Chapter I

REVIEW OF CONCEPTUAL AND EMPIRICAL LITERATURE
Our examination of issues related to Garhwali women’s work and health has drawn upon a wide range of conceptual and empirical work. This chapter discusses the theoretical underpinnings of this research study through an analytical survey of the literature relevant to the themes addressed by it.

We begin with a review of literature on the central theme of this research - women’s health. There exist a large number of micro studies which have looked at multiple factors that purportedly contribute to women’s health, which have thrown up a large number of “causal” factors and relations. They need to be explored to assess the depth of understanding achieved over time and the degree of clarity regarding causal linkages to health.

Given the centrality of work to peasant’s women’s lives and the multiple types of work that they do, it is crucial in our view to understand dimensions of women’s work participation especially of women peasantry. We undertake an overview of empirical literature on peasant women, with a focus on examining studies on the nature of the work participation and its linkages with health. It is now well recognised that women do not constitute a homogenous category but are shaped by societal divisions, hierarchies and cultural differences. It is therefore necessary to explore the specificities of life of women in hill regions. The next section is thus devoted to specifically review research on hill women. We attempt to provide a focus on the situation of rural and hill peasant women though the available literature.

To bind together the threads of analysis of health and work of women, an understanding of theoretical literature on women’s subordinate position in society was necessary. The fourth and final section explores relevant strands of theorisations related to understanding women’s work and health. These theoretical approaches have helped formulate the research problem and set out a broader framework encompassing relevant perspectives and concepts that is necessary for in-depth examination of the research questions and research objectives.
REVIEW OF RESEARCH ON WOMEN'S HEALTH

Women's health was till recently a neglected area of health research. Internationally too it was not until the emergence of international feminist movements in the 1970s, that a critique of existing conceptualisation and policy on women’s health and a redefinition of their health occurred (Sen and Grown, 1987). Women's organisations came to realise the importance of women's health concerns and safe reproductive health services. Research on women's health was to a large extent a response to the women's movement and was conducted by feminist activist. For example, the worldwide best seller produced by the Boston Women's Health Collective: 'Our Bodies, Our Selves ' (1978). In India too, over the past two decades a body of literature on women's health has developed.

A review of Indian research on women’s health reveals that there has been a focus on assessing women’s health situation through quantitative indicators. Macro level demographic studies find a regular place in general report on women’s status where health is taken as an indicator of women’s status. The statistical analyses have indicated the poor health status of Indian women, the symptoms of which are declining sex ratio, high rates of female mortality from birth right upto the age of 30 and high trends of morbidity. During the past decade, the gap between the mortality rates of young boys and girls has widened. (Gopalan, 2000) Despite their innate biological advantages, more girls than boys die. “Maternal mortality” accounts only for 2.5 percent of all female deaths. If women in reproductive age group are looked at exclusively, deaths due to childbirth increase to 12.5 percent. Maternal mortality in India is a silent killer.

While causes of death related to “maternity” are important in India because of the heavy reproductive burden borne by women, majority of Indian women die due to diseases predominately infectious in nature (Qadeer, 1998). Respiratory diseases such as tuberculosis, pneumonia and bronchitis, fevers related to malaria, typhoid, gastroenteric and other infectious diseases are important causes for the deaths of men and women. On the whole, epidemiological studies, surveys and ethnographic studies have pointed out to considerable ill-health among women and also the existence of gender inequalities. Most
rural health surveys record a much higher incidence of illness among women and girls than men and boys.

Existing evidence is again fairly consistent on gender differentials in morbidity and unambiguous on the greater neglect of women in health care and treatment of illness. These are mostly micro level studies, which take one or two variables such as malnutrition, education, occupation etc., which are then examined in relation to health. We cover micro-studies relevant to the health themes and objectives addressed in this research study. Those Indian researches that are shaped by feminist perspectives are attempting to locate women’s health in the context of women’s social status as well as within the processes of socio-economic development. Others are more concerned with a closer understanding of explanatory factors associated with women’s health and in the explanation of their health situation and their health status as well as health services for women.

**Studies On Social Determinants Of Indian Women’s Health And Health Services**

The large body of work on sex differentials in mortality in India (Wyon and Gordon, 1971; Chen and D'souza, 1981; Dasgupta, 1987) ascertains and explains gender differentials and regional variations in mortality rates. Explanations have been largely sought in socio-cultural and economic factors such as kinship and marriage systems, property rights, farming systems, parental gender bias, female labour force participation rates etc. Studies on fertility behaviour of women have focussed on the link between fertility and women’s social status.

Studies on gender differential in household food allocation have well established the fact. Ethnographic literature suggests that girls are not fed as well as boys in northern India (Harris 1986; Miller 1981). Khan et al (1989), Dasgupta (1987) found that boys were given more high quality foods, while girls were given more cereals. Even in households which theoretically have enough food, the way it is distributed leaves women inadequately nourished (Jeffery and Lyon, 1989; Caldwell and others, 1989). In fact the gender differences in food intake are apparent in breastfeeding, where a female child is likely to be breastfed less often and for shorter periods than her male siblings and to be
weaned sooner (IIPS 1995; Kahn and others 1989; Ghosh 1987; McNeill 1984; Kumar 1983; Das, Danoha and Cowan 1982; Levinson 1974). From these studies then we can infer that the under-nutrition that is prevalent in a significant proportion of adult Indian women can be attributed primarily to inadequate food intake during adulthood.

A review of Indian statistics in the area shows that given the nutritional demands of childbearing and lactation, the lack of nourishment puts women at particular risk during their childbearing years. Even when they have enough food, Indian women may be malnourished because of the poor nutritive quality of what is available or because their systems are unable to absorb iron effectively owing to intestinal parasites or malaria. Anaemia affects over 60 percent of Indian women, lowering their work performance both directly or indirectly, through increased morbidity. It is also well-established that anaemia complicates pregnancies; the result is maternal deaths, low birth weight infants and lower child survival (Chatterjee, 1996).

Women's reproductive health has been quite extensively researched. Most studies in the area have attempted to establish the incidence and nature of reproductive illness. Several studies have established the significance of RTI and gynaecological morbidities among women in India (Bang et al 1989, Bhatia et al 1997; Oommen 1996; Koening et al 1998). The researchers have been majorly concerned with diagnosis. They have relied upon variable criteria of clinical diagnosis hence the variations in the levels of morbidities. Women's self-reported illnesses are used and wide range of reproductive health symptoms are found. Menstrual problems and abnormal vaginal discharge are most frequently mentioned along with prolapse, lower abdominal pain and lower backache. There has been a debate whether clinical, laboratory or self-report provide a better assessment, and it has been concluded that certain types of RTI require clinical or laboratory tests and others may be assessed from self - reports and considerable body of qualitative studies have used this methodology. As reported by Oomen (2000) eight qualitative studies have shed light on RTIs and five of them found that vaginal discharge was a major complaint. Women found it a most severe illness and linked it to weakness and backache and may even use these terms as euphemisms to report discharge.
Studies have examined sexual factors (George and Jaswal, 1995); iatrogenic factors, abortion related factors; obstetric practices as determinants of gynaecological morbidity (Jeejeebhoy and Koening 2002). There is no evidence in India on vaginal infections; however there is some evidence that menstrual hygiene and personal hygiene are associated with RTIs. Several studies have described women's perceptions of linkages between lack of food and illness. On the whole, the evidence is suggestive rather than conclusive (Oomen, 2000; Amin and Bentley, 2002; Klienman 1980; 1986; Shatruguna etal 1993).

