ROOTS OF WOMEN'S ILL HEALTH

Power relations mediate all social life and as such, they not only determine our environment, but also define the way we react to it. Our definitions of health and illness depend on the characteristics of the society we live in and our location in it. In a society where commodity production is predominant as long as an individual can work productively or rather, as long as that labour is productive to the capitalist, the individual is considered healthy. Therefore, health services are directed at maintaining this minimum level of health below which the generation of surplus value would fall off (Schatzkin, 1978). In turn, this defines for the worker, the boundaries of ill health such that real health needs from the point of view of quality of life never get expressed. For, the fulfilment of these health needs would be contradictory to the needs of capital accumulation. The patterns of morbidity and mortality express and reflect this contradiction between real health needs of the worker and the level of health necessary for the generation of surplus value.

How does all this affect women? As a component of the labour foce, their needs are subordinated to the needs of capital. Further, a woman's traditional role is to reproduce and sustain labour power. This is the necessary function of women in society--- the maintenance and reproduction of the labour force, which in turn is necessary for the reproduction of capital. For a woman, the definition of health is determined by her ability to perform these functions. Just as in the workplace, the worker's health needs are subordinated to the needs of capital accumulation, women's health needs are subordinated to the need to maintain the work force at that level of health required for the generation of surplus value. Moreover, women as integral units of the family, are necessary not only for the reproduction of the working class, but also for reinforcing the ideological underpinnings of capitalism. Medical and health services are designed to keep women at an optimum level for the performance of these functions. **Thus, the needs of capitalist accumulation mediating through partiarchal relations suppress women's real health needs and their reproductive freedom.**

Medicine legitimates and rationalises social attitudes and notions about women (and men) whether they relate to their physiology or their social role. And since women's oppression is justified by their supposed biological inferiority, medicine obviously plays a very important role, in substantiating this myth. Medicine's 'model' of the normal human being is the upper/middle class male. This makes all women, by definition 'abnormal'! Menstruation becomes a disability, child birth an illness. Female physiology is considered a complication of the basic male physiology especially with reference to the reproductive (Rothman, 1979).

Two of the characteristic features of bourgeois medicine are its clinical paradigm and the dominant mechanistic model of the human body. This locates the cause of all ill-health entirely within the body, either as being due to the intervention of an outside agent or because of the malfunctioning of one or more 'parts' which comprise the human body. This means that women's complaints, if they are not caused by obvious external agents, must lie either in their 'aberrant' reproductive physiology (so different from the male) or in their peculiar female 'psyche'. Moreover, the models of 'normality' in medicine are those that are approved of by dominant ideology and are useful to bourgeois society. For women such a model is the ideal image of wife or mother. Not surprisingly, all health problems of women are seen in terms of how they might affect the fulfilment of that role.

Medicine, which is always articulated within a specific mode of production, contributes to the reproduction of that mode not only at the ideological but also at the economic and political levels. Thus the inappropriateness of medicine for women or its inaccessibility to the poor or to women is a characteristic feature of bourgeois medicine which serves to maintain and perpetuate the current relations of production and reproduction.

Any enquiry, discussion or analysis of health from a radical, marxist perspective must include an analysis of the women - and - health nexus. At the same time, no understanding of the women's status, their oppression and exploitation can be complete without a clear perception of the political and ideological roots of women's ill health.

The Women's Health Movement Abroad

In the '60s, the growing disenchantment of women with institutions and with social norms took the form of women's liberation movement. This

brought women together in consciousness raising groups where women for the first time began to exchange personal experiences and make women-to-women contacts that had been denied them. Among other things, this led to the realisation that their demeaning and dehumanising experience in the health system were not stray and personal incidents but the universal experience of all women. This has over the years generated several analyses of the medical system and has led to specific actions and programmes.

Elizabeth Fee (1970) characterises these in terms of three forms of social criticism, the liberal feminist, radical feminist and marxist feminist. Liberal feminist saw their main challenge as being destroying the myth of a biological basis of women's oppression. They demanded equal pay and equal opportunity for women but did not seriously challenge the social and economic hierarchy. They saw the medical system as reflecting the sexual hierarchy of society with a male monopoly of the upper levels and a predominance of women at the menial jobs at the lower levels. Their solution was centered on demanding a better representation of women at the upper levels, but did not question the hierarchical organisation of health care or of society.

