INFLUENCE OF WORK STATUS ON WOMEN HEALTH IN INDIA

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ABSTRACT

India is on the path of becoming an economic superpower but its performance index in health component of human development, particularly that of women is not at all impressive. The typical female advantage in life expectancy is not seen in India. In the context of the new economics of liberalization and its challenges to work, human security and development it is necessary to understand whether women are in a position to take advantage of the economic take-off. Therefore, an attempt is made in this paper to analyses the health issues of women in India in relation to their work environment, productivity and welfare. It focuses on two broad areas of gender-based differences and inequalities, viz. the links between gender and economic productivity, and the development of human capital.

KEYWORDS: Health, Labor, Gender, Empowerment, India.

INTRODUCTION

When we say that India is a developing country, we include in "development" the progress that is witnessed among women too. In fact development is gender neutral.1 The new and non-income indices of development viz. Physical Quality of Life Index (PQLI), Minimum Needs Approach, Human Development Index etc have in them the vital component of 'health', couched specifically in life span or life expectancy and infant mortality rate. In the Human Development Report (HDR) of 1990 there was a clear emphasis on the health aspect of human development. HDR 1994 underlined the importance of health security. Contextually HDR 1995 introduced the Gender-related Development Index (GDI) and Gender Empowerment Measure (GEM). Women seemed to have come to the centre from the periphery. With Clifford Cobb, Ted Hallstead and Jonathan Row suggesting the Genuine Progress Index, the stage was set for a genuine concern for women in sustainable development (Hans, 2000). However, the causes of the persistent inequality between men and women are only partially understood, be it in education or in health sectors. In recent years attention has focused on inequalities in the allocation of resources at the household level as seen in the higher share of education, health and food expenditures boys receive in comparison with girls. The decision-making process within households is complex and is influenced by social and cultural norms market opportunities, and institutional factors. There is considerable proof that the intra-household allocation of resources is a key factor in determining the levels of schooling, health and nutrition accorded household members. Inequalities in the allocation of household resources matter because education, health and nutrition are strongly linked to well-being, economic efficiency and growth. Low levels of educational attainment and poor health and nutrition aggravate poor living conditions and reduce an individual's capacity to work productively. Such economic inefficiency represents a significant loss to society and hampers future economic growth (World Bank, 1995). For a country that is on the path of becoming an economic superpower India's performance index in health component of human development and particularly that of women is not at all impressive. Although there have been various improvements in health indicators over the years, quality and affordable services have not reached the poor.

The problem is still worse when judged from the gender perspective (Dinesha et. al., 2008). The inequalities that exist within and between regions, social classes and gender prevent the growth of the Indian economy from improving the lives of many everyday Indian people. Nowhere is inequality more evident than in the lives of Indian women, and likewise, there is no sector more affected by the lack of improvement in social issues (Wilson, 2008). This is all the more worrying given the fact that 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 (Velkoff and Arjun, 1998). Surviving through a normal life cycle is a resource-poor woman's greatest challenge. The persistence of hunger and abject poverty in India and other parts of the world is due in large measure to the subjugation, marginalization and disempowerment of women. Marginalized women today are the focus of concern and, several of their issues are points of strong debate to bring about positive changes (Appachu, 2007). Whether it is health and nutrition or any other field, women are noticed to be the worst sufferers. Women suffer from hunger and poverty in greater numbers and to a great degree then men, mainly because malnourishment leads to illness more in case of women and culturally male heads get lion's share of food. At the same time, it is women who bear the primary responsibility for actions needed to end hunger: education, nutrition, health and family income (Coonrod, 1998; Sharma, 1993). Sadly though, women's health is entering the realm of human capital theory only slowly.

WOMEN'S HEALTH: DEFINITIONAL ASPECT

Any attempt to build or study a discipline should start by defining its basic concepts. As regards women's health there are traditional as well as modern definitions. Traditionally, women's health was thought to include only issues of childbirth and reproductive health, and the early definitions therefore, were based on the biomedical model. Thus, women health was defined as health issues specific to female anatomy and included menstruation, child birth, menopause and breast cancer (Wikipedia, 2008). The biological model in health research, however, is biased to women issues in that they minimize them into anatomical and physiological factors (Thomas, 2007).