The influence of social, economic and cultural factors on the biomedical determinants of gynaecological morbidity has not been adequately studied. A few studies exist on women's perception of risk factors (Gittleson etal 1994; Oomen 1996). Some works in the area points to poverty, inequalities, cultural norms and their interaction as crucial factors in the creation of gynaecological morbidity (Oomen 1996; Madiwalla and Jesani, 1997; Gittleson etal, 1994; George 1997; Ramasubban 1995; Ravindran 1995; Unnithan Kumar, 1999; Sharma and Vanjani, 1993; Jeffery and Jeffery, 1989).

An understanding of women's mental health can be gained from Davar's (1995) re-analysis of relevant gender data from community studies, from a gender perspective. She finds a higher prevalence of mental disorders for women as compared to men, and that for severe mental disorder (such as psychosis, organic brain syndrome, epilepsy) there is no significant difference in prevalence between the two sexes. However with respect to common mental disorder (viz. all forms of neurosis) the prevalence is found to be much higher among women. Hysteria and depression are both found to be more prevalent among women.

Somatisation is a common neurotic disorder among women wherein bodily complaints such as aches and pains, headaches, dizziness have no discernible physical basis. Issac and Kapur (1980), Carstairs and Kapur (1976), Chakraborty (1990) all found a great number of somatisers among women in their community surveys. These disorders do not necessarily imply that they are mild or cause very little personal suffering. In fact they can cause enormous suffering, irreparable social alienation, violence, loss and damage, even
self-destruction. Davar also stresses that the greater prevalence of mental illness among women is not because of greater reporting of illnesses by women—there is commensurability between distress and reported severity of symptom. “Higher female predominance of depression is therefore not an artefact of treatment seeking” (Linderstein, 1993). Davar’s work is of importance, though it is only a secondary analysis. However it cannot be treated as a substitute for full-fledged empirical work.

On the whole, it is suggested by the above reviewed studies that rural women’s health depends critically on economic structures and patterns of caste, class and gender inequality, on socio-cultural structures such as kinship and household structures as well as on gender cultural/ideological forces. However, there are very few studies, which consciously take a more theoretical approach that links structural variables and women’s productive and reproductive roles to health. These studies have approached the socio-cultural context of women’s health from two overlapping and equally important perspectives. The first is the ethno-medical aspects of illness including belief about diet, body and health, systems of healing, beliefs about symptoms, cause and consequences. Several of these studies in India on women’s perceptions of health and disease have been grounded in this approach. The second approach is located is studying structural elements such as family and community power positions and relationships in particularly gender power relations as important factors in shaping illness and health. The ability to control one’s physical environment and to control, receive and understand information vital for well-being.

We review below the few studies where attempts have been made to understand at least some of the intricacies of women's health in a holistic manner. These studies have attempted to study the influence of social, economic and cultural factors on women’s health and morbidity. Only a few studies exists on women's perception of health and its associated risk factors (Gittleson et al. 1994; Oomen 1996). Researchers in the Centre of Social Medicine and Community Health, New Delhi have conducted many of these studies. A few of the relevant ones we will detail below (Sagar, 2000; Soman, 1992; Gopalan, 1997). Besides this there are a small number of other such studies as well.
Work in this area points to poverty, inequalities, cultural norms and their interaction as crucial factors in the creation of women’s poor health. Studies have also found an association between livelihood, work and reproductive health (Oomen, 1996; Madiwalla and Jesani, 1997). Gender based inequality in sexuality make women vulnerable to infections (George and Jaswal, 1995).

Moreover, the literature on gender and reproductive health highlights the importance of women's work, childbearing roles, lack of access to resources, socialisation, norms related to shame and sexuality, all of which directly or indirectly influence their physical, mental or social well-being. (George 1997; Jeejebhoy and Koening 2002; Ramasubban 1995; Shatruguna etal 1993; Ravindran 1995)

A study in Tamil Nadu investigated the extent to which the exercise of women's rights in employment contributed to their sexual and reproductive health. This investigation revealed that household work, such as the work involved in carrying wood for fuel, water over long distances, cooking and other domestic chores, affects women's health negatively. Additionally, it pointed out that women in agricultural labour, involved in the processes of rice transplanting, weeding and harvesting led formidably hazardous reproductive lives (Swaminathan, 1998).

Another study, also carried out in Tamil Nadu, studied the beedi industry in Tirunelveli District. This study examines that labour process and its impact on the lives of women workers. The analysis revealed that merely giving women some form of employment without changing their socio-economic institutions or cultural practices did not empower them. In fact, it further demonstrated that the women's employment in rolling beedis, which theoretically should have provided economic security and thus helped in improving their health status, actually created ill health for them(Gopal 1997).

This finding is strengthened by data from a study in Birdhum District in West Bengal. This study examining the lives of women in selected villages demonstrates that women's health (including their reproductive health) is a direct offshoot of the social dynamics of their inter and intra household relationships (Soman, 1992).
Sagar (2000) in her study in slums of Delhi focuses on understanding the health behaviour and socio-economic and cultural basis of the experience of pregnancy among the economically disadvantaged women. Using women’s own perceptions of morbidity in pregnancy, she compared the profile of women’s morbidity in pregnancy and when not in pregnancy and she also studied their health behaviour within a broader socio-cultural context.

Gupte and Borkar’s study (1987), looks at women’s work, fertility and access to health care in two villages in Pune District. Their findings show that most of the work done by rural women, like housework and child bearing is invisible because they are considered private and are accepted as normal duties, which creates conditions for exploitation both inside and outside home. Apart from resulting in gross inequality between sexes, there is also an adverse effect on women’s health in terms of nutrition, maternity and access to health services.

Amin and Bentley’s study (2002) conducted in six villages in Panchamal district of Gujarat found that several discriminatory norms related to work, marriage, sexual behaviour, fertility and seclusion were related to reproductive ill-health. The study also revealed poor psychological and mental well-being which exists as a manifestation of the physical and social stresses they are subjected to. Other studies have also shown similar reproductive symptoms (Nichter, 1981; Patel & Oomen 1999).

