
UNIT 3 WOMEN AND HEALTH

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Learning Objectives



After going through this unit, you will be able to understand:

- health status of women- morbidity, mortality across caste, class;
- factors/ causation of ill- health among women- patriarchy, gender, poverty, reproduction, culture; and
- policies and programs for improvement of health of women.

3.1 INTRODUCTION

Anthropologists understand and analyse individual behaviours, interactions, social structures, health and illness in any society within a cultural context. Culture is an abstraction, blueprint or guide for all sorts of conditions and for social analysis. There is a link between cultural contexts, healing institutions and human behaviour related to illness and health seeking. The ways in which we interpret, perceive health, illnesses, seeking medical care are all influenced by our culture. Pluralistic society in which multiple cultures exist side by side, the dominant or core culture is the one whose norms, values, language, structures and institutions tend to predominate. In health context, bio-medicine is the dominant culture and all other forms of healing systems are subordinate or ‘alternative’ forms of healings. Tenets of science and medicine are considered natural or “correct” and therefore outside of cultural considerations. A medicocentric view focuses on disease, identified through signs and symptoms, and not on the patients’ perception of a problem. A medicocentric physician uses a reductionist model. An ‘emic’

perspective of a patient may relate his or her own illness perceptions and experiences in myriad ways; such as, inability to carry out daily functions, symptom recognition, interpretation, misfortune and discomfort.

However, understanding health only from the cultural point of view leads to cultural determinism. The perspectives to understand health and illness have evolved from 'cultural' to 'ecological' to 'critical medical anthropology' in the discipline of anthropology. In anthropological literature, sometimes nature/biology is pitted against nurture/culture explanation for human conditions. Neither is true. Both positions are too extreme and too simplistic. Real human thought and action is the outcome of complex interplay of cultural, biological, social, psychological, economic and political variables.

Anthropologists have been documenting health concerns of women, listening to their every day experiences of illness, health, birth, death, pain suffering from women's own perspectives and have captured through ethnographic traditions which is a hall mark of anthropologists. However, 90 percent of what has been written by anthropologists in the area of women's health has focused on reproduction. It is recognised that after decades of scholarly neglect, the last twenty five years have witnessed a veritable explosion of social science research on human reproduction (Inhorn 2007, ix).

Anthropologists have contextualised women's health from their larger socio-economic, cultural, and political forces. Using participatory research, anthropologists have explored women's health based on their own lived experiences and determined their own health priorities. However, it is often seen that the health priorities are set up from top down approach by the states, often neglecting the local voices and socio-cultural needs. A lot has been written by anthropologists on 'Child Birth', however, very little has been researched on other aspects of women's health. There is a dearth of literature and research by medical anthropologists in the Indian context, on women's health. Very few studies which are carried out in India are written by foreign scholars. Thus the gaps in the anthropological literature pertaining to women's health in this unit have been filled from other disciplines. This will give a comprehensive understanding of women's health where most of the data on morbidity and mortality is from demographic literature and contributions by the public health specialists and feminist researchers.

The first section of this unit will deal with the morbidity and mortality indicators along with reproductive health of women globally and nationally, recognising the importance of understanding women's health issue separately. The second section will focus on social determinants and linkages to understand poor health among women in India. Third section will deal with the state programs and policies related to women's health and the limitations of such programs from anthropological and public health perspective.

3.2 HEALTH STATUS OF WOMEN

Even though biologically women are a stronger species in terms of survival at birth, and also live longer than men, the social practices put the women in the most disadvantageous position, from womb to tomb and they are discriminated. Most often they are killed when they are still in the womb (foeticide) or when

they are born (infanticide), or they are abandoned, sold or neglected. When they are growing they are subjected to all sorts of discrimination from food, to education to health care. These atrocities are conducted, all due to the preference of a son.

In the marital home, women continue to live subjugated lives, until she bears children, more importantly sons. It is only when the sons grow up, she may exercise some power within the family. Women as care givers in the family often give priorities to the needs of other family members at the cost of their own health. They neglect their health till it becomes critical. Old age adds to the woes of women, especially health care when she is either deserted or live at the mercy of her children.

