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Study on identification of gender discrimination practices to access health care: Gandhi's vision

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Abstract

Persistent imbalance between men and women in all facets of society inevitably leads to discrimination based on gender. Discrimination against women varies in scope and intensity depending on contextual factors such as culture, politics, ethnicity, location, country, and economy. But discrimination based on gender is seen as a major roadblock in progress, and it's been linked to violence against women. Therefore, policymakers around the world are focused on achieving gender equality because it boosts economic growth and ensures the development process can continue. In traditional patriarchal societies it is generally believed that women should remain confined to their families and under legal and customary subjection of their husbands or other male family members. During pre-Gandhian times gender inequality and gender violence were all pervasive. Women were regarded as the root cause of all evil and responsible for downfall of men. Women had a decidedly inferior status and were totally dependent on men. Women were confined to the family and remained under legal and customary subjection of their husbands or other male family members. Customs and practices like female infanticide, child marriage, purdah (veil), dowry, polygamy, sati, repeated pregnancies, permanent and pathetic widowhood, illiteracy, wife beating and verbal abuse made life of common women very hard. In such an atmosphere Gandhi gave a totally new perspective regarding gender equality and non violence. He not only opposed the harmful practices and encouraged regeneration of women but gave the ideal that women are not just equal and different but superior to men. The fact that the culturally entrenched practices of gender discrimination in the distribution of health care facilities is still in fashion, especially in metropolitan regions where access to health care services ought to be universal, highlights the darker side of this patriarchal culture. Gandhiji's famous message almost six decades ago at the All India Women's Conference on December 23, 1936 was: "When woman, whom we call *abala* becomes *sabala*, all those who are helpless will become powerful".

Keywords: Health care, Gandhi's vision, gender discrimination, wards, municipality

Introduction

One of the most telling metrics of a country's progress is its health care system. Health is a crucial component of every nation's developmental and transformative process. Some aspects of economic and social change can either improve or detract from the health status of the population; for example, the health status of the people not only determines the life expectancy at birth, but it also takes into consideration the productive age and economic productivity, employment, and earning capacity, all of which have implications for the economic and social well-being of the population as a whole. On the other side, people's health is influenced by a number of economic factors such as their level of income, employment, buying power, and poverty. Indeed, this feedback loop is characteristic of developing economies (Rani Gopal, 1987)^[7]. As a result, health research is crucial for fostering human resource development and economic progress.

In advancing the idea of "one world health" and ushering in a new age of international cooperation in the area of medicine, the global Health Organization (WHO) has done a major benefit to humanity. In common use, the term "health" refers to a state of physical and mental well-being, within a supportive social network. However, "Health is a

state of complete physical, mental, and social well-being and not merely the absence of diseases" (Sharma, 2000) is the most widely accepted definition of health as given by WHO. In addition, the preamble to the WHO's constitution states, "Governments have a responsibility for the health for their people, which can be fulfilled only by a provision of adequate health and social measures." As a result, in 1970, the World Health Assembly passed a resolution declaring the right to health to be a basic human right. The 30th World Health Assembly then adopted the slogan "Health for All by the Year 2000 A.D." in 1977. Health for all was reaffirmed as a fundamental human right and global social objective at the Alma Ata Conference in 1978. This aim is vital to ensuring that all people are able to meet their most fundamental requirements and enjoy the highest possible quality of life.

"It is health that is real wealth and not pieces of gold and silver" -MK GANDHI

When Gandhiji's name is taken in the context of health, it's essential to quote him. He believed in giving away the materialism that's often seen in the present India. Health is always the real wealth and, along with education, is the corner stone for a long-lasting sustainable development. The

constitution of India guarantees the 'right to life' as a fundamental right and makes the 'right to health' an obligation for the government. But to label it as solely the responsibility of the government is in disregard to the ways Gandhiji had taught us to live. Health is a choice in a continuum and the result is from collective decisions on your lifestyle, environment, thought and spirituality, not merely what you may derive from a health care provider. Gandhiji had a view that modern medicine was the bane of man and was used to circumvent our own shortfalls of lifestyle. When our body tells us our ways of life have been corrupted, we resort to the shortcut of medicines and do not face the need for lifestyle changes.

Methodology

For the selection of the study area, extensive secondary data work was conducted by collecting data from a variety of

sources in order to gain a comprehensive understanding of the area's physical layout. It provides a comprehensive analysis of the area's environment, as well as its socioeconomic, demographic, cultural, and political situations. After that, it's important to conduct an empirical research to examine the study's primary goals. In fact, the study's whole analysis is predicated. Panchyawala, Dhawas, and Heerapura were the sites of the main survey. Unfortunately, not every neighborhood in these three cities could be investigated due to time and funding constraints. The sex ratio, literacy rate, and labor force participation rate were thus selected as the primary criteria for all of the districts in these three cities. These decisions are motivated by the following factors: One of the most important socio-demographic indicators, the sex ratio may be used to predict the skewed gender dynamics of a region's population.

