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Gender Relations in the Context of Women's Health in Chennai

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GENDER RELATIONS IN THE CONTEXT OF WOMEN'S HEALTH IN CHENNAI

Annapuranam K[*] and Anand Inbanathan[**]

Abstract

Changes in gender relations have created enormous pressure on women, which ultimately affects their health behaviour. For them, seeking medical treatment depends on their social position and other issues. The current study is based on 75 in-depth interviews with married women in the city of Chennai, and shows how a high proportion of the poor experienced illness, and delayed seeking treatment despite an early reporting of illness. This extended the length of suffering and severely impacted their routine activities. The situation is worse among the poor, especially where the spouse is deviant in nature, and also lacks responsibility. Here decision-making, medical expenses and physical mobility are highly restricted. However, the traditionally inbuilt responsibility of men enables middle -class women to pursue improved health behaviour. The study suggests that the gap between the cultural claim of norms and the natural claim of the body need to be bridged to improve the health behaviour of women.

Key Words: Gender relation, Ill-Health, Women, Poverty

Introduction

Illness[i] is a significant issue for women because they are more likely to experience illness differently, as compared to men in India. And those who are socially disadvantaged are at higher health risk than the affluent (Narayan, *et al*, 2009; Khanday and Akram, 2012; Gupta and Guin, 2015). In particular, women who are living in a rigid system of gender norms and lack a strong socio-economic background have reported extremely poor health status due to various social conditions, in which gender is an extremely important risk factor, framing their health behaviour (Sen, *et al*, 2007; Sen and Iyer, 2012). The magnitude of the gender gap in health[ii] is increasing over the years, indicative of a continuous fall in health performance of India, which, according to estimates, ranked 141 out of 144 countries in the world, the fourth worst performing country in terms of the gender gap on health and survival (Global Gender Gap Report, 2017). In this context, while there have been several studies on gender dimensions of health and issues concerning abortion, fertility, motherhood etc., (Santhya and Jejeebhoy, 2007; Anandhi, 2007; Sen and Iyer, 2012) that explored their adverse conditions, they have not concentrated on the impact of gender relations on health behaviour[iii].

The framework of 'gender relations'[iv] provides a comprehensive picture of women's health behaviour in any social unit. This paper seeks to answer questions on how gender relations influence women's health behaviour and its effect, the way in which women perceive the pattern of gender relations and the reasons for the same. Answers to these are most significant because gender relations are a fundamental element of the entire society, i.e. norms that regulate the human interaction that

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exemplify health behaviour. Traditional relations are gaining a new social perspective caused by a paradigm shift from the traditional to a post-modern society, further exacerbating the existing situation (Walby, 2011; Chakravarti, 2013). Rapid urbanization, enhancing the complexity of interactions, calls for a rethinking of the risk of gendered acts that reflect in changes in health. The variations in health behaviour are observed through gender performance in accordance with the norms. It also illustrates the dichotomy between nature and culture. We need to identify the core issues of health behaviour thereby contributing to new interventional strategies to pursue better health behaviour that would reduce risks. The objective of the study is to explore the influence of gender relations on the health behaviour of poor women in comparison to middle -class women in the city of Chennai.

Theoretical Underpinnings of Gender Relations

The theory of gender performativity is considered here to understand the health behaviour of women at the household level. It is because the theory claims new directions to look at the issues of women from a social constructionist perspective. It is imperative for the advancement of gender theory and to suggest effective intervention strategies. Butler argues gender is not merely traits, not expressive, not display, not stable identity or locus of agency but performative,[v] the various ways in which a body shows and produces its cultural significance (Butler, 1990). Butler viewed the body as a construction, which limits the performance of individuals, so that it is denoted as a medium of situated subject in the health context. During the process of performance, the body is reduced to norms that produce either negative or positive outcome. In particular, the female body because the constructive notion negates the reality of the body, relevance of science related to birth, ageing, illness, and bodily changes. This shows the ontological differences between the nature and cultural claim of body (Butler, 1993). In this context, the condition of an act related to health needs to be explored with a view of their lives, including their family, kin network, friends, colleagues and the world around them because the matrix of gender relations links the family structure, household functions, the division of work, family interaction, and health promotion activities. Thereby, it can be argued that in the process of intra-household interactions, if the body is reduced to gender norms, that causes disadvantages to their health.

Understanding Gender Relations in the Context of Health

People gain the advantage of having a family through co-operative relations with one another despite having diverse interests. As Dreze and Sen (2002) observed, women are less benefited with a co-operative contribution and intra-family allocation because co-operation and conflict are complex matters of gender relations in the distribution of joint benefits like nutritional in-take and health care. These issues are primarily linked with familial relationships and agency recognition. The family is central in understanding gender relations, since norms and roles govern women. As is evident in literature, there has been a transition of traditional roles among women as homemakers, wives and mothers, to productive roles. As is widely recognized, the role transition with multiple tasks has hampered their physical health.

Attanapola's (2004) work reflects how the change of role has had a direct impact on the health of women in an export processing unit in Sri Lanka. An account of how much time is actually spent on each activity by using the Turkstat Time Use Survey 2006 reveals that those who are at the bottom of the economic status have poor health, and women who perform multiple roles but have the least leisure appear to be worse off than the men (Oncel, 2015). On the contrary, Lee and Powers (2002) documented five different social roles of three age cohorts (18–23, 40–45 and 70–75) of women from a life course perspective in Australia that shows a better health outcome associated with one role than young women who occupy three roles. Middle-aged women had better health as they were able to acquire skills in time management, self-confidence and willingness to deconstruct gender norms when they moved in life. Another issue is the belief in male superiority. Alim (2009) explores Bangladeshis' belief that boys are future income earners, more intelligent and take decisions on important matters, while girls are physically weaker, superiority is given to boys in education, food and health care; also, it is expected that men should run the family.

