pain as well. I did not get time to go to the hospital. This went on for five months. Later, I approached Sathiya Sai Trust, which organizes a monthly medical camp in our locality. I underwent various tests before I came to

> know of diabetes, but tests did not diagnose ulcer. Then onwards, I started taking tablets without following a proper diet, and ended up with severe ulcer. I thought it was due to the regular intake of diabetes medicine, that it was over-dose, and caused severe stomachache. I was not aware that I had ulcer until the doctor diagnosed it during a subsequent visit to collect tablets for diabetes. This is due to the lack of a proper diet because I cannot afford to prepare two food items, and cannot even spend time for cooking. My husband wants only rice, and if it is not ready as he asked, we end up with a fight."

However, the causes of illnesses connected to immediate events and surroundings indicate a similarity between the classes.

Perceived Severity of Illness

In general, the construct of the severity of illness is what they perceive out of their physical discomfort. After falling ill, if they perceive it as severe, because of the pain, it would push them to go to a hospital. There are many cases where they had a wrong perception of the symptoms as indicating illnesses which were not serious, such as skin related disorders, thyroid, asthma, anaemia, uterus and kidney ailments among poor women. In the case of middle class women, fever, uterus problems, piles and joint pain are not perceived as serious, though they may be at a real risk if these were left unattended. Symptoms such as wheezing, headache, stomach ache, bleeding, white discharge are not perceived as alarming, and they ignore such symptoms whenever they appear. When they experience some severity, they take tablets on their own without consulting any physician. Such practices are widely visible among both the income groups, which lead to negative health outcomes, either as acute or chronic illness. One of the scheduled caste poor woman, 40 years old, and had completed primary school education, who situates this issue as follows:

> "I pick up some recycle materials from the dump yard. Since I married him (husband) as his second wife at the age of 13, there is a 20 year difference between us. I had wheezing problem for many years, which severely disturbed my sleep. I raised this issue to my husband, but he did not show any concern. I took some tablets and cough syrup on my own for a long time. Three years ago, when I took a test at a medical camp held in my locality I found that I had asthma and started taking medicines, but the doctor advised me to stop rag picking, which is not possible as it is for my survival, and I do not want to depend on my husband who has become aged. Now, it has turned into tuberculosis" [that is the way she thought her illness had developed].

The present study results support the view of Prasad *et al* (2005) who said that people do not even think that symptoms are severe or serious enough to seek treatment, due to the lack of knowledge/awareness. The present study found that 56 per cent of the respondents generally perceived their symptoms as being in an early stage, and the poor had such a view to a higher extent (63 per cent), compared to middle class women (37 per cent). Those who thought their illness was of moderate

severity were 27 per cent, in which many are from middle class (76 per cent) as compared to poor women (24 per cent). The remaining had the illness identified when it was severe (17 per cent), in which a difference was observed between the poor (45 per cent) and middle-class women (55 per cent).

The result shows that many women have perceived symptoms as being at an early stage, regardless of their class status, but the poor women hardly gave any attention to the illness unless the physical pain became unbearable. If they are not able to carry out their regular activities in their daily lives, only then did they think of taking any health care action, as compared to the middle class. The moderate cases are identified with those who are able to carry out only a few routine activities when they were ill. In this context, domestic worker, 26 years old, and had completed secondary school education stated that,

> "I was suffering from fever. I did not go for paid work, but confined myself to household activities, for which there was no substitute at home. I thought of taking rest from regular paid work and self-medication for getting cured from fever. It did not work, and when it became severe I was unable to do any work at home, and then I went to the government hospital alone, located one kilometer away."

Those identified with a specific illness at a severe stage because of the asymptomatic nature of illness, and unexpected severity of the physical symptoms are characterized as not being able to do any activity, and need self-care support. For example, a woman, 23 years old, who was a domestic worker said, "I had severe stomach ache when I was engaged in household activity. I sat holding my belly, and on seeing this the employer admitted me in one of the private hospitals nearby, and I came to know it was ulcer that had caused the pain."

In the caste groups, as mentioned earlier, 56 per cent of the respondents perceived illness as mild, in which a marginal difference was observed between the non-Scheduled Caste (49 per cent) and Scheduled Caste (51 per cent). Those perceived as moderate is 27 per cent, in which the caste difference indicates variation between non-scheduled caste (76 per cent) and scheduled caste (24 per cent) and 17 per cent perceived their illness as severe, in which non-Scheduled Castes constitute slightly higher (55 per cent) as compared to Scheduled Castes (45 per cent). The observed ailments such as jaundice, heart ailments, kidney problems, tuberculosis, and severe accidents are perceived as serious because they pose a threat to life. In the case of heart attack, severe pain (*maarbunovu-chest pain*) drew an immediate attention from others, as the situation warranted medical treatment. Similarly, in the case of epilepsy, a sudden attack made the person lose consciousness, with uncontrolled body fibrillation and falling down, that could cause serious injuries. Nothing can be done if an illness is asymptomatic in nature—either by the medical field or by the women. The public health system can ensure that they go for a comprehensive health check-up, which is almost completely absent in both the income groups. The health services by and large provide only curative health care with no attention paid to any awareness programme, preventive care, and health promotive care.

