Chapter 1

REVIEW OF LITERATURE
A number of efforts have been made to validate and strengthen the notion that health is rooted in the socio-economic structure of society. Engels' classical work on the conditions of the English Working Class was first published in 1845 (Engels, 1977). He pointed out that the illness of the working class in England was rooted in the organisation of economic production and social environment. Almost simultaneously, Virchow (1849) brought out the role of environment in causation of illness. He attempted to develop a multicausal theory of illness and explained that illness was a product of interactions between social, political, economic, geographic, climatic and physiological factors. But later, due to professional interests of physicians, industrialists and the ruling elite of Britain, this concept was ignored in the formation of ideas, knowledge and their scientific rationality in the field of medicine.

These ideas were further developed by researchers in the present century. Rosen (1958) explored such associations in Great Britain and the United States of the 19th Century. McKeown’s (1971) studies revealed mortality trends in England and Wales since mid 19th Century. Later, Navarro’s inquiries (1974,1977) into health were based on the situations in Latin America and the Soviet Union and Brown’s (1979) concern for health was located in American Imperialism. The focus of Banerji (1971), however, was on Indian society. These researchers emphasised economic, structural and political determinants of health.

In the Indian context, these concepts have been explored by researchers like Banerji (1982), Zurbrigg (1984), Qadeer (1985), Antia (1987) and Jeffery (1988). Banerji (1982) conducted a study in nineteen villages covering eight districts of India and illustrated that the ‘health culture’ of the rural population was intimately linked with changes in overall way of life which was mediated by various social, economic and political forces. Qadeer (1990) argued that the social roots of ill-health do not lie only in the marginalised access to the resources of health services. It is also rooted in the environment in which the people live and which is created by the interaction of socio-economic, political and ecological factors. In this
concept of environment, man made social realities play a role by influencing the objective and subjective conditions. Further, the variations within these environmental conditions are largely a function of the social structure, organisation of production and the ideologies that these generate.

The focus of this review is to develop a concept of Women's Health within the socio-economic context of their life. Though complex, the impact of various roles and activities of women on their health, in an inseparable, continuous and interwoven manner, tend to differentiate women's lives from their male counterpart (Petchesky, 1979 in Doyal, 1995). Women's work outside and within the household, and their unique role of reproduction in the society, form two very critical and mutually impacting spheres in women's lives (Kalpagam, 1993). Any analysis of Women's health, therefore, needs to develop an understanding of the multiple forces and power relations that mould women's lives in these two spheres. The available literature which central to or linked with the problem under study, can broadly be discussed under the following three sub-sections:

- Reproductive aspects of women's life.
- Women's work and its implications for their health.
- Integrated approach to women's health.

REPRODUCTIVE ASPECTS OF WOMEN'S LIFE

In the long history of health services in India, the health of women has mostly been perceived by the planners as that of a pregnant woman or a mother. The focus of attention has been on Maternal and Child Health (MCH) services. The idea of MCH was originally inspired by the Welfare Movement in England and the Planned Parenthood Movement in the West. When institutionalised maternity services
were established in British India, preference was given to western women professionals who were finding it difficult to break the male dominated professional guilds in their own countries (Ehrenreich et al., 1973). The traditional systems and practices of the Dais were discredited and rejected (Guha, 1991). Instead, training programmes were introduced entirely on the basis of British curricula. The British Medical Council forced Indian Medical schools to introduce midwifery as a subject to deal with maternity care (Jeffery, 1979). During the years from 1890 to 1930, it was mostly with regard to child birth that women's health was explicitly and officially dealt in West Bengal (Engels, 1993), the state where the present study villages were located.

In independent India, the health planners continued to give similar emphasis on MCH and the recommendations of the Health Survey and Development Committee (GOI, 1946) for MCH were fully accepted. But the evolution of services left much to be desired (ICMR, 1989). Health planning was marked by major shifts and mismatches. Though initially 'maternal health' was emphasised in the context of national development during the 1950s, the development of infrastructure continued to remain far behind the requirements. Priorities for 'family planning' and 'communicable diseases' marginalised 'maternal and child health' in allocation of funds and it was integrated with other programmes of general health services at the primary health centre (PHC) level. In the name of integration, intermittent shuttling between unipurpose and multipurpose workers at the primary level, weakened the inadequate infrastructure (Soman, 1995). The concept of 'maternal health' was supplemented by 'women's health care' in the plan document since 1980s. In reality, it meant a shift to 'safe motherhood' during the 1980s, followed by another shift to 'reproductive health' in the 1990s. Though these shifts attempted to go beyond the boundaries of motherhood, they seem to be irrelevant in situations where realities did not match the recommendations in health planning.
There is an improvement in the estimated overall rates of maternal mortality. The proportions of various causes contributing to maternal deaths, however, reveals a grim picture. While it is true that there has been improvement in the aseptic conditions of delivery, a preventable cause like anaemia continues to be an important factor for maternal deaths in rural India (Soman, 1994). The evaluation of the National Anaemia Prophylaxis programme has also substantiated this finding and the report admitted the weaknesses of the programme to fulfill its objectives (GOI, 1989). According to the estimates of the World Health Organisation (WHO, 1966), about 50% of all pregnancies end up in spontaneous or induced abortion. As late as in 1972, pregnancy wastage of malnourished mothers was 30% (Gopalan et al, 1972) and much of this pregnancy loss and perinatal mortality was caused by premature birth and malnutrition of the mother (Gopalan, 1973). The situation continued to be the same even in the early 1990s. In addition, it is estimated that for every death, ten to fifteen women are handicapped in one way or another. Constant discharge of urine through vagina, infection of the genital tract and utero-vaginal prolapse are only some of the problems that arise as complications of pregnancy, child birth and abortion. The real extent of maternal death is often hidden as most estimates are based on registered hospital deaths, where causes may often not be mentioned. This under recording conceals the actual number of maternal deaths in India (VHAI, 1992). The current estimate of maternal mortality rate is 2.3% (GOI, 1994).

Women who survived pregnancy and delivery have also been the subject of research, mostly on their ability to produce a healthy baby and their capacity to bring them up. The findings of a study conducted by Indian Council of Medical Research revealed that 56% women living in slums of Calcutta, delivered low birth weight babies. Gopalan (1989) considered it as not only an evidence of poor maternal nutritional status but also as indicators of possible poor future development of the baby. This has been earlier reported by other researchers (Ghosh et al, 1972) too. By computing growth data of the National Nutrition Monitoring Bureau for the years from 1974 to 1979, Gopalan (1989) comments that nearly 24% of
adult women in the reproductive period had body weight less than 38 kg and 16% of them had height less than 145 centimeters. Thus, they fall into 'high risk category' of WHO. This means that they are likely to suffer obstetric complications and give birth to offsprings of low birth weight, especially in situations where antenatal care and obstetric services are below par.

