

Women, Development and Health

Redefining the relationship

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Introduction

The inclusion of health in human rights is a concept, which has become politically acceptable in countries across the development divide. However, realising the ideal of health for all is a process ridden with complexity and, often, contradictions. The process of development or 'progress' first of all influences the definition of health itself. No longer can the prevention of deaths alone encompass the entire range of health goals. Mortality, especially, high mortality among vulnerable groups - infants, mothers, certain categories of workers, certain isolated communities is the starkest indicator of unequal and inadequate health care. However, in general, we find that death rates have declined steadily. It does not seem unreasonable, at this point in history, to examine the situation from the point of view of those who survive but continue to suffer from ill health. Thus, the goal of health for all must be translated not merely as survival but 'well being'.

Redefining health as 'well being' requires a structural shift in our thought because it compels us to enter into areas of great ambiguity. In order to understand what 'well being' means, we need to engage in dialogue with people. We need to reflect on the social and political understanding of bodies and minds. The indicators of good health are no longer in the control of the expert and in the laboratory, but must be uncovered from the homes and lives of individuals. Also, it is necessary to remember that the health care actions of the community are within the control of the expert (or the state). With the burgeoning private sector in modern medicine, together with the informal sector services provided by modern and indigenous health care givers, the options for health care are seemingly endless. Finally, the actions of individuals are mediated a vast range of players and structures (household, health care providers, gender, class, e.t.c)

Development

Thus, to understand the influence of 'development' on women's health, we must study primarily, the changes that occur in women's lives and their consciousness. Their perception of their health is intimately connected to the changing concept of self. On attempting a broad generalisation, we could conclude that, largely, economic development in India has been interpreted as integration into the capitalist market. It is a market, whose forces are often remote and invisible, whose transactions involve the exchange of money and which is governed by the laws of profit rather than custom. It is not so important to impose a judgement on this process, as much as it is necessary to understand the implications of this structural change for women.

We find that with the advent of capitalist production, a whole new network of relationships is established. With the requirement for credit and marketing, the

first contact with non-traditional structures is established. As these are largely situated in the mofussil towns and urban centres, there is intimate and sustained contact with modern medicine through health centres and health personnel. Eventually, as a society begins to produce for a capitalist market, they invariably become consumers of goods in the capitalist market. Specifically, in the context of health care, it opens up the possibility of the use of highly advanced technological services. Essentially, the effect of the consumer health market is the medicalisation of a greater number of biological processes - childbirth, menstruation, menopause e.t.c. With greater proximity to the centres of health care, there is an increase in the degree and invasiveness of the interventions proposed. For e.g. we find that hysterectomy is recommended to all women reporting menstrual disorders.

With the availability of services and the possibility of procuring resources, a larger number of illnesses are recognised and come within the purview of medical care. For e.g. the entire range of cardio-vascular illnesses are reported in a health survey using self-reporting more frequently in a developed community. It would be wrong to assume any automatic rise in the incidence of these illnesses with 'development'. However, as they are more frequently referred and diagnosed by doctors, they are reported more often and treated as such. Once labelled as a 'heart problem', the whole range of tests, procedures, drugs and hospitalisation must be undergone. Expectedly, people's anticipation of costs and quality of care required is also determined by the disease. Once accepted as a disease requiring medical intervention, it becomes obligatory for the household to procure the resources required for medical care. It must be noted that this phenomenon is not class specific. Thus, we find that clientele of most general practitioners and nursing homes in a peripheral area of the town \ city is drawn from different classes. At the same time, not all the consumers are equally empowered to negotiate in this market. For e.g. a small farmer who approaches the nursing home in the suburban area of a small town is completely at the mercy of the private doctor. Not only is his \ her level of knowledge very poor, there is no time or opportunity for this person to explore options.

The effect of the functioning of the market is to link remote players and processes into a network of causes and effects. As there is no regulation of the market, the effects of one on the other can be quite dramatic. For e.g. we find that the unscientific use of frontline antibiotics by individual doctors (and not insignificantly - by self-medicators) has caused a problem of drug resistance serious enough to spark off another epidemic of certain diseases e.g. T.B, Malaria. With the homogenisation of health care behaviour, (e.g. universal use of western medicine and private practitioners) this problem becomes all the more acute - as can be seen in Mumbai in the context of Malaria, where most episodes are treated by private practitioners (trained or otherwise).

