RESEARCH FRONT

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GENDER PARADOXES IN HEALTH AND ILLNESS- A SOCIOLOGICAL ANALYSIS

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Abstract

Health is commonly considered as a state of being free from disease. Health is generally understood to be the soundness or the general condition of human being either physical or mental. Good health is a pre-requisite for the adequate functioning of individual and society. WHO now amplified its definition on health by including the ability to lead a socially and economically productive life. While studying the social dimension of health, gender plays a care crucial role in determining health prospects of any population .The nature; quality and accessibility of health delivery system are also reflecting the contradictions of our present social system. Gender becomes a biological destiny and it affects the subsistence of each and every individual.

It is scientifically proved that females are superior to male in life expectancy, lower mortality rate and the ability to survive at any stage. Females are more fit biologically at birth. But the paradoxes that remains all over the world and particularly in Kerala reveals females tend to fall sick more often and have higher morbidity than their counter parts. This paper tries to address the problem sociologically by using theoretical conceptualisation backed with an empirical study. This sociological imagination illuminates the gender contradictions that is present in the health and health care delivery system

Introduction

Health is commonly understood to be the soundness or the general condition of a human being either physical or mental. To be scientific, healthiness is the state of being free from disease. According to Herbert Spencer “Preservation of health is a duty. Good health is a prerequisite for the adequate functioning of an individual and society (Smith 1968). Health care is no more a topic of contentious discussions. The modern era of science has set forth scientific solution with authority, resultantly having people to do away with superstitious and traditional understanding of being morbid.

As a matter of fact, medical science has taken over from philosophy and religion as a vital agency to dictate the definition of morbidity as well as health. Getting on the wrong side of the situation, the past still hangs heavily over the popular conception of how morbidity is to be addressed and answered. The issue of health has been, fundamentally, a question of existence ever since the beginning of human history. Men used to fear for his existence which gave way to different forms of divine worship. Religion consoles a person when he finds himself affected by unhealthiest of body or mind. Christianity promises him heaven. As Hinduism puts it another way, morbidity is inherent in human body in an implicit form, hanging on to his life for the serious transgression of divine law, by violating the path of duty prescribed by god, an inherent tendency, a legacy from the sinful deeds of his ‘previous birth’. The haunting question of morbidity played a tremendous role in formulating the basic conceptions of religion and philosophy.

Everybody finds something to live for. He wants to live as healthy a life as possible.

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There is a time for everything to cease and so is for human life. How to face the inevitable rule of death has been a question of concern. To be healthy, to live longer, is a matter of concern for everybody. The fear of death may be a primitive and crude feeling of human kind. .

Cultural and socio economic dimensions of morbidity and its political implications hugely attract clinical sociology which shows the changing and inclusive concerns of morbidity studies. Modern medicine is not sharply delineated from sociology. Its culture specific and sex differential aspects and the topography of disease are not to be overlooked as well.

Scientific fields related to prevention, diagnosis and treatment of disease and maintenance of health are not treated in isolation from that of social anthropology and social psychology anymore. Sociology promises the necessary theories, Methods, analysis of vital social features and action application with a view to ensuring 'better health'. Its ability to solve the complex social and personal problems means a movement from the areas of medicine, psychiatry and psychology into the realm of 'social sciences'. (Cockerham , 1988).

Modern Medicine now focuses on morbidity, as a concept which is more functional, precise meaningful, scientific and definable. Morbidity the nature or indicative of diseases is characterised by or appealing to abnormal and unhealthy outcomes. Brain Meredith Davies (1976:14) simply defines morbidity as the incidence of disease and it is more quantitative and measurable. But the socio-economic, cultural and demographic differentials have to be considered to understand morbidity in its totality.

Assessment of Health and Morbidity

The widely accepted and popular definitions of health is that given by WHO (1948) in the preamble to its constitution – "health is a state of complete physical, mental and social well being and not merely an absence of disease or infirmity". In recent years, this statement has been amplified to include the ability to lead a "socially and economically productive life." Among the definitions for health probably the simplest one is absence of disease. But the current definitions of health are elusive, and there is no single yard stick for measuring health.

Many different methods of measuring the incidence of disease (morbidity) are currently being perfected. Some of the most interesting of these have been connected with hospital records. Special studies undertaken called Hospital In-Patient Enquiry and Hospital Activity analysis have also concentrated upon the certificates of sickness received from general practitioners. (Davies 1976)

Health Vs Physical power

People often confuse "health" with "physical power". Sometimes these terms are even used as synonyms. This mix-up leads to serious misconceptions.

