

Women in the Motherland Gender Health Inequalities in India

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Abstract

Gender-related health inequalities in India have not received much attention from health program developers, implementers, and researchers. This paper attempts to put forth the current prevailing issues related to gender and health in India which could form the basis of a number of health program reforms and future research. It also mentions certain health behaviors and diseases for which gender differences remain largely unacknowledged. This article further highlights gender inequalities in the provision of health technology and services. It also presents inequalities associated with utilization of health services which is perpetuated by lack of gender-sensitivity in the planning and provision of these services. It also points out the health policies in place which have not been able to alleviate gender-related health inequities and inequalities. A number of issues requiring urgent attention have been raised which should be addressed to improve over-all gender-related and gender-associated health inequalities.

Key words: Gender inequalities, Gender, Health inequalities, India, Women's health

INTRODUCTION

Health is a multidimensional, composite construct of biological, and socioeconomic factors (Cheng and Goodman, 2014). Extrapolation of the variations in these factors results in difference or disparity in health statuses. Inarguably, such a disparity represents an inequality that has been described as “unfair, unjust, or avoidable” (Adler and Rehkopf, 2008). To improve our understanding of the societal disparities in health and healthcare, it is imperative to study the different factors at play, widening our focus to include not only income but also other markers of deprivation such as gender, religion, caste, and occupation (Murray *et al.*, 1999; Braveman and Tarimo, 2002). Out of these, gender is inherent to each individual and is considered a social construct even though the terms “sex” and “gender” have long been used interchangeably (Pryzgodna and Chrisler, 2000). Gender varies with societies and eras in terms of the gender roles, behaviors, biases, and norms prevailing in society at that time. Gender has had

a varied impact on health outcomes. Such impacts range from the lop-sided access (in favor of men) to resources such as food, healthcare, education, and finances to the subjugation and powerlessness, especially among women from lower and middle-income countries like India (Basu, 1989; Nichter *et al.*, 2010; Duflo, 2012; Aurino, 2017). Therefore, this essay will address if the inequalities in health associated with gender are increasing in India in the 21st century.

Mortality rates among females of all age groups are lower than males in most populations resulting in a greater number of women (Hill and Upchurch, 1995; Pongou, 2012; Regan and Partridge, 2013). Contrastingly, India has long presented with a skewed male-female child sex ratio (Jha *et al.*, 2006). Furthermore, the infant sex ratio in India has deteriorated from early 20th century to its current state in the 21st century [Figure 1]. The situation has been appalling for children aged 0–6 years with a maximum decline in sex ratios and a consistently decreasing number of girls in the past 50 years [Figure 2] which at present stands at 914 girls for a thousand boys. Comparing two consecutive census data has revealed that “made-to-order pregnancies” and “sex selection” have increased over the past 10 years, with an annual rate of 0.57% ($P = 0.02$) (Jha *et al.*, 2011). Skewed child sex ratios have been primarily linked with the sex differentials in the infant and child mortalities. India has long been established as a largely

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www.ijss-sn.com

Month of Submission : 06-2020
Month of Peer Review : 07-2020
Month of Acceptance : 07-2020
Month of Publishing : 08-2020

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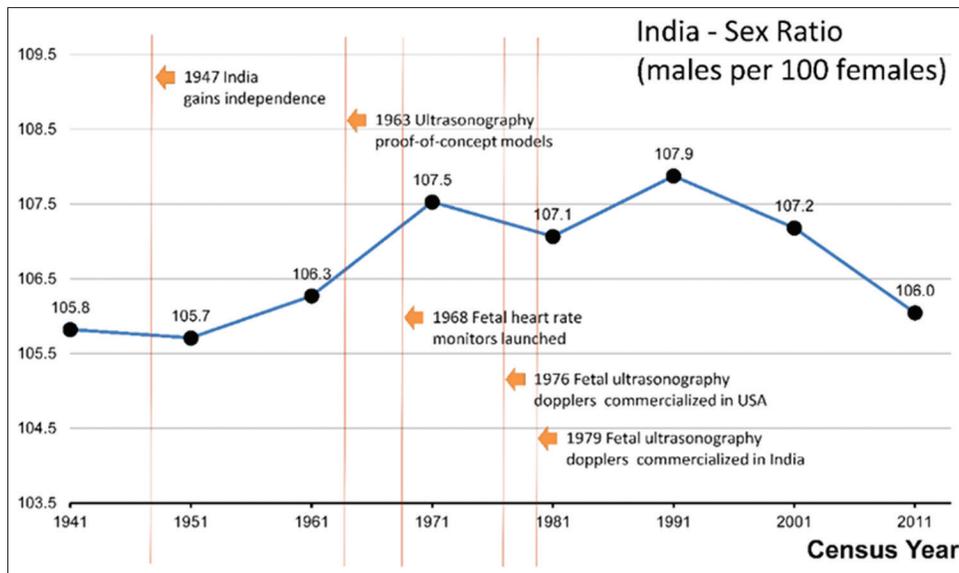


