Gender Inequality in Health - A Study of RCH programme in the District of Burdwan (West Bengal, India)

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Abstract—The gender inequality in health has brought home a new dimension in health research. By correlating differential health outcomes with gender discrimination, this new field has transcended the typical fatalistic explanation of human morbidity. This new approach intends to unravel the structured inequality embedded in a given society in order to make sense of morbidity status of women folk. According to this approach women’s proclivity to fall prey to recurring ailments or morbidity can be explained by the very nature of upbringing of them in given society, which is substantially constructed by patriarchal values. Hence, ‘biology is not destiny’. In fact it is the invisible dictum of patriarchy, which is carried forward by the generations of docile women folk, has structured the very texture of the society concerned. Consequently, a girl child in a family who, unlike her male sibling, has been subjected to systemic discrimination in her entire stages of upbringing (starting from nutritional deficiencies in food allocation, educational preferences, and health related issues) bears indelible mark of discrimination in her health outcome. So, frequent ailments or morbidity of a woman vis-à-vis a man, are the outcome of gender inequality. Hence, this approach has offered a new insight for the public health researchers and policy makers that women health problems can hardly be addressed by a straightjacket approach to health. Even, there cannot be a uniform health policy for women per se, as women as sociological category is anything but homogenous. Therefore, an exclusive health policy for women should also remain sensitive towards socio-cultural diversity in delivering health services. In the backdrop of the above conceptual frame the present paper seeks to interrogate the RCH programme in the district of Burdwan, West Bengal (India) and to see how structured inequality has affected the success of the said programme.

Keywords—Gender, Inequality, patriarchy.

I. INTRODUCTION

The gender inequality in health approach has interrogated the dominant perception regarding (women) health i.e. ‘biology is the destiny’. Instead, it foregrounds the fact that the intriguing coupling of nature and nurture has determined the tenor of morbidity and vulnerability in human being. As a critical determinant of health, gender has complicated the apparent biologic dimensions of vulnerability. Several intermediary factors are held to be responsible for the secondary status of women vis-à-vis men with their invariable impact on health outcome. They include among others, “discriminatory values, practices and behaviours, in relation to health within households and communities; differential exposures and vulnerabilities to disease, disability and injuries; and biases in health systems; and biased health research”[1]. In addition to this, it has underscored another criticality of women health i.e. intersectionality, which may lead to ‘multilayered discrimination’. However, this approach is not free from biases. Unlike the mainstream research in health, which normally overlooks the importance of gender in the variability of health outcome by conflating sex and gender in empirical methods, the gender inequality approach overemphasizes on the vulnerability of women as the only victims of gender inequality, leaving behind the male vulnerability. Hence, at the very outset a few conceptual riddles need to be straightened up. First, there is a general tendency of treating women vulnerability as fait accompli of women, which is interrogated by the gender inequality in health approach; secondly, all sorts of differences in health outcome between man and women should not be bracketed as patriarchal constructions, in fact gender differences in health outcome are sometimes biological in nature and sometimes they are heady concoction of sex and gender. The present paper in the light of a popular health programme i.e. RCH in the district of Burdwan, West Bengal (India), intends to investigate whether the dismal health outcome in the district has anything to do with patriarchal gender constructions and suggests a few possible ways to plug the policy shortcomings.

II. METHODOLOGY

The paper draws on the field survey conducted in 2010-2011 in the district of Burdwan in the state of West Bengal in India. The choice of Burdwan district as the universe of study had the following reasons: first, the district represents the pluri-cultural mosaic of the district; secondly, Burdwan is among a few advanced districts in West Bengal, which has a wider network of health service providers; thirdly, the district has been considered as the epicenter of Left mobilization in West Bengal that came into the limelight for socialist experimentations with land reform, land redistribution and avowed pro-poor stand. To further investigate the relationship between gender and health, two blocks from Burdwan district viz. Bhatar and Memari-I had been selected. Both deliverers and receivers perspectives had been taken into account in the study. Given the nature of the inquiry, the

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study had relied on case study method. For getting receiver’s perspective on the correlation between gender and health, the study had chosen six case studies (three each from each block, representing one Muslim-dominated village, one SC/ST-dominated village, and one general caste-dominated village).