3.2.1 Mortality and Morbidity Indicators

It is now a well known fact that the maternal conditions or the reproductive period (15-44 years) is the leading cause of death and disability among women. According to a combined report of WHO, UNICEF, UNFPA and World Bank (2007), more than 99 percent of the estimated 536,000 maternal deaths each year occur in the developing world. Report of ICPD Cairo conference (UN 1995) states that an early and unwanted childbearing, abortion, HIV and other sexually transmitted infections and pregnancy related illnesses and deaths account for a significant proportion of the burden of illness experienced by women, especially in low-income countries.

It is ironical that for all these diseases, cost-effective interventions exist, still reproductive health problems account for the majority of the disease burden in women of this age group (World Bank, 1993).

In India, even though, women have higher life expectancy of 66.1 years, compared to male members with 63.8 years¹, women lead a highly morbid life due to various reasons, which will be discussed in the next section. Statistics show poor health condition of women in India. According to National Family Health Survey (NFHS) 3, total fertility rate is 2.7 which have come down from 3.4 in NFHS 1 survey in 1992-93.

It is ironic, despite India progressing towards better growth and development, the health of women is deteriorating. The maternal mortality rate (MMR) and infant mortality rates (IMR) are very high in India. The MMR is 212 out of every 100,000 women in 2007-2009 and the IMR is 50 out of every 1,000 infants in 2009, who die during childbirth (Office of Registrar General India, 2011). These high numbers of maternal and infant deaths are attributed to higher percentages of 'home deliveries', compared to 42 % of delivery by the medical professionals. Further, the reasons given are inadequate prenatal care, delivery in unsafe conditions with inadequate facilities, and insufficient postnatal care and severe anemia. Around 33% of women have below normal body mass index (BMI). 56.2% of pregnant women between the ages of 15 and 49 suffer from any form of anemia according to NFHS 3, which has increased from 51.8% in NFHS 2. Severe anemia is responsible for 9.2 percent of maternal deaths in India. There is a negative correlation with the education, 60% of women who are illiterate are anemic compared to 44.6% who have completed 12 or more years of education.

¹ http://wikigender.org/index.php/Women_in_India:_Statistical_Indicators,_2007#Sex_ratio

Similarly looking at wealth index 64.3% anemic women fall under the lowest wealth index, compared to highest wealth index having 46.1% anemic women.

However, the positive aspect is that there is substantial increase in the antenatal care. Utilisation of antenatal care services for the most recent birth among ever-married women increased substantially over time, from 66 percent in NFHS-2 to 77 percent in NFHS -3. The rate of increase was higher in rural areas than in the urban areas. 29.4% of tribal women have no antenatal care (NFHS 3).

The Millennium Development Goal 5 focuses on reducing the maternal mortality ratio (MMR) by 75 percent between 1990 and 2015 and ensuring universal access to reproductive health by 2015 (UN 2007). We have approached 2012 and still far from this goal. These maternal deaths can be preventable, provided timely pre and post natal care, and skilled birth attendance during delivery and emergency obstetric care are available. Not just ensuring the medical services, accessible, available, affordable it is necessary to ensure, good literacy, nutrition and working opportunities to better their lives.

3.2.2 Inequities in Health Conditions across State, Caste, Rural-Urban Distribution

India is the second most populated country in the world. It is also the most stratified society on the lines of caste, class, religion, ethnicity, region and gender. Health is also linked to development, so one can see health of women varies across states, class, and caste groups. The rural and urban divide also influences health of the women. On one hand the health indicator related to women and children in Kerala are as good as any other developed countries and on the other hand the health indicators in some EAG (empowered action group) states like, Bihar, Uttar Pradesh, Orissa, Madhya Pradesh, Rajasthan are worse than Sub-Saharan African countries. Some of the health indicators among the Scheduled Castes groups are even worse than the Scheduled Tribes.