Table 1: Study Area Ward Selection Sample Size

Selected Towns	Selected wards For Survey	Number of Households Present (2001 census)	Surveyed Households
Panchyawala	3 (High category)	540	54
	15 (Medium category)	428	42
	11 (Low category)	457	45
Dhawas	10 (High category)	2040	102
	14 (Medium category)	1512	76
	5 (Low Category)	1565	78
Heerapura	15 (High category)	1305	65
	17 (Medium category)	1471	75
	19 (Low Category)	1613	80
Total(Nos.)	9	10931	617

In-depth field surveys were conducted in predetermined areas of the three cities to collect the main data. A well-structured questionnaire, tailored to the needs of this study, has been developed for data collection. Five to ten percent of all census households in the targeted areas of the three municipalities in 2023 have been randomly picked using a basic random sample approach. Table provides information on the number of homes in the research area that were surveyed by ward. During the survey's target period of 2023-2023, a total of 617 different houses were visited. The completed interview schedule was double-checked and tagged for electronic data processing before being imported into the Statistical Package for the Social Sciences (SPSS) system for tabulation and analysis after each round of fieldwork. All the variables have had their initial frequency counts stated. In order to discover the findings of the research, cross tables of the primary study variables with chosen dependent variables have been constructed. The tabulated data has been quantified, analyzed, discussed, and synthesized through the use of various cartographic techniques, appropriate statistical methods (such as chi-square), visual aids (such as photographic records), and the critical evaluation of relevant literature.

Review of Literature

Maintaining a healthy population is crucial to a country's economic success and human resource expansion. As a result, poor health is now widely acknowledged as both an important barometer of social welfare and a driving force behind economic inequality. The right to health, according to Haq (2005) [3], is the most fundamental of all human

rights, and research shows that spending more on people's health improves their productivity on the job. Reduced illness, low morbidity, and a lighter disease burden are all indicators of an overall population with a higher health status. Good health is, therefore, a goal unto itself. If a country's people were freed from sickness, it might devote its spare time and energy to improving its economic and political standing, as well as its educational and occupational opportunities, among other things (World Bank, 1993) [11]. The fact that health is an indication of well-being is common knowledge because of the obvious positive effects it has on both individual happiness and the economy as a whole (Shariff, 1999) [9]. Hazarika (2000) [1] looked at the gender gap in nutrition and health care spending in Pakistan to learn why parents choose to provide for their boys in South Asia. According to his research, boys under the age of five are given preference when it comes to receiving medical attention. Girls, however, seem to be just as well fed, if not better so, than males. Differential rewards to parents from investing in boys and girls are seen as fundamental causes of intra-household gender discrimination, rather than parental preference for males. Similarly, a cross-sectional household survey in a rural area of South India found that both non-poor and poor women were subject to "pure gender bias" in the form of non-treatment, while poor women were also subject to "rationing bias" in the form of discontinued treatment (Iyer *et al.*, 2007) [2]. Similarly to India and Pakistan, Nepalese researchers Pokhrel (2007) [5] examined the impact of gender on parents' decisions to take their children to the doctor. Illness is only one aspect of how gender roles

influence health care decisions, including who gets the sick kid, how much money is spent on medical bills, and what kind of doctor gets called in. However, research by Sauerborn, Berman, and Nougara (1996) [8] in the West African country of Burkina Faso indicates that parents place less value on the provision of health care for children because they are seen as "unproductive," compared to the provision of health care for adults. Findings did not indicate gender bias in health care use, and parents used income and output stability as a criterion for allocating resources to their children regardless of gender.

Results and Discussions

Access to Healthcare Facilities Based on Gender

The availability of various health care facilities in the research region, split up by gender, to provide a clear image of the real situation in today's urban society. Table displays a breakdown, by ward, of the various treatments received by sick men and women in the chosen wards of the three cities. Table shows that across all of the sampled neighborhoods in the three cities, private facilities account for the greatest share of treatment requests, regardless of gender. This is followed by public facilities; self-treatment, homeopathy, and home remedy measures. Analysis of treatment use by ward reveals that in Basri Municipality's Ward No. 3 (High Category), 48.39% of males and 55.88% of females had visited private physicians or private clinics. Similarly, 51.06 percent of men and 50.98 percent of women in Ward No 10 (High Category) of Dhankiya Municipality choose to get treatment from private institutions, whereas 56.67 percent of men and 57.14 percent of women in Ward No 15 (High Category) of Kalwar Municipality do so instead. According to the data, a similar percentage of sick people of both sexes have sought care from private physicians or private clinics in the affluent neighborhoods of the three cities studied.

