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Short Communication

Implications of living and working conditions on women's health: A study in rural Maharashtra, India

Manjari Sinha
Tata institute of Social Sciences, Mumbai, India
manjari.sinha88@gmail.com

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Abstract

In Indian context where majority of the population belongs to the rural sector, women are generally married at a young age, thereafter become mothers and are then overburdened by domestic and economic responsibilities. Health wise, these women remain mostly anemic and remain the last member of their household to eat and receive any medical attention. In lieu of the background, the broad objectives of the study is to examine how women's living and working conditions mediate their experiences of gynecological morbidities. It is an exploratory study that aims at understanding the process of decision making by a woman to undergo hysterectomy. In doing so the study focuses on the narratives of each woman about their experiences of illness, using an in-depth interview checklist. It follows the case history approach to take an account of their life experience vis a vis respective families and experience at the medical facility, involving first visit, following consultations etc. It is revealed in the study that discomfort due to menstruation cause hindrance in their day to day activities. It is also known that reasons such as past experience of multiple home births with lack of resources and proper care leads to uterine prolapsed which forms a prominent symptom warranting hysterectomy. The other morbidities include abdominal pain, white discharge, heavy menstrual bleeding and Pelvic inflammatory disease.

Keywords: Living conditions, working conditions, women's health, gynecological morbidities, hysterectomy.

Introduction

The social determinants of health as defined by the World Health organization (WHO) are the circumstances, in which people are born, grow up, live, work, and age and the systems that impact the conditions of everyday life[1]. This implies that disease is both the cause of certain forms of separation from normal patterns of life and in circumstances, its consequences. The power structure and the socio cultural system define the way in which disease is conceptualised in any society[2]. This particular statement emerges looking at the history down the ages, wherein women have always been given the secondary status. Traditional patriarchal norms have given women a subordinate status within the household and societal levels. This severely affects women's health, her economic status, education and political involvement. In Indian context, where major population belongs to the rural sector, women are generally married at a young age, thereafter become mothers and are then overburdened by domestic and economic responsibilities. Health wise, these women remain mostly anemic and remain the last member of their household to eat and receive any medical attention. When it comes to treatment seeking for reproductive and gynecological morbidities, it appears even more challenging. The patterns in which the morbidities are reported, reveal important façades pertaining not merely to the health status of various groups, but also signify the inequalities in status and autonomy among various groups of individuals[3].

On discussing importance of family roles in the lives of women and their occupation, the "feminization of poverty" sets up a vicious cycle wherein women's health is put at higher risk, they have lesser resources to cope with, and in turn get sicker[4]. Illness is one component and experience of illness by women either in case of general illness or reproductive unease is another debate. The question arises as what issues are related to the experiences of gynecological morbidities as perceived by women that act as trigger for them to resort to medical care or hysterectomy, to be specific in this context. As the census data reflects, more than half (56.4 per cent) of the non-pregnant rural women in Maharashtra suffered from anemia and almost 25 percent of them had a Body Mass Index (BMI) below normal[5]. A study on women and labour force participation in urban Delhi states that the decision to do economic or rather paid work is usually not decided by the women but is rather the outcome of the external environment and ideology of the marital family. It also reveals that maintaining balance in work life is important for the physiological and psychological well-being of women. Lengthy work hours and the subsequent stress cause deeper psycho-social pressures for women[6]. Similarly another study revealed that forty five per cent of the incidents of women's morbidities were left untreated. In majority of the cases it was noticed that lower economic status restrained women from seeking treatment. However in almost one fourth of cases, women thought that their illness did not require any medical intervention.

Hence treatment was not sought due to accessibility issues, and lack of healthcare facilities. In a general scenario women from vulnerable groups such as those belonging to the scheduled caste and from those staying in the distant villages did not receive healthcare for a large population of their illnesses[7].

Working for household and for "economic" reasons can be literally challenging, especially in the unorganised sector of the economy. A study in Beed district of Maharashtra has exposed the coveted reality of "womb less women". Wherein, the women get rid of their uterus in order to save their jobs. After the surgery of hysterectomy there is no menstrual period. So, there would not be any grounds for taking a break during cane cutting[8]. This is an illustrative example of how hysterectomy is being used or rather misused criminally. It is a known fact that a poor family could go to any extent which would keep their jobs intact, in such a case, choosing to do away a "child bearing organ" from their body is no big a deal for them. This study has attempted to analyse the way the living and working conditions of the women in the rural areas of Maharashtra have had led to emergence of certain gynecological illnesses, for which they have chosen hysterectomy as their solution.

Methodology

As the topic suggests, the study makes an attempt to understand the various reasons of why do women seek hysterectomy, through the lens of their living and working conditions. This study is exploratory and descriptive one; qualitative in nature that looks at the process of decision making by a woman to undergo hysterectomy. It has gazed at the factors involved in each woman's life, contributing to her decision of hysterectomy. The study probes into the narratives of thirty eight rural woman who have had undergone hysterectomy in their past, using an in-depth interview checklist following the case history approach, to take an account of their life experience vis a vis respective families and experience at the medical facility, involving first visit, following consultations etc.

