UNIT 9 : GENDER AND HEALTH

UNIT STRUCTURE

9.1 Learning Objectives
9.2 Introduction
9.3. Understanding Health And Gender.
9.4 Gender Perspective on Difference And Segregation.
9.5 Meaning Of Nutrition And Health Practices.
9.6. Reflection of Gender Inequality in the Domain of Health In Terms of Nutrition And Health Practices
9.7 Difference in Nutrition intake And Health Practices In India
9.8 Let us sum up
9.9 Further Reading
9.10 Answers to check your Progress
9.11 Model Questions

9.1 LEARNING OBJECTIVES

After going through this unit, you will be able to -

- Understand the relation between heath and gender
- Know the meaning of nutrition and heath practices

9.2 INTRODUCTION

Health is a multi dimensional concept that is composed of medical context along with social, psychological, economic and political background (Barreto, 2017). The social, cultural and political contexts in which individuals are situated determine their health status (Dodoo& Frost, 2008). Society organizes the resources and provides care to their members as a response to illness. Social and political values influence the health policy and fund allocation for health (Raphael, Bryant and Rioux, 2006). Socio-economic positions and health related behaviours produce different health outcomes to men and women. Socio-economic positions are gender, class, education, health insurance status etc. Health related behaviours like body mass index, smoking, alcohol consumption, physical activity etc. (Read & Gorman, 2010).

Support of family members, friends, neighbourhood, and community is essential for the recovery of diseased person. Without any social support, the diseased person will suffer more for longer duration and severely (Cockerham, 2016). In this unit are will discuss the relationship between gender and health.

9.3 UNDERSTANDING HEALTH AND GENDER

Health inequalities between men and women are the result of the interaction between biology and society in terms of how society structures and influences our lives. Men and women have different expectations and roles imposed on them by society and this has a significant impact on health.Gender difference is reflected in the form of seeking health care and nutrition intake. Women live longer as compare to men in developed countries like United States. Yet they suffer from diseases like arthritis for a longer period. This diminishes the quality of life among women (Read & Gorman, 2010). Double responsibility of women as home maker and earner is resulted in the higher rate of stress among them (Trypuc, 1994). The study of Guttentag and Secord showed that man has been given more calories than woman in every culture as man is assigned those activities which needed more physical strength (Wharton, 2005).

Gender contours individual's identity, social relation and institution through the process of social interaction and socialization. Gender difference and inequality can be seen at every path of social life. Women are excluded from many domains like politics, on the basis of difference from men. It is justified on the basis of biological and genetic differences between male and female (Wharton, 2005). Culture uses these differences to support the norm of male superiority over female. Men are socialised for public life. Women are socialized for giving priority to the need of family members and make their needs secondary for family (Hare-Mustin&Marecek 1988).

Gender inequality can be seen in every country like US, Japan, Morocco, Uzbekistan etc. However, inequality between women and men

reflects in mortality, natality, basic facility, special opportunity, professional, ownership and household. Mortality inequality is seen in North Africa and in Asia, including China and South Asia. Son preference is noticed in the form of female foeticide and infanticide in many countries like China, South Korea, Singapore, India, etc. Females are excluded from many basic facilities like education. Gender biasness in higher education and professional training can be observed even in some of the developed countries like Europe and North America. Gender inequality can be seen in the promotion and occupation even in Japan also. Men have control over material and non material resources like house, money etc. in India. Gender inequality can be found in terms of sharing the burden of housework and child care (Sen, 2001).Social theory can provide a context in which to interpret health patterns. Feminism is a broad theory, offering a variety of perspectives from which to understand women's position in society. In general, feminists argue that society disadvantages women by constraining them and limiting their opportunities. This is enforced through the domination of beliefs, theories and ideas that support and justify women's subordinate position relative to men. While there were significant advances towards equality during the 20th century in advanced capitalist societies, feminist theory argues that women are still exploited by society's structural organisation combined with embedded cultural attitudes and ideas that function together to exert social control over women (Turner, 2013; McDonnell et al, 2009; Rogers, 2009). Although, like feminism, Marxism is characterised by considerable interpretation, all varieties of Marxism are critical of capitalism. The goal of capitalism is the increasing accumulation of profit, which Marxist theorists believe originates from the exploitation of the labour force - primarily by paying them less than the value of what they produce. Capitalist societies are characterised by significant economic inequality and oppression, with major inequality in wealth between the mass of the labour force and those in control of society's economic resources. Marxists argue that social institutions such as the government, family, media and health system are influenced by the needs of capitalism, and operate to support the continued accumulation of profit to maintain this unequal situation (Miliband, 2004;

Callinicos, 1999). They believe that society's social organisation benefits capitalism at the expense of the majority.

