A STUDY ON WOMEN AND HEALTH IN MANIPUR

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Introduction

India is one of the few countries in the world where women and men have nearly the same life expectancy at birth. The fact that the typical female advantage in life expectancy is not seen in India suggests there are systematic problems with women's health. Indian women have high mortality rates, particularly during childhood and in their reproductive years. The health of Indian women is intrinsically linked to their status in society. Research on women's status has found that the contributions Indian women make to families often are overlooked, and instead they are viewed as economic burdens. There is a strong son preference in India, as sons are expected to care for parents' as they age. This son preference, along with high dowry costs for daughters, sometimes results in the mistreatment of daughters. Further, Indian women have low levels of both education and formal labor force participation. They typically have little autonomy, living under the control of first their fathers, then their husbands, and finally their sons (Chatterjee, 1990; Desai, 1994; Horowitz and Kishwar, 1985; The World Bank, 1996). All of these factors exert a negative impact on health status of Indian women. Poor health has repercussions not only for women but also their families. Women in poor health are more likely to give birth to low weight infants. They also are less likely to be able to provide food and adequate care for their children. Finally, a women's health affects the household economic well-being, as a women in poor health will be less productive in the labor force.

Manipur – Its profile

Manipur is a strategically located state in the North Eastern region bound by Nagaland in the North, Assam to the West, Mizoram to South and sharing a long international border with Myanmar to the east and south. Manipur has area coverage of (22327 sq. k.m.). 10% of Manipur area is valley area divided into four districts Imphal West, Imphal East, Bishnupur and Thoubal holding 65% of the State population. The valley is surrounded by steep hilly forest area divided by five districts holding 35% of state population. The principal language is Manipuri spoken by 65% of the people and the rest are tribal languages without script. Manipur has bounteous rainfall with rivers and hilly streams. Urbanisation is confined to the plains. Vast majority of the people are non-tribal, majority of hill districts is inhabited by the tribals from different community. The capital city is Imphal West in the plains.

The valley districts has high density of population with better road communication and better socio economic development and high agricultural productivity. The five hill districts are very sparsely populated. Poor road communication, jhum cultivation and difficulty to access health

institutions with poor maternal and child health status. Manipur has nine districts, 39 CD blocks, 2582 villages with a population of 2,570,390 (2011 census). The state has sex ratio of 987 higher than the National average which is 940. The population density is 82 per sq. km. Literacy rate is 79.85%.

Women and Health

Women's health plays an important role in determining the health of the future population because women's health has an intergenerational effect. The culture, traditions and customs which have its roots in patriarchal system and male biases philosophy have been suppressing the welfare and development of women since time immemorial. Women in general are not expressive but rather silent in their own cases of health related issues.

To be healthy requires good food, mental and physical rest, economic back up and sound knowledge of health. The deterioration of health care system and the rapid spread of diseases include those associated with malnutrition and inadequate water supply systems.

The meaning of health is culturally defined. Therefore, understanding of the women's perception of reproductive health in *sine qua non* in order to give a holistic representation of women's health. Here, understanding the conceptual distinction between "disease" and "illness" becomes essential. The concept of disease has historically been the most dominant category; it has a biological interpretation and refers to abnormalities in the structure or function of organ and organ systems, pathological states whether or not they are culturally recognised. Health, as a felt experience of the individual, provides another meaning which embodied in the term "illness". Thus, illness is the meaning that individual give to health and refers to a "person" disvalued states including but not limited to disease (Young, 1982). Illness is the individual's consciousness that there is something wrong (Frankenberg, 1980). Thus, disease is the western medical paradigm is malfunctioning or mal-adaptation of biologic and psycho physiologic processes in the individual, whereas illness represents personal, interpersonal and cultural reactions to disease and/or discomfort. Illness is shaped by cultural factors governing perception, labelling explanation and valuation of the discomforting experience, processes embedded in a complex family, social and cultural nexus. Because illness experience is an intimate part of social systems of meaning and rules for behaviour, it is strongly influenced by culture: it is, as we shall see, culturally constructed (Kleinman, Eisenberg and Good, 1978).