It further aims at knowing their perspective about their respective surgeries. Purposive sampling has been used to select the women, who have undergone hysterectomy. The categorisation has been done in a way that it covers maximum diversity, in terms of class, caste, and the ones who have underwent hysterectomy through public health insurance or those of who did it without insurance. The number of interviews was not pre-decided, however it was conducted till the data saturation was reached. The interviews were recorded in Marathi hence help of a translator was sought who transcribed the verbatim in English. Thereafter for the analysis, subsequent codes and then themes were developed. The study was reviewed and certified by the Institutional Review Board, thus confirming to the ethical practice. A consent form was duly narrated and their signatures were sought from all the participants, and participants' identity have not been disclosed anywhere in the study.

Results and discussion

Socio demographic profile of the participants: Out of total number of participants (thirty eight in number), 20 participants belonged to the age group of 40-45 years, thirteen were forty six years and above. And five of them were below forty years of age, at the time of interview. The average age of the participant was forty six years. There were three participants who got the surgery done in the past one year, the minimum duration being three months. While for twelve of them, time lapsed after the surgery was more than one year but less than or equal to three years. Four got operated between last three to five years. While majority of them (twenty), had got the surgery done, more than five years back. Out of thirty eight participants, thirty of them were engaged in agricultural work. Mostly all worked in both their own land as well as on other's land, when there is no water during summers. Very few reported to work only on their own fields.

Role in Agriculture: The tedious manual jobs which are considered secondary and of lesser importance are mainly done by the women folk and the work involving marketing and arranging seeds, fertilizers etc. are seen being done mainly by the male members of the families. In such tasks, the husband and the son contributed. On being asked about the kind of work, the participants do in the field in terms of the activities, kinds of crops grown and process involved in it, it was known that mostly women do the work of sowing, ploughing, watering, and plucking the crops. Some of them grew more pomegranates, while some had more jowar, bajra, some had more onions. But on an average "*Jowar, bajra, kaande (onions), watana (green peas*)" were widely grown crops. Regarding duration of work in the fields, the participants unanimously agreed that they work the whole year, except for summer, when the possibility to work in the field gets inhibited by paucity of water, since there seemed to be no availability of any other source than the rains. There are also women, rather majority of them who work on other's land (fields) also, along with their own land. And the remuneration they get varies from rupees hundred to one hundred to hundred and fifty. Many of them reported to be getting hundred and twenty five rupees. Even among these "rich peasant" families who do substitute hired labour for women's field labour on a substantial basis, women of families continue to do a great deal of "productive" work including much home processing of agricultural products and a fair amount of supervising and cooking for the hired labourers. In other words, the position of rural women- both the majority who work primarily on their own land as peasants, and the minority who work mainly as hired labourers on the land of others, is a dual one.

Women and the household chores: Women are subjected to the unpaid labour category that not only includes the household chores but also other responsibilities such as taking care of the adults, children and the elderly at home. All these chores are along with and is inadequately measured.

If at all 'non-farm' activities are given virtually no attention, and this consistent with the observation, often made that men in rural areas do remarkably little productive work other than the fieldwork and that the non-farm work they do can easily be put aside, if necessary, since it is not essential to daily subsistence. Right from producing food in edible form, an enormous amount of work is involved after harvest-which is the point where the official measurement of 'work' usually halts, threshing, winnowing, drying, boiling (for some crops) and some other activities have to be undertaken between harvesting and storage. Studying the daily routine of the women is an essential aspect for understanding the living and working conditions of the same. In order to analyse how the living, eating and working pattern manifests into certain morbidities, its acknowledgement within self and within family, the accessibility part, decision part, it all cohesively depends on it the living and working conditions.

Stating their daily routine, one of the many participant says' "From morning, I do cleaning, washing, plucking flower, weeding in farm, preparing food, collecting cow dung, fetch water etc. We farmers have same routine every day".

Another woman participant named Asha (32 years) shared "after getting up in the morning, after doing my brush and all… then I fill the utensil with water. When my daughter has time, she also helps me, but when she is in a hurry, then I cook and pack lunchbox for them. Actually I cook for myself also in the same go, so that I do not have to cook again. After they leave, I clean utensils, do brooming, mopping, washing etc".

In a study on the division of household work[9] states that there must be a demarcation as to what all activities count as "housework". Are the ones involving manual labour such as cooking and cleaning or should the work of providing emotional support and showing care for others are also counted. While most studies define housework as the unpaid work which is done by the women to maintain a balance within her family. Although almost all participant shared similar routine, since they work in their own or other's farms. The only difference in amount of work emerged due to number of family members present, especially in families where children were school going and there were elderly in the households. The narratives clearly bring out the number of hours women work for, the entire day, without any rest.

"I cannot sleep during daytime. Even if I am awake the whole night, I cannot sleep during noon hours". The same woman says, "Till death women cannot live a happy life".