Utilizing both theories simultaneously, a Marxist-feminist perspective emphasises that women's position of subordination is largely the result of the interaction between patriarchy - the dominance of men - and the needs of capitalism.

Many feminist perspectives have drawn on the medicalisation of women's bodies as an illustration of social control by a patriarchal medical profession, arguing that most of those in a position of influence are male and use scientific knowledge formulated largely by men. Feminists believe that men also primarily control the reproductive process, including access to contraception, pregnancy and childbirth, and reproductive technology. Women must submit themselves to male authority and knowledge, reducing their ability to make their own informed decisions (Abbot et al, 2008); their submission to such medical intervention reinforces female characteristics of passivity and dependence (White, 2013) and can be seen as an illustration of patriarchal social control over women.

Scientific understanding of women's bodies with regard to reproduction has historically had consequences for their social role (Doyal, 1985). Science is often used as a tool to explain the natural world, and its increasing application to the reproductive process reinforces both the assumption that women's nurturing role is natural and the expectation that they take on the role of carer. Marxist feminists believe this has many advantages for the economy.

Since the advent of capitalism there has been a division of labour between work and home (Zaretsky, 1986). Labour performed at work is valued, while that performed in the home - domestic tasks still largely undertaken by women - has no economic reward or value. Marxist feminists believe that domestic labour performed by women, including childcare, provides the capitalist system with an army of unpaid labourers whose activities enable family members - particularly men - to work, which subsequently contributes to capitalist growth.



CHECK YOUR PROGRESS

1. Fill in the blanks

i) Medicalistion of women's body is an illustration of _____

ii) Marxist feminist argue women's subordination is a result of _____ and value of capitalism

9.4 GENDER PERSPECTIVE ON DIFFERENCE AND SEGREGATION

Wharton (2005) defined gender as a system of social practices which created difference and inequality between male and female. It is believed that women and men are different and male dominance is natural throughout the history. It is first noticed in the first wave of feminism in which voice was raised for women's political right and against the inconsistency between ideology and the treatment of women. In 1960's, second wave of feminism raisel a social consciousness to understand the discrimination against women on the basis of policies and practices like inequality of pay.

Gender is a cultural interpretation of biological difference between men and women. Sherry Ortner considered that physiology of women and their reproductive function appeared close to nature. Women were associated with domestic domain and men were related to public domain of social life. Taboos and restrictions were imposed on women who experience menstruation and after child birth in many cultures. Women receive no salary for the work which they do within household and society does not recognize the social value of their unpaid work. Women are dependent on their male members like father and husband as there is a lack of access to resources among women (Moore, 1988).

Gender difference and segregation are seen from the lenses of biological essentialism, androcentrism and gender polarization. From the viewpoint of socio-biologists, human behaviour was based upon biological difference rather cultural and historical factor. Charlotte Perkins Gilman

developed the concept 'Androcentrism'. It was privileging the male's experience over female's experience on the basis of male superiority as a belief. Judeo-Christian theology and ancient Greek ideology supported the idea of 'Androcentrism'. Gender polarization is an organization of social life which exists in every culture and formed around the distinction between men and women. Gender identity was constructed on the presence and absence of genital organ. For Erik Erikson, female identity was founded on the presence of Uterus. Children moulded into some pre-established cultural pattern through socialization according to their gender. Constructing female identity was essential for the performance of domestic and reproductive function within the male dominated household. A social world was organized from male perspective and men's need is given priority over women's need (Bem, 1993).

Sexual division of labour is seen in the different responsibilities of man and woman within and outside the family. For Talcott Parsons, men has been assigned the role of breadwinner. If they do not perform the assigned job, they will be considered unfit to be as a husband and father. The role of homemaker and mother is considered a primary responsibility of women. This makes them unsuitable for paid work (Wharton, 2005). The power of decision making rests in the hand of men within the household. Men and women have different access to resources, services and wealth. Liberal feminists believe that the gender inequality is socially constructed which has no basis in 'nature' (Ritzer, 2011).Women's role as carers has been justified as a result of their reproductive function. However, while this is determined by biology, the way it is understood is socially constructed and can affect their experience of health. Women's natural reproductive function has increasingly been medicalised. For example, mood changes around the time of menstruation are no longer viewed as a natural period of hormonal imbalance resulting in premenstrual tension (PMT), but is now a medical syndrome (premenstrual syndrome)

With the women's movement, the rate of women's participation increases in the domain of paid work. The pushing factor for women for

entering in the domain of public is both economic and social. In changing circumstances in which men's income is not sufficient to support wives and children, women's salaries help in easing the economic burden of the family. Gender segregation is found in the concentration of woman and man into different jobs. For example, women are seen as more suited for teaching and nursing profession while engineering is considered a male dominated occupation (Wharton, 2005).