Health care facility among the study area's sample population, broken down by gender

Basri Municipality

Type of Health Care Facilities	Ward No3 (High)		Ward No15 (Medium)		Ward No11 (Low)	
	M	F	M	F	M	F
Home Remedy	3.23	0.00	0.00	7.69	0.00	3.54
Homeopathy	3.23	5.88	5.26	11.54	0.00	6.90
Private Facilities	48.39	55.88	57.89	46.15	61.54	51.72
Public Facilities	45.16	38.24	31.58	30.77	38.46	17.24
Self Treatment	0.00	0.00	5.26	3.85	0.00	20.69
Total	100.0	100.0	100.0	100.0	100.0	100.0

Dhankiya Municipality

Type of Health Care Facilities	Ward No10 (High)		Ward No14 (Medium)		Ward No5 (Low)	
	M	F	M	F	M	F
Home Remedy	0.00	3.92	0.00	2.17	0.00	2.99
Homeopathy	6.38	9.80	2.63	0.00	3.85	1.49
Private Facilities	51.06	50.98	71.05	47.83	50.00	43.28
Public Facilities	23.40	21.57	23.68	36.96	40.38	41.79
Self Treatment	19.15	13.73	2.63	13.04	5.77	10.45
Total	100.0	100.0	100.0	100.0	100.0	100.0

Kalwar Municipality

Type of Health Care Facilities	Ward No15 (High)		Ward No17 (Medium)		Ward No19 (Low)	
	M	F	M	F	M	F
Home Remedy	0.00	2.86	0.00	0.00	0.00	0.00
Homeopathy	3.33	11.43	2.56	2.27	2.38	4.65
Private Facilities	56.67	57.14	61.54	45.45	57.14	46.51
Public Facilities	26.67	14.29	10.26	25.00	23.81	25.58
Self Treatment	13.33	14.29	25.64	27.27	16.67	23.26
Total	100.0	100.0	100.0	100.0	100.0	100.0

Specifically, while 51.61 percent of males in Ward No 3 (High Category) of Basri Municipality have opted for less expensive health care options like public facilities, home remedies, homeopathy, and self-treatment, only 44.12 percent of females have done so. Similarly, in Ward No. 10 (High Category) of Dhankiya Municipality, 48.94% of males and 49.022% of females have chosen to use less expensive public health care services rather than more expensive private ones, while in Ward No. 15 (High Category) of Kalwar Municipality, 43.33% of males and 42.86% of females have done the same. Consequently, it is clear that in these highly developed regions, the percentage of female patients seeking treatment from less expensive health care facilities is either lower than the percentage of male patients or is about the same. Ward No. 15 in Basri Municipality, Ward No. 14 in Dhankiya Municipality, and Ward No. 17 in Kalwar Municipality are all considered moderately developed; however, in these areas, 57.89 percent of men, 71.05% of men, and 61.54 percent of men are provided with better and more expensive private facilities than women (46.15 percent, 47.83 percent, and 45.45 percent). Similarly, among residents of Ward No. 11 in Basri Municipality, Ward No. 5 in Dhankiya Municipality, and Ward No. 19 in Kalwar Municipality, 61.54 percent, 50 percent, and 57.14 percent of men prefer to use more pricey private facilities, while only 51.72 percent, 43.28 percent, and 46.51 percent of women do so. When compared to their male counterparts, female patients in these medium and low-income wards are more likely to have access to less expensive health care options like home remedy, homeopathy, government hospitals, and self-treatment measures, further highlighting the discrimination faced by women everywhere.

The research also demonstrates that male patients in all of the study area's other chosen wards have never turned to home remedy techniques for treatment, with the exception of Ward No 3 (High Category) of Basri Municipality. Instead, only female patients have opted for home remedy techniques as a primary therapy option in majority of the research area's chosen wards. Thus, the research reveals the existence of gender discrimination against women in terms of access to health care services used for treatment, particularly in the wards of the medium and low categories of all the three chosen cities. In the top group, there is essentially little evidence of gender prejudice against women.

Gender discrimination in access to health care facilities

This section examines the degree to which men and women experience discrimination in the study region with regards to the availability of various types of health care services.

As can be seen in Table, regardless of the area's degree of development, the majority of patients visit private clinics, followed by public clinics, the self-care, then homoeopathy, and finally home remedy methods. The wealthy may more easily afford the hefty costs associated with private medical care and nursing home stays. Therefore, low-income families often choose for more affordable alternatives when seeking medical care. On the other hand, many of them have been forced to pay for expensive private practitioners and nursing homes because of a lack of doctors, paramedical staff, medicines, and poor quality of health care in the public hospitals in the study area.