The health of women depends on their emotional, social and physical well-being which are determined by different social, political and economic contexts of their lives. India being large country, has a diverse population – socially, culturally and economically; yet, the common major problem that women here face in availing health care, is inequality, between men and

women; among women of different geographical regions, social classes and indigenous and ethnic groups across the country. There are several factors responsible for the current status of women, one is the culture itself.

Women are subjected to selective malnourishment from birth. There is a strong preference for the male child in several states promoting illegal sex determination and female foeticide. This not only poses threat to the expectant mother's physical and mental health but also imbalances the sex ratio, thereby giving rise to several other social problems. The girl child is treated as a financial burden on the family because of customs like dowry at the time of marriage. This is a major reason why sex determination and female foeticide is rampant in some places. Women are not free to control their fertility and decision regarding medical termination of pregnancy is influenced by husband or others family members. There are states with remarkable decline in the fertility rates of females, yet female foeticides continues and strong preference for male child remains in the patriarchal societies like Indian, women on an average have less power, status, autonomy, independence and financial resources. They are mostly the carers, providing both domestic labour and health care for husband, children and elders whenever required. The male child preference exists mainly because of the patrilineal nature of these societies where the property and title are inherited by only male lineage.

Despite all odds, the backbones of the family are women. The family health issues relate to various phases involving fertility and pregnancy, infancy, childhood, adolescence, adulthood, and old age along with the familial relationships. Poor pregnancy outcomes affect not only the mother but also the child, family, and the community physically, mentally and economically. In women and children suffers significantly.

The major gender specific cause of death in India continues to be the maternal mortality, despite this being one of the key agenda in the national health care programs.

The maternal mortality rate is 212 per 1000 which is almost 6 folds higher than that of china. Women's post-natal health appears to take second place for all once the process of child birth is over. The percentage of women receiving post-natal care within two days of delivery across states gives a glimpse of the same. The mothers who do not avail antenatal care and/or give birth unattended by the trained personal, invariably indulge into wrong practices related to child care and hence the child health complications adding to the infant mortality rate (IMR). Early marriage and early child bearing are important factors adding to maternal mortality rate (MMR) and IMR. Every third girl in the developing countries (excluding China) is getting married at the age before 18. Early marriage is observed to compromise the sexual and reproductive health of young women and the adverse consequences are borne not only by young women but also by the child they bear.

The indicator 'Domestic violence' reflects lots about the status of women in society. Women marrying at a later than 18, are seen less prone to domestic violence, may be for their improved awareness about marital life, sexual behaviour and its consequences along with the physical and mental development with time. In addition the women are seen to be participating in deciding about their marriage if they marry at a later age. Mother experiencing intimate partner violence is found significantly associated to infant mortality. Experiencing marital violence not only damages the women's physical being, but also has serious negative impact on the multiple aspects of women's reproductive health. Moreover, it is observed that the marital physical violence by the husband and acceptance of the justification for such violence are significantly associated with decreased chance of seeking care (Ganjiwala 2012).

The gender inequality and mortality analysis reveals that the life expectancy of male and female in India are comparable (65.77 for males and 67.95 for females – 2011 estimates). This small difference also refers to the low social status of the women in the country. As education holds the key to development, women education should be considered more seriously. Comparing the health indicators and empowerment indicators across states, the effect of women empowerment on health can be visualized underage girl marriage is 4.8% in Kerala against 41.2% in West Bengal, 42.7%.

If we see the sex ratio in the above states, Kerala had 1053 against 898 in Uttar Pradesh, 919 in Bihar and 934 in West Bengal (WB). Bihar has overall literacy rate of 47% with 59.7% male literacy against 33.1% female literacy. The status of literacy in Kerala is 90.9% total, 94.2% male and 87.7% female literacy against 68.6% total 77% male and 59.6 % female literacy in WB. So Bihar remains way behind in terms of literacy and education against Kerala.

The IMR in Kerala is 11(per 1000 live births) against unavailable data for Bihar in 2008 and 81 in Uttar Pradesh and 86 in Madhya Pradesh. In Kerala, 99.3% women are reported to avail antenatal care against 28.1% in Bihar showing the awareness of women about their health and also indicating the availability of health care facilities in the two states. The reasons for better indicators on all aspects in Kerala over other states could be liberated and educated women who are capable of taking care of the education and health needs to their children and the rest of the family. School attendance in Bihar is low compared to other states.

