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Investigating Gender Health status among Reproductive and Post Reproductive Women: True,reflection from Central Himalayas

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Abstract:

Across the past three decades, there has been a growing recognition that women's health is influenced by a broad range of 'political, social, economic, and cultural forces' (CSDH, 2008). Referred to as the social determinants of health, this shift marked a movement away from an exclusive focus on women's reproductive functions and biology (Weisman, 1997), to a consideration of gender as a distinct determinant of women's health. In order to access the true picture of health condition of reproductive and post reproductive women in central Himalayas research was conducted on 250 reproductive women and 250 post reproductive women from Hawalbagh block ,district Almora by using multi stage sampling. Statistical analysis was done to obtain deductions and find impact of different variables on gender health. Deductions food taboos, social and cultural constraints as well as domestic violence faced by women acted as a negative factors in their empowerment and development. However reproductive respondent's attitudinal change towards importance of health owing to raised educational level may definitely be regarded as progressive sign towards women development and necessity arises to awake rural masses regarding importance of health.

Key words: Gender, Health, Reproductive, Post-reproductive

Introduction.

Health is the level of functional or metabolic efficiency of a living being. In humans, it is the general condition of a person's mind and body, usually meaning to be free from illness, injury or pain (as in "good health" or "healthy").**Merriam-Webster 2011** The World Health Organization (WHO) defined health in its broader sense in 1946 as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." **(W.H.O, 1946 &2000)** Generally, the context in which an individual lives is of great importance for his health status and quality of life. It is increasingly recognized that health is maintained and improved not only through the advancement and application of health science, but also through the efforts and intelligent lifestyle choices of the individual and society. According to the World Health Organization, the main determinants of health include the social and economic environment, the physical environment, and the person's individual characteristics and behaviors

The average female life expectancy today in India is low compared to many countries, but it has shown gradual improvement over the years. In many families, especially rural ones, the girls and women face nutritional discrimination within the family, and are anemic and malnourished. The maternal mortality in India is the second highest in the world. Only 42% of births in the country are supervised by health professionals. Most women deliver with help from women in the family who often lack the skills and resources to save the mother's life if it is in danger **Kalyani Menon-Sen, A. K. Shiva Kumar (2001**. According to UNDP Human Development Report (1997), 88% of pregnant women (age 15-49) were found to be suffering from anemia.

One of the reasons for the low sex ratio in Uttarakhand can be the poor health of women in the state. The life and work patterns of women here have been grueling and take a heavy toll of them. With 76% women

living in the rural side, their daily lives include heavy tasks of cultivation, fuel and fodder collection by drudging along the mountainous roads and hilly slopes for as much as 10 to 15 k.ms a day, in search of necessities. Women walk daily 1-2 k.ms of mountainous the road to fetch drinking water. The daily work profile of women in this region will include, in addition, cooking and washing at home, looking after the cattle including grazing

Feeding and mulching them, leaning their sheds and undertaking all other household chores, marketing and buying necessities. All these are in addition to the main work of cultivation in a subsistence economy. The never ending work starts early in the morning by about 5 am and stops only by about 10 pm. Unlike women in plain areas, the women here look after all the agricultural operations (except preparing the field for sowing) and trek large areas. Dependent mostly on the rain water in the high altitudes, the women thus fret over unprofitable lands all through the year, just to produce a handful enough for survival. With irrigation facilities for just 43.8% of the total cultivated area, the heavy tasks of the women often do not yield corresponding benefits, particularly since the average size of the holdings is small

Review of literature:

The term 'women's health' has traditionally been associated with women's reproductive functions, which were seen to control women's overall health and mental wellbeing (Weisman, 1997). This focus is grounded in the "medical conceptions of women's health that emerged in the second half of the 19th century, when ideas about biological determinism and fundamental differences between the sexes were becoming prominent" (Weisman, 1997 p 180). The modern Women's Health Movement in Australia, which occurred at a similar time to movements in other countries such as the United States, challenged this view (Jamieson, 2012; Weisman, 1997) Subsequently, a feminist critique of the male-dominated medical profession surfaced, with many individuals advocating for women to be informed and empowered to make their own healthcare decisions (Jamieson, 2012 p 30). During the 20th century there was a growing emphasis on the impact of gender on a broad range of social issues, including gender equity, women's reproductive rights, gender bias in medical research, practice and treatment, and women's access to accessible and appropriate healthcare (Jamieson, 2012). Drawing on the earlier work of Broom (1991), Jamieson observes '' women were dissatisfied with medical services, critical of many of the professionals who delivered them and had a vision of a radically different society, in which women would be no longer subordinate, would be proud of their bodies and would enjoy life conditions that would enable them to be responsible for their own health and health care" (Jamieson, 2012 p 30). The WHO has identified some of the sociocultural barriers that prevent women from accessing health services and attaining quality health outcomes, including "unequal power relationships between men and women, social norms that decrease education and paid employment opportunities, an exclusive focus on women's reproductive roles, and potential or actual experience of physical, sexual and emotional violence" (WHO, 2017). These overarching barriers are reflected in the existing literature, which demonstrates the effects of a broad range of social determinants on women's health outcomes. Determinants identified in the literature include: •

Methodology:

In order to access the true picture of health condition of reproductive and post reproductive women in central Himalayas research was conducted on 250 reproductive women and 250 post reproductive women from Hawalbagh block ,district Almora by using multi stage sampling. Statistical analysis was done to obtain deductions and find impact of different variables on gender health.

Observations:

The comparative figures for Uttarakhand on the health issues of women call for much more attention. In many ways it is behind even the all India average. Based on the general observation regarding the health and nutritional status of women assessing health status became a matter of priority concern. Hence respondent 'health status was assessed to reflect true picture of them in rural India

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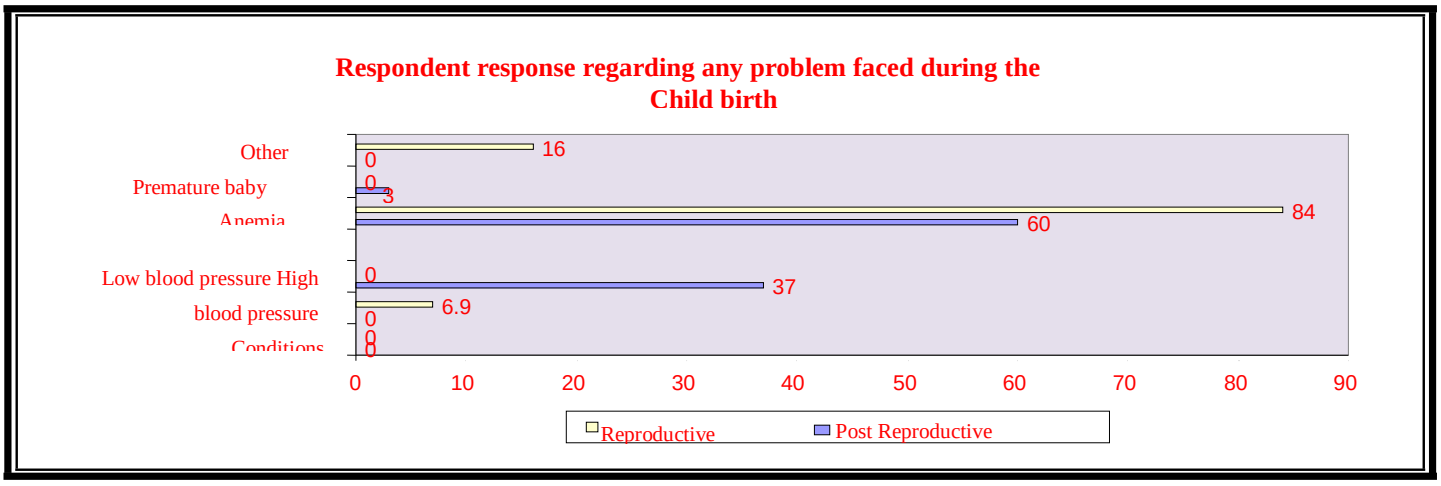
Table 1
Respondent response regarding necessity of special medical considerations for women