Radical feminism demanded a fundamental, restructuring of society, its institutions and values. Many of these women had participated in student, civil rights and anti-war movements. Some had become disenchanted with left parties and official marxist view of feminism as being a form of bourgeois protest and with marxist analyses which appeared to be insufficient to explain women's situation adequately or provide a satisfactory theoretical understanding of the family, reproduction, sexuality. Radical feminism saw the patriarchal family as the major and most important oppressive force in society and a battle of the sexes as being of more consequence than the class struggle. They saw revolution as leading to an annihilation of sex differences. There was an outpouring of radical feminist analyses of society, of institutions and of politics in the late '60s and the '70s, all of which served to expose the operation of paternalist ideology and the structures of women's oppression in society.

Radical feminists saw the medical profession as imitating patriarchal society and were heavily critical of medical mysticism especially in the area of gynaecology and obstetrics. They worked to disseminate information and knowledge about medicine and specially about women's sexual and reproductive functions which had for so long been a monopoly of the doctors. This led to a strong movement against hospitalised childbirth in the US. Groups in many states of the US and in Britain and Europe set up women's health centres and self-help clinics as 'alternatives' to the dehumanised hospital centred medical systems. They provided for gynaecological examinations, and childbirth facilities as well as abortion services. Inevitably they have come into conflict with power groups professional groups; but have survived and proliferated nevertheless.

It was mainly this current of feminist thought which gave rise to a number of significant books and pamphlets such as *Our Bodies Ourselves* (from the Boston Women's Health Book Collective), *Witches-Midwives and Nurses* and *Complaints and Disorders* (both by Barbara Ehrenreich and Deirdre English) and *Vaginal Politics* (by E Frankfort). This and other similar literature has been very influential in rejuvenating the interest of radical and marxist groups in the history, nature and ideology of science and medicine.

Marxist feminists saw their task as the combining of feminist consciousness with historical dialectical method of analysis. They saw patriarchy as both supporting and strengthening capitalism. At the same time they saw capitalism as providing the material condition for the future abolition of sexual distinction between man's work and women's work, but the realisation of these conditions being limited to the extent necessary for the survival of capitalism. "Capitalism... cannot free itself from dependence on sexism any more than it can transcend class oppression or the pursuit of private profit at the expense of the satisfaction of real human needs" (Fee, 1975).

Marxist feminists believe that no one characteristic of the medical system can be analysed in itself, but must only be seen in relation to the entire social structure and its institutions, and the economic order in which it is rooted. Thus, they see the fragmentation of capitalist medicine as a part and consequence of the ideology of medicine which sees the body in parts. They are also critical of the sexist bias of medicine and the emphasis on 'scientific' base which itself has an inherent class and sex bias. They see medicine as ignoring the social roots of illness.

Women's Health Issues in India

In India, women's health issues have not emerged as a major focus of activity or analyses within the women's movement. Women's groups are of course, aware of women's inaccessibility to health care services, the lack of reproductive freedom, sexual harassment of women patients (and of nurses) and to a lesser extent the operation of the sexist ideology

in medicine. But this has not led to a comprehensive theoretical understanding of women's health as a part of feminist theory. Nor has it generated concerted action programmes. There have been individual campaigns, such as the demand for a ban on estrogen-progesterone drugs for pregnancy testing and amniocentesis for sex determination. But while these, especially the latter, has given rise to significant debate and action, one cannot say that they have led to a better perspective of the role of medical technology in the oppression of women. The reason for this apparent uninterest in health issues perhaps lies in the historical and economic roots of the women's movement in India and needs to be examined.

This apathy towards health issues is even more significant when one recollects that rape was one of the earliest issues taken up by the women's movement. It would have been logical to suppose that this would have led to a discussion of broader questions of female sexuality, a realisation of how little women knew about their bodies and ultimately, to a questioning of the male monopoly of the information about women's bodies, its functioning in health and illness. This did not happen, although there was sporadic discussion about such matters as the 'technical' definition of rape and the relevance of injuries on a woman's body. Nor was there significant and sustained effort to provide 'alternative' medical aid to vicitims. Why did this not happen ? Was it because the medical system and the definitions promoted by it hold sway even among those who have little access to it ?

Health issues which would be of concern to Indian women are generally different from those which confronted feminists in the West in the late '60s and early'70s. For instance, by then in most countries of the West, the major achievements of medicine which produced visible and noticeable change had already taken place. The life expectancy had levelled out and there appeared to be after all, a maximum limit to human life. Together with this, the hospital-centred medical system had increasingly become dehumanised, authoritarian and expensive. The women's movement could successfully question the ethos of such a system and its value to women.