Health Promotive Behaviour

The term "health promotion" was first used in 1945 by the medical historian Henry E. Sigerist from Switzerland, and he stated that 'health is promoted by providing a decent standard of living, good labour conditions, education, physical culture, means of rest and recreation' (in Terris 1992: 268). It is a coordinated effort of the system, associated with an individual's life. There are many health-related parameters, but the present study has considered only preventive action, curative action, treatment behaviour and self-efficacy. Each component covers many factors, but here, only a few factors have been considered, which have not received much attention as yet.

Perceived Benefits

The present section deals with the perception of positive outcomes of actions taken by women towards reducing health risks (prevention), and what motivates them to exhibit a certain kind of behaviour or to adopt any treatment. Prevention is an action taken to avoid the occurrence of illness. In this respect, the study includes the use of mosquito repellent, and screening tests as part of exploring how women perceive these preventive measures. None of them uses a mosquito net, which is safer and relatively inexpensive too. In the modern world, many poor families use coils and cream (70 per cent) as they are not perceived as expensive, though some (30 per cent) have been unable to afford them. In their view, mosquito coils and cream are effective in controlling mosquitoes, but they also trigger side effects such as respiratory problems due to inhaling the fumes (mosquito coils). However, they also said that they are unable to stop using them as there is no other choice. Observation reveals that in two cases, residents were severely affected by elephantiasis, which local people termed as 'elephant leg'. In both cases, they perceived this as an outcome of mosquito bites. The narrow space between two streets, filled with garbage and stagnant wastewater, acts as a breeding ground for mosquitoes. The stagnation of water in and around the public water tap, and blockage of drains, in addition to the dump yard, further add to the problem. Such health problems are evident when we look at the issue faced by Sasi, 21 years old, who had completed primary education, and was working as a rag picker. She is from the Naicker caste, and is the mother of a six-month-old baby. She is married to a Scheduled Caste man who does cremation work, and fishing.

> "I often suffered due to fever. It may be because of collecting recycled waste from the dump yard, which is highly polluted. I also take a head bath daily using corporation water, which is also sometimes contaminated. There are lots of mosquitoes in my locality, which cannot be controlled despite the use of coils."

In the case of the middle class, many put wire mesh across the windows (53 per cent), and use mosquito liquid repellent (47 per cent) which they considered relatively less harmful than coils, despite being expensive, while some of them use both. However, poor women who are ill can approach the Sathiya Sai Trust, which conducts medical camps every month for the slum dwellers. In particular, those who are diabetic are able to get their monthly medicines free of cost. They view the Trust as easily accessible, responsive, and cost effective, besides saving time, and working hours. They do not have the practice of going for any general health check-up unless they fall ill. This attitude is not only

widespread among the poor, but is found among the middle class as well. While the cost of treatment is of major concern for the women who are poor, even if medical tests are available free of cost, the lack of interest, and time constraints, are important factors in discouraging them from going for such tests. And the middle-class women nurture the feeling that their bodies function well, and they don't need the tests at all.

Poorer women tend to pay attention to their health only when they fall ill. They look at curative care as a healing process of their illness. Curative care addresses major issues related to treatment, i.e., place of treatment, and delay in taking treatment. About 45 per cent of the poor women were found to have been treated at private hospitals, and 55 per cent in government hospitals. The corresponding figures for the middle class are 70 per cent, and 30 per cent respectively. However, although poorer women find it difficult in spending money on health, if they were income earners, they were likely to go to a private hospital. Their perception was that in going to a private hospital they would get well sooner, they can discuss in detail their health condition and diagnosis with the doctors, there was less of a need to wait for long hours, routine work was not disturbed, and they can meet the doctor at their convenient time.

The public health care system is the only option for those who cannot afford treatment at private hospitals. In this condition, many do not reveal any illness to their spouse due to various socio-cultural constraints. Among the poor women, 57.5 per cent revealed their illness immediately to their spouse, and the other 42.5 per cent of the respondents claimed they had good reason for the delay, until the illnesses became severe. The main reasons are that their spouses become tensed, there is income loss, or they were unsure about their husbands' reactions due to the alcohol habit, violent behaviour, prior experience of unfavourable responses from their husbands, their concern for household chores and child care. The other reasons are when they have menstrual issues and ailments in the private parts that restrict their inclination to talk about them. It indicates that talking about their illnesses as soon as they are identified (by themselves), depends on the traits of their husbands, gender roles, gendered illnesses, and existing social conditions.