Since, gender discrimination is embedded in the interstices of society, mere quantitative method in eliciting information is not adequate. Hence, the study had primarily resorted to qualitative method especially focused group interview and narrative analysis to grasp the intricacies of gender dimension in health outcome. In order to cross-check the data relating to the receiver’s perspective gathered from the six villages, deliverer’s perspectives had also taken into account. Since the health sector in India is marked by medical pluralism, mere data from the biomedical deliverer’s is not enough either to understand the complexity of health sector. Hence, the study had gathered information through in-depth personal interview, and personal narrative from three sets of health deliverers present in rural India- biomedical professional (doctors, health workers, para-medical staff and village-level workers); a group of medical practitioners who are not directly engaged in state health delivery mechanism, but cater the people under study (RMP-Registered Medical Practitioners); and quacks, religious medical men like Ojhas and Tantriks.

The paper has the following sections: section-I provides a conceptual analysis of gender inequality in health; section II situates RCH programme in the above conceptual frame; section III draws on the case study of Burdwan district; and final section concludes the study with some observations for future policy making.

Section-I

This section attempts to offer a conceptual analysis on the correlation between gender and health. There is a literal mushrooming of literature on gender; however a very little attention has been paid to the correlation between gender and health. Before we move on to the said correlation and its impact on health outcome, a distinction between gender differences in health and gender inequality in health seems to be in order. Sounds almost tautological though, there is a clear distinction between these two. Gender differences in health are a normal outcome of biological differences based on chromosomal variation. The chromosomal differences, i.e. sex chromosomes (46 XX vs. 46 XY karyotypes) lead to developmental differentiations in anatomy and physiology of man and women, which in effect cause differences in health outcome[2]. For example, the risks of hemophilia, cervical cancer, ovarian deformities etc are associated with XY karyotypes, whereas vulnerabilities like testicular and prostate cancers are typical of XX karyotypes [3]. Hence, gender differences in health outcome are normal biological phenomenon which begs further scientific innovations, not so much of public policy intervention. The gender inequality in health, on the other hand is differences in health outcome between man and women which are socially and culturally constructed and therefore actionable. The gender inequality in health is only one of the many manifestations of deep-seated structural inequality against women. In fact, gender has determined the structural location of women and men in the society and their subjective experience and not to mention their resultant vulnerabilities. Persistence of gender biases within communities has its invariable impact on health outcome. The life cycle perspective study[4] may shed some light on how gender constructions in a given society has shaped the behavioral pattern of women folk and led to related vulnerabilities. The life cycle perspective may present a nuanced view of different facets of a women’s life starting from very birth to death. In fact, the very birth of the girl child is determined by the society concerned. If a girl child is at all allowed to appear in a given society, she has been taught to withstand a life long journey of compromise, starting from sharing of meals with her male sibling to education and the way of life. A Feminine Mystique [5] is constructed to domesticate a girl. The patriarchal discriminatory values, which have been feeding into a girl child to make her a docile subject, have their invariable impact on her health outcome. Hence, gender inequality in health is not necessarily explicit in nature. The discrimination in treatment of a girl child vis-à-vis male child are mostly implicit or discrete in nature. The issue of gender inequality in health is further confounded in reality as it intersects with a host of other societal issues like “economic inequality, racial or ethnic hierarchy, and caste domination, differences based on sexual orientation or a number of other social markers”[6] and mutually reinforces each other. However, this intersectionality dimension of gender, which has gathered huge attention from scholars these days, seems to have precluded the attention of health policy makers. Intersectionality brings in new understandings about the social determinants of health and social patterning (gendering) of health inequalities [7]. It uncovers the multiple location and variations of marginalization, process of subject formation and differentiation and systems of domination in a given society [8]. It operates at three different levels: ‘the multi-dimensional way in which power operates and subjectivity, subjection, and social location are subsequently constructed; the different levels at which interactions occur; and the differing degrees and forms of penalty and privilege between social locations and subjects’ [9]. Considering, the complexity of gender inequality in health, policy makers are now concentrating on gender mainstreaming, instead of exclusively focusing on women. By putting equal weightage to both man and women, especially their concerns and experiences in designing, implementing, monitoring and evaluation of all sorts of policies and programmes, the mainstreaming of gender perspective is sought to attain gender equality.
Section-II

The gender inequality in health can be better understood if we take the example of a much popularized global health programme – Reproductive and Child Healthcare (RCH). It is one of the flagship programmes initiated by the Government of India with a view to ensuring safe motherhood and child health. In 1997, the Govt. of India has introduced Reproductive and Child Health (RCH) for streamlining the existing family planning programme. It acts as an integrated package incorporating all the essential components of ensuring Safe Motherhood and Child Survival, family planning. It sought to provide client-oriented, demand-based, high quality services to the beneficiaries. This programme had two phases-phase I and phase-II. The first phase of the programme commenced in 1997/1998 for a period of five years culminated in 2001/2002. The second phase of RCH programme i.e., RCH – II had commenced from 1st April, 2005 and continued till 2010. Major components of the programme are the followings: first, provision of antenatal care, encompassing at least three antenatal visits, iron prophylaxis for pregnant and lactating women, two doses of tetanus toxoid vaccine, detection and treatment of anemia in mothers and management and referral of high risk pregnancies. secondly, encouragement of institutional deliveries or home deliveries assisted by trained health personnel; thirdly, provision of postnatal care including at least three post-natal visits; fourthly, identification and management of reproductive tract and sexually transmitted infections.

