MIDDLE CLASS WOMEN'S PERCEPTION OF HEALTH: A STUDY IN VASANT KUNJ LOCALITY OF SOUTH DELHI

Dissertation submitted to the Jawaharlal Nehru University
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MASTER OF PHILOSOPHY

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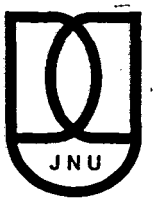

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Certificate

This dissertation entitled **"Middle Class Women's Perception of Health: A Study in Vasant Kunj Locality of South Delhi"**, is submitted in partial fulfillment of the degree of **Master of Philosophy** of this University. This dissertation has not been submitted for any degree of this University or any other University and is my original work.

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Introduction

There has been a lot of literature which documents gender disparities in health. There is indisputable evidence that health indices for Indian women are far worse than those for men, yet women have limited access to health resources. One of the more remarkable demographic features of India is the steady decline of what is called the sex ratio i.e., the ratio of female to male population. This ratio has fallen from 0.972 at the turn of the century to 0.935 in 1981 census (Kynch, J. and Amartya Sen; 1983). They have argued that the real issue here is indeed differential mortality. India is one of the exceptional countries in the world in which the life expectancy at birth is lower for the female than for the male (Ibid.).

Numerous explanations have been suggested for the higher mortality among females and the declining male-female ratio, like preference for male children resulting in the neglect of female babies and higher maternal mortality. According to the Census of 1991, female life expectancy is only 58.1 years. Though, this is an improvement over the 1951 figure of 31.7 years, it is still extremely low (Das Gupta and Chen; 1995). Thus, by and large throughout this century, there has been a declining female sex ratio. It has been established that early childhood and the reproductive years are high risk ones for girls and women and after the peak reproductive years, the female biological advantage shows up again in lower mortality rates for women (Ibid.). In addition, early marriage, malnutrition, high fertility and inadequate access to health care make a woman susceptible to a range of ailments and diseases. Unless an understanding of the material conditions and causes of ill health in general, and gender inequalities of health in particular, are evaluated and understood, most attempts at improving the condition of women will fail.

Attempting to explore these issues, this study chose to examine the health perception of the middle class women, and interpret these in the context of their life conditions. This study has analyzed how health and illness perceptions are socially constructed, i.e. they are intimately linked to social relations and power structures. This

framework resulted in a shift from exclusive dependence on the bio-medical model of health. The concentration on the individual and a focus on component parts of the body, together with the separation of the mind and body has meant that social, cultural, economic, and even environmental factors in the causes of ill health are often neglected (Doyal; 1979, Elling; 1982, Navarro; 1986, cited in Curtis and Taket; 1996). Health-related perceptions deal with layers of thought, conscious and sub-conscious, explicitly articulated or implicit in action. Some may be shared across regions and across sub-groups of a population while others differ. The starting point for developing a framework for studying them is understanding how perceptions are shaped (Priya, Ritu; 2000). They constitute one aspect of 'health culture' of people; health culture being a composite of the available specialized knowledge, technology and delivery system plus lay people's knowledge, the meaning of health and health problems in their lives and their health related practices (Ibid.). However, popular perceptions have been studied largely around specific areas of nutrition, family planning or illness and disease behaviour. In this study, our focus is to understand perceptions related to the everyday phenomena relevant to health.

I have developed the area of research, on particularly middle class women due to dearth of health research on this section of women. Most of the existing literature focuses on the health problems and illness perceptions of people belonging to the lower socio economic strata, slums and other marginalized sections of the society. Women do not constitute a unified and homogenous group. Though they share a gender identity and a common biology, women are located differentially pertaining to the wider socio-economic structures. Health perceptions are known to vary by social context of caste, class and gender. Therefore, to take a fresh look at this subject I have focused on the middle class women's health perceptions. Besides, the relevance of the perceptions of this group for itself, their condition will demonstrate the gender related perceptions of a class, which acts as a pressure group for state policies and action.

Conceptualization of the Problem

Women's lives are deeply embedded in the household and family, thereby in order to understand their health perceptions it is necessary to examine intra-household relationships. It is important to investigate how women perceive their health in relation to other members of the household. So, here we are trying to understand the women's position at the micro-level i.e., their status within the family, which is usually at an individual level. The micro-level is important to focus on women's life experiences, their perceptions of health and well-being and treatment seeking behaviour. It also takes in to account their educational and occupational status, which determines their position within the family, division of labour i.e., the work pressure inside/outside the family and their status vis-à-vis other members of the family. Nevertheless the questions of who controls the resources within the family must be emphasized.