The condition of poverty forces women, particularly housewives, to think of spousal income as more important than their own health. This is also one of the reasons for their reliance on self-medication in the initial stages. When it becomes severe, women take allopathic treatment, in relation to which, half of them relied on private health services despite their poverty. They also experienced time constraints since out-patient services in government hospitals were available only in the morning hours, which involved long hours of waiting, and even if they managed to avail such services, the poor quality of treatment often meant that they did not recover in any reasonably short time. It shows that they are unable to access higher quality treatment at the time of need. Besides these, government hospitals did not discuss their patient's test reports, and diagnosis, or even properly tell them what they should do, although women would like to know all these details. Private hospitals and clinics were more forthcoming with such details.

In the context of ailments, a sufferer is entitled to know about what it is, how one can discern the symptoms, how the ailment affects the body, what could be the possible remedy, and how to prevent such things in future. They perceived it helps them to know the condition of their body, based

on which they can mobilize resources for speedy recovery, acquire knowledge to articulate their health needs, and make treatment choices accordingly. It indicates that the agency of women is often not recognized, including their awareness of their own health condition and health care. In the middle class, many (74 per cent) were found to have revealed their illness while a few (26 per cent) delayed informing their spouses in the early stage of their illness, as they had not considered it as a serious one, or, not to disturb spouse, or because of self-medication. Husbands usually accompanied them (middle class women) to the hospital, besides bearing medical expenses, but such support was not often in the case of the poor.

Cues to Action

What could encourage women to continue to engage in health promotive behavior? It could be either *internal cues* (physical symptoms), or *external cues* (family members, health care providers or media). The poorer women generally visit a hospital only once, when the severity of the illness is high. Many did not go back for any second visit, and family members also did not show any concern for their health. If there is a relapse, or the health problem returns with the same symptoms, they get medicines from shops and by using the earlier prescription. For example, a poor woman, 21-years-old, and had completed her primary education, was working as a rag picker, who stated:

> "I was suffering from fever. After one month, when this problem returned, I bought medicines from shops using the earlier prescription and continued the same tablet. The fever was not controlled, and I was not cured since it was typhoid. I had to move to a private clinic because I was not happy with the treatment received from the urban primary health centre located 1 km away. I fell sick again with the same illness."

Those who were treated in government hospitals did not get prescriptions, since the patient's medical details and prescribed medicines were entered in the computer, and they had to collect medicines from the hospital pharmacy. When they fall ill with what seems to be the same illness, the practice of using an earlier prescription to buy medicines was not feasible with this system. However, the problem is more so due to their inability to check their medical history, when they want further treatment somewhere else. Although they perceive themselves as being at a high risk, when they fall sick, they manage on their own through self-medication. Even if they take treatment, they tend to fall sick with continuous symptomatic illnesses, for example, diabetes, and tuberculosis. Moreover, they find difficulty if the illness is asymptomatic in nature. In the case of a 47-year-old poor woman, belonging to a Scheduled Caste, she said:

> "As my husband suggested, when I went for a master medical health check-up in a private clinic where he was working as an assistant, doctors identified kidney stones and uterus fibroid. Being poor, I tried acupuncture treatment, which was provided free of cost through one of my family friends, the treatment went on for eight sittings, and I was fully cured."

In the case of the middle-class women, with their belief that they are at a lower risk of falling sick, they also do not have any general health check-up, which leads to severity of asymptomatic illnesses. There are two cases were found with thyroid problems, and four with uterus related ailments. They came to know of these specific illnesses when they had gone to the hospital with neck pain, stomachache, and other problems, which needed further tests, and which resulted in a proper diagnosis.

Self-Efficacy of Women

Self-efficacy refers to confidence in their own ability to follow a suggested behavior, which is expected to bring about positive changes in terms of improving health. This includes diet modification, avoiding a harmful environment, and taking rest. Women are convinced that if they do not follow the doctor's advice they cannot be cured, and in respect of which poverty and gender play an important role as is evident from the following narration:

> "I suffered from asthma and the doctor advised me to keep away from the smoke of firewood, used for cooking, but I could not stay away. Cooking was unavoidable since no one was there to do this work at home. After taking medicines, the breathing problem subsided, but due to the lack of preventive action, I fell sick repeatedly with the same illness. If I wanted to change the mode of cooking, that would be an additional expense, which I could not afford. I cannot ask my husband to do cooking as it was my responsibility. If he does, outsiders look down on him. In the case of my illness, whenever my functional ability is curtailed, we buy food from outside" (Revathy, 21 years old, completed primary school education).