At all India level the maternal health indicators gives a very gloomy picture, only 15% received all recommended types of antenatal care, only 38.7% of births delivered in health facility, 46.6% deliveries assisted by health personnel and 41.2% deliveries with a postnatal check-up (NFHS survey- 2005-06). Caste / tribe classification shows that the Scheduled Tribe women has highest levels of anemia of 68.5%, SC having 58.3%, OBCs with 54.4% and others having 51.3% (NFHS 3). The place of delivery is an important indicator to understand the health of women. Between the age group of 20-49 years, 67.5% urban and only 28.9% rural women deliver in a health facility. Among the lowest wealth index, only 12.7% deliver at the health facility compared to 83.7% highest wealth index. The lowest 17.7% tribal women deliver at a health facility (NFHS 3). The reasons for not delivering at health are varied. The most important is that 72.1% rural and 69.6% urban women feel it is not necessary to deliver in health facility, for 26.9% rural and 21.5 urban it costs too much. For 11.8% rural women it is too far or no transport. The other reasons being, non-functional, no-trust, no female provider, husband/family did not allow, not customary. However all these are in the single digit percent.

The social distance is much more serious and greater compared to geographical distance. Millions of women in India lack the freedom to go out and seek medical help. According to the second National Family Health Survey, (IIPS, 1998–1999),

only 52 percent of women in India are ever consulted on decisions about their own health. They resort to medical help only when the ailment is aggravated and become serious. There is also a culture of silence, when it comes to reproductive health problems, especially if it is a male doctor. It is more likely in rural context, where women tries to seek health care and in the absence of female doctors or functional health services in the reach may resort to local remedies or go untreated and their by risking their own health.

3.3 WOMEN AND ILL HEALTH: UNDERSTANDING THE CAUSAL FACTORS/ LINKAGES

3.3.1 Patriarchy

Women are the only oppressed group in our society that lives in intimate association with their oppressors. ~Evelyn Cunningham

Cunningham's quote is apt for understanding patriarchy in the real sense. It is ironical that women are most oppressed by men and they live in intimate relationship with their oppressor. Health of the women has to be understood within the concept of patriarchy.

Marcia Inhorn (1996) in her book *Infertility and Patriarchy: The Cultural Politics of Gender and Family Life in Egypt* offer a general definition of patriarchy that is multileveled and summarised as relations of relative power and authority of males over females. These are learned through gender socialisation within the family, manifested in both inter-and intra gender interactions within the family and other interpersonal milieus, legitimised through deeply engrained, pervasive ideologies of inherent male superiority and heterosexist privilege and institutionalised on many social levels (legal, political, economic, educational, religious, and so on).

Valentine Moghadam has written that under classic patriarchy, "the senior man has authority over everyone else in the family, including younger men, and women are subject to distinct forms of control and subordination" (Moghadam 2004, p. 141). Furthermore, property, residence, and descent all proceed exclusively through the male line. Today, however, this definition may be considered an overly simplistic description because the phenomenon has evolved substantially over time.

As already mentioned, to varying degrees, patriarchy is nearly universally prevalent. Although, as Gerda Lerner (1986) has noted, anthropologists have found societies in which sexual differences are not associated with practices of dominance or subordination, patriarchy does exist in the majority of societies.

Anthropologist Margaret Mead (1973, 48) too is of the opinion that "*All the claims so glibly made about societies ruled by women are nonsense. We have no reason to believe that they ever existed.....men everywhere have been in charge of running the show. ... men have been the leaders in public affairs and the final authorities at home.*"

However, many scholars today hold that patriarchy is a social construction. Lerner has written that there are indeed biological differences between men and women,

but “the values and implications based on [those differences] are the result of culture” (Lerner 1986, 6).

The existence of patriarchy may be traced back to ancient times. Lerner has stated that the commodification of women’s sexual and reproductive capacity emerged at about the same time as the development of private property, thus setting the stage for patriarchal social structures. The sexual subordination of women was subsequently written into the earliest system of laws, enforced by the state, and secured by the cooperation of women through such means as “force, economic dependency on the male head of the family, class privileges bestowed upon conforming and dependent women of the upper classes, and the artificially created division of women into respectable and not-respectable women” (Lerner 1986, 9).

Modern patriarchy is structural, meaning that it underlies the foundations of all of society’s institutions. In most societies, any accomplishments in the direction of gender equality must be made within a larger patriarchal structure. This is one reason why women are at such a constant disadvantage socially, politically, and economically. In the world today, the vast majority of leaders are men. Moreover, Laura Bierema has noted that while women make up over half the workforce, they fall far short of men in terms of pay, promotions, benefits, and other economic rewards (Bierema 2003, 3).