According to Gopalan, the above observations broadly indicate the magnitude of unfinished tasks with respect to improvement of health and nutritional status of the women. Our antenatal services, however, have not made the desired impact on the large number of stunted and anaemic women. This was substantiated by an evaluatory survey of 198 PHCs in 16 states, which explained that half of the PHCs did not cover more than 40% of the pregnant women. A maximum of 60% coverage was observed for both immunisation and iron-folic acid administration only, at 13% and 11% PHCs respectively. The Auxiliary Nurse cum Midwives (ANM) were inadequately skilled for delivery of services. Only 55% of total deliveries took place at home in the sixteen states. However, the study had constraints including under recording of pregnant women at PHCs (ICMR, 1989).

All through this effort to improve maternity care, the social context of maternity and traditional practices in the control of birth was ignored. These events were considered as medical phenomena with the diffusion of the new ideology which saw the act of parturition only as a physiological condition (Oakley, 1986). Over time, MCH programmes in India have either been neglected or treated as appendages to the Family Planning programme - the main thrust of which was on reproductive technologies (Qadeer, 1991). Earlier, Betsy Hartmann (1987) had pointed out, "the misdirection of contraceptive technology begins in the research phase and culminates in its use as a destructive and even deadly weapon in the war on population. It is mainly women who bear the cost, many paying dearly with their health and lives" (p. 161).
On the basis of some contraceptive research findings during 1978 to 1983, she commented that the research has overwhelmingly focused on the female reproductive system. Systemic and surgical forms of birth control have been preferred over the safer barrier methods; and there has been a greater concern for contraceptive efficacy than safety.

The literature till the 1980s revealed that promotion of reproductive technology, influenced by the growth of professionalism, used women as guineapigs and medicalised every aspect of their lives. The highly prevalent immediate complications of reproductive technologies in India were wound infection, pyrexia, pain in lower abdomen, urinary tract infection, thrombophlebitis and back ache. Whereas the late complications were intense weight gain, incisional hernia and menstrual disorders (Patnaik, 1991). Karkal (1992) further indicated that the number of users experiencing complications was going to be high. Forty percent of women under ICMR trials of Norplant 2 discontinued its use after thirty six months due to menstrual problems, while 10% women were lost to follow-up. Once the trial was stopped, none of the 1466 women under trial were followed up. There have been others who noticed that the Population Council trials for developing the Norplant system used IUD users as controls. Problems like bleeding, rejection and infections were very high in the case of IUD. Therefore, when in comparison to IUD, Norplant is projected as safe, it does not say very much (Mintzes et al, 1993). In spite of these problems, the experts have justified the use of Norplant. Women are thus denied the chance of using a really safe and user controlled contraceptive because research funds are diverted to find surer, though not safer, contraceptives which are provider controlled and which make women dependent (Qadeer, 1993).

Banerji (1991) pointed out that, in the planned attempts at linking family planning with the wider development process through a technocentric approach, activation of the health services in our country and
the quality of its organisation and management are actually being neglected. The current Indian statistics on sex determination, abortion of female foetus, sex-specific death rates, year wise breakup of sterilisation procedure, maternal mortality rate and types of attention at birth tell the sad story of reproductive technology and its detrimental impact on Indian women (VHAi, 1993). Government's commitment to improve the situation therefore, does not stand scrutiny, whereas the number of profit-oriented private medicare institutions is on the increase. They are not only heterogeneous in structure but also often manned by untrained workers. By misusing reproductive technologies such as ultra sound and amniocentesis testing and medicalising pregnancy and childbirth, role of these institutions has been very critical in the exploitation and oppression of womankind (Baru, 1993).

Thus, the philosophy of interventions continued to reflect a view that saw women as biological reproducers and not human beings who may have problems other than those related to reproduction. The disadvantageous position of women in the area of reproductive life has also been studied by researchers within the socio-economic context. Goparaju (1985), in a single village study in Andhra Pradesh, attempted to look into the socio-economic context of MCH practices and concluded that the triple burden of child care, agricultural labour and household work have serious implications for the health of women who are never recognised as workers. The prevailing socio-economic stratification only adds to the burden of women at the bottom of hierarchy. This is indicated in the inter-stratum differences at all the three levels of work. This difference also exists in their health status, access to services and attitudes of the health workers towards them. Despite these socio-economic constraints, the poorest do seek help. The quality of care received, however, is determined by their position in the socio-economic hierarchy.
In a similar context, Gupta et al. (1992) later discussed that the major health issues of women and children in Rajasthan are, in large part, the indications of their objective class situation. But the unequal gender relations, while mediating this material reality, produce further deprivation for women. A number of health problems are strictly gender in origin and affect all women regardless of their material status. In health, therefore, issues concerning women may not be reduced to class alone, nor can primacy be assigned to either gender or class.

The interplay between poverty and gender discrimination and its influences on the norms and socio-economic realities around reproduction has also been brought out by Ravindran (1995) in a study of 1452 households in Chengalpattu district of Tamil Nadu. The study revealed that resource scarcity in the rural landless families forces girls to drop out from schools and join the labour force or manage the household. This in turn, frees the older women for wage work. On one hand, the social norms of marriage, motherhood and reality of high mortality makes fertility highly valued, and on the other, inadequacy of nutrition in association with the demand for physical labour and low age at marriage and conception contribute to high pregnancy wastage. In contrast, the Introductory Report of the National Health and Family Survey (IIPS, 1994) ignored the association of socio-economic class in the analysis of their data on family planning and fertility behaviour of women in India.

Doyal (1995) also agreed that women's sickness and health must be explored in a wider social context. She emphasized that the analysis should begin with the identification of the major areas of activities that constitute women's lives, rather than initiating a disease centred approach to women's health. According to her, the balance of women's various activities vary both within and between different societies as well as changing over lifetime of individual women, impacting their health differently. In a
somewhat similar direction, the one village study of Adityapur attempted to locate women's perceptions and articulation of ill-health in the totality of their hierarchical socio-economic existence and gender relations (Soman, 1992).

Our brief review is indicative of the following:

- That the state of health of women as mother or wife continues to be poor.