Unnithan Kumar (1999) situated her analysis of the reproductive health of women of the rural Nagori Sunni Community in Jaipur district in the context of their perceptions and experiences in general as well as in terms of the material, ideological and political dynamics of household, kin and gender relations. In another ethnographic study of rural Muslim and low Hindu caste women in Rajasthan, Unnithan Kumar (2000), found that complaints about menstrual disorder, pelvic inflammation and inability to conceive (usually secondary sterility) were women's self-stated main reproductive complaints. Anaemia, nutritional deficiency, vaginal discharge, uter al or rectal prolapses were so widely prevalent that women regarded them as normal experience.
An indepth study of reproductive historic and experience of a group of rural women in Alwar district of Rajasthan was conducted by Sharma and Vanjani (1993). The study revealed that health had a definite class and caste bias - the poorest, untouchable women were worst off as far as reproductive ill-health is concerned. The researchers concluded that the political economy of reproduction must be understood within women's situation of life, work and general well-being (or lack thereof).

Jefferey and Jefferey's study (1989) of women's experiences of childbearing in rural north India has given important insights into the structural location of women in her conjugal home as wife and worker and the culturally discriminatory experience of process of child bearing. They show how cultural norms and practices of pregnancy have consequences in terms of mishap and how the indigenous methods of labour management have in-built risks. Another set of studies deals with access to healthcare services and their utilisation. A review of this literature shows that a large chunk of studies are concerned with studying factors associated with women's access to healthcare services and the medical attention that they receive. Research unravels an interplay of multiple factors which derive out of patterns of gender inequality and cultural valuations, belief systems and attitudes and socialisation patterns of women into them, nature, quality and structure of state public health systems, class and ethnic factors. (Navaneethan and Dharmalingam, 2001; Bhatia etal, 1995; Raghupathy, 1996; Appasamy etal, 1995; Soman (1982)

Gender bias is evident in a number of social processes that operates at the level of household or at the level of medical services (Minturn, 1984; Pettigrew, 1989; Batiwala, 1988; Basu 1990; Jeffery, Jeffery, and Lyon 1989; Koening, Gillian and Joshi, 2000; Unnithan - Kumar based, 2000). From the household side there is a marked tendency to ignore or devalue women's health problems (Khan and others 1989; Miller, 1981; Chatterjee, 1988), systematically allocate lower resources to their medical attention and provide treatment only when conditions are serious. (Dandekar, 1975; Dasgupta, 1987, Basu 1989b, studies done by IIPS in 1995-96);

Hospital systems and processes are not conducive for independent access by women and they have to depend on the assistance of male kin. Studies of hospital records corroborate
these trends by revealing lower female admission (Kynch and Sen 1983; Navaneethan et al, 2001; Rajeshwari 1996; Ramalingaswamy, 1987), lower rates of medical service utilisation and hospitalisation and higher rates of fatalities and mortalities of women as compared to men (Das, Dhanoa, and Cowan 1982; Miller 1981; Klienman and Taylor 1983; Dandekar 1975; Soman, 1992, Unnithan-Kumar, 2000).

Critical Appraisal of Women’s Health Research

The above review of Indian literature on women’s health shows that conceptually the trend of women’s health studies is to adopt a broad definition of health, and test out women’s actual health situation focussing on a few indicators. Yet, it may be pointed out that the debate around the concept of health does not get reflected in research. Though the conventional biomedical approach to defining and dealing with health has come under severe attack and the social perspective, which sees health as rooted in people’s material reality and shaped by social, political or cultural realities is advocated, women’s health research shows a lack of comprehensive conceptualisations and discrete handling of detriments –especially in social, economic and cultural domains.

The available literature on women’s health also reveals that there is considerable emphasis on prevalence in particular of women’s maternal and reproductive health. Few studies attempt to look at women’s health in its totality in terms of the material, ideological and political dynamics of household, kin and gender relations. Reproductive health problems are important but are only one set of health problems faced by women. Even studies in this area tend to deal with only women’s reproductive tract infection (RTI). Studies have shown that women are more concerned about illnesses other than RTIs. It is this uneven emphasis on reproductive aspects of health and discrete analysis of social detriments in most of the studies that compels us to take forward the integrative view of health. Thus, to build on studies that use political economy framework, we move to review literature on women’s work and health. This would help strengthen our framework.
STUDIES ON PEASANT WOMEN'S WORK AND THE WORK-HEALTH LINK

Women’s work became the subject of intensive research after the publication in the mid-seventies of a national report on the status of women in India, the most striking finding of which was an alarming decline in women’s work force participation. Since then a number of studies have focussed on ascertaining, explaining and assessing the implications of this decline. A most important task has been the unravelling of conceptual biases in defining work. Feminist economists have critiqued the gender bias of economic concepts and developed gender sensitive notions, indicators and measures to make women’s work more visible and get it official recognition and inclusion. They emphasise the need to enumerate women’s domestic labour and realise its significance (Banerjee, 1989; Agarwal, 1985; Duvvury, 1989). Concurrently, there have been attempts at qualitatively and quantitatively examining women’s work in various domains of the rural agrarian economy and the industrial-tertiary sectors both organised and unorganised of the urban economy. The studies have examined how women’s work is structured in relation to poverty and hierarchy, inequalities in work options, in remuneration, in access to the means and opportunities for better work and in the organised bargaining capacity to change. The central question is how patriarchy combines with caste and class hierarchy, to influence women’s access to means and resources for work. Studies have also examined the relationship between work participation, women’s economically productive work and their status (Bardhan, 1985).

Most studies of women in agriculture have been primarily engaged in describing the changing situation of agricultural labour. The body of literature on women’s work is large. Therefore given our focus on peasant women, we only look at studies dealing with their work. Peasant women’s studies have been comparatively fewer than those of female agricultural labour. Though following Boserup’s seminal work (1970), efforts have been continuously made to analyse women’s contribution to and status in agrarian economy, particularly under the impact of modern economic developmental processes on traditional economies. The studies have explored issues of gender division of labour, women’s autonomy, authority and power, their access to resources, indirect power and decision-making.
The studies reveal that in agricultural households the fieldwork participation of women has increased. Small farms can maintain their competitive edge only by greater exploitation and self-exploitation of women. Moreover, women may be withdrawn from visible to invisible work with changes that are negative to status. Women’s status and role in agricultural decision-making is a debated issue. As far as ‘status’ is concerned, women may have decision-making roles but little control of cash and little respite from work intensity. Indeed, Bardhan’s (1985) detailed review of Indian women’s work, welfare and status speaks of peasant women’s productive labour and domestic labour as an overlapping continuum. Studies have begun to take cognisance of the range of extremely labour and skill intensive operations that are crucial to crop production and processing. There are several such studies from Bengal, North and West India and on South India (cited in Bardhan, 1985; Duvvury, 1989; see also Mencher and Saradamoni, 1982).

Examining caste differences in women’s lives in a Punjab village mainly occupied by a middle-ranking peasant caste of Sikhs (the Jats), and the scheduled castes (low status groups), Horowitz and Kishwar (1984) found that inspite of differences in economic status between Jat women (who tend to be married to men who own land) and other women, there are similarities in their lives. Both groups of women work anything upto a 15-16 hours a day in the fields and at home. Women’s work includes care of cattle. The opportunities for landless women to work for money are fewer than for landless men.