Often, patriarchy is associated more strongly with nations characterised by religious fundamentalism. Yet male domination and female subordination are salient features of social structure in virtually all societies, regardless of the race, ethnicity, class, or religion of the members. Most patriarchal societies have adopted characteristics associated with male domination, namely, aggression and power, as well as the consequences of these characteristics, ill health for women.

Resulting from patriarchy is the control of sexuality of women. Some of the cultural, religious practices arising out to control and regulate women’s sexuality are quite harmful for the health of women. In some societies of sub-Saharan Africa, Arab, Malaysia, Indonesia, 80 millions girls and women living today have undergone female circumcision, also called female genital mutilation (FGM). These cultural practices are done on adolescent girls as ‘rites the passage’ and also in order to control their sexuality which are brutal and painful. In some states in USA, this practice has been banned and it is a punishable act under the law. However, in other countries it still persists. There are serious health risks of FGM, like infections, hemorrhage, damage to adjacent organs, scar tissue formation, long term difficulties with menstruation, sexual intercourse and child birth.

3.3.2 Poverty

Women constitute 70% of the world’s poor (UNDP 1995, 4). Under feminisation of poverty, women are much poorer as compared to men world over. Poverty is the underlying factor for poor health status for not just women but the whole Indian population. Women’s low status, poverty and the reproductive risks add to their morbidity conditions. As mentioned earlier girl child is discriminated against boys for all the resources. Girls have higher malnutrition levels due to the disproportionate distribution of food to them as compared to their male counterpart.

A study in the Delhi slums revealed that 40 percent to 50 percent of the female infants below the age of one year were malnourished. And in female children in the age group 5–9, the rate of malnutrition increased to 70 percent (Mahbub ul Haq Development Centre, 2000: 127). Child malnutrition depends not so much on income or food availability as on the health care available to children and women. Income poverty explains only about 10 percent of the variation in child malnutrition (Mahbub ul Haq Development Centre, 2000)².

3.3.3 Gender

Under gender dimension it is pertinent to see how men's and women's life circumstances affect their health status. Gender is socially and culturally constructed and politico- economically situated. It is widely agreed that sex-ratio is a powerful indicator of the social health of any society, it conveys a great deal about the state of gender relations (Patel 2007). Worldwide, there are 43 million more men and boys than women and girls. According to Amartya Sen, there are 32 million missing females in India. (Menon-Sen and Shiva Kumar, 2001:11). Sometimes it is not so much to do with poverty but gender discrimination. It is seen that the sex ratio has been declining, especially in more prosperous states like Punjab and Harayana (George and Dahiya 1998). The sex selection is much more in better socio-economic background, the plush areas of South Delhi has adverse child sex ration compared to East and West Delhi. In rural Punjab, 21 percent of girls in poor families suffer severe malnutrition compared to 3 percent of boys in the same families. Thus, sometimes poor boys are better fed than rich girls (UNDP, 1995). It shows that the gender discrimination is much more significant than poverty. The gender difference in seeking medical help is quite obvious from the childhood. Medical help will be more likely to be sought for boys compared to girls. UNDP (1995) reports this difference to be as great as 10 percent. Other social factors like; early marriages, repeated pregnancies further disadvantage women and leads to ill health as compared to men.

3.3.4 A Dozen Messages on Women's Health

This subsection is based on the list of 157 ethnographies, where Marcia Inhorn captured dozen most important thematic messages about the women's health (Inhorn 2007, 3). It is important to understand the wide range of spectrum in which women's health is captured in anthropological literature. However, the dozen messages are given briefly and not elaborated.

- 1) *The power to define women's health*: It is ironical that women's health is usually defined by others i.e., powerful biomedical and public health establishments rather than women themselves. Numerous ethnographic studies from around the globe document the fact that women themselves rarely define their health problems in the same ways that the biomedical community defines them (Inhorn 2007, p. 7).
- 2) *The reproductive essentialisation of women's lives*: Women's lives are still essentially seen as reproducers. Child bearing and child rearing are seen as the most important aspects of their lives and tie them to the realm of reproduction, ignoring the other capabilities of women's lives like work, activism, leadership etc. 90% of what anthropologists have written in the area of women's health have focused on reproduction.