- That MCH services developed in isolation from the socio-cultural realities of women's life.

- That it is at the cost of women's health, that technology for reproductive services has been given priority. And this social concern for their reproductive health needs to be understood beyond its face value.

- That their health has to be understood in terms of the interplay of larger social issues of class, gender, age and levels of development.

It is important to broaden the understanding of women's health by elaborating the very processes which make them vulnerable to controls, not only in their reproductive and maternal roles but also in their role as a social being. It is but natural that their health, education, general growth and development of intellect and skills are all dependent upon the levels of these controls and their forms. We review some of these issues in the following sections.

**WOMEN'S WORK AND IMPLICATIONS FOR THEIR HEALTH**

With the changing conditions and nature of women's work, the perspective and the analysis of women's work have also undergone transformation over time. The old tools have been replaced by new in
order to understand the emerging trends. The debate on labour and gender is based on the realities that prevail in two major arenas of work. One is women's involvement in the labour force and patterns of employment in social production, and the other is their role in the household. In the household they often combine 'labour for love' with contributions to the actual process of social production, which is often referred to as 'invisible labour'. These two arenas have been addressed by researchers from the disciplines of sociology and economics who often tend to restrict their analysis to their disciplinary domains. The linkages between the two therefore remain unnoticed. In this section we review studies which focus on one or the other. These are critical studies as they were the first step towards the integrated understanding of the complexities of women's labour. Their value lies in highlighting the implications of labour for women's health.

Employment

In the changing social scenario, while women continue to participate in the labour force, they have enjoyed much lower status at work as compared to their men. During the 1991 census, women workers constituted only 27.1% of the total population in rural India as against 52.4% for male workers (Bose, 1991). Majority of the female labour force was employed in the informal sector, which had recruited 90% of the total work force in the country (GOI, 1991). The rest of the women, in much smaller proportions (9.6%), were employed in the formal sector. In both the sectors, however, women are concentrated at lower occupational levels and they earn less as compared to the men.

In India, the rural economy is still dominated by the informal sector. In the informal sector, women are generally employed in agriculture, small plantations, construction work, cotton growing and weaving, match making, stone-quarrying, brick-kiln, handicrafts, automobiles and metal workshops, bidi industry, agarbatti making, chicken embroidery, coir industry, lace making and papad rolling. Researchers have
shown that a large proportion of women in this sector are employed mostly in unskilled and semi-skilled jobs. Besides discrimination in wages, these women have very poor working conditions and experience exploitation and harassment by middlemen, inadequacy of market links and lack of organisation (Bhowmik, 1979; Mohandas, 1980; Mehta, 1982; Bhatti, 1985). Sexual exploitation and caste discriminations, lack of access to resources are yet additional features in this regard. These are true for all the sub-sectors (Banerjee, 1985, 1989; GOI, 1988; John and Lalita, 1995), which provide employment to 82.5% of women in agriculture followed by 11.2% and 6.3% in manufacturing and service sectors respectively.

Over the decades, however, changes have been observed in the pattern of the participation of female workers in rural agriculture. There has been a shift in the composition of the workforce from cultivators to agricultural labourers. While the proportion of agricultural labourers doubled between 1961 and 1981, the rise in female agricultural labourer was in the context of an overall declining female participation (Duvurry, 1989). Over 1971 to 1981, participation of women increased in the form of marginal workers in rural areas while men looked for other opportunities and boys got trained in better skills (Banerjee, 1989 p.ws 14). Over 1977-'88 however, there was a decline in women's employment in the agriculture sector. It remained nearly static in the service sector but showed some increase in manufacturing sector (Table 1).

Table 1

<table>
<thead>
<tr>
<th>Year of survey</th>
<th>Agriculture (%)</th>
<th>Manufacture (%)</th>
<th>Services (%)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Male Female</td>
<td>Male Female</td>
<td>Male Female</td>
</tr>
<tr>
<td>1977-1978</td>
<td>80.4 86.8</td>
<td>8.9 7.1</td>
<td>10.7 6.1</td>
</tr>
<tr>
<td>1983</td>
<td>77.2 86.2</td>
<td>10.2 7.8</td>
<td>12.3 5.7</td>
</tr>
<tr>
<td>1987-1988</td>
<td>73.9 82.5</td>
<td>12.3 11.2</td>
<td>13.8 6.3</td>
</tr>
</tbody>
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Within the manufacturing sector, a large proportion of women (26.9%) are employed in the household manufacturing units as against only 9.3% in the non-household manufacturing units (GOI, 1991). Despite being marked by low pay or no pay and insecure employment, household manufacturing is becoming the main area of opportunities for the women, as men are leaving in search of better opportunities. The services sector, which absorbs much smaller proportion of work force in rural areas, also represents a considerable difference between the proportions of female and male employees indicating a disadvantageous position of women in rural employment.

In a rural economy, though the relevance of formal sector is limited mostly to the peri-urban villages, it has an impact on women's bargaining power in the economy of these peri-urban areas. This is an indicator of the importance of formal sectors in raising women's bargaining capacities. It is in this sector where women have been able to obtain their rights and benefits such as pay scales and leave allowances. These, in turn, are used by women's groups as a benchmark in their bargaining with employers and the State for improvement in the terms and conditions for women's work in the informal sector (GOI, 1988). These struggles, however, are only a post-1970 phenomenon and therefore the impact is limited. Within the formal sector per se, studies indicate that, despite an increase in female employment after the 1960s, (Lalita and John, 1995), women have little to choose in terms of their limited employment opportunities. They often perform strenuous and unorganised roles, are assigned unskilled work and are paid less (Mehta, 1982; Banerjee, 1984). This shows that a smaller proportion of rural women who are employed in this sector also, experience similar disadvantageous deals at work.
Given the employment scenario where women have been gradually converted into unorganised labour force, the organisation of their work has created new forms of bondage and denied them opportunities and status. The relationship between women's work as employees or wage earners and their health has become a complex one. The complexities arise from the unhealthy working conditions and the associated social and psychological factors that influence women's perceptions and actions. The common assumption that women's status or position and their health will automatically improve with the improvement in their earning capacity, is riddled with problems. The idea that women working outside home enjoy better health holds true only in specific situations, when improved income is also associated with increased control over it (Dweyer and Bruce, 1988), when increased demands on their time do not become a burden on their already existing load of work schedule (Khan et al., 1988), or when the increased income is able to inculcate a feeling of right to consumption (Palriwala, 1993). However, while women's work in the labour force does bring some cash and creates the possibility or potential for improved health, the reality is very different.