In the context of India, coping with work-life balance is hard for working women because it diminishes their health. Eapen (2004) draws attention to the poor women who are large in number in lower caste groups. They often face serious health issues, not only due to the kind of work that they do in a poor working environment, but also due to the nature of the work that they perform, increase in their responsibilities, multiple tasks, and how they sacrifice their self –interest, hobbies, consumption and leisure in Kerala. Mani (2013) describes how work-life balance, lack of recognition, gender discrimination, elderly and child care issues, quality of health, problems in time management and lack of proper social support are the major factors that influence overall life in Tamil Nadu. Similarly, Kimmel (2004) asserts that women fulfill their roles in multiple spheres of life that weaken their overall living conditions. In particular, married women are less satisfied with their lives than men. At the same time, husbands with lower levels of risk behaviour and fewer psychological problems, enjoy better health benefits than women.

Physical violence is seen as a major aspect of subjugation of women in marital life. It occurs due to unequal power relations which enable one to exercise power over others (Nussbaum, 2000). Violence against women is relatively high in South East Asia, (followed by Africa) and India shows striking differences in wife beating. This is highest in Bihar and Tamil Nadu holds the second position (Beall *et al*, 2012). Studies from various parts of the country (Kundu, 2007; Visaria, 2008) have found that especially young married women often face physical violence by their husbands, which is socially accepted, and has a shared meaning among the community like the concept of 'Chukle', which means mistake born as female in Maharashtra. Its implication on health is shown in a World Health Organization (2013) report that says women who suffer violence face major health issues such as maternal mortality, abortion, sexually transmitted infections, and depression when compared to others. But many do not report or seek help, and as a result, the violence continues to be perpetuated in their lives.

The literature draws attention to the fact that self-reporting of illness appears to be higher for women than men in India. Evidences based on National Sample Survey Organisation-2004 data for Kerala found that self-reporting of prime age group (40-49 years) is not associated with their economic

status while a significant predictor for 50+. It was noted as high among OBC and SC/ST. In fact, Kerala has the highest literacy and it should have facilitated early diagnosis of illness, but the situation is reverse. The prevalence of illnesses such as diabetes, hypertension cancer and coronary heart disease are greater but the reasons are unexplained (Dilip, 2007). A similar issue was noted by Subramanian (2009), that individuals with no or low formal education, post-secondary school, and are socially disadvantaged reported higher levels of poor health than those who are better educated. As Dilip (2007) noted, self-reporting of illness by individuals was greater than that by their family members during interviewer visits. In how many cases family members were aware of an individual's illness have any effect on reducing the risk of illness, duration of ailments, and decision on health care were not explained.

Decision-making is a robust predictor of women's autonomy. Senarath and Gunawardena (2009) observed that the decisions on women's health were made without their participation, and was highest in Nepal (72 per cent), followed by Bangladesh (54.3 per cent), and India (48.5 per cent). Some of them made joint decisions, in which how many were forced to accept and their life situation, was not explicitly discussed despite women's participation that increased with their age, education and number of children (if more than two). The decision-making in connection to their children was discussed only for Nepal and Bangladesh, not for India. Other factors also influenced the process of decision-making as suggested by Osamor and Grady (2016). The transnational review emphasized that for women, autonomy is positively associated with decision-making and better health outcomes, in accordance with their age, education, and income in developing countries.

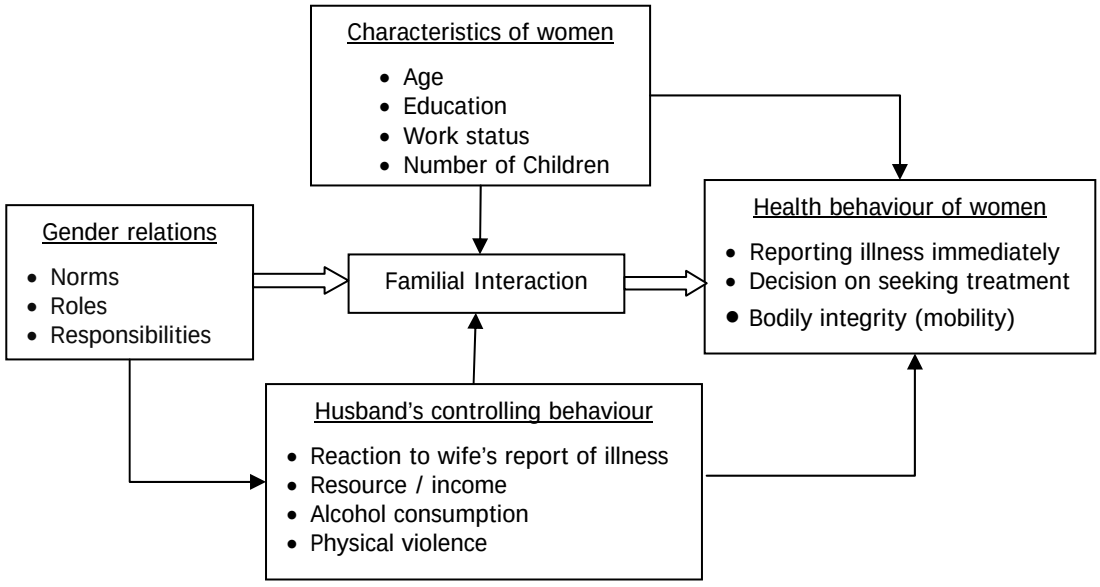
Sabarwal and Santhiya (2012) made a comparison between married and unmarried women's (15-24 years) health-seeking behaviour, using data on situation and needs survey, 2006-2008. The samples drawn from six states, viz., Andhra Pradesh, Bihar, Jharkhand, Maharashtra, Rajasthan and Tamil Nadu, indicates seeking treatment from private providers is positively correlated with women's autonomy, while awareness about reproductive tract infection was negatively correlated with intimate partner violence. Further, an analysis based on National Sample Survey Organisation 60th round data showed that education and economic position of women are closely linked to receiving health care (Borooah *et al*, 2012). However, a wide range of literature draws attention to the fact that multiple roles and deep-rooted gender norms are strongly associated with poor health outcome of women but not explained by the social position of their husbands.