The program is sought to bring about a “change in mainly three critical health indicators i.e. reducing total fertility rate, infant mortality rate and maternal mortality rate with a view to realizing the outcomes envisioned in the Millennium Development Goals, the National Population Policy 2000, and the Tenth Plan Document, the National Health Policy 2002 and Vision 2020 India”. In reality, however, the programme fails to create much headway in ensuring safe motherhood and child survival. The present paper unlike the traditional supply-side oriented explanation of the relative underperformance of RCH, intends to investigate if there is any problem in the demand –side and use gender as an analytical tool. In the following section, possible correlation between gender and RCH programme will be analyzed in the light of Burdwan district.

Section-III

This section mainly dwells on the survey. The study revealed that gender prejudice is embedded in Indian society which has substantially shaped the health seeking behavior of women folk. The underlying patriarchal structure, cutting across religious and ethnic identities seemed to have determined the curriculum vitae of a woman not to speak of her health seeking behavior. Consequently she has to suffer. Further, a culture of silence prevailed in the women community in general and the women community in the area under study in particular, has reinforced their sufferings. From sharing of gynecological problems to the choice of contraception, to the selection of place of delivery, patriarchy appears to have determined everything through an invisible system of domination. Gender identity deprived women of their legitimate right to health and wellbeing.

Receiver’s Perspective

Several local narratives[10] generated in course of interaction with the receivers (villagers) on programmes like RCH and immunization, re-confirmed the centrality of gender factor in the health seeking behavior of the women in the area under study. Sometimes gender intersects with several other social markers like religion, cultural values etc to the disadvantage of women health. In the study, we have come across such popular narratives of disapproval of contraception in several occasions, which cut across economic, educational and gender background. Jahanara Bibi, 53, a housewife and a mother of six exclaimed Contraception is against Islam. Child is a blessing of Allah. To abort a baby in the womb and stopping it from coming on this earth amount to great sin. It is against the will of almighty Allah! Similar kind of conviction was echoed in the words other respondents as well. Here religious sentiment is evoked to rob women of their right to decide about their family and its size. An interesting narrative of Afroza Begum2, 33, a housewife, educated till standard eight, would be relevant here to mention as to how gender discrimination determines the health seeking behavior. :

“With the blessings of Allah I could conceive some seven months before. I started to feel mild abdominal last pain year. I thought it would be automatically cured. I took some hajmi golis(digestive pills) but the pain did not reduce. I was hesitant to tell it to my mother-in law. On day the pain became severe and I lied down. My mother-in law came to my bed and in a harsh tone said ‘will you not cook today?’ I was restless in pain when she raised her tone and grumbled saying that now-a day the married girls are clever they pretend sickness only to avoid the kitchen! After some hours the pain became extreme and I was howling when my mother-in law rushed to my husband. I heard her saying Aquil you see your wife howling’. My husband came and asked with irritation what makes you howl? Tell me quickly, I need to go to the field. Tears rolled down from my eyes when he said go to hafez sahib. He may give you some medicine for digestion. With a low tone he said I have only a few bucks which can buy only two bundles of bidi. Some coins are there under the bed, I will tell my ammi to take you to Hafez sahib. He may give you some medicine for digestion.”

The animated arguments in favour of faith healing, male dominance and the religious-cultural practices in this situation become mutually constitutive. The accumulated impact of this mutual constituity is to junk the state mode of delivery of health services. The role of male dominance in
perpetuation of this constitutivity is subtle but not imperceptible. The religio-cultural variables are instrumentalized in the vested interest of male community which insulates the latter from direct commitment to the cause of health of the women community. The instrumental use of religious and cultural variables also does not allow these variables to operate independent of the larger context of a gender divided society. In the prevailing healing practices the male members therefore are privileged to dominate over the women in terms of health related decision making. The value-proximity of the women community aligns them morebefittingly to the religious convictions and cultural symbols than to the distantly located delivering agency of the state. It is here where the faith and cultural mode of delivery gets normative preponderance over the state mode of delivery. Another narrative, generated in course of the survey deserves special mention here, which demonstrates how social customs and practices are invoked to deprive women of adequate medical attention. Interestingly, here women themselves act as the agency of patriarchy. Nazia Bibi, a housewife aged 53, from Debipur village made a comment on health seeking behavior, which is indicative of dominant cultural perception regarding women health: Now-a-days it becomes a fashion to visit a doctor. In our times, we did not visit doctors so frequently. After all we come in this world as women. So we must learn to suffer. Seeing doctor for mere abdominal pain in those days (menstruation) is a luxury!