Studies of the sexual division of labour in agriculture have pointed out that it is necessary to more carefully examining regional variation and the temporal variation due to changes in technology and due to other structural factors (Chatterjee, 1984; Saradamoni, 1987). Most of these studies have been conducted in the southern regions but here too sharp regional variations are found in patterns of work. Harris (1979) found that peasant women’s withdrawal from ‘visible’ to ‘invisible’ work has negatively affected their role and status in decision making. But there are studies which show that with agricultural modernisation and new technology, peasant women are consulted in agricultural decision-making. However their role in decision-making
declines with the rise in the position of the household in social hierarchy (Devadas, 1975; Sisodia, 1985; Sharma, 1983 cited from Duvvury, 1989). Studies have also shown that peasant women may have little actual control of cash and therefore cannot demand expenditure on facilities that may reduce housework such as paying for grain milling; general sanitation etc (Epstein, 1976; Chakravorty, 1975 cited in Duvvury, 1989).

**Women's Work And Health**

Considering that work, whether paid or unpaid is central to most women's lives, the association between work and health has been poorly addressed and understood. We have little information on how women's daily work activities influence their health. In the Indian context, feminist scholars have rightly warned against any simple or straightforward association between women's work and their health (Bardhan, 1985; Swaminathan, 1997). To quote Bardhan:

"The rate of workforce participation may have a role in determining women's status, but that role is qualified by questions of work quality, the class variation in the double burden and whether productive labour is a sufficient condition for autonomy and voice, whether it is even a necessary condition in a class-and-hierarchy-ridden society. Aside from these components of women's status, on which differential work participation may have some intermediate effect, there is the bottom-line component of the value and care accorded to female life. (Bardhan, 1985)

Overall there is an absence of ethnographic and epidemiological studies linking household structures, nature of domestic and non-domestic work that will help make connections between work, mortality and morbidity in India (Swaminathan, 1997).

The Shramshakti report (1988) on labouring women documented health hazards in various occupations in the informal sector. Health problems for agricultural workers arise out of postural problems, exposure to dusts and chemicals, use of unguarded implements and working barefoot. Women suffer a number of general gynaecological health problems, injuries and toxicities. Physically strenuous domestic works such as carrying water, lifting heavy weights were also seen to bring great physical strain and general and reproductive health problems (Shramshakti, 1988).
In the agriculture sector, women were found to suffer from generalised body aches, cough, respiratory allergies, fungal infections, injuries, toxicity and so on. There are several additional gender specific dimensions in agricultural work which affect women’s health situation. The nature of agricultural work exposes women to particular health hazards (Agarwal, 1990). An association between working in rice fields and gynaecological infections has been noted in rural Asia (UNDP, 1980). Micro study evidence on women’s agricultural work and health is mainly from the South, viz. for women of Tamil Nadu (Swaminathan, 1998) and for women agricultural labourers of Kerala, Tamil Nadu and West Bengal (Mencher and Saradamoni, 1982).

Examining the importance of seasonal variation in health, it is found that malnutrition, morbidity and mortality peak in the wet season of agricultural production. Women and children are especially vulnerable to hardship, malnutrition, sickness and death. The extensive and often strenuous physical labour that women perform combines with male preference in household allocation of food to account in good measure for malnutrition among Indian women. One study estimated that when women's physical activity, including field and domestic labour, was taken into account, women had a higher daily expenditure of calories than men in the same households (Batliwala 1982).

Productive responsibilities are hardest on young women in their childbearing years. Typically, women work until late in their pregnancies; no special provisions are made for rest or additional food, and most women resume work before they have fully recovered from childbirth. The conditions set in a cycle of "maternal depletion" that can have devastating consequences for a woman's health and undermine her ability to carry out her responsibilities, both productive and reproductive. A woman whose physical reserves are already exhausted by childbearing, lactation, anaemia, and heavy agricultural labour has no reserves to ensure that another pregnancy will be safe and healthy. Continued physical activity until late in pregnancy and a lack of adequate rest not only negatively affect women's health but also contribute to excessive rates of stillbirths, premature births, and intrauterine growth retardation (Khan, Ghosh and Singh 1982; ICMR 1977).
Environment, Work and Women’s Health

Environmental factors have been one of the many the leading causes or exacerbators of death in the developing countries (Dankelman et al, 1988; Kettel, 1993). The natural and constructed ‘life space’ within which women carry out their various gender-based involvements as domestic workers, producers and income-earners impact significantly on women’s health (Kettel, 1996). Domestic chores are much more labour and energy intensive in the typical Indian rural setting. The range of back-breaking domestic activities - fuel and water collection in particular carry with them a number of different health problems. The increased time and energy required to collect fuel cannot but be detrimental to women’s health. (Basu, 1993).

Exposure to domestic pollutants continue to increase women’s and girls’ exposure to serious and fatal diseases. Caldwell and Caldwell (1990) reported that long hours spent by them in dark smoke-filled secluded kitchens led to appreciable increase in bronchitis and asthma. Crude stoves, biomass fuels and poor ventilation had a detrimental impact on the respiratory health of women and children. Infections and accidents, not childbirth, are the leading killers of women even during the reproductive age. Poor quality housing means poor heating, lack of space, damp living conditions, lack of hot water and inadequate furnishings. Separately and in combination, these difficult conditions have an ongoing impact on the women’s health (Bhatt, 1989).

To conclude, studies of rural, agrarian economy based women tend to suggest that despite a significant role in agricultural productivity and a high level of involvement, there is no unambiguous link between their work and status. Patterns of gender division of labour show that women are not on equal terms with men. One the whole, few studies have looked at larger implications of work for women, in particular for their subordinate position in society. The key question is which type of work is harmful or beneficial for women, under what conditions. An important area to examine effects of status and work would be health, but as the review has shown, the work-health link is inadequately addressed.
HILL WOMEN’S WORK IN THE CONTEXT OF ECOLOGICAL DEGRADATION AND MALE MIGRATION

In the ecologically degraded hills of Garhwal and Kumaon and other Himalayan regions, women’s work has undergone an enormous increase. As highlighted in the introduction, common property resources became privatised and state controlled, thus scarcer and inaccessible to dependent people. A high rate of male migration has made women’s burden all the more disproportionate. Studies examining aspects of changing economy and ecology throw light on the contemporary milieu in which hill women live and work.