Figure 1: Infant sex ratio in India from 1941 to 2011 using census data. Extracted from Jha *et al.*, 2011

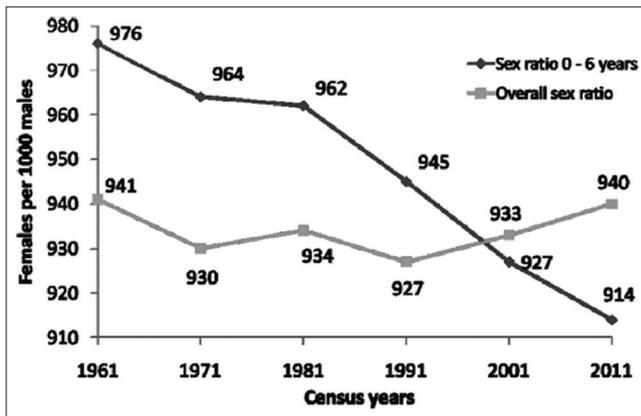


Figure 2: Dwindling child sex ratio in the 0-6 year age group (As adapted from National Census data from 1961 to 2011— Census India, 2011)

“patriarchal, patrilocal, and patrilineal” society (Silva *et al.*, 2017). Female foeticide and infanticide plagues, the Indian society due to the much prevalent “son mania” and girl-child considered a “burden” the geography, ethnicities, and socio-economic status of the population. Surprisingly, research has shown that an average educated Indian woman is also more likely to actively choose a male child (Aravamudan, 2007; Ansari, 2018), The distribution of power, resources, on the one hand, and occupations and risk factors, on the other hand, are all governed by the prevailing gender bias (Johnson, 2001).

Even for the surviving female child, an acute differential in the child care exists. Analysis of breastfeeding patterns among the Indian population showed significant differences between the length of breastfeed received by sons in comparison to daughters (Jayachandran and Kuziemko, 2011). This is in line with existing literature

showing that Indian parents choose to allocate greater resources to the male child (Pande, 2003; Osters, 2009). This trend continues through into the 21st century as the costs of living rises, reducing family size with the son seeming to be the more “profitable investment” (Hesketh and Xing, 2006). A similar inequity is seen between immunization coverage for the male and female children in a family, seen by comparing the coverage from 1992–1993 to 2005–2006. Despite increased incentivization and immunization programs introduced by the government, there is a steadily lower immunization coverage among females, even though the overall percentage coverage has increased (Corsi *et al.*, 2009). A number of studies have shown a distinct parental discrimination against the girl child in providing basic food and health care which has been understood as a major cause for existing gender disparity in health-care provision, nutrition, and child survival (Gupta, 1987; Basu, 1989; Mishra *et al.*, 2004). Despite the inherent biological advantage, females in the Indian context are dealt a tough hand in terms of the existing oppressive patriarchal social structure which has marginalized women through the centuries into the 21st century as well giving them an environmental, material, and psychosocial disadvantage (Banerji, 2016; Purewal, 2018). Since only a small percentage of the women are involved in monetarily fruitful work, an average woman is at the mercy of the male head of the family to allocate funds and resources for her health and well-being (Santow, 1995; Banerji, 2006). Even with a rise in the employability, education, and economic status of women, there has been only a small reduction in the gender disparities, despite the overall improvement of the health status of the Indian population (Corsi *et al.*, 2009; Saikia *et al.*, 2016).