The dropout rate in Bihar is 48 in 1^{st} – 6^{th} standard itself for both sexes. The proportion of girls getting married before the age of 18 in Bihar is 69% and more so in rural areas this proportion is as high as 75%. The number of children per women in Bihar is 4 against 1.9 in Kerala. The mothers who had atleast 3 antenatal care visits for their last birth in Bihar is very high than the anaemia prevalent in men in the same state. This proves the gender bias in the state. The domestic violence in Bihar is rampant at 59% against only 16% in Kerala. These are all strong

indicators, why a state were women are better empowered and have an active role in the society, is faring far well, compared to the other states. Therefore women empowerment should be ensured in all the states as it is identified as a key to progress development for the states and hence the nation.

The condition of women in Manipur in particular is not different from the rest of the country. Manipur being a male dominated society has certain obligations and duties that are attached to a female, as mentioned above cultural traits seems to be an obstacle in women status in the family and society. India as a whole has never had a clear cut policy for women's health, but a range of policy decisions has directly or indirectly influenced women's health. Women's health covers morality, morbidity, nutritional status and reproductive health. Linked to these are environmental degradation, violence and occupational hazards, all of which have implications for women's health. The report of the committee on the "Status of women in India", 1974 "towards equality" focused among other things on the declining sex ratio in India attracted international attention. The sixth five year plan (1980-85) attempted to integrate and interlink issues related to women across sectors to guide the various ministries dealing with women's issues. Another report of the National Commission on Self Employed Women and women in Formal Sectors (1998) recognised the occupational health hazards of women.

The government of India undertook programmes for women's health like Maternity and Child Health (MCH), Family Planning Programme (FFP) and nutrition and Immunization programmes. These were brought into the frame of the family and transformed into a reproductive and child health (RCH) strategy. Another programme is the Integrated Child Development Scheme (ICDS) which was started in the year 1975. Unfortunately, in Manipur the policy of declaration on health by WHO (World Health Organization) and emphasis given by the Government of India for improvement of health still remains a distant dream for poorer section of the society. Most of the Health Centres in Manipur, District Hospitals and Health Sub-Centres are far below the required standard.

Moreover, the present political scenario and conflict situations make doctors and health workers to excuse themselves of not giving to rural remote areas or places. Apart from this problem, in Manipur private run Health Institutions are becoming more popular day by day whereas Government run Hospitals and centres are decreasing its standard even at the heart of the capital city, Imphal. There are two state level hospitals which has more than 200 beds each. There are Primary Health Centres (PHSC), Hospitals run by Non-Governmental organizations and churches in Imphal and Churachandpur. There are Nature Cure Hospitals too in the state.

In the valley the existing health care institutions are functioning but in the hills due to shortage of funds and due to prolonged armed conflict most of them are defunct now. The World Health

Report 2004, noted that with the exception of Sri Lanka all countries in South Asia fall in the "high child and adult" mortality stratum. Women's access to Health and Health seeking behaviour is affected by their low economic status, social norms and cultural values.

In Manipur the incidence of Reproductive tract infections (RTI's) and Sexually Transmitted Diseases (STD's) remain high and the spread of H.I.V. (human Immune Virus) infection is increasing at an alarming rate. Communicable diseases such as Tuberculosis, Malaria, and Dysentery are also major health problems especially in rural areas. During illness fewer women than men seek and received treatment. There is a gender asymmetry in the utilization of health services. Early and forced marriages, young motherhood continues and mal-nutrition, anaemia and higher morbidity persist. As a result young adolescent girls who discontinue their education and vocational training are denied information about their bodies, thereby constituting a life cycle of deprivation and discrimination resulting in a continuum of health related vulnerabilities for women and young girls.