Women often work for long hours compared to men (Jain and Chand, 1983) and often spend more energy for equal duration of work (Battliwala, 1983). Their nutritional intake is much below the standards and also less than men (Gulati, 1978). They are subjected to sex bias (Horwitz and Kishwar, 1982; Chen et al, 1981; Sen A.K., 1984), which are socially shaped and begin to influence girls in early years of life (Aziz, 1989; Kanhare, 1989; Malobika, 1993) and are firmly internalised by adolescence (Chatterjee and Kapoor, 1990). Investigations using indirect indicators provide strong evidence of sex-differential and discrimination in this respect (Taylor and Faruque, 1983). Sen and Sengupta (1985), studied 'Malnutrition of Rural Children and sex Bias' in two villages of West Bengal through various socio-economic associations of the physical growth of children (weight for age). Sex bias was found to be associated with weaker caste and economic positions of the families and certain cultural factors. The cultural factors included were mother's education, practice of sending the older children to economic
activities as well as the dependence of the older persons on daughters for physical labour. Whereas sons were considered for economic support.

Although employed, women are more undernourished compared to their male counterparts in Kerala (Gulati, 1978). Their independent access to employment and cash becomes an important factor for the nutrition of children in the poor rural households. The nutritional shortfalls of especially female children are related more closely to the mother’s employment, than that of the father who generally spends on his personal needs (Gulati, 1978; Mencher and Saradamoni, 1982). The study conducted by the International Labour Organisation in Maharashtra (ILO, 1979) also supported these findings.

Although women played a significant role in the economic arena through their labour and productive activities (Gulati, 1975; Banerjee, 1985; Mencher and Saradamaoni, 1982; Bardhan, 1985; Agarwal, 1985), the woman industrial labourer used her leisure time for household work and the housewife accepted non-recognition of her labour (Government of India, 1988). By bringing work home she created a category of ‘invisible hands’ (Agarwal, 1988; Duvurry, 1989).

Strong associations between ill-health of women, economic level of their family and the conditions related to their work got effectively reflected in the findings of large scale surveys. The NSS data reveal that women are more often absent from work due to sickness than men. Moreover, they are exposed to a range of health hazards related to their occupation, whether it is work in the informal sector alone, or in combination with domestic work such as cooking, carrying water and collecting fuel and fodder from distances or processing grains at home. The Task Force on Health set up by the National Commission on Self-Employed women (1988) mentions about a range of occupational health problems that women are confronted with. These included problems like back ache from bad posture at work, damage to eye-sight
associated with embroidery or other export related industries including garment manufacture and electronics assembly, and symptoms associated with exposure to dust and toxic chemicals at tobacco, cotton or textile industries, mines and plantations. The report also highlights various forms of mental stress, anxiety and depression for women. There are researchers who have also drawn attention to gynaecological problems that labouring women suffer from (Chatterjee, 1993; Ravindran, 1995). It has been pointed out by some that occupational hazards affecting women are often dismissed as being only due to poverty, so that no specific measures are considered necessary in order to change women's working conditions. Quite in contrast to the findings of these researchers, the World Development Report (1993) totally ignores the important role of women as producers. Instead, it views women in their traditional roles of mother and caretaker. While prescribing 'education' and 'empowerment' for women, the report certainly points at 'Removing discrimination - in the labor market, in access to credit, in property law and so on - can boost women's earnings and financial security' (p. 49). But, these are only for promoting 'family health', as 'women need to be healthy themselves to fulfill their roles as mothers and household managers' (p. 49).

Briefly, this review provides us the following understanding of women in their economic roles:

- That in the conventional economic statistics, women labour force is under represented.
- That mostly they find place in the unorganised sector where exploitation and harassment is rampant.
- That their marginalised position pushes them into the unorganised sector where they are denied their rights and are actually tied into new bondages.
- That their occupational health is camouflaged by general illnesses and poor nutrition.
- That the pressure of the economic and household work adds to their overall burden and leads to poor health.
So, on one hand we find that raised incomes do not necessarily ensure good nutrition and health for women; and on the other hand, longer working hours and occupational health problems undermine women’s health more than that of men due to gender-insensitivity of the industry. The possibilities for women’s participation in the labour force are constrained by their household responsibilities and care. It is the process of women’s adaptation to new situations, created by the economic activities, that creates a special interest for this study. How women adapt to these situations and to what extent they are able to maintain the traditional role of a mother or wife and caretaker of the family, are a few questions which arise out of the above literature.

Caring for the Household

Women’s studies have taken a different turn over the last three decades. They have particularly challenged the assumption that the family is a homogenous unit or that all the members of a household derive equal benefits. They have highlighted the role of household dynamics in women’s overwork, deprivation and new forms of oppression in the struggle of the urban and rural poor for survival (Krishnaraj, 1989). These researches have also drawn attention to the substantial contribution that women make to the sustenance of the household and yet they suffer from relative powerlessness and lower status. A consequence is their inadequate health, nutrition and education. Simultaneously another view exists in the literature, which explains gender inequality against women through the specificities of low female employment and culture. However, culture is treated as if it is not gendered (Basu 1995). Such a view, does not stand scrutiny as it does not explain the basis of culture itself. The tendency of using macro level data on selected variables, without an attempt at checking it at the field level, leaves out the possibility of understanding the complexities around ‘women’s roles’ and the social structuring of gender at the household / family level. Further, such simplistic explanations of gender inequality in isolation from the household dynamics, only substantiate the need for deeper understanding of family and related social
institutions. Agarwal (1994), while 'conceptualising gender relations' in South-Asia, quite logically
demonstrates the importance of an analysis within and outside the household / family.

From being viewed as a homogenous unit with simple division of labour or being ignored as a
unit in the analysis of gender inequality, households are today visualised as dynamic, ever changing arenas
of power balance between and within gender. They are considered as open formations constantly under
the influence of social, economic, political and cultural context. Instead of being the units of study of the
society, they are today subject of analysis by themselves, particularly for understanding women's domestic
work, reproduction and caring roles. The content and boundaries of such a construct are shaped by the
wider social and political relations in which household is located. The conceptualisation of households
therefore in itself becomes a major challenge.