Many studies have brought out the migration endemic character of the region with men migrating as far as the cities of Delhi and Mumbai (Dhobal, 1977; Bisht, 1994; Rana, 1995; Bora, 1996). Examining the structural characteristics of sedentary hill agriculture, the historical development of migration and the causes of migration, Whittaker (1984) found that contrary to the view of labour migration as an instrument of economic development, the transference of labour from a subsistence agricultural sector of low productivity to high productivity capitalist, industrial sector, Himalayan migration and agrarian change have brought about mixed, including many negative, consequences. Male migration is a response to decline in per capita production levels in the agricultural sector. The purpose of migration is therefore to provide cash support through remittances and pensions earned outside the hill area, for a resident population (usually women, children and old people) which operates an agricultural system that is unable to meet its subsistence requirement and which possesses a weak facility for structural transformation (Ibid, 1984). The majority of moves undertaken by hill labour are circular in nature, not extending beyond the duration of an individual’s working life.

Bora’s (1996), recent study of two districts viz. Tehri Garhwal and Pithoragarh in the hill region of Uttar Pradesh reiterated some of the factors which accelerated out-migration. These are pressures of population on land, scarce resources, small landholdings, landlessness, degrading subsistence agriculture, unemployment and backwardness of the regional economy. At present, the increase in male education and the lack of commensurate job opportunities in the hill regions are further propelling men to migrate
(Guha, 1989; Bisht, 1994; Mehta, 1997; Pathak, 1997; Bora, 1996; Rana, 1998 and so on). Studies have also brought out that the poorest and lowest caste groups, had a lower propensity to migrate than high status groups (Bora, 1996; Bisht, 1994).

Contrary to beliefs of the economic benefit of migration, Bora’s study shows that annual benefits to an average migrant household in the form of remittances and pensions were lower than earnings forgone due to out-migration. Thus net-benefit due to out-migration is negative. Only in households having out-migration as well as return migrants, was the net-benefit per household due to out migration positive. Return male migrants were available to households to earn some income locally and are not surplus to the local economy (Bora, 1996).

Studies ascertaining the quantum and nature of women’s work in changing hill economies have all established the enormous work contribution of women in family farms. Bhatti and Singh (1987) acquaint us with women’s contribution to agricultural economy in the hills of Northwest India. The study estimates the household’s total labour inputs and examines how the division of labour is organised in 120 marginal, small and other farm households located in 10 villages in Himachal Pradesh. They take into account labour inputs in direct production during the entire twelve month agricultural cycle, accounting for the actual number of days of agricultural work performed by different household members. The study showed that about 77 to 80 percent of family workforce was engaged in agriculture and women’s labour accounted for 62 percent of the total familial agricultural workforce. Women performed 61 percent of total farm work, greater in animal husbandry than crop production. There is a tendency towards sexual division of labour in both tasks and women’s work rarely finds a reduction in working hours. Bhat et al (1987) studying the agricultural role of Kashmiri women show that the rate of female labour participation was higher than male labour for all farm-size classes and farms, based on diverse cropping patterns and irrigation facilities. A household survey in Una district of Himachal Pradesh during the agricultural year also showed higher female than male labour participation. However, wages for women were much lower.
Similarly, Vir Singh (1987) showed greater work quantum of women in Almora. Ploughing and levelling operations are done by men while women perform inter-culturing, irrigation, manure transportation and its application in the fields, harvesting and threshing. Three-fourths of the total work in agriculture is performed by female workers of the family. But majority of decisions with respect to agricultural operations is taken solely by men. A comparative study of women-managed farmholds in the hills with those in the plains of rural Uttar Pradesh, showed that the participation of the former was greater (Singh, 1988).

Aggarwal’s study has drawn attention to how environmental degradation has made conditions of women’s subsistence work more arduous and less productive. Village commons and forests have traditionally provided and continue to provide (although decreasingly) a wide variety of essential items – food, fuel, fodder, fibre, small timber, manure, bamboo, medicinal herbal oil, material for household buildings and handicrafts, resin, gum, honey, spices etc. – for personal use and sale. Many of these products have also been critical for tiding poor families over periods of seasonal or acute food shortages (Aggarwal, 1989). In the hills, deforestation has made the task of fodder fuel and water collection more arduous (Agarwal, 1992). Male-migration makes women workers and managers of farms. Caste-class hierarchy in the hills is less marked as compared to the plains, which reduces availability of hired labour (Chen, 1989).

Soil degradation and erosion have compounded problems of crop production. Studies have focussed on the escalating ecological degradation and food insecurity, which are tied with the fragmentation of village communities on one hand, and women’s “primary but subordinate status” on the other. With rapid commercialisation, the best land is devoted to cash crop resulting in shortfall in food grain production. Gender inequalities and declining access to land and food have disturbing consequences for the well being of the local ecology and household food security (Agarwal, 1987; Mehta, 1996). In the Himalayan region of Nepal too, farmers have to cope with food insecurity. The majority of mountain population is severely undernourished and for increasing proportion of village people, survival has become a permanent crisis (Bhole, 1998).
Women’s role as invisible water managers, responsible for supplying the water needs of the household, domestic animals and agriculture have been highlighted (Davidson, 1993). Decreasing water bodies and eutrophication has been observed in the entire Himalayas (Afroz et al, 1989). Natural springs are drying up due to the indiscriminate lopping of native broad-leaved tree species like oak and alder (Afroz, 1991). This decline in water tables due to deforestation has compounded the problem of drinking water. Women trek for hours to fetch water, the situation worsening considerably in the summer months (Bisht, 2002). Women’s time and energy are further exhausted with the decline in common grazing land and acute fodder shortage in the region. More than 40 percent of rural households in Kumaon district in Central Himalayas have to trek a distance of three to eight km (one way) to obtain fodder and fuelwood (Pandey, 1986, Debnath, 1987).

The gendered nature of agrarian communities is reflected in access to resources and control over environmental decisions and technologies in a study of Tehri Garhwal conducted by Manjari Mehta. The adoption of commercially oriented agricultural practices (developed in the plains) are intensifying ecological vulnerability. Traditional genetic diversity is being eroded and then is a gradual loss and devaluation of the wide repertoire of indigenous knowledge on which the sustainable use of resources has traditionally drawn. Male migration leaves women to bear the brunt of agricultural production and maintenance of households. Remittance leads to the household’s improved standard of living upto a point, and women do get a share. But money is rarely made available to women to hire labour for highly labour-intensive tasks such as collecting fodder and fuelwood. The study also found that households now keep buffaloes instead of cows as a result of declining forest and field fodder resources and changing household demography. Even though female literacy rates are higher for hill women as compared to plains women, they can expect little more than a life confined to the parameters of the village (Mehta, 1996).

Ursula Sharma’s study of village Chaili in Himachal Pradesh also shows conditions of depressed agriculture, in small underdeveloped villages, where peasants use traditional methods of cultivation. Moreover women shouldered more work in order to release men for urban wage labour, without gaining autonomy, decision-making powers,
entrepreneurship or access to family resources. It strongly reiterated the devolution of additional agricultural work upon women. Male control of virtually all productive assets shows that women’s increase in labour is disconnected to their “de-facto” powers, better work options or even the perennial hazards of dependence. Moreover in many villages of Himachal Pradesh, which earlier practised bride price, the shift from bride price to dowry is near total and dowry amounts have increased manifold (Sharma, 1980; 1979).