Thus, we find that 'development', which essentially brings isolated groups and communities into a mainstream, exposes hitherto protected individuals to the dangers of the vagaries of the market. Needless to add, when the state abdicates its responsibility to mediated between the various players, those who already suffer from the oppression of hierarchical structures (e.g. class, caste, gender) are disadvantaged further.

Of course, it must be never be forgotten that with the transformation of society that accompanies 'development', opportunities and 'niches' emerge for the disadvantaged groups. For e.g. with the spread of health care services in the smaller semi-urban areas, the availability of emergency care has increased. With

improvement in transport and communication networks, the spread of information and knowledge is facilitated and a certain degree of awareness is spread universally. The possibility of organising large masses of people separated by long distances is possible (as was evident in the Narmada Bachao Movement). Certain egalitarianism is forced into society by the inability of any class to gain hegemonic control. Within the large homogenised market, there exist innumerable local variations and differences. In the case of health care, we find that local practitioners adapt their treatment regimens to the needs of their patients. Traditional remedies are repackaged and sold commercially and used alternatively by people with western medicine.

Women and Development

Apart from the general influences of 'development', there are specific consequences for women. It would be impossible to generalise about the changes wrought in women's lives by 'development'. But invariably, we find changes in the nature of their work, the organisation of their households and in their living environment. Much more deep-rooted changes occur in the understanding of self and the experience of their bodies. All these have implications for the health of women. However, it is not possible to explore the process by which these changes occur and are absorbed into everyday life without reference to a particular context.

There exist no universal pattern in which communities experience 'development'. The changes in the economic base of the community are very important in determining the direction and route that 'development' takes. How the community assimilates these changes also depends greatly on its social, political and cultural profile. Thus, the experience of women in a changing society is also multi layered and unique. The history of that community will determine how much advantage, women will derive from the flux induced by structural change.

Case study

Households

In our study of household health conducted in Nasik district, Maharashtra,¹ we encountered a set of three villages that would be defined as 'developed'. In relation to the rest of the villages in the Igatpuri taluka, there were distinct differences in the mode of production and the life style and social organisation. These are also reflected in some of the indicators. The developed villages were predominantly upper caste while the majority of the households in the other villages were tribal. However, it is important to note that even in the 'developed' villages, one third of the households were tribal.

	Other villages		"Developed Villages"	
	Households	%	Households	%
<i>Upper castes</i>	57	8.80%	90	47.90%
<i>Farming castes</i>	117	18.10%	1	0.50%
<i>Artisan castes</i>	24	3.70%	15	8.00%
<i>Unspecified Hindu castes</i>	15	2.30%	2	1.10%

¹ Health, Households and Women's Lives; a study of illness and childbearing among women in Nasik district, Maharashtra; 1999; (In print)

<i>Other Hindu Castes</i>	156	24.10%	18	9.60%
<i>Scheduled castes</i>	71	11.00%	18	9.60%
Mahadev Kolis	136	21.10%	28	14.90%
Thakur / Katkari	160	24.80%	26	13.80%
Other scheduled tribes,				
nomadic tribes	44	6.80%	8	4.30%
<i>Scheduled / Nomadic tribes</i>	340	52.70%	62	33.00%
<i>Muslims, Christian</i>	21	3.30%		
Total	645		188	

While agriculture in the rest of the villages was largely seasonal and dependent on rain water, in the 'developed' villages, year long cultivation was possible due to irrigation. While only 7.0 per cent of the households on the other villages owned irrigated land, 24 per cent of the households owned irrigated land in the developed villages. Our using our categorisation of households - landless, cultivator labourers, sole cultivators with rain-fed land and sole cultivators with irrigated land; we find that the composition of the households is very distinct in the developed villages. The proportion of landless households is, in fact, marginally larger in the 'developed' villages. However, we find that the highest class in the 'developed areas is significantly larger in the same villages. This indicates a greater level of disparity with a more powerful elite class. Thus, we find that the largest social class in the 'developed' villages is of upper caste cultivators with access to irrigated land.

Expectedly, the family size in the 'developed' village households was larger than the other households, being 7.23 as opposed to 6.26 persons. The average number of women above 12 yers too, was marginally higher in the 'developed' villages being 2.51 women as opposed to 2.07 women. The implication of these figures when translated into actual experience means the existence of joint households with women of two to three generations living either in their natal or married home.