In the '70s in India, although the state health system was weak and inefficient, it was at least able to bring some relief, especially in acute illness and during crises. Moreover, by this time several groups, frustrated and disgusted with both the state systems and the rapacity of the private practitioners had set up 'alternative' health programmes in the rural areas. And many of these had made maternal and child health programmes their main focus. Undoubtedly, this brought about positive changes in women's (or rather maternal) health status. Therefore the women's movement in India had no immediate and concrete targets in the area of health. The demand for birth control measures and abortion were two major areas of activity of the women's health movement in the West. In India, such measures were, in fact, being forced on women as part of a determined and massive family planning programme.

Further, the sex-wise mortality and morbidity picture in the West was and is quite different from the Indian. In the US, for instance, women show lower mortality and morbidity rates and also a greater frequency of contact with the medical system. Women there were concerned with countering the criticism that women were generally, hypochondriac, and in voicing concern and initiating action about the increasing consumption of tranquilisers and painkillers by women.

What then, are the issues which demand concerte action, research and discussion in India today? It is hardly necessary to point out that women's health status has been steadily declining. In 1901, the sex ratio (number of women to 1000 men) was 972 which declined to 930 in 1971. In almost every age group (except 10 to 14 years) until 34, the age-specific death rates are higher for women. Or in other words more than half the deaths among women occur before they are 35. According to one report, 20 per cent of all deaths among women in the age group 15-34 are because of childbirth and associated causes (SNDT 1981). However, maternal mortality is not the major cause of death among women in that age group. And yet most health programmes are directed only at reducing maternal mortality without any alteration of the accessibility of this group of women to general services.

Women have also been the major focus of family planning programmes. Most of the measures proposed and implemented — sterilisation, abortion, oral contraceptives, copper T, injectables — have affected women's health significantly, and even disastrously.

The changing patterns of economic development have put a heavy burden on women which is reflected in their health status. In a society where women hold a lower social status, any situation of deprivation is bound to affect women adversely. The marginalisation of farmers, landlessness and forced migration, temporary and permanent, have undoubtedly affected women's health and nutritional

status. The growth of the small and the cottage industries sector has depended heavily on female labour. And most of these do not come under the purview of any kind of safety legislation. Therefore, women have, in the last decade become exposed to new kind of health hazards. Added to this is the fact that women risk their lives in the performance of domestic labour. According to Rajni Kothari a woman spends approximately 73,000 hours on an average in the kitchen, most of which are environmentally harmful and unsafe (Raj and Patel, 1982).

The number of 'workers' among women is estimated to be only 20.01 per cent. But the Census definition of 'work' does not include cooking, collecting firewood, fetching water, etc. activities which take up half the energy expenditure of women. At the same time adult women eat consistently less than men and also much less than the recommended calorific allowances, which are themselves based on somewhat questionable assumptions. According to a recent survey carried out by the National Institute of Nutrition, Hyderabad, 60 per cent of the rural population is anaemic, most of this group being women. Malnutrition is not only aggravated by diseases but renders women more prone to illness. Ironically enough, although women suffer from illness more or at least as often as men, they seek help less often.

There is little hard-core data available to support any analysis of women's health status. And this itself is a telling comment on how unimportant women's health is. Nevertheless, there is sufficient evidence — experiences, personal observations—that women's health status presents an apalling, dismaying and deteriorating picture. In this, the second issue of SHR, we examine a few facets of this picture.

Sathyamala discusses the sexist ideology of medicine and its operation in the past and currently. She convincingly shows that the sexist ideology is so closely integrated with the theory and practice of medicine that it is difficult even to identify it, let alone accept it.

Our next offering is an article by Barbara Katz Rothman, reproduced from the book *Women: A feminist perspective* edited by Jo Freeman (1979) giving a slightly different theoretical explanation of the sexist bias. She sees sexism in medicine as a component of the mechanistic, positivist bourgeois medicine and calls for a critical examination of the medical mode of women's bodies and health.

Nirmala Sathe provides an overview of health issues in the women's movement in India.

Srilatha Batliwala writes on the energy-health-nutrition nexus with reference to women. This paper gives credence to the fact that the gap between expenditure for energy and intake of calories is larger for women than for men. These data and the accompanying analyses gave for the first time, (when it was first presented) hard-core information and statistics about some aspects of women's health status.

Meredeth Turshen's article is an extract from a book *Third World Medicine and Social Change* (edited by John Morgan and published by Lanham) which is just out. It analyses the nutrition-health complex with reference to women in Africa. It looks at the health situation of women from the perspective of Africa's changing economy. It seeks to show the linkages between political and economic measures, changes in cropping patterns, food imports, international loans and changes in land tenure, women's nutritional and health status.