Conceptualising the Research Issues

The literature informs us of the presence of an association between gender relations and the health of women. It is directly or indirectly linked to each other in spite of various other factors being responsible for their health. The studies show gender roles, norms, status, and violence are linked with reproductive health, reporting and decision-making on seeking care. It is understood that appropriate action improves their health behaviour and social position too would have a direct effect. If they take regular treatment and rest, it would result in improved health outcomes, for which the contribution of family members is most significant. In particular, the husband's relationship is found to have direct correlation to recovery from illness because the interest of women works through relationship with husband.

That the pattern of interaction in relation to health behaviour of women and the way in which men and women interact each other is strongly influenced by their social standings are endorsed by socio-cultural norms and values (see figure. 1). Healthcare seeking differs not only according to their financial position and gender vulnerability but also age, education, employment and specific health knowledge (Sen *et al*, 2007; Borooah *et al*, 2012). Wherever these factors are largely dominant in the family interactive process, they would be either advantageous or disadvantageous to health behaviour. In fact, intra-family relations are shaped by resources, household work, sexuality, motherhood and customary practices, in which women face challenges in the private sphere and that excludes women from public sphere due to ascendency position of male (Walby, 1997; Geetha, 2009). Ascendency position means hierarchy or ordering but does not necessarily imply power and autonomy, through which men can control the activities of women (Sen and Iyer, 2012). A chance of a person to carry out his own will in a social relation implies power (Weber, 1978) while autonomy is viewed as liberating women from external control to perform an activity by their own choice. In this context, Butler (1990) argues women fail to materialize things because negotiation with obligatory norms is ultimately an exercise of power in daily life. One cannot choose norms but can find as the way it is exposed to live within the limit of recognizability. The limit is viability and eligibility of women's existence, in other words social ontology of persistence within which women seek recognition in order to make their life more livable when they are not confined to gender categories because the imposed categories take away freedom. Evidences (Senath and Gunawardena, 2009; Sen and Iyer, 2012) show that autonomy of decisions on their health is very low in India, but age, education and income have significant effect, and that depends on the characteristics of the family.

Figure 1: Gender Relations and Health Behaviour



The nuclear family gives more space for working women in taking decisions on various family matters if the husband permits. Thus, society expects employed women to be subordinate to their husbands, take care of children and elders. If women's relationships are better with husbands, they have a positive effect and that gives greater freedom to own choices, physical mobility and spending. If they confront the husband, that would end up in conflict, because authority primarily is in the hands of male, and if a joint family, with in-laws (Allendorf, 2012; Mani, 2013). The bargaining power allows them to participate in decision-making but depends on a wide range of social factors like women who have sons, and those employed, are more privileged (Agarwal, 1994).The poor men are able to negotiate the financial barrier as the fact of being male, and availed service from private doctors, but such capacity is under mined in poor women due to class and gender disadvantage. If an income earner, it is possible that they discontinue their treatment due to opportunity cost and time required for domestic work but these issues remain context specific (Sen and Iyer, 2012).

The prevailing situation opens up a new analysis in the context of gender relations, i.e., the way in which gender relations are constructed by obligatory norms (Butler, 1993).The study attempts to explore gender relations and their effect on the health behaviour of women in two different social conditions. The key variables related to health behaviour of women during their sickness are included here, based on subjective experience of illness, which causes pain and requires fairly regular medication. The study includes type of illness, steps taken to solve health issues, duration of illness and potential effect on routine activities. The variables related to gender relations are broadly denoted as norms, roles and responsibilities having a direct impact on the familial interaction at the household level. These macro phenomena give values, and the values are ideals of conduct widely practiced and recognized. In the case of women, age, education, work status, number of children and physical mobility are included since these are significant predictors of role performance and the women's ability to take decision on health. The reaction of husbands to reporting of wives' illness largely depends on the social position of their husbands.

The Context

Tamil Nadu was chosen as the study area because it is one of the States with a steady increase in the proportion of ailing persons despite the progress made in improving the health of its population. The study is located in Chennai city where the proportion of the urban poor is increasing at a faster rate than in other parts of the State. Two places identified within the city as the study area: The first is Rajarathinam Nagar, a slum, which is selected on the basis of three criteria: a chunk of families living below the poverty line, settlements of people who are a mixture of various castes and religious groups and, thirdly, susceptibility of the residents to frequent illness, due to a garbage dump yard nearby, which is 300 acres in area and situated just opposite to the slum, surrounded by an extremely polluted Coovum canal and Kodungaiyur drain. There is a total of 1,500 families residing in pucca and semi-pucca houses and a few extremely poor inhabiting kutcha houses. The condition of the slum is precarious, often the garbage is not disposed of, and household sewage lines are mostly open, inviting all types of bacteria to take birth and thrive. Women have no alternative but to fetch water from public taps, with the water scarcity worsening during summer months.