Work

The work routine of women in the 'developed' villages was torturous. While in the other villages, the work day started at dawn and was over by mid day (during the weeding season), in the 'developed' villages, it stretched from mid-morning (8 o'clock) to sunset with a short break of one hour for lunch. The rest of the chores, filling water, cooking dinner and child-care was undertaken after sunset and continued till night. Women informed us that they often had no time left for a bath or breakfast, dinner being the only relaxed meal. This work routine is typical for the type of cultivation undertaken - a mix of rice, groundnut, sugarcane, pulses, fruits and vegetables. Especially, the packing of fruits and vegetables has to be undertaken late at night or early morning causing an enormous extension of the working day.

On speaking to a group of women about the changes in their work, they stated that single crop cultivation was much more relaxed and allowed for larger periods of rest. They also asserted that they were sicker than their mothers or grand mothers had ever been. The reason that they assigned to their health problems was

overwhelmingly 'work'. They commented on how girls were called to in laws immediately after marriage, as more and more people were required to farm the land. As marriages were consumed sooner, child bearing too was hurried. They also pointed out how their personal needs for hygiene and rest were neglected due to the long working day. Normally, the women use the hour before daylight for defecation and bathing. In this case, this time too was encroached upon.

Living Condition

On the other hand, we observed a much greater variety in the food eaten by the households as well as it being more substantial in quantity. The quality of clothing worn by the women too, was superior. Substantial amounts of jewellery was worn by the women. The temples in the village were large and well maintained. We also observed that the physical condition of the houses, in general, was superior. We also found that 36.2 per cent of the households had access to a public or private tap, while the rest had access to perennial wells. Most houses had electricity connections and reasonably regular supply. Thus, though the survival needs were more easily fulfilled, the most striking impression that remained was that of women working continuously without rest. The relative affluence in these villages was apparent in the number and variety of consumer goods owned by households.

The literacy rate for adult women was 26 per cent as opposed to 16 per cent for the other villages. We also find that 16.5 per cent of the adult women had reached secondary school. However, as with women in the other villages, they were largely employed in the cultivation of their own land. There was no significant difference in the marital status of women in both types of villages. We do find that very few women above 17 years were not yet married. Although not completely reliable as sexual history, we find that proportionately more women between 18-25 years in the 'developed' villages had children as compared to women of the same age in other villages. This substantiates the assertion of the women that childbearing for the younger generation of women commences earlier than before.

The Health Condition of Women

The reporting of illness in the developed villages was much higher. 546 women in 1000 reported being ill in the previous one month as compared to 501 in the other villages. 922 episodes were reported for every 1000 women in the developed villages as compared to 749 in the other villages. This indicates the greater complexity in the reporting of illness by women in the 'developed' villages.

This greater complexity is a reflection of the greater awareness about ill health and more concern about the body. It was not surprising for us to find that health as an issue for research met with much enthusiasm and interest. Apart from women themselves, we found that male leaders and co-workers also approached us with problems suffered by their female relatives and acquaintances. It was almost distressing to see the high degree of concern in women's minds about their bodies. We find that of the total episodes reported by women, 29.5 per cent were reported in the 'developed' villages. On disaggregation, we find subtle differences in the pattern of problems. The prevalence of reproductive problems and weakness was reported to be much higher in the 'developed' villages. Also more prevalent were fevers. This is, certainly, on account of the canals and reservoirs surrounding the villages, which serve as fertile breeding grounds for mosquitoes.

Type of problem:

The higher reporting of weakness and reproductive problems is significant. We can not assume that there exist any epidemiological differences in the profiles of the two sets of villages. However, that the health problems are experienced differently by women in the two sets of villages is apparent. The reporting of weakness is an indicator of a general feeling of ill health that may or may not have any biological basis. That this complaint is more frequent in the 'developed' villages is noteworthy. It signifies a heightened awareness of health problems as well as an articulation of discomfort not necessarily amenable to medical treatment.

The understanding of ill health is integrally linked to their experience of their family and their environment. Drawn from the remarks of our investigators, I cite an example of the reporting of illness.

A 42 year old woman, spouse of the head of household and mother of 3 children. *During her delivery, her veins had become cramped (sheera gola jhala) that is why her limbs hurt. As her mother was not present during her childbearing and she was living with her sisters in law, she had to work. Due to the exposure to cold and cold water, this problem began.*

In the 'developed' villages, we found that 436 health facilities (informal and formal) were utilised per 1000 persons. This was higher than the figure (402) for the other villages. The use of formal facilities i.e. clinics, dispensaries and hospitals is also higher in the developed villages. 341 per 1000 persons as opposed to 299 in the other villages. If we assume that formal care is the preferred choice, we do find that the 'developed' villages are more privileged. However, this does not necessarily translate into better health care. More number of health problems are medicalised and the treatment sought is also more sophisticated. We find that 3.2 per cent of all episodes and 5.4 per cent of all treated episodes involved hospitalisation. This is much higher than the figures for the other villages (0.7 and 1.0 per cent respectively).