Response	Reproductive		Post-reproductive		Total	
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
Yes	185	92.5	15	30	200	80
No	10	5.0	35	70	45	18
Cannot say	05	2.5	-	-	05	02
Total	**200**	**100**	**50**	**100**	**250**	**100**

The respondent response regarding necessity of special nutritional facilities for women were analyzed. Data reveal that 80% respondents favored requirement of medical facilities. These respondents considered pregnancy, lactation and old age as three biological stages where utmost medical concern was required. Significant difference was observed between reproductive and post reproductive group as majority 92.5% reproductive respondent favored special medical care owing to their educational status whereas majority (70%) respondents in post reproductive were not in favours of any special care as they said it was unnecessary. However in post reproductive group also 30% respondents supported that during pregnancy and lactation, special care was required. However, there is an urgent need to educate women about ensuring the importance of health care

Table 2
Respondent response regarding any problem faced during the time of birth of child

Conditions	Reproductive		Post-reproductive		Total	
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
High blood pressure	-	-	-	-	-	-
Low blood pressure	74	37	-	-	74	29.6
Anemia	06	03	42	84	48	19.2
Premature baby	120	60			120	48
Other	-	-	08	16	08	3.2
Total	**200**	**100**	**50**	**100**	**250**	**100**



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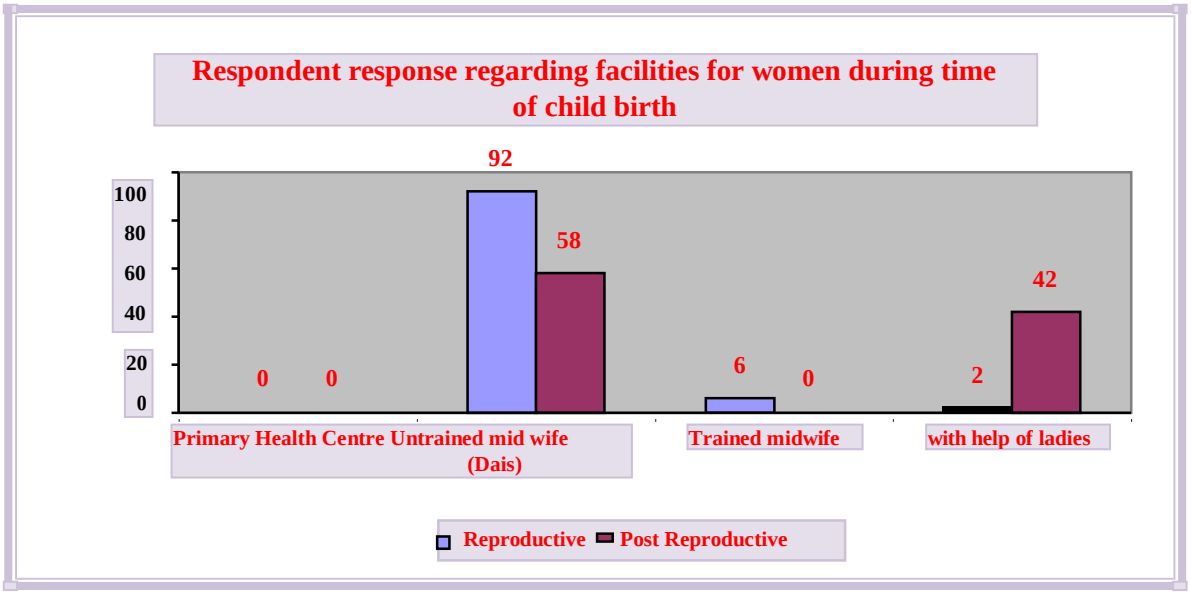
Studies have found that between 50 to 90 percent of all pregnant women in India suffer from anemia. Severe anemia accounts for 20% of all maternal death in India**. (The World Bank, 1996)** Severe anemia also increases the chance of dying from heammohrage during labor. In similar context respondent response regarding difficulty faced at time of birth of child was analyzed .Data reveal that maximum (64.8%) suffered from anemia which was followed by low blood pressure (29.6%) and premature babies (2.4 5). However, still birth (3.2%) was also reported. Respondents reported that all these problems were due to their heavy workload which was not reduced even in the time of pregnancy as well as lack of nutrition due to various prevalent food taboos as well as ill treatment given by dunked husbands was also reported as a factor for still birth.