For the most part, women who received less monetary support from their husbands have to bear the family burdens and responsibilities, informal paid work, and illness. A domestic worker who suffered from osteoporosis, was unable to take rest, as she perceived her existing social condition as explained here:

> "I am the main breadwinner of the family. I cannot stop walking as a doctor had advised to reduce the severity of the disorder of joint pain. The habit of consuming alcohol by my husband reduced monetary support, though he works as a sweeper, and my kids are also young. That is why I have no confidence in my husband, and since my relatives are also poor it is not justifiable to ask for their help, and besides, they stay some distance away from my locality" (Rani, 36 years old).

There are two cases where the women had problems with their heart valve, and blood vessels, which were blocked. In both the cases they were not able to undergo the recommended surgeries as they were expensive, and not covered by any health insurance scheme that they could avail. There was the availability of cashless treatment for major illnesses under the Chief Minister's Comprehensive Health Insurance Scheme but these women were not covered by this scheme, and they did not know anything about it. Even if they were to undergo a surgery, there was no one nearby to take care of their kids, do the household chores, and they would also lose their incomes. After a long struggle, the one

who had suffered with blood vessel problem underwent the surgery at a lower cost, carried out by a well-known surgeon who has his own clinic, besides being a government practitioner as well. The husband took care of her in the hospital, and after being discharged from the hospital, when she felt better, she took up small work with the help of her daughter, and rested whenever she got the time. The same conditions were observed in many cases. It clearly indicates that poorer people cannot completely rest for long, and they had to manage their routine responsibilities on their own due to the gender role responsibilities. They were also hindered by the inability to maintain a proper diet, lack of timely support to carry out their routine work, and financial burdens.

Middle-class women are able to manage their diet and household chores with the support from either daughters or maternal family, or maidservants, or if there was no one to help, they could depend on technology to get things done. This enables them to take rest unlike poorer women. Moreover, they do not have the kind of financial problems for health care as the poorer people, as many of them have been covered by health insurance through the company where the women or their spouses are employed. They enjoy a better housing, living environment, and can manage other facilities such as infrastructure through the residential association. However, middle class women also face challenges. For example, a woman who had migraine and took tablets, was unable to avoid noisy surroundings where she worked as a primary school teacher, and where she lives, and there was tension due to family affairs as well.

Conclusion

To conclude, the perceptions of health varies, depending on knowledge and earlier experience, but socio-cultural conditions are the main barrier to poorer women adopting health promotive behaviour. This is mainly due to their views and beliefs about illness, an ineffective support system in the private and public sectors of health care, which are not adequate for the poor despite state initiatives. Further, women from both class categories are not exempted from their respective gender roles, and for poorer women, poverty greatly restricts health promotive behavior. In both the groups, spousal responsibility and financial support promote an improved health behavior, but more so among the middle class. Keeping these issues in mind, the study suggests that there is a need for giving specific attention to structural factors, i.e., cleaner environment, transformation of health knowledge, change an unfavourable gender construct, and reduce poverty. Changes in these indicators may transform their health beliefs, which promote their health practices. In addition, when it comes to policy, gender-specific illnesses demand immediate attention along with family-based health promotive behavior.

End Notes

[1] The participants' names wherever they appear in the text are not actual, considering ethics of research.

[2] *Pucca* houses are those with walls and roofs built with cement, concrete, bricks, stones, and timber. *Semi-pucca* houses have the walls built with brick and cement materials and the roof made up of other materials like bamboos, asbestos sheet roofs, and *kutcha* houses are made with walls and roofs of leaves and bamboo materials.

[3] The informant is a female, an Anganwadi Teacher, 40 years old, Anganwadi Centre Number– 12124, Rajarathinam Nagar, Kodungaiyur ward, Chennai.

[4] Class refers to the study population that is divided into two categories -- low-income group and middle-income group. This is based on the report given by the Tendulkar committee; state-wise estimates of average monthly per capita consumption expenditure are Rs. 2,534.32 and Rs. 30,411.84 per annum for urban areas of Tamil Nadu (see press note on poverty estimates – 2011-12, Planning Commission, Government of India, 2013). In addition, the families living in a slum under deprived conditions and who hold green colour ration cards indicate the line below which are those in acute poverty (below poverty line, BPL for short), and families that are above the line of poverty, have women relatively better off in terms of education, employment, income, and maintain higher standards of living, and have been reclassified as middle class.

[5] The caste is a system of social stratification (Subedi 2013). It encompasses a life-style and its people are associated with specific socio-cultural practices.

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