Impact Of Gender Bias On Health And Nutrition Of The Tribal Women In Relation To Dynamics Of Development In India

R Balgir

Citation

R Balgir. *Impact Of Gender Bias On Health And Nutrition Of The Tribal Women In Relation To Dynamics Of Development In India*. The Internet Journal of Biological Anthropology. 2008 Volume 3 Number 1.

Abstract

Tribal communities in India are economically and socially backward and mostly live in forests and hilly terrains isolated from the other elite communities. They have their own way of living and different socio-cultural and eco-geographical settings. Lack of proper education and health facilities, faulty feeding habits, certain irrational belief systems and special tribal chores are likely to aggravate their health and nutritional status. Tribal women, in general, enjoy better status in the society than the general caste people because they exercise decisive role in the family (mother work), society (social work) and economy (other work) in India. However, the ideological devaluation of women's contribution and reorientation of gender and sex have brought about concomitant drastic changes in the status of women and their empowerment in different dimensions of deprivation and exploitation, and imposed restrictions on daily folk-chores of life. In few communities, a definite decline has been observed threatening their very existence. This decline may not be due to low level of fertility but rather high level of mortality and illogical health practices. The success of dynamic tribal development is dependent on various factors like improved literacy rate, sustainable socio-economic status, women's empowerment, better health care and other human resource indicators. It is much desirable to make reproductive health care accessible and affordable, extending basic amenities, empowering women and enhancing their employment opportunities, and providing the transport and communication facilities.

INTRODUCTION

It is well known that India treats its women badly. The World Economic Forum (WEF) measuring gender equality around the world has placed India shockingly at the bottom, at the 113th position out of 130 countries, such as Bangladesh and the United Arab Emirates[1]. The rankings, which were topped by Norway, are based on how much progress the nations have made in the areas of jobs, education, politics and health as a measure of gender parity. While India has scored remarkably well in the area of political empowerment - owing, perhaps, to reservations for women in village Panchayats - in the areas of economic participation and health and survival, Indian women are worse off than all of the counterparts. Particularly, the significant is the abysmal ranking India has achieved in the health and survival category. India's ranking 128 out of the 130 countries surveyed, manages to place ahead only of Azerbaijan and Armenia[1].

Gender based disparity includes any kind of verbal or physical force, coercion or life threatening deprivation, directed at an individual, girl or woman. This deprivation may cause the physical or psychological harm, humiliation or deprivation.

The inequality is not due to sex, but due to the social attributes which govern the living of men and women. The biological difference in sex at birth does not determine the preferential environment created for male and female in our society. Gender is socially learned behavior associated with men and women with the expectations. In the Indian society, different roles are ascribed to two sexes. The expected behavior from each sex is different and there is discrimination in vesting power and control in the family and community. Men and women do not enjoy equal opportunities in decision making and they do not have equal access to and control over various kinds of resources in the family. Women's opinions are seldom valued even in the matters of pregnancy, abortion, delivery, contraception, etc. Repeated child births and abortions often bring in adverse consequences like anemia, reproductive tract infections, uterine prolepses and urinary incontinence.

This subordinate status of women in the Indian society deeply influences their health status. Excessive emphasis on one biological aspect (child bearing) leads to early marriage, repeated pregnancies, abortions (preference to male child) and reproductive problems are compounded. Added to this, lack of adequate nutrition – partly due to poverty and partly due to lack of freedom – limited or no opportunity to rest and relax further aggravates women's reproductive health.

Gender inequality in every domain of life is setting back the achievement of the Millennium Development Goals (MDGs). A thorough commitment to accountability towards women alone holds the key to realizing these goals. That's the message given by "Progress of the World's Women 2008/2009: Who Answers to Women". Unless gender equality becomes a standard against which all public decisions and outcomes are gauged, accountability to women cannot be ensured. This requires that egalitarian norms be brought in force where they are absent, and existing ones enforced to ensure that women get their due in politics and governance, in access to public services, in economic opportunities, justice, and even in the distribution of assistance for development and security[2].

Achieving gender equity in health implies eliminating unnecessary, avoidable and unjust health inequalities between men and women.