Table 3

Respondent response regarding facilities for women during time of child birth

Facilities	**Reproductive**		**Post-reproductive**		**Total**	
	N	**%**	**N**	**%**	**N**	**%**
Primary health centre	-	-	-	-	-	-
Untrained mid wife(dais)	184	92	29	58	213	85.2
Trained mid wife	12	06	-	-	12	4.8
With help of ladies	04	02	21	42	25	10
Total	**200**	**100**	**50**	**100**	**250**	**100**



Place of birth and type of assistance during birth have an impact on maternal health and mortality .Births that take place in non-hygienic conditions or births that are not attended by trained medical personnel are more likely to have negative outcomes for both mother and child. **(India Registrar General, 1996)**[3]In the same reference respondent response regarding type of facilities available for pregnant ladies during delivery or child birth was assessed. Data reveal that majority (85.2%) respondents are attended by untrained mid wives (dais) who were as such equipped with experience but still in serious conditions, found themselves helpless. As a result turned fatal for delivering women .Similar trend was observed for both groups.

Table 4

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Respondent response regarding vaccination

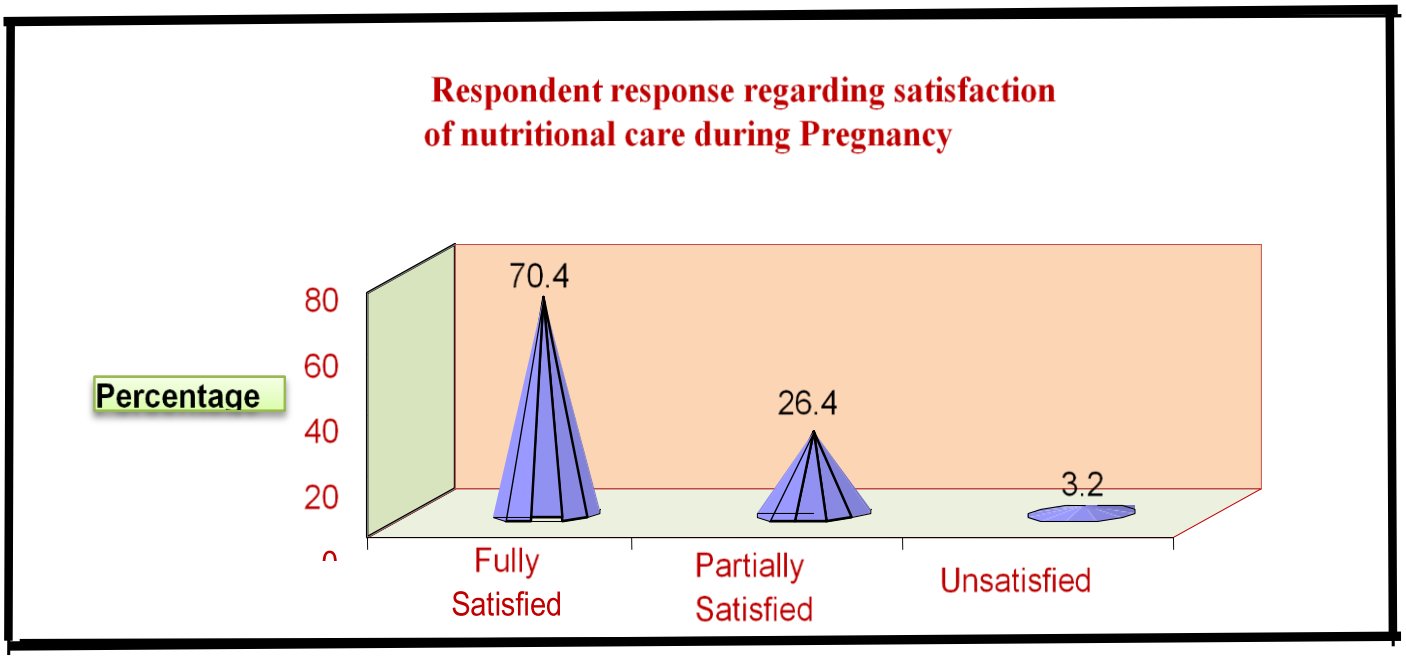
Response	Reproductive		Post-reproductive		Total	
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
Yes	200	100	42	84	242	96.8
No	-	-	08	16	08	3.2
Total	**200**	**100**	**50**	**100**	**250**	**100**