² (http://www.adb.org/Documents/Books/Defining_Agenda_Poverty_Reduction/Vol_1/chapter_23.pdf)

- 3) *The cultural construction of women's bodies*: Lock (1993) provides evidence that the body itself is a cultural construction. Cultures construct the body images and notions of beauty. Plumpness in one culture may be viewed as beautiful and desirable and in other cultures it can be seen as obesity and disliked. Recent anthropological literature has gone beyond reproduction and there are excellent ethnographies on teenage dieting, breast augmentation, plastic surgery, living with disability.
- 4) *The increasing medicalisation of women's lives*: The normal stages of women's reproductive life cycle from menarche to menopause and most important child birth have been pathologised. All the important stages of transition or growing up phase, like menarche, child birth, menopause, aging has been medicalised.

Medicalisation

Medicalisation is a social process through which a previously normal human condition (behavioral, physiological or emotional) becomes a medical problem in need of treatment under the jurisdiction of medical professionals. The process of medicalisation is based on the biomedical model of disease, one that sees behaviors, conditions, or illnesses "as a direct result of malfunctions within the human body" (Beard 2010).

- 5) *The increasing biomedical hegemony over women's health*: Italian social theorist Antonio Gramsci (quoted in Inhorn 2007, 16) defines hegemony as domination achieved through consent rather than force. In terms of biomedical hegemony over women's health, physicians rarely have forced women to accept them as their primary medical practitioners, such consent has come from women who have actively participated in this process of medicalisation and have often demonstrated their desire for cutting edge biomedical technologies, especially in western context. However, there is a resistance and protest against harmful technologies and its impact on women's bodies.
- 6) *The production of health by women*: Ethnographers who study ethnomedicines have documented the ways in which women around the world 'produce' health, often through their formal and informal roles of traditional healers and midwives. In medical anthropology the term 'household production of health' has been used to designate the ways in which women of the household produce healthy families by countering hegemony of biomedicine wither because they do not trust them or due to inaccessibility (Inhorn 2007, p. 19). Van Hollen study in Tamilnadu Birth on the Threshold: Childbirth and modernity in South India' (2003) documents the rituals related to pregnancy '*cimantan*' to fulfill the desires of the pregnant women and also gives ethnographic accounts of giving birth literally at threshold.
- 7) *The health demoting effects of patriarchy*: Inhorn notes that whether it is the 'micropatriarchy' of authoritarian doctor-patient relationship found in many bio-medical settings or the 'macropatriarchy' of gender oppression and its ill effects on women's health, patriarchy has health demoting effects on women. It can be seen in many ways, 'missing girls' undernutrition, neglect, violence, abuse perpetrated against women. Elisabeth Croll's (2000)

incisive ethnography *Endangered Daughters: Discrimination and Development in Asia*, shows how the perceived benefits of sons and the perceived disadvantages of daughters have led to cruel 'culture of gender' rife with both overt and covert daughter discrimination.

- 8) *The intersectionality of race, class, gender (etc) in women's health*: There is a need for exploring intersectionality of various forms of oppression in women's lives, based on gender, race, class, age, nation, religion, sexual orientation, disability, or appearance (Schulz and mulling 2006, cited in Inhorn 2007 p. 22). There are multiple forms of oppression that may intersect in women's lives. In Indian scenario, caste/ tribe is another major factor for ill health among the women, discussed in the previous section.
- 9) *The state intervenes in women's health*: State is the most powerful agents of surveillance and control over its citizens. Indian state has been controlling the population by having anti- natal policies, going in for coercive, targeted family planning program (Rao 2004). This is one such intervention apart from other interventions, like immunisation etc.
- 10) *The politics of women's health*: Women's bodies and health becomes the site for overt and covert, micro and macropolitical struggle. Studies show how women's health is politicised and inturn there is health activism and resistance. In Indian context, there are women's groups, feminist writers, public health activists who have been protesting and resisting coercive and harmful contraceptive technologies.
- 11) *The importance of women's local moral worlds*: Many women's issues are not just political but also moral in nature. Arthur Kleinman (1995: 27 cited in Inhorn 2007: p. 27) highlights the notion of 'local moral worlds' shows the importance of 'moral accounts....of social participants in a local world about what is at stake in everyday experience'. For women around the world the local moralities, often religiously based, have major effects on women's health decision making, particularly when the moral stakes are high. Issues related to abortion, assisted reproduction using third party donations in IVF – sperms, eggs, embryos, uterus as in the case of surrogacy are prohibited as per law or if there is a religious ban.
- 12) *The importance of understanding women's subjectivities*: There is need to understand women's own subjectivities by listening to the narratives of women on their subjective experiences of health and illness.