The second line of analysis is at the community level - meso-level. Women's status or social position i.e., the women's status may be inevitably linked to their family's location within the community. This will lead us to understand the family's social standing within the community, i.e. focusing on the members' occupational status, the socio-economic category to which they belong, their educational status etc. – which shows their class position, caste identity, religion, and political power.

However, we are not focusing only on women's position within the middle-class households, which shapes their understanding of health, illness and well being but, necessarily linking it to the broader social structures that influence and have an impinging effect on women's health perceptions. Most importantly women's identity is shaped by their location in society i.e., taking on the larger question of caste, class, gender, religion and also place of their residence (urban/ rural) areas etc. So, the third line of analysis is at the (macro-level), which refers to the society at large and the culture in which people live.

Thus, the research study can be understood along these three dimensions:

a) Micro-Level – Women's position in the family

b) Meso-Level – The family's position within the community inevitably shapes women's status.

c) Macro-Level – Women's position in the society

Women's understanding and their perception of health, illness and well-being has to be linked with their social status and location in the society which also comprises of the community and the family. Their experiences of life and identity within these larger societal processes moulds their understanding of action for their own health. So, in this present study, there has been an attempt to understand women's condition in the household – as family is a microcosm of the exploitative relations that exists in the society. Conceptualizing the linkages between these three levels and then exploring methodological approaches to study them was done through a review of literature. Then a small empirical study was undertaken.

The Empirical Study

Objectives

The major theme which has been explored in this study, is the middle class women's perception of health, illness and well-being, relating it to the closely intertwined social structures of society. The main objectives could be broken into the following sub-objectives:

- To locate the position of women within these three levels (micro, meso and macro) and the women's understanding of their identity
- How they negotiate in their daily lives with other members of the household as mothers/ wives/ daughters-in-law.
- To explore women's understanding of health and well-being and treatment seeking behaviour.
- To explore women's perception of their own health status vis-à-vis other members of the household.

Methodology

a) Selection of Area

An attempt has been made to analyze women's perception of health within their life context through case studies in one middle class unauthorized colony in South Delhi. Vasant Kunj Enclave, an unauthorized colony still in the process of development and construction, was chosen purposively due to its physical proximity to JNU as well as access of the researcher to its middle class residents. Cooperation from middle class respondents was expected to be a problem and therefore this was an important consideration. The Phase-B locality of Vasant Kunj Enclave comprised of thirty-five houses, out of which two were vacant and in three of the houses the women were inaccessible as the men were suspicious and did not permit interviews to be conducted in privacy. So, the study was conducted by interviewing women from thirty households.

b) Tools

An interview schedule was prepared. Interviews were conducted in each respondent's house and followed the format of informal conversation. This interview schedule did not consist of pre-determined questions but was developed in a manner to encourage the respondents to elaborate freely on their life stories and concerns. Interviews were conducted with all the adult women in the thirty households i.e. thirty-five in all. Of these, only the thirty younger women/daughters-in-law were included for in-depth interviews.

c) Data Collection

I was introduced to the residents of this colony by two key respondents. They had been settled in this colony since four to five years. I was introduced as a researcher who was working on middle class women, their life conditions, and how it affected their health. Initially, few of the women were reluctant to share with me their life experience. Few of them also responded that there was no necessity for health research on middle class women as compared to that of women residing in Jhuggis. Women were of the opinion that as they were economically better off, they faced no problems in seeking

health care. The younger women were mostly hard-pressed for time, as they had to carry out the domestic work. Yet, the younger women were more cooperative than the mothers-in-law. Out of five mothers-in-law; two of them were reluctant for their daughters-in-law to be interviewed. They repeatedly kept on saying that their daughters-in-law were busy and could not spare time. They were suspicious about what kind of questions, was I engaging with their daughters-in-law. Therefore rapport building was done to make the atmosphere more conducive. After regular visits to the households, the women became quite free with me. They even disclosed their problems in the family.

The discussions were flexible enough to allow women to speak of their experience of coping with illness, their understanding of health and well-being and the issues that were paramount in their lives. In other words, women were encouraged to 'tell their story'. With each woman, a standard set of topics was raised, in an attempt to elicit the health histories of their families, about themselves and their attitudes and beliefs about health and well-being. Within this framework, they were encouraged to talk what was most salient to them. Questions covered various aspects of women's lives, their beliefs about illness and well being, treatment seeking patterns, position in the household, their identity in relation to the other members of the family, and the daily management of their health and that of the family members. This was done from the perspective that it is a complex set of circumstances that surround and shape the women's experiences and thus their perceptions of illness.