Proper vaccination was essential for wellbeing of both children and women. Table 4 reveals respondent response regarding vaccination. It was good to observe that vaccination was done on regular basis by (96.8%) respondents. The functioning of primary health Centre was good in this direction apart from that various Aaganwadi workers was appreciating.

Table 5

Respondent satisfaction regarding nutritional care during Pregnancy

Satisfaction	Reproductive		Post-reproductive		Total	
	N	%	N	%	N	%
Fully satisfied	176	88	-	-	176	70.4
Partially satisfied	24	12	42	84	66	26.4
Unsatisfied	-	-	8	16	8	3.2
Total	**200**	**100**	**50**	**100**	**250**	**100**



Women in rural areas were much less likely to receive prenatal care than women in urban areas .Most women did not receive health care during pregnancy as they said that it was unnecessary **(IIPS, 1995)**. Similarly respondent response regarding nutritional care during pregnancy was analyzed. Data reveal

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that 70.4% respondents were fully satisfied which definitely indicate good step for enhancing their health status. It is important to note that although respondents had been provided by nutritional care but this care was severely hampered by various food taboos. Secondly restriction in food owing to food taboos and no reduction in workload during biological conditions was another factor affecting their health status. Significant difference was observed in both groups. In reproductive group respondents were fully satisfied whereas in post reproductive group 26.4%were unsatisfied. Thus, there is a significant need to educate post reproductive respondents about importance of health care for ensuring health programs and delivery.

Table 6

Respondent response regarding nutritional care during lactation

Response	For boys			For girls		
	Reproductive	Post reproductive	Total	Reproductive	Post reproductive	Total
Fully satisfied	185(92.5)	35(70)	220(88)	15(7.5)	-	15(6)
Partially satisficed	15(7.5)	15(30)	30(12)	173(86.5)	12(24)	185(74)
Unsatisfied	-	-	-	12(6)	38(76)	50(20)
Total	**200(100)**	**50(100)**	**250(100)**	**200(100)**	**50(100)**	**250(100)**