On recalling the everyday hardships that they faced during the process of treatment, a participant mentioned "I was advised to stay in the hospital for seven days in total, but I came back to home two days earlier. Because my family was facing problems, like my daughter was missing school, so I preferred coming home early. I went to hospital again for getting the stitches cut".

In one of the narratives shared, a participant says "I have 2.5 acres land. There I do all sorts of work like cutting Jowari, onions (kaanda), pluck vatana (green peas), all these kinds of work. I stay in the farm till 6 in the evening. Thereafter return from the field. Clean my hands and feet, and then make tea, and then start preparing dinner, have food and sleep".

The extent of the unpaid and unacknowledged work by women clearly signifies that a large share of their time is spent on maintain her "inside and outside" which is often at the cost of leisure and rest. Literature indicate the role played by public policies in causing a rise in this kind of unpaid labour, either because of "reduced social expenditure that places a larger burden of care on women, and inadequate infrastructure that increases time spent on provisioning essential goods for the household or simply because even well managing policies are often gender blind" [10].

Accessibility to healthcare services: After the day to day living and working conditions, emerges another aspect which is the utilisation and accessibility part during times of illness. The utilisation component of medical care is a complex phenomenon and utilization of care depends on both external and individual factors. Patient, decision on whether or not to use care is related to gender and socio economic status. The poor and the marginalised section of the population remain more vulnerable to illness and disability leading to restriction of activity than do those belonging to higher caste and class. The former have less accessibility to many types of health services and receive lower quality care in many respects[11].

There are four broad aspects that in totality determine women's access to and utilisation of health services. The four areas being need, permission, ability and availability[12] wherein Need is the extent of ill health among women which also serves as a measure of the degree that women must seek healthcare. Permission here is meant by the familial and societal rules that prescribe whether a woman can or cannot seek health services. Ability depends mostly on the women's economic status. And the availability of health services in general and specifically for women serves as the major factor that determines women's access to health care.

Looking at the availability of health services, it was found that only the participants who stayed in the semi-rural or the peripheral areas only had proximal availability of health care service, whether it was a private clinic run by a group of doctors or a govt health centre. Also presence of mobile clinics was reported to operate in certain villages, some of the BAMS/BHMS doctors practising allopathy privately in rural and peripheral areas. Most of the participants were not told about the exact nature of disease they were suffering from. In some cases, the doctor said that there is problem with your uterus (mostly referred to as pishvi (bag) for which you will need surgery. Fibroids in uterus are referred as gaath (tumour) and pelvic inflammatory disease is referred as sujan (swelling).

Many women were told that they have cervical erosion, technically called as "pishvi Jhakhamjhaale" in their local terminology.

It is also important to understand the value they attach to their illness, when it is a normal cough and cold, fever etc or when it becomes unbearable and perpetual. That would decide the kind of treatment they would resort to. On that, a woman said that for general illness, they visit the nearest health care centre. It took ten minutes on a vehicle. Though there are both private and government health centre but they prefer private because in government health facility there is a long queue; it is more time consuming. Perceptions play a vital role when it comes to permission and ability part. When a woman realises that she is ill and need medical help, she discusses with her family regarding treatment. There comes in, the perception about certain health care services. Whether private is good or public. This would be feasible for the family, which one would be less time consuming and so on. In trying to understand the perception of their health care accessibility, there was a divided notion on private and public health providers. Some were happy with the government or government aided hospitals, since their experience was not bad. Another group had bitter experiences of the public health care.

One of the woman named Surekha (46 years) perceived, "In a government hospital, the doctors just keep giving medicines and ask to come for follow up… who has so much of time to visit again and again. Time and money both are required for travelling in taking treatment in a government hospital…. They said private hospitals are better as they take better care of their patients. In my experience also, staffs were polite, and they answered all the queries".

A daily wage labourer who has very limited amount of resource and for whom each day's remuneration counts, for her, it is a wise decision to avail her treatment in some private hospital where she need not visit several times and lose a day's wage.

Conclusion

The findings of the study are indicative of the fact that women are burdened with responsibilities at both levels; the household and her economic work. Along with household chores, and the tedious farm work that they do, other chores include taking care of the family members; no matter how sick they feel within themselves. The muted voice of these rural women within households result from their limited access to economic opportunities, traditional social norms as well as lack of proper legal framework and poor enforcement of any provision of good laws, if there is one. Lengthy working hours with negligible leisure time cause stress and strain among women, which is an important dimension to explore further in terms of consequences of workforce participation. The tedious and exhaustive work at home and also in the fields such as carrying heavy loads of water to spine affecting stooping agricultural work throughout the day leads to weakening of female bodies hence paving the way for different illnesses, both general and gynecological. Many a times the symptoms are not strong enough to force them to seek medical treatment as it is in benign condition. But later on, if ignored turns into a large fibroid and then gradually creates serious trouble to the women. In order to maintain the work life balance, many women chose to take treatment for their gynecological morbidities; some in government hospital while the others in private clinics. The study has tried to capture the way the women experience control in their everyday lives and the way they respond to such operations of power. In the current context for women belonging to lower socio economic background, hysterectomy becomes the most practical solutions for most of the gynecological morbidity faced by them.

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