Recent definitions encompass a broad range of influences and issues about women's health. They recognize all diseases and disorders that affect women, include an awareness of the impact of social, cultural, economic and political influences, and emphasize prevention as well as treatment (Shaw, 2008; Goldman and Maureen, 2000). The modern definitions include medical situations in which women face problems not directly related to biology, for example genderdifferentiated access to medical treatment (Wikipedia, op. cit.). A few modern definitions may be examined here. The National Academy on Women's Health Medical Education states that women's health is devoted to the preservation of wellness and the prevention of illness in women; it includes the empowerment of women to be informed participants in their own health care; and recognizes the importance of the study of gender differences. Similarly the American College of Women's Health Physicians defines the practice of women's health care as, "A sex-and gender-informed practice centered on the whole woman in the diverse contexts of her life, grounded in an interdisciplinary sex-and gender-informed biosychosocial science". Along the same lines, Dr. Laith Farid Gulli in her essay on women's health in the Gale Encyclopedia of Medicine (2002) defines women's health as "the effect of gender on disease and health that encompasses a broad range of biological and psychosocial issues." The Society for Women's Health Research in the United States, defines women's health more broadly than issues specific to human female anatomy to include areas where biological sex differences between women and men exist. It says that research has demonstrated significant biological differences between the sexes in rates of susceptibility, symptoms and response to treatment in many major areas of health, including heart disease and some cancers (Goldman and Maureen, op. cit.; Wikipedia, op. cit.).2 The Women's Health Office in McMaster University's Faculty of Health Sciences defines women's health as involving, "women's spiritual, emotional, cultural, and physical well-being, and is determined by the social, political, cultural and economic context of women's lives, as well as by biology". It further states that, "In defining women's health, we recognize the validity of women's life experiences, and women's own beliefs about, and experiences of, health. We believe that a woman should be provided with the opportunity to achieve, sustain and maintain health, as defined by the woman herself, to her full potential". Thus, the modern view of women's health is comprehensive in reference and analysis to include besides epidemiologic perspective, the social, environmental, occupational determinants of health, diseases and disorders. The concept beings with the birth of a girl child, goes through woman's entry into reproductive years to midlife, and to her aging.

However, these are emerging and evolving definitions and cannot be called as entirely new or final. For instance the aspect of "reproductory health" which has surfaced prominently in recent times has been in the roots of women's health, its knowledge and practice.3 Today it has acquired a distinct feminist touch and policy orientation. Yet, these definitions have several advantages in relation to women's health because they

- Emphasize the complex web of interrelationships that determine women’s health
- Go beyond the biological and the individual
- Acknowledge the crucial role of the social milieu
- Highlight the importance of justice and equality in determining the well-being of women.

Gender Perspective of Health – the New found Importance

Today women's health is being viewed as a distinctive area. Why should it be separate from the rest of health? The answer is twofold. As an area devoted to women's health it makes finding information about women's health matters faster; and it focuses directly on topics that are major health concerns for women. Although women and men share many health problems women also have their own health issues which deserve special consideration. Women's lives have changed over the centuries. Historically, life was particularly difficult for most women. Apart from the numerous dangers and diseases, women became wives and mothers often when they were just emerging from their own childhood. Multitude of pregnancies – which may or may not have been wanted – risky childbirth and very high maternal mortality rate (MMR) were common in the past. The MMRs for girls under 16 are more than for grown up mothers. The World Health Organization (WHO) estimates that 500,000 women die each year due to pregnancy related problems. Approximately half of all women in the reproductive ages and two-thirds of pregnant women in developing countries are anemic (Karkal and Pandey, 1989). Most women in the past did not live long enough to be concerned about their menopause or old age. In 1900, a woman's life span was about 50 years. Now, at the new millennium, life expectancy for American women is 82 years and is continuously rising. Even in many of the developing countries (e.g. India, Pakistan, Sri Lanka etc) there is some improvement in female life expectancy (see table 1). Not only are women living longer, they also have the possibility of enjoying a better quality of life throughout their span of years. But for actuality, it is essential that women take charge of their own bodies and comprehend how they can maximize their health. It is also helpful that men understand and are supportive of the health concerns of the women. While women continue to be in a state of marginalization, there are also positive developments as in the case of gender sensitization, women empowerment and even emphasizing the role of ‘homemakers’. Today the overall quality of life in a country is amply measured with several of the indicators of women’s status.

Table1. Female Life Expectancy at Birth – Selected Countries

Country	1980	1990	2000	2005
Albania	72.3	75.9	78.0	79.5
Belgium	76.8	79.4	80.8	82.4
Canada	79.8	81.0	81.7	81.8
Denmark	77.3	77.7	79.0	79.1
Estonia	74.1	74.9	76.0	78.1
Finland	77.6	78.9	81.0	82.3
Germany	76.1	78.4	81.0	81.8
Hungary	72.7	73.7	75.6	76.9
India	54.7		63.3	65.3
Japan			84.1	85.7
Kazakhstan	72.0	73.4	71.6	71.7
Luxembourg	75.4	78.7	81.9	82.2
Malta	72.7	78.1	80.2	81.4
Norway	79.2	79.8	81.4	82.5
Pakistan			59.5	64.8
Russian Federation	73.0	74.4	72.4	72.4
Sri Lanka			75.0	75.6
Tajikistan	69.4	72.6	73.9	69.0
United States	77.4	78.8	79.6	80.4
Vietnam				75.7
Yemen				63.1
Zambia				40.6