3.4 POLICIES AND PROGRAMS FOR IMPROVING HEALTH OF WOMEN

There are various programs for improving the health of women by the central government carried out by the state government. Two of them are given below.

3.4.1 Integrated Child Development Services (ICDS) Scheme

ICDS was launched on 2nd October 1975, today, ICDS Scheme represents one of the world's largest and most unique programs for early childhood development. Though the objectives of ICDS Scheme is to improve the nutritional and health

status of children in the age-group 0-6 years, the services are also meant for lactating and pregnant woman. The services comprises of supplementary nutrition, immunisation, health check-up, referral services, and nutrition & health education³. The pregnant and lactating women from the below poverty line families are given supplementary food, iron and folic supplements and immunisation at the Anganwadi centers.

3.4.2 Reproductive and Child Health Program

Ministry of Health and Family Welfare, Government of India identified National Institute of Health and Family Welfare, as National Nodal Agency for coordinating the training under RCH 1, in December 1997. The second phase of RCH program i.e. RCH II commenced from 1st April, 2005 till year 2010. The main objective of the program was to bring about a change in mainly three critical health indicators i.e. reducing total fertility rate, infant mortality rate and maternal mortality rate with a view to realising the outcomes envisioned in the Millennium Development Goals, the National Population Policy 2000, and the Tenth Plan Document, the National Health Policy 2002 and Vision 2020 India.⁴

3.4.3 Janani Suraksha Yojana (JSY)

The JSY is an Indian government-sponsored conditional cash transfer scheme to reduce the numbers of maternal and neonatal deaths and increase health facility deliveries in BPL families. JSY was launched by the Indian government as part of the National Rural Health Mission (NRHM) in 2005, in an effort to reduce maternal and newborn deaths by increasing institutional deliveries. The JSY covers all pregnant women belonging to households below the poverty line, above 19 years of age and up to two live births. The JSY integrates help in the form of cash with antenatal care during pregnancy period, institutional care during delivery as well as post-partum. This is provided by field level health workers through a system of coordinated care and health centers. Benefits for institutional delivery are more generous in rural areas and in low-performing states, ranging from Rs.600 to Rs.1,400. A subsidy is also available to private sector providers for emergency caesareans, on referral. The program also provides a cash incentive to the health worker who supports the woman throughout her pregnancy and accompanies her to the facility.

3.5 SUMMARY

Thus it can be summarised that India lags behind in ensuring healthy lives to its women in spite of sustained economic growth. Secondly anthropologists especially in India have a greater responsibility to understand women's health and possibly carry out applied research which will improve the health of the women. There is a need to understand the subjective experiences of women's health from their own real life experiences. It is important to understand women's health with the interface and advancement in science and technology, opening new avenues for reproductive technologies and the practice of surrogacy in today's globalised world. I would like to end this unit with a very meaningful quote by none other than famous anthropologist Margaret Mead.