The second study locale is Krishnamoorthy Nagar, located parallel to the slum settlement, where a few middle-class households are identified and women from them interviewed to make a comparison of study phenomena. These women live in pucca houses and maintain a high standard of living, with each house linked to the city corporation water supply system; possess independent toilet facilities, access to better quality of basic amenities, good housing infrastructure, and consumer durables. These households have better access to hospitals and transportation services. All the other conditions, by and large, remain the same for both the areas. Though there is a comparative advantage of opportunities for education, employment, transportation facilities and healthcare, the study finds that due to personal and social constraints, only some households are able to put these facilities to good use. The two social groups live in extremely unequal social conditions, that characterize their interaction influenced by social norms or customs.

Methodology and Data Collection

This paper is based on a study carried out in2015 in Chennai, India, that followed a mixed method approach. This approach is flexible, encompassed various tools and advocates multiple perspectives (Greene, 2007). A flexibly structured in depth-interview and observation technique was used to obtain primary data. The group of families in a slum were identified based on their income and standard of living that was deplorable in RRN. Green ration cards[vi] had been distributed to them and the rest were classified as middle-class families who live in KMN. The study purposely chose women who were married and living with their husbands[vii]. Their marital status was ascertained since married women from poor households are generally more prone to vulnerability owing to dysfunctional relations, poor healthcare and exploitative gender relations (Bottorff *et al*, 2011). In all, 75 women, comprising 43 from poor families and 32 from middle–class, were interviewed; they belong to various social categories. The inductive analysis was done separately for quantitative and qualitative information, the audio taped voices were transcribed, selective coding of those responses helped to group into categories, and sub-themes were integrated into two main themes: gender norms adhered to in the spousal interaction and gender responsibility turned out as controlling strategy of men, which determines women's health behaviour. Each theme is defined in detail with observed patterns.

Profile of Participants

The characteristics of women is described by their social standing (Table 1). The study with an average age of 33 years among the poor women is lower than that of middle-class women at 41 years. The corresponding figure for men is 40 years and 47 years respectively. The mean age at marriage for women is relatively low for poor than the middle class, but the class difference indicates three years in the case of women as well as men. However, the gender gap in marital age is 6.14 years because it is 20.47 years for women, and 26.61 years for men. These families followed a monogamous marriage practice, which indicates that they hold ideal marriage values, in which parents play a major role in mate selection if it is an arranged marriage. In the traditional set-up, women are expected to obey the husband, and responsible in caring for family members than the women who married outside their own caste group by their own choice. The caste composition of the sample shows non-scheduled caste

(NSC) are more than scheduled caste (SC). Those married outside their caste group are more among the poor. In a way, it indicates the caste system loses its own structure but the middle class still have a strong hold. The nuclear families are huge in the sample and predominantly male headed. The average family size is 4.52, including an average of 2.4 children, thereby determining their health status in terms of resource allocation. The poor manage with an average monthly income of Rs. 7,349 while the middle class ones did so with Rs. 40,421. The income disparity mirrors the wide range of income difference existing between two income groups. The housewives are more than the employed. The conventional structure forced housewives to be dependent on their husbands in addition to the transition of economic structure. This transition poses an additional challenge for women who lack skills and educational qualifications since many had not moved beyond school education, while some are illiterates. The poor were largely confined to home- based entertainment, lack a social network, and social participation and exposure to the world are highly restricted.

Table 1: Profile of Participants (Poor = 43; Middle class = 32)

Social characteristics		Poor	Middle class	Total
Caste group	Non-Scheduled caste	19 (44)	25 (78)	44 (59)
	Scheduled caste	24 (56)	7 (22)	31 (41)
Marriage pattern	Within caste	9 (21)	13 (41)	22 (29)
	Outside caste	34 (79)	19 (59)	53 (71)
Family structure	Nuclear	33 (77)	23 (77)	56 (75)
	Extended	10 (23)	9 (28)	19 (25)
Work status	Housewife	21 (49)	18 (56)	39 (52)
	Working	22 (51)	14 (44)	36 (48)
Education	Illiterates	11 (26)	-	11 (15)
	Schooling	32 (74)	14 (44)	46 (61)
	Graduates	-	18 (56)	18 (24)

Note: Numbers in parentheses indicates percentage

Source: Information drawn from in-depth interviews conducted with women during June – October 2015

The economic activity of the working poor is higher, but they depend only on the informal sector as daily wage labourers, domestic workers, rag pickers and vendors. The economic activity of middle-class women is relatively low, but their income contribution is higher as they have better education and employment. A few middle-class women had discontinued school education and the rest are graduates. Only seven graduates work in the formal sector as teachers, software engineers, police inspectors and clerks while others depend on the informal sector as saleswomen, clerks, petty business women and earn a decent salary. This determines economic relations besides gradually influencing the other spheres of their lives, such as intake of food and healthcare. The study also found that many were housewives despite being educated, often due to the husband's mindset that 'sending a wife to work and earn lowers the family's status and prestige'.