According to radical feminism, hidden violence is practiced along with overt physical violence in order to maintain male dominated and patriarchal society. Violence like unpaid work, under paid work, tyranny of motherhood, female infanticide is practiced against women (Ritzer, 2011). Females are getting less salary as compared to males' salary due to their less professional qualification. These inequalities are transferred to other fields like health. There is an unequal health condition in terms of differential access to health services. Health inequality creates unequal possibility to take advantage of medical advancement (Barreto, 2017).

9.5 MEANING OF NUTRITION AND HEALTH PRACTICES

"Nutrition is the intake of food, considered in relation to the body's dietary needs". Food is required to provide energy for performing function and to prolong the life. Nutrition is one of the important components of good health. Poor nutrition can reduce the immunity, increase the chance of disease, hinder the physical and mental development, and reduce productivity of affected person (World Health Organization, 2018). Pokarna (1994) recognizes the significance of food for the maintenance of health. Excess and deficiencies of nutrition like calories, vitamin, protein etc. may affect on the health on the affected person (Cwikel, 2006). The indicator used for nutritional status is the body mass index (BMI). BMI is defined as the weight in kilograms is divided by height in meters squared (kg/m2). This indicator uses to assess both thinness and obesity of person which affect the health of affected person (Mehrotra& Chand, 2012).

Health practice is defined as "sum total of people's reactions, through personal practical experience, to the health services operating in a community and the way these experiences fit in their frame of reference". Health practices are depended on the culture prevailing in the society and are guided by certain beliefs and principles. People follow different type of health practices for healthy living, identification of disease and treatment. These practices are secular-rational health practice and non-secular non-rational health practice (Pokarna, 1994).

Secular- rational health practices include dietary practice, physical activities, use of clean water, maintaining hygiene, avoiding addiction, consultation with doctor etc. for treatment and prevention. Non-secular non-rational health practices are magico-religious practices like visiting faith leader, praying, conducting rituals, using amulets etc. (Pokarna, 1994).

9.6 REFLECTION OF GENDER INEQUALITY IN THE DOMAIN OF HEALTH IN TERMS OF NUTRITION AND HEALTH PRACTICES

Medical advances have greatly benefitted the health of men and women. In the patriarchal society, men and women are not equally placed. This can be seen in the subordination of nurse to physician and the interaction of male physician with their female patients. Subordination of women is not limited only to home but also to the domain of health. For example, it is believed that contraceptive device librates women from an endless cycle of child birth. Indeed, it proves dangerous for women's health. In the United States, thousands of women have suffered from the infection due to the use of contraceptive device (Muszynski, 1994). In most of the countries, women receive less attention and health care as compared to men. According to the FAO, most of women and children confront hunger as a defining characteristic of their lives (Tiwari, 2017). Due to this gender bias, the mortality rate of females has increased in comparison to males (Sen, 2001).Women are the main providers of informal care to children, disabled and older people and, men. The effects of this role can include

reduced sleep, less leisure time and increased risk of poverty for women who are full-time carers. All of these can have serious negative consequences for both physical and mental health.

According to the FAO, most of women and children confront hunger as a defining characteristic of their lives (Tiwari, 2017). Cultural beliefs influence the food habit of women which affect their nutritional status and health. The study of Green (1994) showed that female cooked food according to the preference of family members. In some societies there is a tradition in which male members eat the food first and female members eat the left over. As a result, sometime enough food or balanced meals that include all the needed nutrients may not available to females. This has negative effect on their health resulting is malnutrition.

Developed countries have better health condition than that of developing countries. In any country whether developed and developing, population have different health condition according to social, economic, geographical, political and ethnic context. In 1979, the British National health system had submitted its report to government which showed unequal access of health services among different social groups (Barreto, 2017). The position of all women is not same in the context of nutritional intake and health depends on the economic position of the families to which they belong. Healthy pattern of behaviour is found among affluent family (Green, 1994).