Power means "the ability or capacity to perform or act effectively or "the strength or force exerted or capable of being exerted; might (www.answers.com). Indeed, physical strength is possessed by man more than female. This fact is illustrated in the following.

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Some Olympics records are cited here for example.

Event	Male	Female
100 M Dash	9.63 Sec	10.75 Sec
Long Jump	8.31m	7.12m
High Jump	2.30m	2.05m
10,000MLongrun	27Hr-30mts-42sec	30Hr-20mts-75sec

Source: Results Olympics records, 2012.

Even though man is physically stronger than woman there is no reason to believe that she is inferior to him when it comes to health. By a little anthropological and sociological knowledge, we can assert that power relates social rather than biological. In addition to that it is scientifically proved that she is superior to him in some respects (Beauvoir 1964).Keeping to these it is very difficult to digest the unreasonably high morbidity rates among women.

Why Morbidity among females?

Studies state that females are more fit biologically at birth and has higher life expectancy, lower mortality rate and higher ability to survive at any stage from womb to tomb. Data from biology also show that females have better physiological and endocrinal protection, are less susceptible to diseases like cancer and other chronic problems. Hence they may be termed as more healthy in the sense of this operational definition. But the scenario is paradoxical women tend to fall sick more often and they have high morbidity rate.

Except for physical strength, the male lack a second x chromosome which makes him in many aspects the weaker sex. Male infants are more likely than females to be still born or malformed. Over thirty hereditary disorders such as haemophilia and webbing of the toes are found only in males. Throughout the life cycle, the death rate for males is higher than it is for females. Although in the US about 106 males are born for every 100 females, the ratio of the sexes is equal by the time a generation has reached the mid-twenties and among people over sixty five there are 85 males for every 100 females. Women are more resistant than men to most diseases and seem to have a greater tolerance for pain and malnutrition. (Cockerham 1988).

As an organism, the male appears to be more vulnerable than the female, even before they are exposed to the differential social role and stress situation of later life. Social rules and psychological strategy also make the male life threatening. Prevalence of heavy use of alcohol, cigarettes, automobile accidents rate, occupational competition and pressure etc., cause a challenge to the social well being of male. So the genetic and environmental condition for adequate functioning of the organism is more adaptive to females. But many studies and referral experiences from our medical case premises indicated those women are more prone to diseases.

The hospital outpatient, in-patient registers, medical case records etc. shows prevalence of high morbidity among females. Even the medical practitioner indicates the sex differential in the morbidity of females. Such a situation should be analysed not only through the help of biology and medicine but through social and psychological dimensions also.

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Health problems of women

Health problem of women are complex and unique because of their historical features on the one hand and discrimination they face on family and social front on the other. These discriminations continue to and work to their disadvantage. This gets reflected in severe problems of malnutrition, early marriage, high incidence of infant, child and maternal mortality rates, etc these problems culminate an adverse sex-ratio. There are also occupational health hazards for women mostly employed in the urban informal sector. In addition there are health problems unique to women. As rightly observed by barber miller in "the fundamental sex" the issue of health is fundamentally a question of survival, basic to life itself more so in the case of Indian women. .

Available evidence of health and morbidity shows that the incidence of disease is more among women. According to US National Centre for Health and Statistics (1996), females have higher rates of acute illness- namely, infections and parasitic diseases, and digestive and respiratory disorders. The rate of the illness from these diseases are eleven times greater for females than males, as for chronic conditions females have higher rate of hypertension, thyroid, anaemia, gall bladder conditions, chronic enteritis and colitis, migraine headache, arthritis, diabetes and other diseases of urinary system and some skin conditions.

These changes cannot be addressed only through biology and medicine. But the quality, discrimination and even annihilation faced by a female gender from womb to tomb and the socialisation process also may be a debateable area in this regard. Medical practitioners and biologists now admit the importance of personality and social traits of morbid indices.

Sociologists rejects the biological explanation of illness they find the source of deviant behaviour in the relationship between individual and social system. Illness is viewed by functionalist as deviance. As illness involves violation of norms for health, it is viewed as deviance. Illness is dysfunctional to person and society or society seeks to control it. Society does it with the help of medical profession. They control by both curing and preventing disease and by establishing technology by which sick and handicapped persons can assist in self maintenance of the social system.