In their paper on 'Gender Relations and Household Dynamics', Adams and Castle (1994) give
an account of the attempts in various disciplines to understand this dynamics. They evaluate:
'Demographers collecting and using survey data generally employ definitions centered on the provision of
food from a common granary, the use of common hearth or cooking pot, or the enumeration of all persons
who look to the same household head (United Nations 1980). Cross-sectional analyses of this kind have
resulted in the widespread misconception that households are clearly bounded entities with an age and
gender based hierarchical structure. Complex intrahousehold relationships and functions are overlooked
and important networks of support and obligation that extend beyond household boundaries are also
neglected.

'Anthropologists, on the other hand, prefer the term "domestic domain", which relates not only to
the preparation of food, but also to processes such as socialization of children, the transference of property,
the maintenance and reproduction of household values and its influence (Bender 1967; Goody 1976).

Anthropological enquiry tends to focus on the classification of kinship and household size and profile (whether a stem, joint or multiple family) in relation to production activities. While useful, this approach does not illuminate what goes on within households and especially how social, economic and power relationships influence reproductive behavior' (p. 162).

The authors add, "Proponents of the "new household economics" also tend to overlook important disparities among social, economic, and power relations central to the analysis of reproductive decisions and outcomes. They assume instead that all household members are united by a common desire to pull resources and maximize collective benefits (Becker 1976). Alternative models of household economic behavior have been advanced to better capture the variations in individuals' means and motives by conceptualising theories of bargaining or "cooperative conflict" (Sen 1985, 1990). These theories recognise inequalities between individuals in the same household in terms of their access to economic resources and power, and thus document intrahousehold and extrahousehold economic transactions in a more realistic way. However, their primary focus on economic activity underestimates other important motives influencing individual and household behaviour, including reproductive decision making. Responding to monetary-based theories of economic activity, Bruce (1989) emphasizes how intrahousehold transactions and negotiations often involve currencies other than cash - such as labour, time and information. Even this analysis pays little attention to differentiation within genders' (p. 163).

The use of any concept, however, depends on the purpose of analysis. The main focus of Adams and Castle is reproductive decisions. Therefore even though they recognise the importance of women's interaction with markets and the outside world, their major concern is intra-familial decision making. There are others who have a broader concern and a set of more comprehensive questions.
The composition and organisation of households have direct impact on women's lives, as women's existence is shaped by internal structures, rules and resources within the household. The families are in close interaction with the market and non-market institutions which combinedly constitute the external context within which households reproduce or transform themselves (Friedman, 1979). Thus women's ability to gain access to resources, to labour and to income is dependent upon the composition and organisation of the household (Moore, 1988). Thus, household refers to the relationships in a society through which its primary productive and reproductive activities are organised, recognising that these frequently involve principles of kinship and residence. The economy of the household then refers to the rules, relations and practices which govern household production, acquisition and distribution of resources essential for meeting the needs of its members (Kabeer, 1994).

Research in South Asia has challenged the gender insensitivity of the collective welfare approach to household ensuring equal distribution of resources to all its members (Agarwal, 1994). Macro research has shown a male-favouring sex ratio in the northern region (Visaria, 1967; Bardhan, 1974; Miller, 1981; Dyson and Moore, 1988). Several micro-level researches have confirmed the existence of gender bias at the family level. While some point to unequal division of labour (Lily, 1989), there are others who talk of gender discrimination in socialisation (Aziz, 1989; Kanhare, 1989), in property rights (Jahangir, 1986) or in access to areas such as health and nutrition (Chen et al., 1981; Kynch and Sen, 1983; Jain and Banerjee, 1985). Highlighting the reality on the basis of the existing literature, Kabeer (1994) commented that, "according to the household systems of northern India, Pakistan and Bangladesh, men own most of the household material assets, control the labour of women and mediate women's relation to the extra-familial world. Consequently, they also dominate the household decision making" (p. 128). Studies in Brazil and the Philippines (Thomas, 1990; Senauer, 1990) have revealed that, when women's access to family income
meant expenditure on goods for more nutrition for every member in the family, men preferred to spend on alcohol, meals eaten out, cigarettes and 'female companionship' (Hoddinott, 1992). These also indicate that women in the household have different preferences which lead them to allocate resources within their jurisdiction in systematically different ways, as against their men.

Within the household, women exhibit a great deal of adaptability to changing life situations (Thorner et al., 1985). In addition to their significant contribution to the family income (Devadas et al., 1988), women perform a range of 'labor of love' which, in turn, help in producing status for the family and future generation as well (Papanek, 1989); still women are mostly seen as non-workers and are not considered as the bread winners for the family. At home, they not only perform indirect support activities for the paid work of other members in the family, they also provide support to children and create aspirations in them for status. Moreover, they participate in the political system as well as patronage network and spend time and energy in religious acts and rituals for the benefit of other members of the family (Papanek, 1989). Despite significant transformation in different aspects of life, an exploratory study in Adityapur village of West-Bengal revealed that women continued to perform labour within the boundaries of households and tradition without actively participating in the decision making process. Hence, their labour is controlled by other members of the family (Soman, 1992).

Recognition of labour-time as a key resource at the disposal of households and allocation of household labour between multiple uses including market production, home production, domestic work and leisure is yet another dimension of the new understanding of household work in the light of gender. Women who participate in the activities of the market have to maintain their home at the cost of their leisure (Folbre, 1984). Popkin (1983) noted that increase in maternal work decreases maternal leisure time; men even at home devote very little time in such activity and show no preference for extending a helping hand in
household work. Women not only worked for longer hours in economic as well as domestic activity as compared to men (Bennet et al., 1981; Agarwal, 1985), but poorer women were most likely to combine wage labour and income replacing work (such as provision of fuel and water, care of livestock and poultry, domestic labour in cooking, cleaning and child-care). In contrast, however, specialisation purely in domestic work was an activity largely of the women from wealthier households. (Sen and Sen, 1985).

Providing education (Aziz, 1989) or employment to the women may change the situation to certain extent for some but, for the rest, a change in the inherent cultural traits of the society, reflected in the family norms, is necessary. Researchers who have only emphasised the importance of larger social issues (Menon, 1982), fail to highlight the relevance of cultural factors which mould women’s personality to maintain her subordinate position (Dietrich, 1983). Whereas our study of Adityapur village in West Bengal has pointed out that though culture certainly has a socio-economic context, it is not necessary that all contextual changes would always change the cultural practices. In other words, though culture depends upon socio-economic realities, it plays an active role in shaping that reality as well (Soman, 1992).