However, a somewhat bleak picture emerges when breaking down access to health care by gender in various wards at varying development levels. It's fascinating to discover that outside of the most advanced hospitals, a far smaller percentage of female patients than male choose to use private health care services. Specifically, the research shows that in areas with a medium or low level of development, female patients are actively encouraged to seek treatment from cheaper health care facilities like home remedy, homoeopathy, government hospitals, and self treatment measures, highlighting the discrimination that exists between the sexes.

Table 2: Availability of health care services for both men and women in various wards

Type of Health Care Facilities	Name of the Towns: Basri, Dhankiya and Kalwar								
	Selected Wards of High Category			Selected Wards of Medium Category			Selected Wards of Low Category		
	M	F	T	M	F	T	M	F	T
Home Remedy	0.9	2.5	1.8	0.0	2.6	1.4	0.0	2.2	1.2
Homeopathy	4.6	9.2	7.0	3.1	3.4	3.3	2.5	3.6	3.1
Private Facilities	51.9	54.2	53.1	64.6	46.6	54.7	55.0	46.0	50.2
Public Facilities	30.6	24.2	27.2	19.8	31.0	25.9	34.2	31.7	32.8
Self Treatment	12.0	10.0	11.0	12.5	16.4	14.6	8.3	16.5	12.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

This proves that women are still being disadvantaged in terms of access to medical care, particularly in areas with medium and low levels of development. In more developed neighborhoods, however, signs of gender prejudice against women are less noticeable.

Conclusion

According to the results of the research, despite the fact that girls are generally healthier than males, they have greater rates of morbidity. This suggests that concerns about women's health and mortality are being mostly ignored in the region under investigation. The survey also found that although the overall percentage of people taking "no health action" is low, it is much higher among sick women than men. This is likely due to the fact that women face far more obstacles while attempting to travel than males do. Women are more likely to be excluded from making use of the health system's amenities than males are because of the institutional nature of the Indian healthcare system (Mathur, 1995) [4]. Women are less likely to seek medical help because they have learned from generation to generation that men tend to ignore their pain and because they worry about the costs involved (Rana, *et al*, 2005) [6]. Women are disproportionately responsible for taking care of children and maintaining the home. Because of this, people are often too busy or unmotivated to address their health concerns.

This study's findings suggest that the gender gap in this field changes with the sample study location's degree of development. This is evident due to the interconnected nature of factors such as the literacy rate, educational status, work participation rate, income, and standard of living of individuals, all of which contribute to shaping the general public's worldview and cultural perception of "gender practise" within society.

References

1. Hazarika. Gender Differences in Children's Nutrition and Access to Health care in Pakistan. Journal of

Developmental Studies. 2000;57(1):73-92.
 2. Iyer A, Sen G, George A. The dynamics of gender and clan in access to health care: evidence from rural Karnataka, India. International Journal of Health Services. 2007;37(3):537-554. [http://www.ncbi.nlm.nih.gov/pubmed]
 3. Mahbub-ul-Haq Human Development Centre. Human Development in South Asia: 2004. Oxford University Press; c2005. p. 66-88.
 4. Mathur D. Gender Dimensions of Health in India. In: Mathur I, Sharma S, editors. Health Hazards, Gender and Society. Rawat Publications; c1995. p. 171, 172, 176, 182.
 5. Pokhrel S, Snew R, Dung H, Hidagat B, Flersa S, Sanerborn R. Gender risk and child health care utilization in Nepal. Health policy. 2007;74(1):100-109. [http://linkinghub.elsevier.com/retrieve/pii]
 6. Rana K, *et al*. The Pratichi Health Report, No 1, The Delivery of Primary Health Services: A Study in Rajasthan and Jharkhand. TLM Books and Pratichi (India) Trust; c2005. p. 49.
 7. Rani Gopal K. Economics of Health and Nutrition: Some Aspects of Growth and Welfare. Chugh Publications; c1987. p. 2, 25.
 8. Sauerborn R, Berman P, Nougata A. Age bias, but no gender bias, in the intra-household resource allocation for health care in Rural Burkina Faso. Health Transit Review. 1996;6(2):131-145. [http://www.ncbi.nlm.nih.gov/pubmed/1016396]
 9. Shariff A. India: Human Development Report: A Profile of Indian States in the 1990s. National Council of Applied Economic Research, Oxford University Press; c1999. p. 132-150.
 10. Sharma OP. Rural Health and Medical Care in India. Manak Publications; c2000. p. 43.
 11. World Bank. World Development Report, Investing in Health: World Development Indicators. Oxford University Press; c1993. p. 17.