The gender associated health inequity is not restricted to certain age groups. This disparity persists through older ages, with women being more likely to suffer from a disability and chronic health conditions. In addition, older women are at a higher risk of dependency, isolation, poverty, and neglect. They have higher chances of being left out of various social security programs due to low literacy, confinement at home, and gender relations, as experienced in daily life (Case and Paxson, 2005; Sen and Östlin, 2008; Pandey and Ladusingh, 2015).

An accepted historical generalization has been that “Women get sick and men die” which has been reiterated with time (Oksuzyan *et al.*, 2008). Saikia *et al.* (2016) illustrated that this gap has persisted through the 20th into the 21st century, although it has narrowed. Several studies have revealed the existing and widening disparity in the prevalence of common non-communicable diseases (NCDs) (such as obesity, diabetes, heart disease, stroke, cancer, and chronic respiratory diseases) between the genders (Anish *et al.*, 2013; Bonita and Beaglehole, 2014). According to the 2014 National-level data, overall NCD prevalence has been found to be higher among women (63%) as compared to men (47%). It was also seen that rural women (86%) had a higher risk of NCDs in comparison to rural men (64%) and urban men (53%) (Patra, 2016). Factors such as differential exposure to risk factors (such as stress, tobacco use, and occupational hazards), division of labor on the basis of gender, accessibility to preventive services, and treatment culminate in poor health outcomes for women (McDonough and Walters, 2001; Hosseinpoor *et al.*, 2012; Silva *et al.*, 2014). The perpetuating state of women is further reiterated by the social role theory, which suggests a vicious cycle between the social role played by a gender in society and their occupation which mutually and reciprocally affect each other (Eagly, 2012; Koenig and Eagly, 2014).

Gender does not affect health in isolation; instead, it is a complex interplay of other social determinants. Poverty and social class are other important factors which affect the health outcome of a population. Batra *et al.* (2018) and Pandey *et al.* (2018) noted the unfavorable gender differential toward women in terms of expenditure for hospitalization and cancer treatment. Pathak *et al.* (2010) analyzed national-level health surveys from 1992 to 2006 and found that the utilization of unskilled home delivery has reduced only by 1.8% among the poor pregnant women in comparison to 11.3% among the non-poor. Such a marked difference perhaps is influenced by the cost of service, distance to health facilities, cultural beliefs, level of education among the poor and non-poor women, and their families. This perhaps indicates that with improved socio-economic status, there is improvement

in the health status of women. Similarly, Saikia (2016b) assessed the gender difference in health-care expenditure (HCE) using national level data from 2004 to 2012 and found that female HCE to be significantly lower than male HCE with other demographic and socioeconomic factors controlled. Distinctly lower HCE was found for females for both chronic and short-term morbidity, with the disparity widening from 2004 to 2012. This HCE discrimination persists from youth to adulthood and widening in old age. Such a consistent disadvantage for the women probably stems out from the complex web of deeply entrenched patriarchy, poverty, and social position of women eliminating her health from priorities of the household since the women are traditionally more invested in household activities that are not directly associated to economic gains. Thus, they would postpone addressing their own health needs giving priority to the males of the household who are the “bread earners” and bring income (Santow 1995; Das *et al.*, 2018).

It has been reiterated time and again by the Black report (1980), the Acheson Report (1998) and the Marmot Report (2012), that significant health inequalities are seen through the 20th into the 21st century associated with gender, social class, ethnicity, and other factors. Inequities corresponding with gender are further magnified with the complex of socioeconomic status and the prevailing health services situation and poverty status of India. Even though there have been general improvements in health indicators in the population, the most deprived women remain the unhealthiest. Despite an improved health status among women, they still lag behind when compared to their male counterparts. Despite the efforts of the government in terms of newer reforms, national-level health programs and incentivization of a number of health services for the women, the sheer magnitude of centuries of social disadvantage, prejudice, and continued bias to the male child looms large on the health disparity faced by women in India.

ACKNOWLEDGMENTS

The authors would like to thank Professor Wendy Martin for being a constant source of support and ideas.

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How to cite this article: Mehra R. Women in the Motherland Gender Health Inequalities in India. *Int J Sci Stud* 2020;8(5):15-18.

Source of Support: Nil, **Conflicts of Interest:** None declared.