Violence and sexual coercion have a severe impact in increasing women's vulnerability to HIV/AIDS. "Women are often burdened in the care economy exclusively as care givers rather than as receiver of care (Kipgen 2010). Manipur is one of the six states identified by the Government of India as high HIV prevalence state. The HIV prevalence rate among the women who attended antenatal clinics in the state is 13 out of 1000 (according to 2005 sentinel surveillance report of MACS). It is very dangerous that HIV/AIDS is steadily attacking the innocent women of the state who do not indulge in risky behaviour like drug injection and sex selling works. Out of the total 161,813 blood samples tested for HIV up to August, 2006 there are 23,856 cases of HIV infection, 5323 of them are women. Majority of them are housewives who get the virus from their husbands. Furthermore when a woman is found positive on HIV, there is an escalation of domestic violence by family members especially after the death of the spouse/partner. Many of them are thrown out of their marital homes and deprived of their property rights and maintenance and have to constantly struggle and fight for what is their very own.

Women face a great deal of occupational health hazards in the work that they do, be it formal or informal sector. Due to excessive use of pesticides in agriculture workers are often found suffering from visual impairment, dislike of bright lights, night blindness, mental disturbances, anxiety insomnia and depression. Again women living in the forest/hill areas due to deforestation lose their source of nutrition, medical herbs, plants, roots and fruits which led to increase in diseases and mortality in women. Environment degradation has serious consequences on women's health, due to deforestation rural women are also losing valuable working hours. Each day looking for fuel and fodder takes its toll on the health of women which causes body ache, joints pains and other physical problems. Over a period of time due

to carrying of heavy load on the head postural defects of the neck, spine and pelvis may develop. Again, women suffer due to the increase in population which deprived them of privacy and complicate health problems in the absence of toilet facilities.

In and around conflict situation women's health suffer too because they are targeted both by state and non-state actors. It has given rise to many women-headed household. Often many of the widows resort to drinking liquor, drugs or even go to prostitution to earn money for their livelihood. This also greatly increases the risk of getting infected with HIV/AIDS, sexual slavery and the spread of sexually transmitted diseases.

In the hill areas of Manipur women are sandwiched between the police/armed forces who seek information about insurgents and the sick and the wounded insurgents who seek the villagers help. Taxes taken by the armed groups causes yet another problem for them, since there is a price hike of medicine and many of them especially women are not able to afford essential drugs, due to prolonged armed conflict large number of them cannot have access to health care even pre-natal and post-natal care. In addition to all these problems, incidences like rape, unwanted pregnancies and lack of decision making are roaring high among the women in Manipur.

Conclusion

I would like to highlight the need to incorporate women's perception of reproductive illness while designing reproductive health programmes which are culturally sensitive to bridge the gap between what is considered as the need and the actual need at the grassroots level. There is also need to understand traditional knowledge and practices in the recommendation on health and training for family and planning providers. It is also time to remove ignorance from the mind of the public in order to get rid of the stigma and discrimination. Education and awareness about good health in the need of the hour. The Non-Government Agencies/ Organization have an important role to play in promotion of the health of women, and this can be undertaken not only by women's organization but also by those which have mixed membership and working in the wider range of social development. There can be various measures suggested for the upliftment and wellbeing of women's health like their access to health care and information related services must be within affordable and easy. Preventive measures should be promoted for women's health, male responsibilities must be emphasised in the family and society including gender sensitization for elimination against women in all spheres should be voiced and increase in resources and monitor follow up for women health should be made. Empowering the women folk in all spheres be it in the private or public sector should also be encouraged.

References

Chatterjee, Meera, 1990, *Indian Women: Their Health and Economic Productivity,* World Bank Discussion Papers 109, Washington, DC.

Desai, Sonalde, 1994, *Gender Inequalities and Demographic Behaviour,* India, New York.

Frankenberg, R.(1980) *Medical Anthropology and Development: A Theoretical Perspective, Social Science and Medicine,* 14B: 197-207.

Horowitz, Berny and Madhu Kishwar, 1985, "Family Life – The Unequal Deal", in Madhu Kishwar and Ruth Vanita, eds., *In Search of Answers: Indian Women's Voices* from Manushi, London, Behaviour, India, New York.

Kipgen, Tingneichong, G.2010. *Women's Role in the 20th Century,* Manipur. Delhi: Kalpaz Publications.

Kleinman, A., Eisenberg, L. and Good, B. (1978): *Culture, Illness and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research, Annals of Internal Medicine,* 88:251-258.

The World Bank, 1996, *Improving Women's Health in India,* Washington, DC.

Young, A. (1982): *The Anthropologies of Illness and Sickness,* Annual Review of Anthropology, 11:257-285.