The more frequent use of health care does not necessarily result in a greater feeling of 'well being' as is evident from the higher morbidity rates reported. The reason for this apparent contradiction must be sought in a wide range of factors. The treatment taken is merely to alleviate the symptoms, so that work is not disrupted...

A 32 year old daughter in law having 2 children and working on own land *During her period, her lower back becomes completely numb. That is why just before her period or a little later she gets herself an injection. (This same woman reported burning during urination as a separate complaint which she did not seek treatment for as she related it to tea drinking in summer)*

Also evident is the fact that ideal conditions required for continuing and completing the treatment are not possible to create. Households get caught between the obligation to secure health care for the person and the difficulty in sustaining the supply of resources required for the same. In such a situation, hierarchical structures determine the priority given to each member.

A Maratha Household having their own land and jeeps used for commercial purposes

C's eldest son died last year. He had a heart problem. They took him to Bombay to fit a new heart valve. But he died there. They had to pay attention to his illness because he was the earning member. C neglected her daughter's health. Now that daughter is married. She used to have problem with her menses. But because it was so expensive to treat her brother, they did not pay any attention to her problem... Their grandchild fell into the fire and his arm was burnt completely . They had to spend 20,000 for the surgery and hospitalisation. The economic condition of the house is quite good. Before their son died, he was ill for 6 months with jaundice and joint pain. Afterwards they told them to get a valve fitted. Although the doctor had told them that he needed surgery, they consulted a bhagat to see if he had been possessed. The bhagat told them that he was alright, so did another doctor in Bombay...

This remark reveals the complexity of problems facing households in the 'developed' villages. With access to services, information and some resources, they are drawn into a system, which has its own momentum. They can no longer ignore the possibility of modern medicine effecting a cure, even while they take recourse to the traditional providers to resolve their dilemma.

Conclusion

The above case study has been used to explore a particular situation. However, it unfolds some of the processes that communities are experiencing world wide in the course of 'development'. Although the basic needs of food, clothing, shelter, water and sanitation have been fulfilled, there remains a large quantum of health problems. The operation of social and economic factors, of course, ensure that these are inequitably distributed. In spite of this, one sees that the general standard of living has improved. However, health is not determined by any simple equation of above factors. The deep rooted structures of inequality distort the process of 'development' and make its experience ambiguous. The relative disempowerment of people in relation to the state, the market and of women in relation to men is reflected in their traumatic relationship with these agencies. Women are offered hysterectomies in response to their menstrual problem, but are never counselled to cope with the psychological and hormonal disturbances that follow. While households are willing to use their own resources to access private health care, neither the state nor the health profession plays any role in protecting them from unethical and improper health practice. A general rise in the standard of living does not change the relative position of women. In fact, it increases their work burden and neglect. They articulate their feeling of oppression and actual physical discomfort as ill health.

It is quite evident that 'development' in itself is not likely to increase women's feeling of well being without a change in the underlying structures of inequality and oppression. Only occasionally, one finds evidence of the potential that such transformation holds for women.

A 40 year old, Maratha woman, widow, mother of two, head of the household.

A's husband died 15 years ago after a heart attack. She now trades in vegetables. She goes to Nasik Road and loads the vegetables into a truck and takes them to

Kalyan to sell. She does not come home every day - only once a week. She has rented a room in Igatpuri where she puts up. For a while after her husband's death, she lived with her natal family, but now she lives with her daughter and daughter in law. She gives them money for provisions and other things once in a fortnight. Her son is not earning, he is studying. Her daughter in law had a step mother. She made her lift heavy pots of water when she was young. That is why her spine hurts and her lower back as well. Her mother in law is her paternal aunt as well and is very good to her. Now she takes treatment from in specialist in Bhagur town. She is a gynaecologist and is also treating her for other problems. There is a TV, a Showcase, a tape recorder, a cupboard, cooking gas, a mixie and clock in their house. Both sisters in law seemed to be living together like sisters. They gave us very good information.

References:

Health, Households and Women's Health: A Study of Illness and Childbearing among women in Nasik district, Maharashtra; 1999 (In print)

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The Right to Development; University of Mumbai; 1998; Neha Madhiwalla, Draft paper