The sick role-theoretical

The concept of sick role (Parsons 1951) represents the most consistent approach to explain the behavioural characteristics of sick people. It is based upon the assumption that being sick is not deliberate and knowing the chance of sick person, illness may occur as a result of motivated exposure to infection or injury. Thus, while the criminal is thought to violate social norms because he "wants to", the sick person is considered deviant only because "he cannot help it". Parson warns however, that some

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persons may be attracted to the sick role in order to get away from, their socially sanctioned responsibilities. Generally society accounts for the distinction between deviant roles by punishing the criminal and providing therapeutic care for the sick. Both processes function to reduce deviancy and change conditions that interfere with social norms. Both processes also require the intervention of social agencies, law enforcement or medicine, in order to control deviant behaviour. Being sick, is not just experiencing the physical condition of a sick state; rather it constitutes a social role, because, it involves behaviour based on institutional expectations and reinforced by the norms of society corresponding to these expectations.

A major concern being sick is that they are unable to take care of themselves. It thus becomes necessary for the sick to seek medical advice and co-operate with medical experts. This behaviour is predicated upon the assumption made by parsons that being sick is an undesirable state and the sick person wants to get well. By engaging in help seeking behaviour, the role of the sick person becomes involved with the role of the physician in a complimentary but asymmetrical role relationship.

Parsons insist that illness is dysfunctional because it represents a mode of response to social presence that permits the evasion of social responsibilities. A person may desire to retain the sick role more or less permanently because of what parsons calls a "secondary gain" which is the exemption from normal obligations and the gaining of other privileges commonly accorded to the sick. Hence medical practice becomes a mechanism by which a social system seeks to control the illness of its deviant sick by returning them to a normal state of functioning as possible.

The specific aspects of Parsons' concept of the sick role can be described in four basic categories.

1. The sick person is exempt from "normal" social roles. An individual's illness is grounds for his exemption from normal role performance and social responsibilities. This exemption however is relative to the nature and severity of the illness. The more serve the illness, the greater the exemption. Exemption requires legitimating by the physician as the authority on what constitutes sickness. Legitimating serves the social function of protecting society against malingering.
2. The sick person is not responsible for his or her condition. An individual's illness is usually thought to be beyond his own control. A morbid condition to the body needs to be changed and some curative process or power or motivation is needed to get well.
3. The sick persons should try to get well. The first two aspects of the sick role are conditional on the third aspect, which is recognition by the sick person that being sick is undesirable exemption from normal responsibilities is temporary and conditional upon the desire to regain normal health. Thus the sick person has an obligation to get well.

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4. The sick person should seek technically competent help and co-operate with the physician. The obligation to get well involves a further obligation on the part of the sick person to seek technically competent health, usually from a physician. The sick person is also expected to cooperate with the physician in the process of trying to get well.

"In parsons' discussion of the sick role we see both his general theoretical ambitions and his concern for concrete interactions of daily life at work. At one and the same time he is challenging the idea that "the invading microbe" is the root cause of all sickness, while at the same time claiming for sociology a part in the fine-grained analysis of health and illness, within not outside-society". (Holton 1998)

Deprived state of women is unique while comparing to their complementary sex. Familial and social role-set made women a conception as inferior sex. This inferiority and less dignity actually refer to less care and less concern. Less care of a sex means collective discrimination. It leads to anxiety and a complex of being inferior. Gender identity, sexual orientation, sexual practices and the acceptance of these aspects of one's personality by the society, and the complementary sex as well, proves part of the complex system of social behaviour to which one's sex role is absorbed. These things constitute the ideal environment for female morbidity to prove as a 'social role'.

Health problems of women are complex and unique because of their biological factors on the one hand and the gender discrimination they face on the family and social front on the other hand. Even though her problems of health is unique, it cannot be tackled just by addressing her backwardness in distinct. Health is a reflection of the social system in total. A harmonic social system alone can give healthy individuals. Hence programmes on health alone can't be a panacea for her unique problems.