The process of social control of women continues at the family level. The acceptance by women of their prescribed roles and images play a very critical role. This can be understood in the historical context of women’s status in India. A summary of the texts and scriptures of ancient India by Bhattacharjee (1990), reveals the limited and confining role prescribed to women as mothers in the patriarchally organised society. The glorified motherhood allowed women only self-sacrifice and ritual practices for the well being of the father and son. The ‘mother goddess’ and the human mother belonged to diametrically opposite planes. While the former discharged her functions ‘without any pain with divine light’ (p. ws56), the human mother lives a life full of roles and responsibilities imposed on her by the society. ‘Sati’ and ‘Shakti’ became the symbols of the traditional Indian women where ‘sati’ essentially was the pre-requisite for self-sacrifice in the
service of others (Ramu, 1989). This suited best her domestic role. This ideology provides the iron cage for the women which they must never leave if they want the security of social support and family.

In the Indian situation where women are the chief producers of health care within the household, they are also the most neglected as far as their own health is concerned. The concern over health in relation to women's performance of roles within the household is an outcome of trends reflected in statistical and other data collected through micro studies. Though the national level data on nutritional status and consumption pattern over the period 1975-1990 (NNMB) shows no significant difference between the sexes in the trends among pre-school children, a number of micro-studies show that girls are breast-fed less, get poorer quality food, and are less likely to be taken to hospital if sick (Devadas and Kamalanathan, 1985; Das Gupta, 1987; Chen et al, 1981; Soman, 1992). The culture of 'son preference over daughter' (Miller, 1989), negative contribution of traditional beliefs and values and the role of 'pardah' or seclusion (Islam, 1989) affect women's health by influencing allocation of resources against them. Anthropological studies have shown that food distribution within the household is detrimental to women's health; and the reason as argued by Khare (1976) and Appadurai (1985) lies in the inferior position of women within the family. This aspect is also reinforced by Barbara Harris (1989) in a study of 'hunger' - a perpetual companion of poor women - which is considered by the author as 'euphemism for want and deprivation' (p. 379). Even in the better-off households where low status of women is combined with their own low self-esteem, women often practice 'self-denial' or self-control, when it is time to take action against ill-health (Soman, 1992).

Research findings of micro-studies or broad based comparative regional analyses reveal that there are certain larger social forces which influence the health of women in the household. Processes influencing health in poor households have been traced by Zurbrigg (1984) to elucidate the marginalised
position of women in the family, where there is a constant interplay of the constraints of poverty and other social forces. Similarly, while describing women's health situation in the rural population of Chengalpattu in the state of Tamil Nadu, Ravindran (1995) has pointed out that the interplay between poverty and gender discrimination seems to be the 'lynch-pin' in any explanation of women's health problems. While class and gender differentials are found to co-exist against women in the prevalence of illness (Dandekar, 1975; Chakrabarty et al., 1978; Taylor and Faruque, 1983; Kannan et al., 1993; Soman, 1992; Ravindran, 1995), it is also reported that, as compared to men, a large proportion of women receive no treatment at all or are treated with traditional medicine instead of modern medicine. This is not because of the preference of women; it is also not due to a notion of differential value of traditional medicine by the two sexes, but because it is cheap and mostly available in the village. Women's ailments are usually ignored at initial stages and medical help is sought only when the illness is either chronic or serious (ICSSR, 1977). The low priority accorded to women's health as reflected in the patterns of utilisation of health care, however, reflects the influence of the patriarchal social-setting (Soman, 1997).

Following the reporting of gender differentials against women in social and economic arenas, an exploratory study on social dynamics of women's health in Adityapur village of West Bengal revealed that, despite significant transformation in different aspects of village life, the life of women was least affected. They continued to stay within the boundaries of their households and performed labour without actively participating in the decision-making process of the family. Even those who were employed, did it to the minimum required and remained within the bounds of tradition. However, what seems critical was that even though certain social processes at the family level were observed across all socio-economic categories, their manifestations varied in those categories. The processes included factors such as economic level of the family, availability of and accessibility to health services and information, attitude of other members of the family towards women's labour and their ill-health, the level of women's self-image and practices of self-
denial or self-control in expressing illness. Criticality of women’s labour in the survival and security of the family as a unit was yet another factor influencing the family dynamics of women’s health (Soman, 1992). Moreover, the larger socio-economic forces such as family’s land ownership and productive capacities, earnings and ability to employ labour, interacted with and influenced the intra-familial dynamics and moulded the criticality of women’s labour within. The family requirements of their labour thus, is a very critical determinant of women’s health. Adityapur however, was a village not yet affected by the urbanising influences of cities and it therefore retained its traditional community life.

The illustrative data from Bangladesh and The Gambia (Mahmud and Mahmud, 1985; Seager and Olson, 1986; Sen, 1990; Svedberg, 1988; New Internationalist, 1985; Haswell, 1981; Greeley, 1987; Hamid, 1989; World Bank, 1980; Maine et al., 1986; WHO, 1987), compiled by Kabeer (1994) in her essay on ‘Gender and Household economics’ reveals that though women from these two different regions perform common ‘invisible’ domestic jobs and responsibilities, the linkage between their work and well-being is a complex one. In these cases, despite the commonality of performance of domestic labour, the ‘visible’ female labor force participation rates are juxtaposed to each other (13% for Bangladesh as against 71% in The Gambia). While the low female labour participation rate was associated with practice of ‘purdah’ or seclusion limiting women’s contribution to market-oriented production and field-based agriculture, the higher female labour participation rate was associated with better organisation and female autonomy at work. In health or well-being, though the countries had differences in the overall life expectancy for women as against men (35:32 in Bangladesh; 46:47 in The Gambia; both in 1980), the figures matched with the pattern of their respective regions i.e. South-Asia and the rest of the world respectively (Sen, 1990). However, they were similar in many other indicators of health and well-being such as high rates of fertility (6.7 children in Bangladesh as against 6.4 children in The Gambia), prevalence of nutritional anaemia in the reproductive years (66%-70% in Bangladesh and 80% in The Gambia (New Internationalist, 1985) and
deaths due to maternal mortality too. This common reality of women’s health cannot be explained in the light of differential labour force participation rates of women in the two countries. However, the female disadvantage in relation to the demand on women’s time and energy, particularly during the reproductive phase of life, which is more for the Gambian women, does explain their health scenario to a certain extent.

As observed by Kabeer, the linkages between work and well-being differed in both the countries. While in Bangladesh it appeared to be associated with gender discrimination and distribution of ‘welfare resources’ within the household, for Gambian women it was the distribution of their work burden and energy expenditure that mattered. However, for both, the impact was maximum during the reproductive years. It is apparent that household dynamics becomes a major determinant in permitting leisure and relief to working women and hence influencing the state of their health or ill-health.