*The Chipko Andolan* initiated at gaining control over forests brought hill women into national and international focus. Women were actively involved in *Chipko* Movement and displayed remarkable ability to organise and protest, not only against the commercial exploitation of forests, but often against men of their own community. *Chipko* history is replete with examples of women protesting against commercial forestation, anti-alcohol protest and so on. The movement clearly highlighted the ways in which environmental degradation has made conditions of women’s subsistence work more arduous and less productive. (Bandyopadhyay, and Shiva, 988; Haigh, 1988; Mehta, 1991; Guha, 1991; Agarwal, 1992).

There is a dismal lack of research on hill women’s health. Most available studies are conducted by NGOs with a narrow fact-finding approach.

A study of Tehri Garhwal hill women assessed the reproductive health status. The study findings indicated that overwhelming majority of women had some gynaecological problem indicating poor reproductive status: anaemia, leucorrhea, abdominal pain and painful menstruation. The study also established considerable reproductive wastage in women, due to foetal loss, complications during child birth and early infant death. The study stated that there were difference among the six districts but these differences do not lend themselves to any meaningful interpretation. Based on this it is ambiguously said that “this leads us to think that where reproductive health status is concerned, habitat is more important than differences in life styles, levels of exposure to tourism, male migration and cultural peculiarities”. The statement is not further explained (Dhri Bhuvaneshwari Mahila Ashram, 1999).
Rawat (1998) is one of the five studies which looks at the social impact of deforestation on peasant women of Uttaranchal hills. Two hundred women (aged 20 – 40 years) from Hawalbach and Takula block (Almora district) were surveyed and medically examined. The study revealed prevalence of leucorrhea, anaemia, worm infestation and backaches. Other studies conducted in the hill region including Garhwal also indicate high prevalence of reproductive morbidity (Rachna, 1999; Samta, 1997, Ram et al, 1998).

On the whole, literature available on the status of women in this hill economy has highlighted the enormous work loads that women bear, examined the socio-economic imperatives which compel households to participate in external economy and how this in turn effects the organisation of agricultural activities. There is however, a need for a more consciously systemic level analysis to understand women, the hill household and their relationship to the wider political economy. A better and more fuller understanding of how the sexes are positioned within the domestic economy needs to be developed that will provide an understanding of gender relations and women’s status. As described in the introduction, this study is an attempt in this direction through linking women’s status, work and health.

A systematic analysis of this linkage requires a conceptual framework. The conceptual review of theoretical writings undertaken in the next section aims to develop this framework.

**CONCEPTUALISING WOMEN’S WORK AND HEALTH**

Given the centrality of labour and work in Marxian theory, theoretical perspectives on women’s labour have come to be grounded in Marxist political economy and dominated by Marxist feminist debates. Following Engel’s classic formulations on the origin of patriarchy, the materialist school raises questions about how men’s and women’s relations to the means of production create different social relations among them and create complex and multifaceted structures of patriarchy which do not reflect universal gender based essences. Rooted in Marxist political economy that emphasises the inter-relationship of economic, political, social and cultural structures and processes, feminists have theorised on women’s domestic and wage labour, paid and unpaid labour, under
different modes of production taking account of family/household relationships. These have broadened and enriched our understanding and provided the framework for analysing women's labour and its processes in the peasant economy. While the study of "what women do" has been the major thrust of this work, symbolic and cultural valuations of work and gender ideologies have also been realised as crucial for a comprehensive understanding (Moore, 1988).

Like work, our conceptualisation of women's health issue as drawn from and are guided by (1) the political economy approach which is informed by Marxist critique and (2) materialist feminist approaches that seek to locate women's health in the wider context of women's subordination. We discuss in this section ideas of some key theorists (including materialist feminist). Theoretical perspectives especially relevant to analysis of women's work, role and status in the rural social system are also incorporated.

Conceptualising Women's Work: Production, Reproduction And The Sexual Division Of Labour

The theoretical nature of the understanding of the relationship between women's work and her subordination has been considerably advanced by feminist debates over the concepts of production and reproduction and their linkages and the nature of the gender division of labour. Taking into account public and family production systems and relationships, they have provided the framework for analysing women's labour.

The relations between production and reproduction are central questions for anyone concerned to analyse women's oppression today (Beechey, 1987). According to Beechey the separation of reproduction (or patriarchy) from other aspects of mode of production leaves the Marxist analysis of production untouched. She favours an approach which links the spheres of production and reproduction and analyses the ways in which gender is constructed and used as a structuring principle in both. Of particular relevance to this study would be the conceptualisations of the political economy of gender relations in pre-capitalist formulation which would help in understanding the nature of gender structuring and relationships within Garhwal society. These are briefly reviewed in the following section.
The path breaking work in historically understanding link between production and reproduction was that of Mellaisoux (1981) who set out to analyse the social relations of production within domestic agricultural community. His key contribution lies in highlighting that in agricultural societies control over labour is central in defining relations of production as compared to control over means of production. Kinship structure is the key mechanism of control. Under pre-capitalist productive regime, labour is produced and reproduced and allocated through differing kinship forms. According to Mellaisoux, the control of reproduction is more important than production and he shows this in his analysis of social relations of production within the domestic community. He shows how the dependency of sex and age are crucial to understand social reproduction of societies. However, Mellaisoux did not specify or analyse the forms of women’s subordination.

Critiquing Mellaisoux, Harris and Young (1981), argue that it is the relationship within which women are implicated that must form the basis of analysis. Thus the importance of focussing on concepts such as reproduction and production rather than women as such. They wish to emphasise how and in what ways gender relations are incorporated in conditions of total reproduction.

It would be important to consider in some detail, Harris and Young's (1981) formulation about pre-capitalist societies because some of them may be modified to apply to Indian feudal pre-capitalist formations (including that of Garhwal) and the way women are constituted in them. According to them it is important to distinguish control over women's labour and the product of that labour and control over women's capacity for biological reproduction. The latter again involves – (1) control exercised over the children born by women and over their capacity for labour, (2) the control exerted over categories of men especially young men by restricting access to women as sexual beings, (3) control over rate and conditions of biological reproduction and by whom it is exercised.

Marriage is one of the ways by which access to means of production (and to labour) is allocated in many pre-capitalist societies. No concept of private individualised ownership
exists but concepts of use rights does. These usufruct rights are transmitted through birth but access may be gained through clientage and slavery. In societies where commodity exchange or market does not dominate, the control over exchange including that of women, is a major factor in overall allocation and control over labour. Women are objects of exchange and gender relations are defined by kinship structure.