The widespread disparities in resource availability, regions, states, districts, urbanisation, those within rural areas, within a village among different strata, and so on determine the health status of people. So the first step should be to identify deprived groups and to provide facilities commensurable with the magnitude and seriousness of the problem

Methodology

The sample for the study was selected from the government and private health institutions of Malabar area. The sample was selected using multi-stage sampling method. This is a sampling procedure carried out in several stages. The first stage was selection of the institutions from the list of institutions. 3 government and 2 private institutions were selected as to get a representative sample of the population. Community health centre were out-patient, in-patient departments are well functioning i.e., Narikkuni, Thamarassery and Balussery were selected. Two private institutions among which one is hospital and other one a clinic were selected to get a clear socio-economic representation to the study. Among the list from hospital registers males and girls below 12 years are excluded from the sampling frame. Minor injury cases, pre and post pregnancy cases etc were purposefully excluded from the sampling frame. A systematic sampling method was adopted at selected equal intervals by random sample method. A total 120 samples were interviewed, 90 from government institution and 30 from private institutions.

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Results and Analysis

Gender Paradoxes in Health and Illness, a Sociological Study conducted on morbidity among females in three community health centres and two private hospitals of Malabar area in Kerala state. The important findings of the study are as follows:

Level of morbidity is higher among females compared to males. Regression analysis shows that compared to the age group 12-18 years, all the age groups above 33-39 are statistically significant ($P<0.05$). It is not significant for the age group 19-25 and 26-32 as much. It indicates a positive relation between morbidity and age. From the middle age onwards the morbidity level increases as age increases.

Religion has no specific influence on morbidity in the area under study. The regression analysis indicates that religion has no significance ($P>0.05$) with morbidity. This may be because of the high level of education and awareness among individuals irrespective of religion. In Kerala health care services and education are handled and managed by religious minorities. This shows an egalitarian opportunity in health services and utilisation of services in Kerala

Sections whose education falls below the secondary level show higher morbidity level than others. By taking professional education for comparison in regression analysis, it is evident that illiterate and primary level education are significant ($P<0.05$) while college and secondary education is not significant. It indicates that lower level of education worsens morbidity level. It further indicates a secondary level education is necessary to maintain healthy living. Education has capacity to act independently in influencing the life course of the people.

Unemployed females and private sector employees show higher morbidity level as compared to manual, government and professional employees. Regression analysis suggests that morbidity and occupational status in comparison to government service is significant ($P<0.05$) to unemployed and private sector employment. It is not significant to professionals and manual labourers. This indicates, higher morbidity level is present among individuals belonging to private sector and those who are not engaged in any kind of occupation. The non-significance to professional may be due to their high income level via education and greater awareness on healthy living. The non-exploitative nature of labourers in wage and work present in Kerala may constitute a good health profile to manual labourers.

Family organization (nuclear and joint) has no significance in morbidity. Regression analysis shows family organisation has no significance in morbidity. Hence it is evident that family organisation is not significant ($P>0.05$) in dealing with morbidity. This may be due to the changes taking place within the family system, expansion of media, woman's employment and education often facilitated some drastic changes within joint families

Married and single women are not significant while separated wives and widows show significant position in morbidity. Regression analysis showed that in comparison to married women, widows and separated women show significance ($p<0.05$) where as single women is not significant. This indicates that separated women and widows are more often morbid than single and married women. Sick role behaviour, family 'affection' and 'care'

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seeking behaviour may be a signal for this. This analysis also supports the hypothesis and the theoretical framework of this study - sick role

Rural Urban typified, place of residence have no significant relationship to morbidity. The analysis of data shows, that the place of residence under the rural – urban classification have no significance ($p>0.05$) in morbidity among females. It indicates further segregated and in-depth study is necessary on the nature of residence with physical dimensions of dwelling

Age at marriage is found not to be significant in determining morbidity in this study. But, below 5 hours of sleeping shows significant relationship to morbidity as compared to 6 and above hours of sleeping. In this study majority (82.5%) of the people have necessary hours of sleep. But some minority (17.5%) lacks sufficient hours of sleep. 5-6 hours of sleep is essential for well-being of body and mind. Hence from the data, regression analysis reveals that in comparison to 5-7 hours of sleep, below 5 hours sleeping is significant ($P<0.05$). It is not significant to higher hours of sleep. This indicates if the sleeping hours are low to the standard level, there is a chance to get morbid

Also in qualitative analysis, vocational satisfaction as well as marital satisfaction is poor among females of the area under study.