Value in parenthesis () indicate percentage

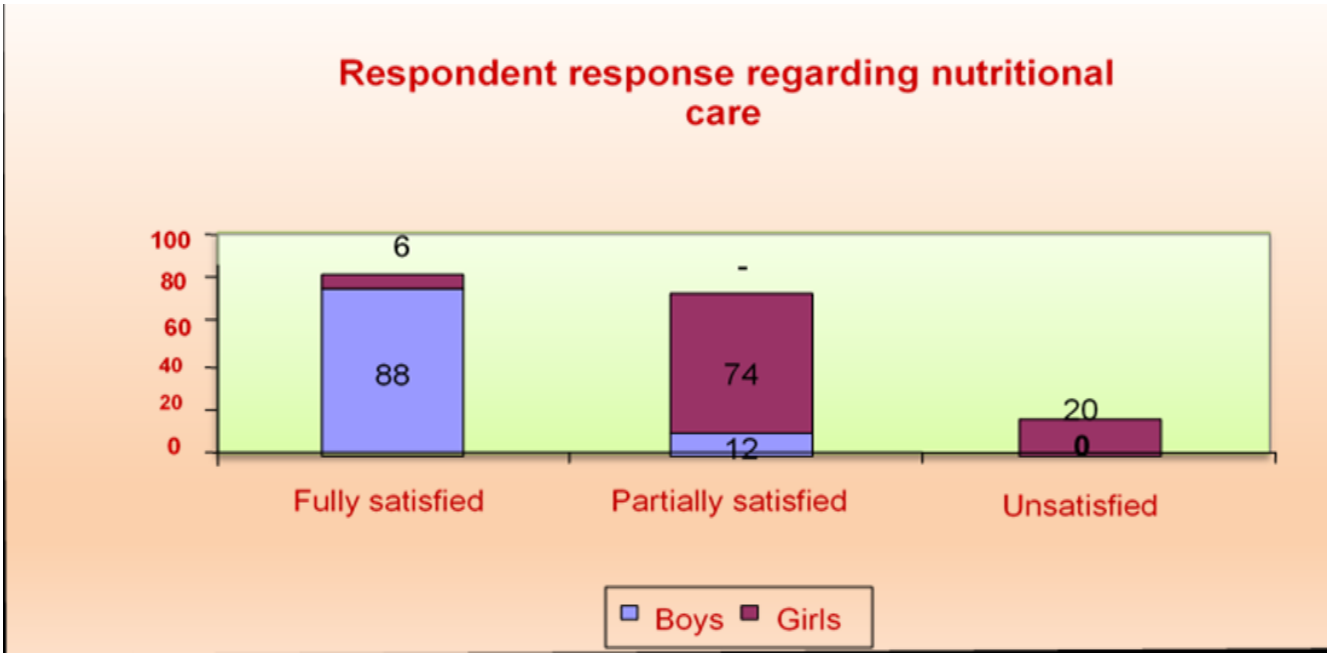

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Table 6 reveals respondent response regarding satisfaction of nutritional care during lactation. Gender biasness was clearly reflected in case of nutritional care during lactation. It was observed that when women gave birth to male child, all respondents revealed that they received best nutritional care as possible. Hence, they were fully satisfied. However on giving birth to girl child 80% were satisfied which may be considered as a good Statististics in direction of women Empowerment. Slight difference was observed between both groups. In case of girl child majority (94%) were satisfied in reproductive group however in post reproductive only 24% were satisfied. It is important to note that Lactation is the major biological condition and if proper care of the women is taken then her health is secured .It was observed that if the baby born is girl then mother is not given much care in comparison to that mother who gives birth to baby boy. This gender discrimination is observed at every point of the life.

Data reveal that majority of the respondents 74% were partially satisfied with their nutritional care which was followed by 20% of respondents who were satisfied. The underlying reason was that respondents revealed that in their time much care was given to them. However, it is important to note here that lactating women had to face difficulties due to various social constraints and food taboos. Hence necessity arises to educate rural masses regarding importance of health care during vulnerable stage.