Similarly, cultural factors especially shared belief, myth, taboos play determining role in shaping one’s health seeking behaviours, which in turn determine the fate of a given health programme. Generally, in a given society patriarchal values sneak in through socialization process. The innumerable customs, myths, shared belief, and taboos exist in every society on pregnancy and new born, which are customized by the patriarchy. For example, nutritional deficiency is one of the major factors behind the perennial vulnerability of women. Interestingly, in the society under study we find that patriarchy has indoctrinated its women folk of ideal womanly behavior, where they are expected to abide by a host of discriminatory behavioral practices as normal. A girl child is taught about her difference from her very infancy and a code of conduct to be followed, which includes among others girls should not eat in the first place, she should give lion share to her male siblings, etc. Consequently, a girl child, who has been suffering from perennial nutritional deficiency would fall prey to a host of avoidable ailments by the time she reaches her adolescence. The patriarchal indoctrination is so encompassing that women who are basically involved in the kitchen are considering such discriminatory allocation of food and practice of giving male members precedence over girl child as absolutely normal. A few such puzzling narratives emerged out of discussion are indicative of gender discrimination, which have their impact on women health outcome: One Bobochaya Mukherjee, 42 said: ‘we as women have lot of responsibility. We cannot take our food with other family members. As mistress of the family we make sure male folk of the family must be fed first. We female members should take our meal afterward. It brings prosperity in the family.

The RCH programme is replete with examples where cultural factors play determining role. The RCH programme was conceived to address among other the silent killer like RTI. Under the programme, awareness generation among the adolescent girls is given utmost priority. For, most of this problem is generated due to ignorance about sexual hygiene and fear of social stigma and sanction. On being asked why he had refused ANC and PNC for his wife, One Aminur Molla, a marginal worker aged 38 with secondary education said:

Yes I am aware of ANC and PNC. But how can I send my pregnant wife to the health centre, which is always overcrowded. She had to wait for long hours in such an embarrassing state (pregnant state) just to get some free bors (Tablets)! We strongly believe in the grace of Allah and leave it to the hands of Allah. No matter what the problem might be, Allah will bail us out.

The above narrative speaks of underlining patriarchal sanctions, which deter women to avail public health measures since they are not compatible with patriarchal value system. The patriarchal social structure sanctioned the public appearance of pregnant women. Sometimes, cultural and religious sanctions are also imposed to ensure the patriarchal domination. For example, a fear of evil air was often instilled to restrict women folk within the four walls of the family. Our study further revealed similar presence of patriarchy, which acted as powerful deterrent for the women to realize their health needs. For example family planning was treated as an absolute male prerogative. Women were never consulted upon. In case of permanent family planning, instead of vasectomy the IUD measures for women like cooper-T were generally adopted. In course of discussion on family planning, one Amina Bibi, aged 32, a mother of two has come out with such life experiences: I can distinctly recall those restless afternoon and sleepless nights when Sakila was only 9 month’s baby. An unknown fear of imminent danger haunted me. I had lost my body weight in an alarming rate. I was always in a bitter mood, and it changes erratically and without any reason. I kept on requesting my husband to take protection. But he did not care about it.. The elderly of my family and my mother-in law had refused to give any importance of my ill-health, and kept on insisting for a baby boy for retaining family lineage. Thanks Allah that I could give a baby boy or else I had to suffer the pangs of child bearing for many more times. Finally Aynul was born and my husband took me to a private hospital for ligation.