Health Profile of Participants

The study showed that a relatively high proportion of the poor experienced illness, as compared to middle-class women in the past one year (Table 2). The former often suffered from fever, uterus-related ailments, asthma, heart diseases, thyroid, joint disorder and diabetes. While the middle-class women also had experience with similar kinds of illnesses, their proportion is lower. A common practice among the women was directly purchasing tablets without consulting a doctor to restore their health irrespective of the class. They visited a hospital only when illness became severe and sought treatment, either in a private hospital (54 per cent) or, a smaller number (46 per cent) resorting to government hospital services. The poor preferred private hospitals though they were not able to afford it because their perception was recovery is faster than after treatment taken from a government hospital while the middle class predominantly relied on private hospitals. Thus, they suffered for more than one week (75 per cent) as calculated from the day the symptoms were identified. The class distribution shows us the poor constitute more than the middle class. The possible explanation would be living in an unhygienic environment, presence of a dump yard, irregular intake of food, lack of regular medication, self-care, support of family members and chronic illness. In particular, the proportion of the housewives appears to be higher among the above one-week sufferers due to lack of physical activity, poor diet, poor perception and socio-economic factors.

Table 2: Health Profile of Participants (Poor =43; Middle class = 32)

Health status		Poor	Middle class	Total
Illness experienced	Yes	40 (93)	23 (72)	63 (84)
	No	3 (7)	9 (28)	12 (16)
Place of treatment	Private	18 (45)	16 (70)	34 (54)
	Govt.	22 (55)	7 (30)	29 (46)
Length of suffering	One week	14 (35)	2 (9)	16 (25)
	Above 1 week	26 (65)	21 (91)	47 (75)

Note: Numbers in parentheses indicate percentage. The place of treatment and length of suffering are calculated only for those who experienced illness in the past one year: Poor - n=40, Middle Class - n=23.

Source: Information drawn from in depth interviews conducted with women during June-October 2015.

Norms Adhered to in Spousal Interaction

The norms referred to shared rules that guide people's behaviour in specific situations while roles connected to the expected behaviour associated with a status (position of a person occupies) (Lindsey, 2015). As norms are instrumental in understanding the link between gender relations and the health behaviour of women, the social position of women and their husbands were considered to see the health behaviour of women, for which self-reporting status of illness to their husband is kept as a constant. The position of women denotes their location in the larger spectrum of social life, as working women or housewives, educational attainment, age, number of children, caste and class.

Gender attitude conditioned women in reporting illness

In the study, more than half of the women (63.5 per cent) revealed being ill as soon as they encountered it. Among them, class variation indicates poor women appear to be more (57.5 per cent) than the middle class (42.5 per cent). The caste distribution indicates scheduled caste women (SC) were more among the poor while non-scheduled castes (NSC) were higher among the middle class. Women worried about their family responsibility if they fell sick, the lack of support system in the nuclear family, customary practices, aggressive behaviour of husbands if they delayed self-reporting, and severity of illness that made them to discuss it at the earliest. A woman in her 50s from Gounder caste (NSC), has her own petty shop. When she felt severe chest pain, after informing her son over the phone, she went alone to the hospital, leaving her husband behind in the shop. She attributed her troubles to ageing. In another case, a middle-aged woman worried about family responsibility. "My husband took me to a private hospital a day after my complaint, where the illness could not be diagnosed, and then it was identified in another hospital as typhoid after four days. "This indicates their cooperative effort as conditioned to the family situation, which in a way helped them to identify the illness and take appropriate treatment. The perception differs according to their age in reporting of illness. More of the women who reported their illness to husbands belong to the age group of 31- 40 years (50 per cent) than the below 30s and above 40s. This result is consistent with the earlier studies (Santhya and Jejeebhoy, 2007; DeMello, 2014:37). Even if women were ill, younger women (15-29 years) were found to be less likely to share the information with their husband due to fear of husband's reaction and a culture of silence.

While early reporting was numerically higher among poor women who are below graduates (includes primary, high school and higher secondary - 57.5 per cent) analysis shows that those who had graduated in the sample were able to well describe the symptoms. This result is in accordance with Sen's (1992) argument of female education making a substantial difference in their social standing and having an effect on their health. One woman who suffers from diabetes at the age of 43, belongs to Nadar caste, has a son and sells water cans. Though she is under medication, at times diabetes weakens her health. She informed her husband of her poor health whenever it became severe as she perceived it may have serious effects. But her husband did not accompany her to the hospital every time because he would have had to spend a day in the hospital, which in turn, affected his income and they cannot afford a private hospital.

Among the women (36.5 per cent) who failed to report their illnesses at the earliest, there were significant differences in perception. The perception among the poor women was: if they complained of any illness, it would disturb their spouse, or create tension, and affect the spouse's income. Some women did not consider it as a serious issue; and the earlier experience of poor response from their husband, lack of attention to prolonged illness, their not wanting to spend on health at the initial stage, poverty, and husband's sickness were some reasons that made the women not to tell them about their sickness, and to try to treat themselves with self-medication. The perception of middle-class women was: it would create tension or disturb their husband, especially if they kept reporting the same minor illness. Some felt the husband himself might fall sick, not to disturb their spouse for minor illness, and the illness could also be due to some evil eye. They trusted god to take care of their health. It

illustrates how conjugal relations have systematically made women more submissive. It is strongly in favour of the husband. This embodied complex life of women excludes them when their health needs the husband's attention.