In the study of Morris et al. (2014), delay in health seeking behaviour is found among women due to many reasons in Madagascar. Preference is given to non-secular non-rational health practices like visiting faith healer than consulting physician for treatment. Women prefer to visit faith healers due to their friendly nature and negative experience with in health facilities. Elders family members like parents, sibling, partner etc. play an important role in the decision making in terms of seeking health care practices.

9.7 DIFFERENCE IN NUTRITION INTAKE AND HEALTH PRACTICES IN INDIA

Socio-cultural factors like beliefs and traditions influence the healthcare practices. Poor health condition of women can be reflected in prevalence of anaemia and nutritional status (Mehrotra& Chand, 2012). According to National Family Health Survey (NFHS-4) of 2015-2016, fifty-three percent of women between the ages of 15-49 years are anaemic. Females have poor health status as compared to males due to the discrimination against females in the allocation of food and health care within household. Gender discrimination is reflected in the childhood feeding, immunization, treatment seeking and nutritional status. The need of the son in the form of feeding is given more attention as compared to daughter (Mehrotra& Chand, 2012).

According to NFHS-3, women consume less nutritious food than man. The major indicator of female status is maternal health. Maternal health has relied on socio economic conditions and facilities provided by government. Poor maternal health discloses the low status of women in the society (Mehrotra& Chand, 2012). All communities especially rural community, consider menstruation as dirty or polluted. There are traditional customs and cultural practices which are suggested during menstruation. Females are expected to sleep on floor and prohibited from performing religious activities during the period of menstruation (Pokarna, 1994).

A high percentage of women are not receiving health facilities during pregnancy which influence their survival condition as well as their child. Anaemic and underweight women give birth to underweight and premature baby. Son preference is seen in the form of excessive mortality of female child (Mehrotra& Chand, 2012). The Medical care of girls is neglected as compared to boys (Sen, 2001). The Majority of rural women are not seeking any health care facilities as they do not have any rights in decision making process. Education, occupation, economic status and awareness have positive effect on the health condition of women and ultimately on their status (Mehrotra& Chand, 2012).



CHECK YOUR PROGRESS

QB1. Who developed the concept of androcentrism

QB2. Name two factors which have positive effect on the health of women



9.8 LET US SUM UP

- Gender inequality is found in the action of individual and expectation from individual that regulates the interaction, composition of social groups, structure and practices of institutions
- Life expectancy of women is longer than men due to their biological and behaviour patterns.
- Despites of this, they have to suffer from diseases for longer period. It is believed that men are suited for public and women are suited for domestic domain of social life.
- Women receive no payment for their domestic functions like caring of family member, doing household chores etc. As a result, there is a different access to resources, wealth and power among male and female.
- Differences in nutritional status and health practices among men and women stem from the root of patriarchal ideology.
- There is a relationship between poverty and health. Lack of access to basic facilities and resources make women dependent on male members like husband.
- The problem of Malnutrition and unequal access to health facilities are more affecting the population of poor country.
- Poor nutritional status of women results in the decrease the immunity, increase the chance of disease, hinder the growth and reduce productivity.

- The significance of 'motherhood' role leads women to ignore their needs and give priority to the needs of husband and children.
- Double role of women such as home maker and earner is not good for the health of women.
- It decreases the leisure time of women and increases work hours which creates stress in the life of women.
- Rise of medicalization also objectified the body of the women (Muszynski, 1994). This declines the value of woman as a person with the introduction of the process of 'in vitro fertilization'.
- Health practices reflect the behaviour of the people towards their health.
- Cultural beliefs and socio-economic status influence the health practices of people.
- Taking nutrition diets, maintaining hygiene, avoiding substance abusing and taking treatment are essential for healthy living.
- Non-rational health practices are followed due to friendly nature, accessibility and less fees of faith healer.Gender discrimination is observed in the childhood feeding, immunization, seeking treatment and nutritional intake.
- The study of Pokarma (1994) revealed socio-cultural barriers in seeking treatment like influence of traditional healer, nature of relationship between mother-in-law and daughter-in-law, and lack of trust on doctor.
- The problem of malnutrition and unequal access to health facilities become focal point of policies makers.
- Creating equal opportunities in the context of education and occupation can change the health condition and status of women.
- International agencies like WHO and non- governmental organization is also working in the area of health through creating awareness among people.