The above literature highlights the following:

- that the secondary status of women in the household is marked by lack of recognition of their physical labour as well as economic contribution and absence of a sense of security.

- that social and economic factors act upon the family where subordination of women’s economic independence, rights, self-confidence and control are major components of survival strategies of the families.

- that the ideology of control of women propagated through traditions glorifies their roles in the family and offers them security and support for social survival.

- that women’s caring role in the household thus becomes non-negotiable in most circumstances. Hence, it may lead to conflicts wherever women attempt to create some space for themselves.

- that the implications of all these forces are important for women’s health.
INTEGRATED APPROACH TO WOMEN'S HEALTH

Studies in health which have been discussed at the beginning of this chapter focused on the social and economic structures of the society. They did not pay enough attention to specific gender differentials in their analysis. This gap left by these insightful analysts has been filled in by the growth of feminist studies which can be grouped under four broad categories. Fee (1983) summarised these perspectives in her book titled 'Women and Health: The Politics of Sex in Medicine'.

According to Fee (1983), although the liberal and radical feminists had a common goal of achieving equality with men, their views on the roots of the problem of inequality differed. So they varied in their strategies towards fulfilling the common aim. While the liberals attempted 'equality' within the existing social and economic structures, the radicals opted for an entire transformation of the existing social institutions, which were shaped by the 'patriarchal norms' of the family. The Marxist as well as socialist feminists tried to understand the position of women primarily by utilising and later developing upon the methods provided by Marx and Engels. The Marxist feminists believed that oppression of women is part of social contradictions and can be effectively understood through Marxian analysis. Whereas the socialist feminists, while adhering in principle to a historical materialist approach for understanding social realities, borrowed from other theoretical perspectives as well to best capture women's oppression and exploitation in the society. Feminist interpretation of psychoanalysis is an important attempt in this regard (Jagger, 1983).

Understanding of women's existence in the stratified and hierarchical structures of society also got reflected in health research. While Fee (1983) analysed women's subordinate position in the health care systems in the United States, Canada and 19th Century Britain, Zurbrigg (1984) attempted to bring
out women’s powerlessness within the social and economic construct of ill-health in India. Following this, Hartmann (1987) came up with her critique of the global politics of population control and contraceptive choice and its implications for women’s health, power and social position. Engaged in research attempts assessing the impact of the ‘Bhopal Gas Disaster’ on the local female population, Sathyamala (1996) pointed out that the gas tragedy not only affected women’s biological reproductive health but it also had implications for their social and psychological dimensions of health. Similarly, through analysis of gender and political economy of health, Doyal (1995) has attempted an inquiry into the self-posed question of ‘What makes women sick’. She has emphasised more on the concept of ‘ill-health’ that is socially constructed, rather than its limited bio-medical interpretation as ‘disease’.

Some of the health surveys conducted in the country revealed that our women and female children are most susceptible to illness and receive poorer health care compared to the men and male children (Dandekar, 1975; Chakrabarty et al, 1978; Taylor and Faruque, 1983). Also, compared to men, a larger proportion of women receive no treatment at all or are treated with traditional medicine instead of modern medicine. Women’s ailments are usually ignored at initial stages and medical help is sought only when the illness is either chronic or serious. This restricted access is illustrated by the ICSSR (1977). The reality, however, is not very different in rural West Bengal even in the Nineties. A survey of 272 households in Adityapur village of Birbhum district revealed a clear differential in reported illness across various economic categories and the women carried a heavier load of illness as compared to men in all categories (Soman, 1992). Certainly, there existed a gap between women’s realisation of ill-health and seeking out treatment. The delay in treatment was marked not only by poor quality of treatment as compared to men, but was also associated with a range of factors rooted in the health culture of the family.
The differentials in illness between man and woman have been explored only partially. Such efforts were observed in the studies of the Medico Friends Circle (1985 and 1990), Varma (1987), Daniel et al (1987), Sathyamala (1989, 1996) and Bhandari et al (1990). The studies of the Medico Friends Circle had observed alteration in menstrual cycle, gynaecological disorders and increased pregnancy losses in the gas victims of the Bhopal disaster. Whereas, Varma and Daniel et al found pregnancy loss and no adverse impact on the spermatogenic functions among the exposed population respectively. Referring back to the gas tragedy, Sathyamala reported that, of the victims, women bore an additional burden of gynaecological disorders, which were completely neglected in the official process of offering compensations. Moreover, she pointed out that, though the impact of the exposure to toxic gases had left an adverse impact only on the menstrual patterns and not on the age at menarche or fertility of women, the women had to socially compromise their marriage prospects as all affected women were perceived as diseased and therefore undesirable. This not only had implications for their social well being but also for their physical and mental well being in a society with patriarchal conventions where marriage was an index of social acceptability and status. Bang (1989) described the extent of women's suffering in terms of high prevalence of gynaecological and sexually transmitted diseases among the tribal women living in Garchiroli village. Even though women take a much larger burden on their health compared to men, they are often blamed for spreading disease as in the context of AIDS in the country. The undifferentiated categories of 'prostitutes' is everywhere represented by the doctors and media alike as a dark threat, going about spreading AIDS in India. The fact is that a woman stands a far greater risk of contracting HIV (the virus) infection from a man than the other way round (Bhandari et al, 1990). Moreover, the whole issue of the societal structure in which 'prostitution' is perpetuated as a means of women's survival, is not taken into account while conceptualising such a public health problem (Banerji, 1992). Even in the formulation of population policies in India, a woman's fear of lack of control over her own body and low health with high disease-proneness, her social, cultural and economic subjugation are most easily forgotten (Shiva, 1991; Ritupriya, 1996). Similarly, at the family level
women are given less attention when sick, compared to men in a given economic category, even though this difference reduces with the improvement in economic capacity of the family. In a study in West Bengal, this was mainly reflected through the delay in visiting a medical person. While on one hand, the delay was contributed by the lack of women’s own expression of their needs, on the other, it was also due to the negligence on the part of their families to initiate health action (Soman, 1992).

There is another set of studies which attempts a deeper exploration of the social restructuring of life that takes place around illness. Kleinman (1987) argued that the meaning and experience of illness is nested in a complex personal, socio-economic and political nexus. The emphasis, however, was on personal. In an empirical study of immigrant women in Canada, Anderson et al (1991) showed that the experience and meaning of illnesses were actually determined by material conditions, social relations and restructuring of life. They proposed that illness experience of women were rooted within social, economic and political aspects of their life and not in the culture. Britain and Maynard (1984) had earlier agreed that culture does not have a free floating reality independent of any structural constraint. Whereas the exploratory study of Adityapur village in the state of West Bengal in India has pointed out that though culture certainly has a socio-economic context, it is not necessary that all contextual changes always changed cultural practices (Soman, 1992).