Reaction of husbands to wives' reporting of illness

Women who had early reporting of illness (40 out of 63 women who suffered illness) received multiple responses from their husbands that varied from one another. Their responses have been grouped into four categories: women were taken to the hospital, received money for treatment, husbands advised their wives to take treatment, and husband did not give attention to their wives. Those accompanied by their husband (52.5 per cent) to the hospital, in the case of poor women, were able to seek healthcare within two-three days of reporting illness because leave from paid work and money was a major constraint. The middle-class women were taken to the hospital on the same day or next day of complaining. A few cases took two-three days because of their situational constraints. The account of a woman has been given here to understand the context in which the responses of their husbands differ, that would promote them to seek healthcare. A Paraiyar woman (SC), a mother of three children in her early 20s, who works as plastic cutter says, "When I had a severe stomach ache, the immediate attention of my husband helped me to avoid huge medical expenses incurred when I had Dengue in the previous year."

Some received only money (17.5 per cent) from their husbands who were daily wage labourers worried about the loss of income, and they were away for the purpose of their job or other family affairs. This situation led to the responsibility usually falling on their mothers' shoulders. Some whose husbands had advised them to take treatment (10 per cent) felt happy but poverty was a major constraint as they relied on urban primary health centres. The poor who did not have money had to borrow it, with the repayment being their own responsibility. Those who had a good network were able to fetch some amount, after the money lender verified their husband's occupation, income and repayment capacity. At times, some had to postpone their treatment as they did not have money. Sasi belongs to Aunthathiyar caste (SC). In her early 30s, she has two children, and works as a construction labourer. She put it this way:

> I often had headaches and dizziness. When it happened recently, my husband asked me to take rest and eat well. But on the third day, I was unable to move. So, he asked me to take some tablets from the medical shop. He fetched only water, did not perform any other house work. And even if he does, neighbours would laugh and look him down on him. Then he went to the construction work site. I borrowed some money with five rupees as monthly interest and went to the hospital.

Poverty entangled with gender, in the form of differential evaluation of work, has advantaged men not to perform household work. This has, in turn, disadvantaged women. In that way, societal perception devalues women and that creates inequality. Some other husbands did not accompany their sick wives to the hospital (20 per cent) due to lack of money as they spent most of their earnings on alcohol; were not regular income earners; were incapacitated due to ageing and illness; had spousal

misunderstanding; discouraged wives from projecting minor health issues as something big. To quote what a woman said:

> My husband is an alcohol addict, and earns a meagre amount by pulling a cycle rickshaw. When I told him about my suffering from fever, he angrily responded, 'Why do you keep on complaining about your health when sitting at home for 24 hours? Though I do strenuous work daily, it has not affected my health'.

Rosy, an illiterate in her 30s, takes care of her two children, depends on her husband for money, and is not aware of healthcare services. The gender construct draws attention to her husband who has restricted her from talking to others. Her interaction with *anganwadi* workers where the nurses deliver health service was also stopped because her children are in primary school.

Then there is the case of a woman like Jaya (age 18) who has only three years of schooling and belongs to Naicker caste (NSC), and had an inter-caste marriage with a Nair man. Consequently, her relatives maintain a distance and have branded her an 'eloped woman. 'She had fever two month ago, and informed her husband who was drunk. He did not take it seriously, and as she is new to city life, she had to go back to her mother who helped her despite her anger over her choice of husband.

Many women often fought their husbands over their spending on alcohol, and ended up in conflict. This resulted in violent behaviour triggered by intoxication, that resulted in women not getting either monetary or moral support when they needed it to maintain health. Women perceived such reactions as their fate and felt as though they were born to face such situations with patience and tolerance. Some felt society blamed only women, even when the husband was in the wrong. If a woman was not living with her husband, even her own parents and relatives did not respect her. In the case of middle-class women, only two reported receiving less attention and help from husbands, who thought that the wives kept complaining about the same illness (joint pain and diabetes) and therefore had to take care of their health on their own.

Ascendency position of men in decisions on seeking treatment

The overall response indicates that husbands play a vital role in taking a decision on seeking treatment (40 per cent) despite early reporting of their sickness. The study illustrates the context in which husbands take decisions. The poor women perceived a lack of awareness, being economically dependent, and it being the responsibility of men as the three main reasons for delay in seeking treatment. In the case of housewives, an illiterate woman from the fishing community who has two children at the age of 28 said,

> As I have no money, I am unable to take treatment for prolonged joint pain. The family lives on the meager amount earned by my husband from loading materials, so he takes the decisions. I accept whatever decision he takes. It is a mutual help in marital relationship and that gives meaning to our life.

The financial constraint not only determines the decision on seeking health care but also who takes the decision. To illustrate with examples: A Paraiyar woman, age 26, completed post-secondary, is a housewife and has one child. She had stomachache. She depends on her husband for money. The

other issue is the lack of awareness as to where good healthcare service is available. A 30-year-old poor woman had a similar issue to access medicine for diabetes. As her husband is an under graduate and works as a sales representative, he knows things much better than her. One who works as rag picker, suffered from asthma. Her four adult children are married and settled far away. She perceived it as her husband's obligation to take care of her despite there being not much help from him as he is sick; but he instructs her on what she should do. The traditional claim of status quo of male superiority has made middle-class women depend on their husbands to decide and seek treatment though they are better educated and employed.

The context in which couples made joint decision (30 per cent) was based on their health condition, and their routines were affected. In view of Raji who had chikungunya, the severity of the illness made them seek treatment in a private hospital. The couple who jointly do business are worried about their income loss. In some cases, the gender non-conforming behaviour in the sense that wives did not co-operate for other family affairs when their interest was not recognised. At times, women also had a different approach to get things done from their husbands. A 36-year-old domestic worker uses a different strategy. She refuses to serve food, denies any sexual relationship and does not take care of his relatives. As she puts it, 'If I take care myself, and he takes care of his own, there will be no sharing and caring.'