GENDER IMPACT ON HEALTH

Change cannot be forced at personal level; therefore, laws are enacted in the society. All we can do is to attempt to change the factors that dictate such a choice, by improving the workable social status accorded to our daughters, through assured schooling, healthcare, employment opportunities, and substantive legal equality. But even as we do this, we would need to continue to monitor and punish medical personnel who seek to thrive on one of the most pernicious forms of hate crimes known to modern Indian society - the hate crime called female feticide.

The child sex ratio shows a negative trend and causes serious concern to anthropologists, population scientists, policy makers and planners. Low sex ratio trend in India is due to large scale practice of female feticide. Female feticide or sex selective abortion is the elimination of the female fetus in the womb itself. The decline in child sex ratio may be due to different factors such as neglect of female children resulting in their higher mortality at younger ages, female infanticide and female feticide. Female feticide refers to a practice where the female fetuses are selectively eliminated after prenatal sex determination, thus, avoiding the birth of girls. High incidence of induced abortion and the sharp decline in the child sex ratio clearly proves the practice of female feticide [3].

Factors Responsible for Female Feticide:

- The obsession to have a son
- The discrimination against the girl child
- The socio-economic and physical insecurity of women
- The evil of dowry prevalent in the society
- The worry about getting girls married due to the stigma attached to being an unmarried woman
- Easily accessible and affordable procedure for sex determination during pregnancy
- Failure of medical ethics
- The two-child norm policy of the Government

Implications of Declining Sex Ratio in the Population:

- Decreasing number of females in the society likely to increase sex related crimes against women
- Lead to increase in social problems like rape, abduction, bride selling, forced polyandry, etc.
- There will be increase of prostitution, sexual exploitation and increase in cases of STD and HIV/AIDS
- Growth in crime against women and cause various physical, physiological and psychological disorders in women
- Health of women is affected as she is forced to go for repeated pregnancies and abortions.

The basic principle is that every woman has a right to the highest attainable standard of health, to safe reproductive choices, and to high-quality healthcare. We can concentrate on preventing unsafe abortion, improving treatment related complications, and reducing its consequences. We should strive to empower women by increasing access to services

that enhance their reproductive and sexual health in a conducive environment by introducing the new technologies, training, research, and technical assistance:

- support the development of women-centered reproductive health policies,
- improve the quality and sustainability of services,
- ensure the long-term availability of reproductive health technologies, and
- promote women's active involvement in improving health care.

Women's empowerment is the empowerment and development of the family and the nation.

Tribal women, in general, enjoy better status in the society than the general caste people because they exercise decisive role in the family (mother work), society (social work) and economy (other work) in India. However, the ideological devaluation of women's contribution and reorientation of gender and sex have brought about concomitant drastic changes in the status of women and their empowerment in different dimensions of participation perpetuated by deprivation and exploitation and imposed restrictions on daily folk-chores of life.

Many households lack access to water in or near their premises, women spend as many as 40 billion hours each year collecting water. The magnitude of wasted human efforts involved in this fetching of water can be gauged from the fact that women spend so much time in securing such a basic necessity of life that their efforts are equal to a year's worth of labor by the entire Indian workforce!

Though data on the impact of environmental degradation and climate change on poor women is scarce, the women's time burden will increase if drought, floods, erratic rainfall, and deforestation undermine the supply and quality of natural resources. This is

because the women often ensure household food security and do the bulk of water and household fuel collection.

REPRODUCTIVE HEALTH

Another worrying global fact is that maternal mortality is dropping very slowly – at just 0.4 per cent a year, compared to the 5.5 per cent needed to meet the MDG to improve maternal health. This has been attributed to the fact that health services and schools are often too far off or too costly, and agricultural services are male oriented. Thus, the litmus test of government accountability is service delivery that responds to women's needs. But this is a formidable challenge in many parts of the world including in India. The very meaning of accountability undergoes a shift when women come into the picture, as women's experiences and perceptions are significantly different from men's. So, women perceive higher levels of corruption in public services [4].

Maternal Mortality Ratio (MMR) is the number of maternal deaths (during pregnancy, childbirth, and puerperal period) per one lac live births, but unfortunately, no reliable significant data available on these aspects even on general population in India, what to talk about tribal people. Even if, we take the most conservative estimate of 400 per one lac live births (which is in the lower side), even in this case also more than one lac women die every year in India due to causes related to pregnancy and child birth.