Further qualitative explorations in the villages of West Bengal located close to Adityapur revealed how women’s ill-health was shaped by the interplay of forces between social class and family, and the norms and values regarding the role and status of women in poverty. The importance of gender in development and social ethics, however, is often overlooked in the discourse on socio-economic development (Soman, 1997). We argue that the interplay of forces between social class and family, the prevailing norms and values regarding the roles and status of women within social classes and the socio-
economic development, become the centre of interest for further explorations. It is necessary to understand what kind of changes in the socio-economic conditions begin to alter norms and values, and unto which point in this process of change, traditional norms and values continue to exert pressures to maintain the status quo. This dynamics, in turn is critical for developing an understanding of women's health and its relative poor state in the Indian context.

Relating the patterns and trends of illness to socio-economic development, has also been an aspect in the developmental discourse. The increase in morbidity over time has been interpreted differently by the researchers. While some have attributed this change to higher survival due to improved medical technology, they have also associated the change with a higher risk of having one or multiple diseases (Panikar and Soman, 1984; Alter and Riley, 1989; Riley, 1990; Kumar, 1993). Whereas the second set of possible explanations is in the improved health infrastructure and better perception of morbidity with increased levels of literacy and education (Sen, 1994). Gumber and Berman (1995), however, rejected all these hypotheses on the basis of the NCAER data of 1991, concluding that morbidity in India is inversely related to the level of development. Differing methodologically from these large scale time trend and statistical analysis, our exploratory micro study of women's health / ill-health in a stratified village cluster of 272 households, attempted to study women's expressions of illness within their historical, socio-economic, political and cultural context in contrast to that of their men (Soman, 1992). Our data on reported illness revealed that significant transformation took place over the previous five decades in the agriculture patterns, educational facilities, political system in the village as well as in the transport and communication facilities. This, however, touched the life of women very lightly as compared to their men. Besides, the data on reported illness had shown an indirect relationship between the gender gap against women and the economic levels of the families.
In Adityapur, the focus of our study was on women's health which included quantified assessment of human expressions of illness through self-reporting by the people as an important component in it. As a consequence, it carries the possibility of incorporating biases of people themselves in the approach itself as against the medical bias of the so called 'objective' studies that use medical diagnosis.

In his detailed search through the available literature, Vaidyanathan (1995) pointed out the 'objective' and 'subjective' factors that influence people's reporting of illness in various ways. Objective factors like economic costs of illness, access to drinking water, sanitary conditions, proportions of old age population who tend to report higher illness loads than others, and case fatality rates influence the reporting in either direction. Whereas determinants and consequences of the subjective factors are far more complex. The diverse levels of realisation of ill-health by people or their diagnosis or identification, the delay between feeling unwell and getting treatment are some of the forces that tend to introduce bias into perception of morbidity. Whereas other factors such as sex of the informant and interviewer, the professional specialities of the latter, information level of the key informant (generally adult males leading to low reporting of female morbidity) had also implications for similar perception. In addition, people's attitude to illness is influenced by their levels of income, access to medical services and education and exposure to modern medical care also have implications for self-reporting, to certain extent.

Moreover, the social norms of 'normal health' prevailing in the society, sex discrimination and people's acceptance of certain signs and symptoms are also important factors in this regard. Johansson (1991), in his narration of such norms has written: "..... almost all the women had more than one serious disease, even though none had disrupted their daily routines to any great extent. In a cultural sense the women were healthy, although many had symptoms which they regarded as painful or unpleasant. As long"
as they shared those symptoms with many or most women, they considered them a natural part of a woman's lot in life, rather than the manifestation of a disease which required professional assistance. As long as none of the multiple diseases which the village women suffered were severe enough to disable or kill quickly, the villagers saw no good reason to interrupt their daily routines or seek costly treatments* (p. 52).

In cross-checking the validity of data on reported illness, Johansson argued against clinical assessment. While pointing out the possibilities of inherent bias in diagnosis due to lack of standardisation, variations in clinician's criteria for diagnosis, the time and extent of specialisation of the professional, he commented that any amount of clinical advancement will not be able to reduce the pains and sufferings of the people. According to him, assessment of an individual's pains and sufferings should be the primary basis for any assessment of health status of a people. Yet studies have shown that clinical data, if properly collected for cross-checking self-reported morbidity, may successfully identify even the pains and sufferings perceived by individuals, which may not meet clinical criteria of disease (Murray and Chen, 1992). Our micro study of Adityapur village, constrained by resources, could not go for a clinical cross-checking of reported illness. However, it did succeed in grasping women's pains and sufferings to a great extent by incorporating gender-sensitive anthropological components into it (Soman, 1992).

Considering other aspects of biases, our study of Adityapur had chosen a method with some additional care. In this study, the woman in the family kitchen, who had the maximum information on the well-being of other members of the family, was the key informant. Information provided by her was always cross-checked with the other members of the family as well as with the neighbours or members of other sections of the village community or the healers who were associated with health and well-being of the people. Our study also had the advantage of a woman investigator who reduced the gap in communication and
reporting. Moreover, while living in the village and participating in the village life, there was sufficient opportunity for making better rapport and direct observations which, in turn, ensured a better reporting as well as cross-checking. The survey was conducted over two months. The seasonal variability, however, equally affected both sexes and did not alter our observations of gender differentials in the families.

This brief review of integrated approach towards women's health revealed the following:

- that to understand women's health, it is necessary to take their social status and place in the family into consideration.
- that given social structure, the secondary status of women has serious implications for their general and reproductive health.
- that for studying the above complexities a gender sensitive methodology is required.

Our review shows that developing a comprehensive understanding of women's lives has now become a challenge for researchers and many multi-disciplinary efforts have brought to the centre the complex relationships between women's existence, family dynamics and socio-economic developmental processes. The use of this frame to understand and analyse health however, is limited. Most studies on women's health tend to use the objective medical criteria without adequate assessment of women's own perceptions, socio-economic constraints, family attitudes towards them and their economic independence. We see this as a major area of study as these factors are the prime determinants of women's health.

Our review helped us delineate the research problem and identify an appropriate methodology, which we present in the following chapter.