In the case of wives who made independent decisions (30 per cent), it was only possible if they were income earners and also the position of the men was relatively weaker. The poor women were relatively liberal in making their own choices than the middle-class women (six per cent) because their husbands were into risky behaviour, were not income earners, were aged, sick, stayed away, the family had less than three children and lacked knowledge. Rajathi, a poor woman who has four children and works as vendor, explained:

> My husband is not an income earner as he was when younger. He drinks alcohol and it results in severe stomach aches, so I care for him and the entire family. Our relatives can help, but we are not in touch with them as they keep distance from us because ours is an inter-caste marriage.

The prevailing social condition has enabled women to take decisions on their own. As Lorber (1991; Butler, 1990) argues, gender is not only being a woman as category but the product of social doings that makes differences. Misunderstandings within couples has caused trouble for women. Valar belongs to the fishing community, works as sweeper and earns Rs. 6,000 per month. She married at the age of 13, and has two children. Her husband would drink regularly, fight with her saying she was not faithful to him, and did not like her talking to other men. He often tried to find out her where abouts and she needed to take his permission even to visit her parents. He would often hit her on the road, and threaten to leave her. Once he poured kerosene on her. As things got worse, she felt she had to live for her children and moved to the house of her brother-in-law. He has been taking care of her for the past 15 years. But when it comes to her health, she finds no help.

> Chikungunya put me in trouble for one month. There was no support from my brother-in-law as I am not his wife, but I feel his presence protects me from strangers

and my husband. My situation means it is up to me to take treatment. At times, my 13-year-old daughter helps me to carry out the household chores.

The norms strictly limit women in the binary framework in terms of taking decisions. At the same time, the possibility of deconstructing gender norms along new lines is opened up. Poor women perceive their situation to be restricted with the husband's risk-taking behaviour and poverty. On the other hand, those from middle class perceive it as earning a bad name, if they fail to respect the husband. This demonstrates how authority and decision-making are vested with one's husband, a predominant phenomenon especially among women from the middle class.

When physical mobility to seek healthcare is restricted

In our patriarchal society, permission from one's husband to go to hospital is linked with the wife's early reporting of illness. In our study, the physical mobility of a considerable proportion of the women (55 per cent), mainly from the middle class, was restricted by their husbands. More specifically, middle-class housewives from Nadar, Agamudaiyaar, Muthaliyars, Vishwakarma, Brahmin, and Sheik. The husbands' education level was relatively higher and they had socially respected occupations such as doctor, general manager, revenue inspector, etc. In the Sheikh group, aged women were able to move around more than the younger ones. They needed to abide by the rules of family life although the husband had promised his wife's parents that he would look after their daughter. As mentioned earlier, restrictions were imposed for reasons of protection. If they went out without permission, it would lead to fidelity being suspected and charges that they did not respect their husbands. The experience of some of the women in poor households showed that they were compelled to seek permission, failing which they faced beatings, suspicion, quarrel, no interaction for a few days and being denied money for household expenses. These were mostly faced by housewives as compared to the employed. It showed that the status of women from different income groups did not mean anything when it came to the conventional practice of seeking permission even to access healthcare at a time of emergency or need.

Responsibility Turned Out as Control of Men

Responsibility is socially expected from men and women who have a certain obligation to perform to accomplish their tasks (Lindsey, 2015). While carrying out a certain task, the process of interaction between two individuals is widely influenced by norms and roles, which become controlling factors for their husbands. Control refers to its exercise by somebody in the economic activities of the household, work, mobility and decision-making, that are manifested in different ways.

Gender construct limits in accessing economic resources

Medical expense is one of the underlying factors to understand the health behaviour of women. Among the women, more than half reported that their treatment cost was borne by their husbands (67.5 per cent). Middle-class women were largely dependent on their husbands though some of them reported illness early. It shows a profound link between wives reporting illness to their husbands and the consequent incurring of expenses. Women largely perceived it as a responsibility of the husband

because this attitude is culturally imbibed and restored with repeated actions in similar ways. In a way, women viewed it strengthening their marital bond. This traditionally inbuilt responsibility seems to have been constructed as a controlling strategy of male members in the family. In poor families, cost of treatment was borne by many of their wives themselves, but differed according to their situation (27.5 per cent). Their family condition in the metropolitan city forced both husband and wife to be income earners, certainly not based on the idea of claiming equality. The working poor women had little freedom for spending on their own health, and often due to insufficient income discontinued their treatment. Of course, there are a number of government hospitals and health programmes to provide subsidized medical treatment through various insurance schemes, but among the women we interacted with, only 25 per cent had insured themselves under the Chief Ministers' Health Insurance Scheme except in three cases where they were privately employed. Here too poor women were fewer compared to women from the middle class. They were hampered by lack of awareness, and long procedure to get insured. Health workers did not visit homes to keep track of the health status of people as they delivered services at *anganwadi* centres. The centre is an outlet for women to get their illnesses treated, but only those have young children go there.

Cases of health expenses being met by family members were fewer (5 per cent) since many live in nuclear families. Only nine women between the ages of 25-40 years lived with in-laws/mother and two women above 50 lived with their daughters-in-law in poor families. Five women lived with their mothers-in-law/mothers in middle class families, and four lived with their daughters-in-law. Among those who live with the mother-in-law as housewife were often criticized for repetitive health expenses. A middle-class woman belonging to Isai Vellalar caste (NSC) with low education in her 40s said:

> My menstrual bleeding continued for a month. Although my husband asked me to go to hospital, my mother-in-law interrupted and said that it is normal for a woman who reaches the menopause stage. It extended to another five months. I lost my weight, discussed with my friend, and she also said the same. Finally, mom took me to hospital.