Four mothers die for every 1000 live births each year in India. Every five minutes a woman dies as a result of complication attributable to pregnancy and child birth[5]. As per estimate for each woman who dies as many as 30 other women develop chronic debilitating conditions and seriously affecting the quality of life.

One has only to examine the maternal mortality rate to see where India has performed so dismally. This rate is 450 for India, amongst the highest in the world, and an evidence of just how limited access is for women to quality health care. An Indian woman can expect to live healthy or as long or even a year longer than a man. But given that in most parts of the world, women outlive men by as much as 5-7 years, this is hardly as uplifting a statistic as it may seem.

It is interesting that the WEF report measures the incidence of paternal versus maternal authority. Unsurprisingly, India is awarded the worst possible score on that account, cementing our reputation as an extremely patriarchal society. That such a score is warranted and indisputable in the light of so-called honor killings that still occur in our society. Sex ratios are the most skewed in favor of males in some of the richest parts of the country, proving that economic growth alone cannot result in better lives for Indian women.

Nearly 12% of all maternal deaths are attributable to abortion related complications in India. Anemia is the underlying cause for 20%, toxemia 13%, puerperal sepsis

13%, and bleeding during pregnancy for 23% of maternal deaths[5].

Maternal mortality is high in those communities in which fertility (number of births) is also high. Maternal mortality is high in those communities in which children are born to very young women with closely spaced pregnancies[6]. Lack of participation by men results in poor utilization of pre/antenatal, natal and postnatal services for the pregnant women. Either they are unaware of the importance in seeking preventive care or they are simply indifferent. In 25% of the maternal deaths in India, family members were not aware of the seriousness of women's condition and took no action towards obtaining medical assistance.

EMPOWERMENT OF WOMEN

To ensure gender equality and empowerment of women in terms of educational parity should be within reach. But to replicate this in political representation and employment is still a distant reality. Greater political representation of women ensures a greater silence of women's issues in policy making. However, at the present rate of increase, it will take 40 years for women in developing countries to reach the parity zone of 40 to 60 per cent of seats in assemblies and in the parliament of the country.

The National Population Policy (NPP) 2000 and Reproductive and Child Health (RCH) program in India has reflected a paradigm shift from earlier demographically driven target oriented coercive policy to emphasis on human development, gender equality, adolescent reproductive health and rights, and development of issues related to stabilizing Indian population. The female age at marriage is low relative to the legal minimum age of 18 years in comparison to men (21 years). Age at marriage has far reaching consequences on fertility rates, child bearing, and other health issues such as infant and maternal mortality[6]. Menarche or the onset of menstruation cycle constitutes the land mark for female entry into the institution of marriage[7]. Women are pressurized to have children soon after their marriage in order to prove their fertility and worth. Hence adolescent marriage becomes synonymous with adolescent child bearing[7]. Early marriage has adverse effects on the health of mother and child. The high rate of maternal, neonatal infant and child deaths are positively associated with early marriages[6]. Female education and raising investment on adolescents' social and economic prospects, and enhancing their self esteem can do a lot of improvement in their health, nutrition and development.

IMPACT ON NUTRITION

A diet that provides sufficient calories and micronutrients is essential for a pregnancy to be successfully carried to term. Proper nutrition and avoidance of unnecessary pregnancy related taboos can reduce serious complications during pregnancy and child birth.

Infant mortality rate is an important index of the level of socio-economic development and quality of life. It is a sensitive indicator of the availability, utilization and effectiveness of the healthcare particularly perinatal care. It is persistent undernourishment of women and girl child in particular, that is emerging as critical factor responsible for infant mortality[5]. Poor maternal health results in low birth weight and premature babies. Infant and childhood diarrheal diseases, acute respiratory infections, and malnutrition contribute to high infant mortality rates[5].