Women occupy clearly defined and significant positions in (1) the reproduction of individuals within class position viz. the function of allocation to class positions, (2) reproduction of socialised labour, viz. the function of ideological reproduction and (3) day to day maintenance and material reproduction. With respect to the allocation function, marriage regulates women's capacity to bear and also their relation to production and means of production. They lose rights to property. For the ideological function, women are assigned the task of early socialisation of the following generation into ideological structures. Ideology is understood as set of ideas and material practices embodied within patterns of behaviour and social institutions. The third function of reproduction of labour is achieved through the daily performance of domestic labour. Further, according to Harris and Young, in pre-capitalist systems like the feudal, ruling classes assigned labour by gender, age and rank (such as age-grade-system and caste systems of India).

**The Production-Reproduction Continuum**

Dualism arises out of reproduction and production as two analytically separable aspects of life. The social relations of reproduction or the sex gender system are a set of relations that reproduce human groups from generation to generation and which include ways of conceptualising and organising such things as sex, gender, procreation or domestic labour and consumption. These social relations of reproduction are located in the family household – and although they have impact on organisation of production, they are distinct from economic relations of production which are the subject of traditional Marxist analysts (Vogel, 1983).

However, the understanding has been contested that production relates to economically productive activity and reproduction to biological reproduction and domestic labour and
that there is a marked separation between the two. Further, there are varying views on whether production or reproduction is the critical domain of woman’s subordination. It has been held that conceptual dichotomies such as production vs reproduction or public vs private spheres have helped obscure women’s economic role. This is so particularly in agrarian economies where the division between production and reproduction is conceptually artificial.

The distinction was influenced by the domestic vs. public model of anthropology because it provided a way of linking cultural valuations to the organisation of gender activities in society. How Moore sees it is that women’s reproductive role has not stood in the way of public production, taking women’s role beyond public and domestic hierarchy. Both their categorical separation and relative relationship are open to question (Moore, 1988).

The concepts themselves have been narrowly or broadly used. Reproduction is usually used to include biological / human reproduction and the servicing of labour. Beneria and Sen (1986) include social reproduction i.e. perpetuation of social systems – though inheritance systems for which societies have developed different forms of control over female sexuality and fertility. This control is the root of women’s subordination along with control of other people’s, including women’s labour.

Further, according to Beneria and Sen, the form, extent and significance of domestic work vary according to society’s stage of economic transformation. In a subsistence economy, materials used for domestic economic consumption are not bought in the market, they are transformed in such a way that households and non-household production are closely linked so that it is hard to draw a line. Domestic work for eg. extends to activities such as gathering wood, growing vegetables. It also becomes part of agricultural process. Production is carried into reproduction when agricultural goods are process in home for consumption. Process of reproduction includes large numbers of productive tasks geared to household’s own consumption such as animal care, agricultural work along with food preparation and water collection.

Maria Mies (1980) finds little analytical value in distinguishing between subsistence production and reproduction especially in realm of use-value production. One may talk
of a continuum of activities - subsistence work or subsistence reproduction. Only under capitalism are separations valid. Mies follows Engels in terming production of means of subsistence and production of new life or procreation both as "production". Both are dependent on human co-operation. Both these processes are interlinked, as Marx noted:

"The production of life, both of one's own in labour and of fresh life in procreation, now appears as a double relationship: on the one hand as a natural, and on the other as a social relationship. By social, we understand the co-operation of several individuals no matter under what conditions, in what manner and to what end. It follows that a certain mode of production, or industrial stage, is always combined with a certain mode of co-operation, or social stage, and this mode of co-operation is itself a productive force" (cited in Mies, 1980).

In so far as the production of life and of living working capacity are the necessary preconditions of all modes and forms of production, Mies prefers to call this the subsistence production and reproduction.

Subsistence reproduction thus defined involves a variety of human activities ranging from pregnancy, the birth of children, to production, processing and preparation of food, clothing, making a home, cleaning as well as satisfaction of emotional and sexual needs. In all these activities, human energy is spent to transform 'nature' into human life. Therefore Mies calls this activity subsistence work.

The Gender Division Of Labour

The gender division of labour connotes the actual system of allocation of agents to positions within the labour process on the basis of sex and lastly a system of social construction of gender (Eldholm, Harris and Young, 1977). Culturally legitimised ways of defining women and men in a particular historical period contribute to gender division of labour. Mostly it gives advantages to men irrespective of class (Mackintosh, 1981). In this view the social construction of women (and men) and the roles, attitudes and behaviours assigned to them have to be analysed as a process. The gender division of labour should not be confused with division of labour between production and reproduction activities (Deere and deLeal, 1981). The former is heterogeneous and responsive to material conditions of production and the latter is homogenous.
The feminist argument is that understanding gender division of labour is crucial to understand women's social position. Gender division of labour is important because it appears to express, embody and furthermore perpetuate female subordination. Women workers are placed in certain sectors and tasks. New categories of women's work come to be established creating and recreating the gender division of labour. It exists in all categories of work. Further, it is not the work per se but meagre share of benefits and rewards in return for it that matters; women are forced to work longer hours to achieve a lower standard of living (Mackintosh, 1981). As cash economy spreads it is reorganised and strengthened to women's detriment.

The sexual division of labour has existed historically and certainly predated capitalism. If we wish to understand male dominance we have to analyse social processes of the creation of two unequal genders of which the gender division of labour is a crucial part. The tasks tied closest to human reproductions are rigidly and strictly allocated to women and tied to gender identity also. Why? Gender typing is most rigid in social relations of human reproduction - i.e. of marriage, filiation and procreation. Household has become a mediating institution of two sets of social relations, marriage and filiation and the wider social relations (Eldholm et. al. 1977).

Beneria (1982) raises the question of whether allocation of women to production is conditioned by narrowly defined role in reproduction. While there is high degree of integration she emphasises importance of reproductive role in determining the gender division of labour. Conversely however, it has also been suggested that reproductive biology may be shaped by culturally determined productive activities (e.g. hunting/gathering) and women's sustained work input as food providers influences fertility levels, child spacing and infanticide. Deere and DeLeal (1981) feel that human reproduction does not determine productive activity.

All this suggests that it is not really possible to talk of any precise and unchanging nature of gender division of labour, or allocation of production and reproduction, outside a consideration of patterns of rural transformation, processes of differentiation among peasant households and impact of such processes on structures, ideologies and internal
dynamics of households. One would agree with Deere and DeLeal that gender divisions of labour are subject to change and situations must be specifically investigated, a task that this research has set for itself.

Land And The Gender Structuring Of Production

Davison (1980) is specifically interested in women's relation to land and how it affects the political economy of women's lives. However, she rightly holds that looking at land alone will not explain what is happening to women's role in agricultural production. Nor she suggests will it explain how women's reproductive role as perceived by different societies and shapes women's productive potential. Davison has developed the concept of gender relations of production in an ongoing construct that encompasses both social and economic relations. Economic relations of production, including the division of labour and allocation of resources, subsume social relations of production and reproduction, including gender relations.