Table 7

Respondent response related to ideal structure of children

Response	Reproductive		Post-reproductive		Total	
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
2 sons	23	11.5	27	54	50	20
2 daughters	-	-	-	-	-	-
1 son 1 daughter	132	66	18	36	150	60
2son 1 daughter	45	22.5	05	10	50	20
Other	-	-	-	-	-	-
Total	**200**	**100**	**50**	**100**	**250**	**100**

Several studies have found that one of the main reasons for the poor health of Indian women is the discriminatory treatment girls and women receive compared to boys and men. **(Das Gupta,1994;Desai 1994)[5].**The most chilling evidence of this is the large number of missing women (girls and women who have apparently died as a result of past and present discrimination). In relation to the context respondent response regarding ideal structure of number of children in their family was analyzed.Data revealed that maximum (60%) preferred one son and one daughter as ideal structure for number of children of their family. This was good indicator as it was similar to ideal structure preferred in urban areas .However, findings reveal that preference for son was still strong prevalent. Respondents revealed that it was essential to have one son or more else women had to suffer from physically and mental torture. They included one girl in their ideal structure due to ritual of kanyadaan which according to Hindu mythology was necessary for attaining salvation and preference was given to boys ,owing to the notion that more boys more the helping hand in the economy of the family

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Table 8
Respondent response regarding distribution of best part of food

Response	Reproductive		Post-Reproductive		Total	
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
To husband	134	67	42	84	176	70.4
To children	43	21.5	8	16	51	20.4
To wife	23	11.5	-	-	23	9.2
Other	-	-	-	-	-	-
Total	**200**	**100**	**50**	**100**	**250**	**100**

Gender discrimination regarding food entitlements both quantity and quality is one of the most important factors affecting women's health status**.** Indian social customs and traditions dictate differential attitudes, behavior and practices related to their food entitlements. Girls are breast fed for shorter time than boys and as grow older receive less quality food. In this reference respondent's response regarding distribution of food during scarcity of food. **(Chetna,2000).**

Table reveals respondent response regarding distribution of best part of food. Data reveal that maximum (70.4%) respondents favored serving larger portions to husband and 20.4% favored serving to children. It was reported that first food was served to male children and after that they do serve their female children and they tend to ignore the importance of their own food requirements which is leading cause of malnutrition and ill health. The distribution of the meal is correlated with the distribution of best part of food. In families were husband is given food first he consumes the best part of meal. Secondly the children and other family members and at the end was the wife who use to get the left over part of the food.

Table 9
Respondent response related to practicing of food taboos during pregnancy and lactation

Response	Reproductive		Post-reproductive		Total	
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
Yes	187	93.5	50	100	237	94.8
No	13	6.5	00	00	13	5.2
Total	**200**	**100**	**50**	**100**	**250**	**100**

In some cultural and social contexts in India, women are prohibited from eating essential quality food particularly during mensuration, pregnancy and lactation such as milk and G.L.V. **(Chetna,2000).** Data reveal that 94.8% respondents agreed that several restrictions were imposed on them. Typically rural women have to work until late in their pregnancy and depriving them of adequate food and rest at a time when their nutritional requirements are highest, definitely make them anemic as well there is high risk of unsafe delivery. Similarly women after child birth had to immediately start her domestic and productive tasks before she had adequate time to rest and recuperate .In addition several restrictions imposed on them grossly effect women health.

Respondent reveal that they were not allowed to consume banana and ghee as it was believed that baby get stick in the uterus as a result womenweredeprivedofcalciumandenergy.Itwasalsobelievedthatpregnant women

should not eat pulses as they cause gastric trouble in the stomach but as a consequence women's diet remains deficient in protein. They thought that curds, butter, milk, lemon and citrus fruits lead to edemas and arthritis due to which women became deficient in vitamin C which was essential for formation of blood. Hence the above restrictions clearly indicate the ill effect in health of women husband

Table 10

Respondent response regarding death of women during birth of child in family /village

Response	Reproductive		Post-reproductive		Total	
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
Yes	200	100	50	100	250	100
No	-	-	-	-	-	-
Total	**200**	**100**	**50**	**100**	**250**	**100**

Maternal mortality and morbidity are two health concerns that are related to high level of fertility .India has high maternal mortality ratio : approximately 453 death per 100,000 birth .The high level of maternal mortality are especially distressing because the majority of the death could be prevented, if women had adequate health services**. (Jejeeboy and Rao, 1995**)

Data reveal that all respondents reported death of women during child birth owing to poor health practices. It was revealed that delivery done by untrained professional was one of the main risk factor formaternMortality.Situationturnedmorecomplexwhenevenduringemergency, pregnant ladies were not taken to hospitals and delivery was done under the supervision of dais. The unavailability of the medical facilities in government hospital and unwillingness of doctor to serve in interiors, due to which work was done by nurses and compounders. Thus on part of government strict steps should be taken by government for redressed of medical facilities.