Some of the variables for which data exist in a comparable form are (i) women's literacy, (ii) women's age at marriage, (iii) birth rate and mortality rate, and (iv) women's access to health care facilities. While these may not be the most important factors influencing women's status, they are indeed the critical ones in that they contribute to raising the position of women in society (Nair, 1988). Naturally, therefore, women's health has emerged as one of the vital areas of health economics. A simple truth to be admitted: health programmes launched anywhere will neither be complete nor successful if women are left in the periphery. This realization has manifested in the thrust given to programmes of health of mother and child (Hans, 1997). Therefore, it is important that every woman has access to knowledge related to the spectrum of women's health issues, not only about her reproductive system.

WOMEN'S HEALTH IN INDIA

In India women suffer from low health status and have been marginalized. The pace of marginalization has accelerated with the adoption of structural adjustment programme. Poor health conditions and poor access to health infrastructure have become features of gender disability and deprivation (Hans, 2008a). One of the guiding principles adopted by the Bhore Committee – appointed in October 1943 for evolving health policies and services in India – was that the health services should be located as close to the people as possible to ensure maximum benefit to the communities served. (Sagar, 2006; Hans, 1997, op. cit.). But even today in a typically backward village of India, women travel long distances not only to fetch potable water but also to get treatment for their ailments and for deliveries. According to the National Council of Applied Economic Research (NCAER), in nearly 20 per cent of cases of illness rural people traveled more than 10 km for treatment. In the state of Meghalaya, in 54.56 per cent of rural illness cases and in the state of Orissa, in 33.47 per cent of rural illness cases, patients traveled more than 10 km. Woeful inadequacy of health workers has resulted in high incidence of deaths, particularly among mothers (Hans, 2008b). Demographic research over the past two decades has confirmed that psycho-social factors like preference of sons over daughters, coupled with economic discrimination against women and girls have conspired to ensure that boys have greater access to health care and even food than do their sisters. Such a tendency amounts to overt neglect of girls and marginalization of women. At the extreme it may even assume proportions of social and political oppressions at the local level. While representative democracy may succeed in institutionalizing inclusive growth, conflicting opinions and priorities may make the power equations to ignore or under-represent the interests of the disprivileged – women (Chandoke, 2007).4 The pro-women public health interventions being inadequate has made the proactive role of voluntary sector essential. That women have been losing in health care is also evident from the striking gender differences in health care expenditure. A study by Ashokan (2005)5 reveals that in rural Kerala the average outpatient (OP) expenditure by male population is Rs.265.49 whereas by female population it is Rs.224.48; in case of patient (IP) the figure is Rs.5790.99 for males and Rs.4180.45 for females; and the OP-IP ratio is 20.52. Also, ceteris paribus, females are less privileged to quality and specialized health care (Ashokan, 2008).

Health: Impact on Labor and Development

There is a circular relationship between good health of one generation and another (figure 1), the knowledge of which must never be lost during HRD programmes in any sector. Deterministic models of Becker (1967), Ehrlich and Lui (1991), Zhong (1998), and Ehrlich and Yuen (2000) show that income distribution in the population is linked fundamentally to the corresponding distribution of human capital attainments. Parents optimize on investments in the quantity and quality of children (Ehrlich and Kim, 2007).6 At the individual level, health has been observed to share a high degree of positive correlation with productivity, earnings and standard of living (Ramachandran, et. al., n.d.). We need not only to create more jobs but also ensure that women get a decent share of it. Nobel Laureate Edmund Phelps is of the opinion that jobs, particularly for the disadvantaged and poor can lead to distributive justice. High wages enable workers to solve various problems, participate in the growing economy and live with dignity. The way the market economy determines wage, it creates problems of inclusion. The government should step in to regulate, if necessary. There should be a vibrant labor market for equalizing wage rate for same type of work (Sharma, 2008).