- Most of the morbid females expect more care and affection from the intimates. They would be happy if they enquired about their illness.
- Majority (69.66%) of the morbid females do not get any help from others in the family in day-to-day domestic work.
- Majority (97.55%) of respondents is strong believers, and a minority even believes that faith alone can cure the disease completely.
- Majority (61.31%) of them, especially those who take treatment in government health centres are not satisfied with the present treatment.
- 45.83% of the respondents expect medicine to cure them of the disease, followed by the 26.67% who resort to their faith in astrological factors. 18.33% of them expect a cure through change in life style. The rest (9.17%) of respondents have no hope of cure.

Conclusion

Health problems of women are complex and unique because of their biological factors on the one hand and the gender discrimination they face on the family and social front on the other hand. Even though her problems of health is unique, it cannot be tackled just by addressing her backwardness in distinct. Health is a reflection of the social system in total. A harmonic social system alone can give healthy individuals. Hence programmes on health alone can't be a panacea for her unique problems.

The widespread disparities in resource availability, regions, states, districts, urbanization, those within rural areas, within a village among different strata, and so on determine the health status of people. So the first step should be to identify deprived groups and to provide facilities commensurable with the magnitude and seriousness of the problem.

Results of this study bring forth a number of suggestions and some of them are:

- The problem of health is a complex affair; it cannot be tackled by health department alone. It should be an integrated and inter-sectoral approach which includes better opportunity for education, employment, community development, water supply,

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sanitation etc. An effective monitoring with people's participation is necessary to see that the desired results are achieved.

- One of the major contributory factors of the poor health status of women is their poor status in the family and community. An effective change can be made by using mass media and micro level organizations.
- Adult sex education is necessary to meet the health problems of women to a great extent. Male counterparts should know the physiological and features of womanhood. it helps to eliminate myths regarding the complementary sex, leading a healthy co existence with each other.
- The discrimination against girls in terms of nutrition and education has to be tackled, by focusing special attention on these aspects.

  This can be achieved through an enriched midday meal upto secondary level and providing more scholarships for girls in all levels of education
- For those who work in unorganized sectors, the problem of health care is severe and they should be given due care and economic security especially during pregnancy. More security measures and funding are essential in this regard.
- Though majority of women are said to be unemployed, most of them are arduously involved in many domestic and economic activities. Their activities should be directed to and collaborated with 'Kudumbasree' activities.
- Kudumbasree – Women oriented community based poverty alleviation programme which is being implemented by the state and India government - should be extended to all sectors of the community. 'Kudumbasree' should be strengthened to avoid exploitation of the informal sector and arm the women with reasonable profit resources.
- Adolescence Education Programme of secondary level should be extended to include the importance of age at marriage, optimum maternity age, adequate interval between bearing children and the desire to have the maximum number of children. In a democratic set up like us, legislation is not everything but education, should be a means to cater public opinion and media support.
- We have reasonably sophisticated infrastructure and field network, even though it does not yield the desired output. So public health and community medicine should be planned with people's participation, micro level planning and localized administrations are necessary. Thereby we can make the system effective and community oriented.
- India being poor and populous country, government by itself cannot be expected to shoulder the entire burden on all matters. It should promote, support and encourage self-help efforts in the case of women and children.

  The sources of the voluntary agencies also have to be relied upon in providing health care to the people.
- The relationship between education and morbidity as indicated by the study suggest that a minimum education of a secondary level is inevitable for keeping life healthy. So efforts should be made to universalise secondary level education to the benefit of all sections especially girls.
- Execute health insurance to all deprived and less privileged groups, so that health care seeking behavior can be utmost supported to vulnerable groups to the extent possible.

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Further Research Implications

This research is an exploratory study which provides new insights in order to formulate a more precise research hypothesis or to develop a research problem. This is only an indication of a wide area and specific study is needed.

This study could not compare female with its complementary sex, male. A comparative study will be fruitful only when both the deprived and privileged genders are evenly studied. Also, the study only incorporated morbid females who approached a medical centre, thereby excluding a major portion of samples and it shortened the area under study.

All morbidity studies orient towards a specific disease. A Morbidity statistics is usually prepared according to a specific disease. But here, a broad range of diseases are included and such a research may be non-specific in nature. Qualitative analysis and broad study can be included. Physical dimensions of morbidity can be analyzed through the particularity of dwelling and nutrition. For evaluating these, wider and more systematic interview schedule should be executed, thereby including those who do not consult a physician.

Hence, further research should specify a particular kind of morbidity by detaching the study from a hospital framework, using a wide interview schedule of both the sexes.

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