Table 11

Respondent's response regarding family planning

Response	Reproductive		Post-reproductive		Total	
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
Yes	-	-	-	-	-	-
No	200	100	50	100	250	100
Total	**200**	**100**	**50**	**100**	**250**	**100**

Most of the unmet need among younger women as for spacing birth rate than limiting them. This implies that method other than female sterilization need to be considered .In similar context respondent response regarding family planning was analyzed. Data reveal that no matter reproductive or post reproductive, neither literate nor illiterate did not adopt the practice of family planning. It was observed that number of frequent pregnancies and unable to keep parity due to lack of education were bitter results of not adopting family planning.

Respondents revealed that post reproductive respondents considered children as gift of god therefore they never adopted such practices .They still believed in the notion that more the male child more the economy of household .Hence, for preference of male child they never adopted any measure of family planning. However

respondents also revealed that male members considered it against their pride. However respondent's revealed that discretion regarding family planning lied in hands of their husband hence, they were helpless.

Table 12

Respondent response regarding pregnancy.

Response		**Reproductive**		**Post-reproductive**		**Total**	
		Frequency	**Percentage**	**Frequency**	**Percentage**	**Frequency**	**Percentage**
Abortion being done	Yes	187	-	50		237	94.8
	No	13	-	_	-	13	5.2
	Total	200	100	50	100	250	100
No.of birth	1-2	12	6	-	-	12	4.8
	2-3	114	77	32	64	146	58.4
	3-4	74	37	18	36	92	36.8
	Total	200	100	50	100	250	100
Respondent age during birth of first child	>15	-	-	12	24	12	4.8
	15-20	175	87.5	38	76	213	85.2
	20-25	25	12.5	-	-	25	10
	Total	200	100	50	100	250	100
Respondent age during birth of last child	25-30	183	91.5	-	-	183	73.2
	30-35	17	8.5	38	6	55	22
	35-40	-	-	12	24	12	4.8
	40-45	-	-	-	-	-	-
	Total	**200**	**100**	**50**	**100**	**250**	**100**

Table 12 reveals respondent response regarding pregnancy. The problem of female feticide, which is of utmost concern at present time may also be regarded as forced abortion where female child is aborted in the uterus of the mother. It is also observed that abortion is carried for the preference of male child under pressure of husband or family members. Hence female also accept such practices on account of social and cultural constraints of society. In similar reference respondent response regarding information related to pregnancy was collected. It was shocking fact to observe that maximum (94.8%) respondents had done abortion, not only this the number of abortion was reported 2-3 times by 58.4% respondents. It was observed that maximum abortion was due to preference of male child and because of ill-treatment given to pregnant women at time of pregnancy. Secondary sources also reveal that not keeping parity and frequent pregnancies was also a reason for still birth of child due to which abortion was done.

Respondent response regarding age at birth of first child was 15-20 which a risk factor was for women .Similarly 30-35 years was reported as the age during birth of last child due to frequent pregnancies which made women anemic.

Conclusion:

It was observed that reproductive respondents had better health in comparison to post reproductive which may be attributed to difference in education level. However all food taboos, social and cultural constraints as well as domestic violence faced by women acted as a negative factors in their empowerment and development. Although reproductive respondents' attitudinal change towards importance of health owing to raised educational level may definitely be regarded as progressive sign towards women development and necessity arises to awake rural masses regarding importance of health.

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