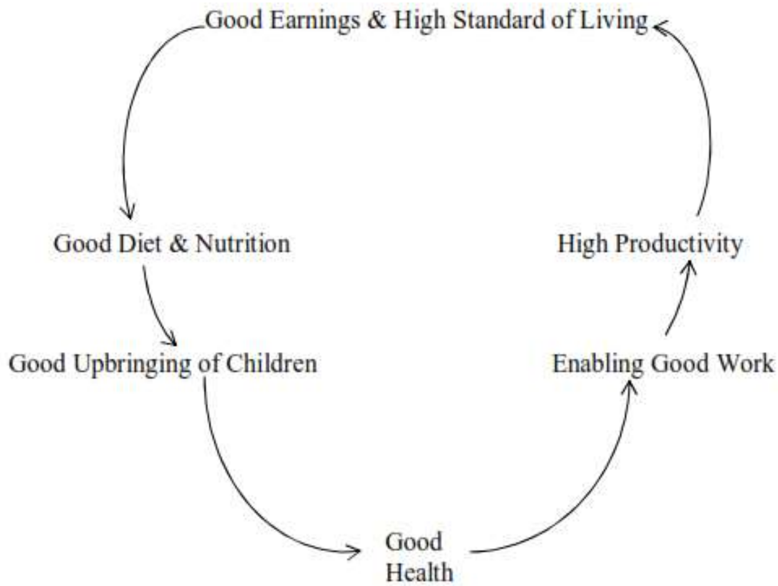

Figure.1. Health-Labor Productivity Relationship

In India the work environment for women both in rural and urban areas is not conducive for upkeep of health and productivity. Environmental and health risks at workplaces have profound impact on women's health because of their susceptibilities to the toxic effects of various chemicals. These risks to women's health are particularly high in areas where there is a high concentration of polluting industrial facilities. The high incidence of depression, anxiety, neurosis, psychosomatic disorder, increasing rate of suicides among women are also emerging as major problems in women-health domain. Chemicals used in agricultural and industrial operations, in food preservatives and fashion and beauty products are also causing occupational health hazards to women. The congested dwellings/work cabins and inadequate sanitary facilities make cities/offices breeding ground for various ailments. The cell phone menace, micro-oven, X-rays and sonography etc. have both positive and negative aspects (Mahapatra, 2005). Substantial number of man-days is lost due to sickness of women. In a study of six villages in Andhra Pradesh, female labor force participation was found reduced by 22 per cent on account of disability. Studies prove that short term or transitionary health, demonstrated in weight-for-height, influences the marginal productivity of labor. (Sharma 1993, op. cit.). Even deformity is causing loss of women’s labor. Repeated pregnancies, and/or prolonged illness and absenteeism affect the income levels of women adversely, particularly when they do not have secured jobs. One has to enter the realm of cost analysis and assess the social cost, real cost and opportunity cost of women’s health deprivation.7

More Power to Women: Empowerment Mechanism

Women’s empowerment is a new phrase in the vocabulary of gender literature, a phrase used in two broad senses i.e. general and specific. In a general sense, it refers to empowering women to be self-dependent by providing them access to all the freedoms and opportunities, which they were denied in the past only because of their being ‘women’. In a specific sense, women empowerment refers to enhancing their position in the power structure of the society. The word women empowerment essentially means that the women have the power or capacity to regulate their day-to-day lives in the socially, politically and economically – a power which enables them to move from the periphery to the centre stage (Bhuyan, 2006). It justifies and activates the process of inclusion for growth and development. Promoting gender equality and empowering the women is one of the eight Millennium Development Goals (MDGs) aimed at eradicating poverty and improving the welfare by the year 2015. Two other related MDGs are (i) improve maternal health; and (ii) combat HIV/AIDS, malaria and other diseases. These are part of the strategy against social exclusion (Sachidananda and Kumar, 2006). In public health, empowerment has traditionally been defined by its opposite, as powerlessness (Wallerstein, 1993). Gender bias is a constant feature in Asian countries such as India, Pakistan etc., undermining their own and their children's nutritional outcomes and development, and causing rampant poverty, ill health, violence, exclusion and discrimination (Sethuraman and Duvvury, op. cit; Chalapathi et. al., 2008). Gender equity, therefore, is an antidote and can be a life-saving and life-changing event. Economic equality without gender equity is impossible and gender equity without health empowerment is irrelevant.

Empowered women contribute to the health and productivity of whole families and communities and to improved prospects for the next generation. Inclusive policies for women's development – terms of health – should take into account the rights-justice perspective of health and human development. Four criteria to be adopted here, therefore, are availability, accessibility, affordability ("3A") and quality of health services. Accessibility includes not only physical reach but also the principle of non-discrimination. The International Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) of 1979, refers to access to health and medical care without discrimination. Articles 10, 12 and 14 of CEDAW affirm women's equal rights to access health care, including family planning, appropriate services for reproductive health care and pregnancy and family health care services. Similarly the Beijing Declaration and Platform for Action (1995) brings into focus the holistic view of health and the need to include women's full participation in society in these words: "Women's health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology. To attain optimal health, equality, including the sharing of family responsibilities, development and peace are necessary conditions."

CONCLUSION

India's missing women cannot be brought back but the roots and branches of gender bias and its consequences are being researched upon. Gender sensitization is touching vital aspects of human development – health, education skill and enterprise. Gender sensitivity approach and strategies need to go beyond family welfare and Reproductive and Child health (RHC) Programme to holistic view of woman's life – personal life, family life, community life, work, and life after retirement. Total security is what women and all those concerned with women empowerment genuinely should aim at. Gender divide is unhealthy. Gender equity is required for enhancing productivity and performance of women in various roles in society. It is on India's agenda for sustainable livelihoods.

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