Wrong perception delayed treatment and the continuous blood loss further worsened her health. In contrast, one woman from Vishwakarma caste (NSC), who lives with her mother, received good support even at the age of 55):

> Ageing caused me kidney and uterus ailments, for which the doctor suggested the removal of uterus while medicine was prescribed for the kidney problem. As my husband had recently met with an accident, I take him to the railway department hospital once in fifteen days. But we are not happy with the treatment there. My mom agreed to spend for my health as she receives pension from the education department.

In such cases, the low social standing of being a housewife, lack of income and lack of in-laws' support are main factors in delayed treatment. In these situations, the woman's mother has to perform a caretaker role as an obligatory function when the husband is either controlled by the mother or may have natural limitations like physical disability.

Transgressive behaviour impoverishes women's health

Alcoholism by husbands of sick women affects early reporting of illness. Cases of regular and excessive consumption of alcohol are more pronounced among the poor as compared to the middle-class. Although such women were reluctant to disclose their illness because of previous experience of unfavourable response from their alcoholic husbands, some of them still reported it (37.5 per cent). And violent behaviour is often entangled with intoxication because wives saw their husbands as not really in their senses. This transgressive strategy of men enabled them to justify their disloyal repetition of gendered action to curtail the freedom of women. A middle-aged poor woman from the fishing community (SC) who is a plastic cutter stated:

> My husband did not take me to the hospital for typhoid since I used to scold him whenever he got drunk and behaved violently. One day, he broke my teeth when I talked back. To moderate his unruliness, I serve him food laced with sedatives so that he falls asleep.

In poor families, the husband often gets angry, especially when the wife asks for money or when the food is not ready or that it is not hot or tasty. The wife is suspected of illicit relations if she does not obey him, or refuses any sexual relations with him. Similar is the response among the middle-class men too, but their proportion is very low as compared to those from a poorer background. The study demonstrated that physical violence is a common tool used to control women's activity. The result of violent behaviour was severe burns and body ache in many cases. A few women had head injury and some had their teeth broken. Women had to adjust for the sake of a smooth-functioning relationship and peace in family or else the family bond will not be stable.

Conclusion

The paper aims at answering how gender relations influence the health behaviour of women. The analysis shows early reporting of illness is more among the poor but conditioned to financial status, family responsibility, women's concern over their spouse, the husbands' risk behaviour, and severity of illness. The pattern here is that husbands who are alcoholic and violent in nature do not give much attention to the wife's reporting of illness as much as husbands who do not often indulge in such vices. Those who lack husbands' support tried to deconstruct the gender norms. Women tried self-medication with tablets at the onset of illness, but this was also one of the reasons for prolonging their suffering. Independent decisions on healthcare by women depended on their social position and the condition of housewives was worse than that of the employed despite being educated. The poor women were constrained by various circumstances and faced challenges in managing daily activities associated with their role.

Among the middle class, despite women delaying in reporting illnesses, they were taken to the hospital on the same day they complained of ailments, in cases where men who do not often have exposure to bad habits. The study highlights the responsibility of men towards their wives but shows the choices of women were highly restricted with respect to decisions on seeking treatment, physical mobility, medical expenses, and in-laws' support. An unequal distribution of power in accessing

resources made housewives dependent on men. In fact, they must wait for their husbands' consent even to go to the hospital. This behaviour is highly culture-specific, gender-biased, and influenced the mindset of women to feel as though they are 'less important.' The study draws attention to prevailing gender relations which is a strong cultural phenomenon having a bearing on women's health. It confirms that cultural claim of gender relations continues to neglect the natural claim of the female body in terms of seeking treatment and rest.

Notes

[i] The disruption of the normal physical functions of the human body is due to external factors which affects their routine life denoted as ill-health. It is termed as illness with a specific name when it is diagnosed.

[ii] Health means a state of optimum capacity that enables individuals to perform effectively to attain socially valued tasks (Parson, 1975).

[iii] Any activity undertaken for the purpose of preventing or detecting disease or for improving health and well-being (Conner and Norman, 2005:2).

[iv] The ways in which a society defines norms, roles, and responsibilities of individuals in relation to each other. It acts as a controlling mechanism of human behaviour within the boundary of institutional framework that is considered a major social force in determining individuals' location in the wider spectrum of their social system, where the individual's world is constructed through day-to-day interactions that reflect the social reality.

[V] Gender is a social construct and can be understood as a discursive practice that is both a hegemonic, social matrix and a performance gesture with the power of repetition, which means the construction of gender reproduced through the repetitive actions that depends on the individuals' capacity. The actions occur through an interactive process by reiterating a set of norms. The repetition regulated by power within the boundary of gender relations, is derived from the social system (Butler, 1990: 140)

[vi] Those who fall under average monthly per capita consumption expenditure of Rs. 2534/- (meant for urban areas) in addition the families who live in a slum under deprived conditions (Planning Commission, 2013) and the families are above the line of poverty, have women relatively better off in terms of education, employment, income and maintain a high standard of living, and have been considered as middle class.

[vii] The selected women were interviewed with their full consent of participation by giving prior information about the purpose of the study, areas in which questions were grounded on and were assured that their identity and information they provided would be kept confidential. Each interview took nearly one hour or so.

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