By gender relations of production are meant socio-economic relations between men and women that are characterised by differential assignment of labour tasks, control over decision making and differential access to and control over the allocation of resources, including land and income. Labour tasks refer to both productive and procreating aspects of labour. Connecting this idea to our earlier discussion, it seems to be the overarching explicit or implicit position of the analysis of women's work today and there seems to be a consensus.

Thus gender structuring is defined as a process through which a society structures relation between female and male sexes – including productive and procreative relations – it is not biological but socially imposed (Davison, 1980). The way gender is defined in any society is related to historically prevailing system of organising social production. Often relations of production translate into relations of power. All people work, but only some enjoy power. Embedded in relations of production are implicit relations of power. Relations of production exist between husbands as holders of power and their wives as also between older people and younger dependants. Davison's conceptualisations move beyond separate enquiries into production-reproduction and the gender division of labour.
and they help grasp the total reality of gender structuring. It is useful as a perspective to look at both women's work and health.

In conclusion this section on work has reviewed efforts to interweave gender relations within production relations. In fact, following Harris and Young (1981), Beechey (1981), Beneria and Sen (1986) and Davison (1980), this study will consider productive systems as gendered fundamentally structured by gender.

**Theoretical Perspectives On Women's Health**

Understanding women's health in a larger sense and not linked to women's reproductive function or bio-medical models requires its exploration from a number of perspectives that are currently available. Conceptually and methodologically, our study draws on perspectives and postulates on health from political economy, material feminism, social constructionism and critical anthropology.

The political economy critique of health focuses on identification of the political, economic and historical factors that shape health, disease and treatment. It questions the whole bio-medical approach to diagnosis and treatment and suggests that causes of ill health are more complex and related to socio-economic factors and results of development processes. Health is seen socially rather than biologically determined and cannot be viewed independently from the society in which it is studied. This insight lays the foundation of a materialist or radical epidemiology which has gained support (Kelman, 1975). Similarly, Doyal places issues of health within a wider context and considers relationship between biological and social, between health, illness and society. She focuses without crude attribution on the possible effects of capitalist development (Doyal, 1979). Turshen's approach seeks to combine political economy and feminist work on women's subordination. It sees women's subordination as located within gender relations and male dominance and within the economic organisation of society. The concept is dynamic and historically specific. Women's health status is reflected by gender and economic relations, viz. gender division of labour, forms of productions, changing conditions of reproduction (Turshen, 1989).
Doyal’s work has been particularly influential in combining political economy health research and feminist health research. She propounds that the first question that needs to be considered is the relationship between the biological and social, viz. health, illness and society. Social and economic factors including gender have critical importance. There is an argument that this has nothing to do with capitalism or economic system but according to Doyal, health needs of populations conflict with requirements of capital accumulation and cause historical changes in patterns of mortality and morbidity (Doyal, 1979, 1995).

The following materialist feminist work on women’s health is located in gender ideology and gender relations of production and reproduction. Reproduction in the sense of child bearing/birthing process as well as reproductive tasks and productive work form part of the material base on which health is constructed. Feminist work researching health perceives illness as a product of the gender/patriarchal system, rather than biology or environment. Patriarchal ideology and relations breed gender discrimination and oppression in production and reproduction (Stacey, 1988; Turshen, 1989; Doyal, 1979, 1995).

Feminist perspectives draw attention to patriarchal belief systems, practices and institutions in the domain of illness diagnosis and treatment. Ideologies and dominant discourses of reproduction inscribe women's bodies. Relations of power are exercised and reproduced in daily life, women are subject to these conditions of dominance and exploitation and lack of power relative to men in critical areas of their well being. Women are exposed to dangerous health hazards and treatments that create health risks. Women's reproductive and general health is thus ideologically determined and their physiological symptoms are subject to ideological interpretation and diagnosis.

Dominant patriarchal ideology controls which health problems of women are officially recognised and who is ultimately is designated sick or healthy. They affect health policies which in turn adversely affect women. Natures of treatment regimes and rehabilitation programs, as well as decisions regarding their applicability, are determined by patriarchal values. Since class and racial groups are also subject to conditions of dominance and exploitation, poor women experience double jeopardy. Women lack power relative to
men in these critical areas. A predominantly male medical establishment fails to question or investigate in depth any of these aspects.

There has been a constant tension in feminism about “the body and medicine” viz. between recognising the uniqueness of women's embodied experience and the desire to deny that such uniqueness exists. Biomedicine has supported hegemonic ideologies of gender roles. Yet, feminists today recognise that medical systems have also contributed to women's liberation. Ehrenreich and English have lucidly articulated the difficulties of feminist standpoint on biology and have pointed out the real dangers of either understating or exaggerating our needs as women. Women's biology has underlined their patriarchal subordination but not patriarchal exclusion from hard labour (Ehrenreich and English, 1978).

From the foregoing perspectives, it is clear that there is the social nature of the definition of “problem” in health has a social dimension. Health is any society is socially determined. The materialist approach to the study of health can begin with the axiom that human beings are the basis of both the forces of production (physical ingredients of production such as labour, resources, equipment) and the relations of production (division of labour, legal property and social institutions and practices) in any society. Therefore appropriate organismic condition (i.e. health) can only be understood in the concrete context of the particular mode of organisation of production and the dialectical relationship between the productive forces and relations (Kelman, 1975).

Finally we need to consider the social constructionist and critical anthropological perspectives that illuminate theoretical efforts to fully comprehend health. Social constructionism does not call into question the reality of disease or bodily experience but holds that these states and experiences are known and interpreted via social activity and therefore should be examined using cultural and social analysis. The approach can descend into relativism - that all knowledge forces are social products and any one knowledge like the bio-medical, is not necessarily more valid or reasonable. Yet as Lupton suggests, the approach need not be uncompromisingly relativist - experiences
such as pain and death exist as biological realities but they must always be understood through social processes (Lupton, 1994).

Medical anthropologists have been traditionally concerned with interpretation and lived experience of illness. Culture influences illness experience. Recently political economy and social constructionism has influenced medical anthropology and led to field of critical medical anthropology. The areas of concern include the social production of medical knowledge, social control in medicine and public health and the relation of health and medicine to power. Equally important are issues of consciousness and agency in health related behaviour and belief, the identification and labelling of disease, the contestable nature of medicine and disease as biomedical realities and the meaning of illness experience. Recent critical approaches are interdisciplinary, incorporating political economy concerns with structural economic features and how they impinge upon health status and process with a social constructionist interest in epistemology and use of language (Lupton, 1994).

The review highlights the empirical nature of health and health service studies where causal linkages are explored by very few researchers. The problem with the literature is that though comprehensive approaches put up theoretical proposition, actual empirical evidence is lacking. On the other hand those who look at social determinants select only few dimensions that leave out some key social determinants like work or migration. Thus literature when seen against the studies of women work status and social relations compels us to look at theoretical formulations that explains the secondary status of women and shows that gendered social and economic relations are at the core of women's health status. This is the essential frame that helps us articulate the research problem in the next chapter.