The ill effects of food and nutritional insecurity can be linked to the life cycle of an individual. When a child is weaned from mother's milk to other foods, very commonly the protein and energy requirements are not met. Due to inappropriate complementary or supplementary feeding practices, the energy gap widens. This is because for the proper growth after 6 months of age, the requirement of the extra energy cannot be fulfilled by breast milk alone. This is displayed as Protein Energy Malnutrition (PEM), which is very common form of malnutrition. The onset of malnutrition starts from the period between 7-8 months of age and if not mitigated then effects persist for the whole life. In the existing scenario where we see gender disparity existing in families, the male child may make up for these nutritional losses while this cannot be always the case with a girl child[8]. In rural areas, girls are mostly married off at a lower age than prescribed by the law and hence also become mothers at a young age. With the nutritional status of mother herself being inadequate, the birth of a child only adds to low availability of nutrition for herself. This is a vicious cycle and further deteriorates the nutritional status of the woman generation after generation.

The Dietary patterns of people also affect the nutrition security of a community. In many cultures, the dietary patterns followed do not meet the nutritional needs (quality as well as quantity, minor and major nutrients) of the individuals and affect the health and nutritional status of the community. Low dietary intake by already malnourished

women has adverse effects on the health of both mother and child[8].

DYNAMICS OF TRIBAL DEVELOPMENT

Curving population growth is not a goal; it is only a mean to development. The success of dynamic tribal development is dependent on various factors like improved literacy rate, socio-economic status, women's empowerment, better health care and other human resource indicators. The vision is economic and social development and to improve the quality of lives that people lead, to enhance their well-being and to provide with opportunities and choices to become productive assets in the society[9]. It is much desirable to make reproductive health care accessible and affordable to all, as of increasing the provision and outreach of primary and secondary education, extending basic amenities, empowering women and enhancing their employment opportunities, and providing the transport and communication facilities[9].

A country's productivity, economy and health increase as the gender gap narrows down. Investment in public health care and education are essential. Until we put more of our girl children in school - the female to male enrolment ratio in secondary education is a dismal 0.79 - we can forget about progress. As long as Indian society continues to regard women as essentially appendages to men in a patriarchal society, we will find it difficult to achieve the global power status to which we so aspire.

CORRESPONDENCE TO

Dr RS Balgir, PhD Head, Division of Biochemistry, Regional Medical Research Centre for Tribals (ICMR), Near Medical College, P.O.Garha, Nagpur Road, Jabalpur-482 003, Madhya Pradesh, India E-mail: balgirrs@yahoo.co.in

References

1. TOI. Editorial. No Woman, No Power: Study places India in bottom, 20 countries for gender equality. The Times of India, November 20, 2008. New Delhi Page: 14.
2. Agarwal Anuja. Of gender inequality. The Hitavada (Woman's World). October 2008, 15, Jabalpur. Page 1.
3. Philipose Pamela. Women versus girls. The New Indian Express. April 5, Bhubaneswar. Page 8, 2006.
4. Balgir RS. Medical Genetics in Public Health Administration in India: A Handicap of Bureaucracy, Bias and Corruption. Health Administrator (Theme: Health of the Educational Systems), 2005, 17(2): 101-109.
5. Balgir RS. Infant Mortality and Reproductive Wastage Associated with Different Genotypes of Haemoglobinopathies in Orissa, India. Annals of Human Biology, 2007, 34 (1): 16-25.
6. Balgir RS. Parental Age and Incidence of Cleft Lip and Cleft Palate Anomalies. Acta Anthropogenetica, 1984, 8: 231-35.
7. Balgir RS. Age at Menarche and First Conception in Sickle Cell Hemoglobinopathy. Indian Pediatrics, 1994, 31(7): 827-832.
8. Balgir RS. A Cross-Sectional Study of Growth and Physical Development in Fifteen Major Scheduled Tribe Communities of Orissa, India. International Journal of Child and Adolescent Health 2008, 1 (3): 243-252.
9. Balgir RS. Tribal Health Problems, Disease Burden and Ameliorative Challenges in Tribal Communities with Special Emphasis on Tribes of Orissa. Proceedings of National Symposium on "Tribal Health" 19th-20th October 2006, Regional Medical Research Centre for Tribals (ICMR), Jabalpur. 2007, pp. 161-176.

Author Information

R.S. Balgir, Ph.D.
Division of Biochemistry, Regional Medical Research Centre for Tribals (ICMR), Near Medical College