Misuse of medical technology is at times a sore topic of discussion. The use of amniocentesis for sex determination, aroused great deal of discussion a year ago. It was in fact, one of the few issues that women's groups took up all over the country and pressed for a ban on such tests being used indiscriminately. Vibhuti Patel concisely traces the major features of this debate and highlights the misuse of such medical technology which more often than not leads to female foeticide.

How healthy are workers in the drug industry? A large number of women are employed in the pharmaceutical industry , but there are few studies of their health status. Sujata Gotoskar, Rohini Banaji and Vijay Kanhere report a case-study of women workers manufacturing vasodilators. A drug such as this is prescribed to produce a definite physiological change in those who need it. What happens to normal women who have to breath in the powder day-in and day-out? This study, highlights the need to gather more information of the hazards women face at work places.

We wind up this issue with a review and report of 'health' problem which is currently facing the Kashtakari Sanghatana working among the adivasis in Dahanu in Maharashtra. And this is the torture of women 'bhutalis' (witches). The Sanghatana has attempted in this paper to locate the issue in a socio-economic perspective. Who is the witch? Why

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led to a hysterical state. Modern thinking has reversed this understanding. It is believed now that emotions acting through hypothalamus effect menstrual function considerably.

The process of professionalisation includes learning attitudes about work, about relations with colleagues and about patients or clients. In medicne these attituides are strongly coloured by a demeaning regard for women. For, after all, such attitudes about women are pervasive in society and moreover the medical profession has been virtually a male monopoly. This may be disputed in India since the majority of gynaecologists here are women. Unfortunately, they too have imbibed the sexist values in society. We are all products of our cultural expectations---- and our culture devalues women.

The answer does not lie in doing away with gynaecologists. The more mature way would be: (i) to recognise inadequacies that exist in our knowledge and be more open and receptive to women's personal experiences; (ii) to redirect research priorities and focus on problems that women consider as important; (iii) to end the medical monopoly of knowledge about women's physiology, their illnesses. Only then can we hope that medicine will serve those who need it most.

References

1. Applebaum, R. M. The modern management of successful breast feeding in *Paediatric Clinics of North America*, 17 : 1 February, 1970.
2. Armitage, Schneiderman, Bass. Abstract of article : Response of physicians to Medical complaints in men and women *JAMA* 241; 2186-2187; 179.
3. Burns, Janice. The medical system as a source of sexist ideology. Paper presented at the Women's Studies Seminar on Women and Health, New Zealand, 1978.
4. Ehrenreich, Barbara and English Deidre, *Complaints and Disorders—The Sexual Politics of sickness*, Glass Mountian Pamphlet.
5. Howell Mary C. What medical schools teach about women. *The New England Journal of medicine* 304-307 pp. 1974.
6. Llewellyn Jones, Derek, *Fundamentals of Obstetrics and Gynaecology*. Vol. I and II ELBS.
7. Lennane, K. J. Alleged psychogenic disorders in women—a possible manifestation of sexual prejudice. *The New Eng. nd Journal of Medicine* 288: 288-292, 1973.
8. Scully, Diana and Bart, Pauline. A funny thing happened on the way to the orifice : women in gynaecology textbooks. *American Journal of Sociology* 78: 1040-1050, 1973.
9. UNICEF. *Questions and answers on infant feeding*. April 1981.
10. UNICEF Information 1981.

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does witch-hunting take place with greater frequency during certain seasons? There are no simple answers. This article looks at the entire complex fabric of the adivasi's way of life, the status of women, and how factors such as deforestation, modern diseases, increasing unemployment and impoverishment and a deterioration and disappearance of trbial knowledge of medicine may be generating a set of circumstances which could perpetuate and strengthen the belief in the bhutalis and thus lead to increasing persecution of women. We especially ask readers to respond to this article.

Our focus throughout the issue is on women as consumers of health care. Women also comprise a large proportion of the providers of health care and we hope to devote a seperate issue to the topic sometime. We hope you find this glimpse of the many health issues which concern women, insteresting.

padma prakash

References

1. Fee, Elizabeth. Women and Health care : A comparison of theories *International Journal of Health Services* 5 (3) 347-415 1975.
2. Raj, Maiteyi and Patel, Vibhuti. An Indian Perspective on Housework (They quote Rashmi Mayur's study)
3. See article on *Women, Health and Medicine : A feminist perspective* By Katz in this issue.
4. Schatzkin, Arthur. Health and Labour power *International Journal of Health Services* 8 (2) : 213-234, 1976
5. SNDT Women's Studies Unit. *Women in India 1981*