Every time we liberate a woman, we liberate a man. ~Margaret Mead

³ <http://wcd.nic.in/icds.htm> accessed on 3 March 2012

⁴ <http://www.mohfw.nic.in/NRHM/RCH/Index.htm>

References

- Bierema, Laura L. 2003. "The Role of Gender Consciousness in Challenging Patriarchy". *International Journal of Lifelong Education* 22: 3–12.
- Croll, Elisabeth. 2002. *Endangered Daughters: Discrimination and Development in Asia*. New York: Routledge.
- Dudgeon, Matthew R. and Marcia C. Inhorn. 2004. "Men's Influences on Women's Reproductive Health: Medical Anthropological Perspectives". *Social Science and Medicine*, Vol. 39, No. 9, pp. 1303-1314
- Guarneri, Christine and Dudley L. Poston, Jr. 2008. "Patriarchy". *International Encyclopedia of the Social Sciences*. Vol 6. Second Edition. Pp. 173-174. William A. Darity (Ed.). Detroit, MI: Macmillan.
- Inhorn, Marcia. 1996. *Infertility and Patriarchy: The Cultural Politics of Gender and Family Life in Egypt*. USA: Univ. of Pennsylvania Press.
- Inhorn, Marcia C. 2006. "Defining Women's Health: A Dozen Messages from more than 150 Ethnographies" *Medical Anthropology Quarterly*. Vol. 20, No. 3 pp. 345-378.
- Inhorn Marcia. 2007. *Reproductive Disruptions*. New York: Berhahn Books.
- Lerner, Gerda. 1986. *The Creation of Patriarchy*. New York: Oxford University Press.
- Lock Margaret. 1993. *Encountering with Aging: Mythologies of Menopause in Japan and North America*. Berkeley and Los Angeles: University of California Press.
- Mead, Margaret. 1973. "Review of Sex and Temperament in Three Privative Societies". *Redbook*: 48.
- Meade, Teresa, and Pamela Haag. 1998. "Persistent Patriarchy: Ghost or Reality?". *Radical History Review*. 71: 91–95.
- Moghadam, Valentine M. 2004. "Patriarchy in Transition: Women and the Changing Family in the Middle East". *Journal of Comparative Family Studies*. 35: 137–162.
- Patel, Tulsi. 2007. *Sex-selective Abortion in India: Gender, Society and New Reproductive Technologies*. New Delhi: Sage Publications.
- Pateman, Carole. 1989. "God Hath Ordained to Man a Helper: Hobbes, Patriarchy, and Conjugal Right". *British Journal of Political Science*. 19: 445–463.
- Rao, Mohan. 2004. *From Population Control to Reproductive Health: Malthusian Arithmetic*. New Delhi: Sage Publications.
- Sabu, George and Ranbir S. Dahiya. 1998. "Female Feticide in Rural Haryana". *Economic and Political Weekly*. Vol. 33, No. 32.
- United Nations Development Programme. 1995. *Human Development Report 1995*. New York: Oxford University Press.

United Nations. 1995. *Population and Development, Vol. 1: Programme of Action*. Adopted at the International Conference on Population and Development: Cairo: 5-13 September 1994. New York: Department of Economic and Social Information and Policy Analysis, United Nations.

Van Hollen, Celia. 2003. *Birth at the Threshold: Child Birth and Modernity in South India*. California: University of California Press.

World Bank. 1993. *Investing in Health: World Development Report*. New York: Oxford University Press.

Website Links

Beard, Ren. "Medicalization of Aging." *Encyclopedia of Aging*. 2002. <http://www.encyclopedia.com>

Office of Registrar General. India. 2011. http://censusindia.gov.in/vital_statistics/SRS_Bulletins/MMR_release_070711.pdf

United Nations. *Millennium Development Goals Report*. 2007.
www.un.org/millenniumgoals/pdf/mdg2007.pdf

World Health Organization, UNICEF, UNFPA, World Bank. 2007. *Maternal Mortality in 2005*. www.who.int/whosis/mme_2005.pdf⁵

World Health Organization. 2002. *WHO Global Burden of Disease (GBD) 2002 Estimates (Revised)*.
www.who.int/healthinfo/bodestimates/en/

Suggested Reading

Lingam, Lakshmi (ed). 1998. *Understanding Women's Health Issues: A Reader*. New Delhi: Kali for Women.

Pal, Manoranjan, Bholanath Ghosh and Premananda Bharati. 2009. *Gender and Discrimination: Health, Nutritional Status, and Role of Women in India*. USA: Oxford University Press

Sample Questions

- 1) Women's health in India is precarious. Substantiate your answer with the morbidity and mortality indicators.
- 2) Patriarchy has demoting health effects. Discuss how it manifests in social practice of female foeticide and gender discrimination.
- 3) What the one dozen messages pertaining to women's health as drawn by Marcia Inhorn?
- 4) What are the efforts made by the Indian government to improve the health conditions of women?