Deliverer’s Perspectives

The above narratives and comments from the receivers have been validated by similar narratives of the deliverers. This section provides a brief overview of deliverer’s perspective. Sometimes gender construction is so encompassing and stifling that in some societies the issue of
reproductive health is considered as taboo. Hence, these are rarely discussed in public, let alone asking for remedies. Adolescent girls are taught not to discuss this issue with others and utmost secrecy to be maintained during menstruation. Even, parents feel embarrassed to share the basic physiological information with their daughter. Consequently, they rely upon some half-baked information leading to several gynecological problems including infertility. One MBBS doctor from the area under study has cast some light on it by sharing his experiences: Most of the gynecological cases that I encounter everyday are caused due to ignorance and suppression of facts. From the very childhood girls are taught to maintain secrecy about their normal physiological events like menstruation. Sometimes the lower abdominal pains during menstruation are often belittled by giving the little girls some digestives. Consequently, these girls developed the symptoms of deadly RTI. Gender construction is so pervasive in the area under study that creating awareness about sexual hygiene, pre-natal and post-natal cares etc which come under the fold of RCH programme have suffered serious setback. Cloaked in the garb of an apparent nonchalant attitude, the health seeking behaviour of the people in the universe under study bears the mark of a strong gender prejudices as it is evident in the words of a health workers of Bhatar block hospital: We always try to educate the women folk, especially those who could not afford sanitary napkin, as to how they could go for some cheap homemade alternatives like cotton pads. We teach them how to make this piece of cotton hygienic and safe for the next use. But in most cases the rural women either avoid our suggestion or did not care much. Even those who abided by our prescription often kept those cotton pieces in such places where secondary infection was only obvious. Moreover, rural women often wash the cotton pads in contaminated water, leading thereby to several reproductive tract infections like itching, white discharges, and so on. They are always haunted by the fear that they might be caught by someone drying up those things... They are taught to maintain utmost secrecy in drying up those things.

Here, ignorance about sexual hygiene was not the only reason for the attrition to the RCH programme, gender construction in association with cultural factors like taboo, fear of stigma and embedded inhibition all work in unison in shaping health seeking behaviour of the people. Sometimes, even myths are constructed to maintain gender expectations. For example, one health councilor of Memeri Block Hospital, had shared a very interesting myth regarding menstruation, which could have played spoil sport for the government sponsored RCH programme. I had encountered one of the most debilitating myths regarding menstruation in one of our awareness generation camps on sexual and menstruation hygiene. When I was interacting with the villagers and making them aware of possible ways as to how they could maintain hygiene with homemade cotton pads, one of the participants from that village questioned the feasibility of maintaining hygiene. She said that our suggestion of washing and drying up the cotton pads for re-use was not applicable since they did not have discreet and hygienic place to dry up those pads. She said that she was always apprehensive of the possibility that somebody would have seen those pads or came in physical contact with them when they were put on the sun or come in proximity of the foul air emanating from it. For any such incident would affect the health of her husband or prospective husband in case of adolescent girl. Such deeply lodged was the myth among the village women that, they preferred dark and humid and unhygienic corner of the room for drying up cotton pads, instead of out at the sun. Consequently, most of the women were suffering from fungal infections like itching, white discharges etc.

Similarly, in our study we found that women though suffering from low hemoglobin, only a handful of them availed freely distributed iron and calcium tablets. On being asked why they did not collect those tablets, most of the receivers said that they could not collect medicines due to some preoccupations. But one village level health workers in course of our interaction had given us the clue. He told us that women generally refused to take those medicines because that required pregnant women to be physically present at the sub-centres.

IV. CONCLUSION

In sum, gender factors, as evident from the study, in juxtaposition with other intersecting variables like caste, religion, culture have acted as the potential deterrent in the realization of RCH (public health) programme. Since health like gender is a multidimensional concept, mere homogenous approach is not enough to make sense of the relative underperformance of any health (RCH) programme. Hence, health policy should be contextually customized so that socio-cultural nuances of health including gender constructions will be duly figured in the formulation and implementation of health policy. However, transforming health sector into a gender sensitive one is not very easy as gender factor usually intersects with a host of other social markers and comes in different combinations. Therefore, success of any given health programme is not contingent upon supply-side alone, demand-side of health policy is equally responsible for its fate. Sometimes due to the intervention of socio-cultural factors, demands for specific health programme are not raised, leading to its failure. Health policy makers should therefore take proper cognizance of the followings: contextuality of the policy milieu; intersectionality dimension of social markers; sex- segregated data and so on for the success of gender mainstreamed health policy.

REFERENCES


[3] Rachel Snow, ibid
Life cycle perspective is a popular research methodology, mostly applied in sociological and anthropological research. It offers a multidimensional paradigm for making sense of people’s lives, and their structural and social context.


Aditi Iyer, Gita Sen and Piroska Ostlin, ‘Inequalities and Intersections in Health: A Review of the Evidence’ in *Gender Equity in Health*, ibid, p.69


This section draws on the survey conducted in 2010-2011 in the district of Burdwan in West Bengal (India). The narratives presented here were mainly generated in course of interaction.