Socio-demographic data was also obtained to help construct a profile of the women. From the initial topics a set of broader analytic themes were devised. Each theme usually incorporated a number of topics that reflected the women's perception of health, illness and well-being. Besides collecting the data on socio demographic profile, we also enquired about the kind of illness and treatment among the middle class women. Here the questions covered were: -

- the common health problems that women suffered
- how they perceived their illness, the causes for the occurrence of a particular illness, details of each illness episode.

- the health condition of the family members (including male members)
- what do they do to alleviate their illness condition for themselves and that of family members
- if they take any preventive measures, or other kinds of treatment sought i.e. home remedies or consulting ayurvedic/ allopathic practitioners.
- whether they prefer private or government health services and
- how do they decide when to seek treatment.

There is also an exploration into women's life conditions which necessarily influences or shapes their perception of health within the family or household. For example topics like

- the division of household duties in the family
- women's access to family resources
- pros and cons of working or not working
- decision making within the household, e.g. when and how many children, which school for children, building a house, where to live, having a say in household expenses, who to marry, freedom of movement etc. were included in the category of women's identity and how they negotiate with issues in their daily life.

While trying to link women's health perception and behavior with their life experiences, they were asked to give details of

- their status/ position in their maternal and marital family, and what were the changes noticed.
- was her life better in the former or the latter?
- if life was better here, what were the reasons for it.

The necessity or the motive in invoking this question is to try to know if she faced any kind of discriminatory practices and unequal treatment as a young child, her experiences then, and later as a wife or a daughter-in-law.

The middle class women were also asked to compare their own and family's health with that of the slum dwellers, and we also tried to elicit their views regarding issues on national development and how they perceived certain changes in society during their stay here.

d) Analysis

The data was analyzed under four broad themes: -

a) Socio-demographic profile

b) Perceptions of illness and treatment

c) Issues concerning women's identity

d) Women's life experiences, overall assessment of their life, perceptions regarding changes in the society.

Therefore this enquiry into the existential experience of illness raises issues that pertain to the management of illness in the everyday life of a woman in the family. We have tried to explore or examine the patterns and processes in women's life. In presenting the case studies we have argued that to analyze women's experiences and perceptions of health, it is important to look at the social circumstances of their lives and the context in which the experiences or perceptions of health are embedded. An analysis is made on the women's subjective experience of health and illness. The main findings refer to the parallel between women's general view of the world and their view of health and illness.

Besides the minor illnesses, which affected women's health condition, we would like to elaborate on certain specific illness-episodes. It is interesting to examine the details of these illness-episodes through which we tried to derive an account of how women cope with the illness in their daily life. When they seek treatment; what kind of

treatment is sought and who decides; and do they receive any support from other members of the family; mother-in-law, husband, children, father-in-law, etc. or their maternal family. In this study we have also tried to draw a comparison in dealing with health problem of the male members in the household with that of the women. In this context, the questions raised were – is there any kind of difference in the illness treatment among men and women; and how did the family members respond to the illness situation. These set of questions or issues were considered necessary to invoke while studying the middle class women's perception of health in order to examine the differential treatment towards women during her illness experience. Women were also asked to assess their own and family's health in comparison to that of slum dwellers. It was important to raise this question as it provided us with a reference point to analyze middle-class women's self-perception in relation to that of the people belonging to the marginalized sections of society.

This study is basically divided into four chapters. Chapter I is the review of literature which comprises the issues in defining class; the concept of middle class, the growth and composition of the Indian middle classes. There has been an attempt to explore the gender and class dimension; women and the household domain. Various studies concerning the health perceptions of women, well-being, autonomy and agency were also conceptualized. In the second chapter, I have discussed the importance of gender dimension; the interface of caste, class and gender inequalities and have linked it with women's health issues. I have also looked into over-medicalization of women's health on one hand and lack of access to much needed health-care services on the other. Added to this I have discussed the theoretical approaches which provide us the lens through which we can understand how various factors play an important role in shaping women's perception of health, illness and well-being.

The third chapter presents findings of the empirical study. I have described the profile of the locality where the study has been undertaken, with a brief explanation of unauthorized colonies. This situates the colony and its residents within the larger power structure of the city. A profile of the resident households, their income and family structure as well as a socio-demographic profile of the women respondents comes next.

Against this background, I have attempted to analyze women's perceptions of health within their life context. Finally, in the discussion, I conclude by raising issues that come to the fore from this exercise and by trying to draw the threads together from all the previous chapters.

e) Limitations of the empirical study

This is a very limited sample. The fieldwork was conducted over a period of three months and more time was needed to go into each case study at greater depth.

I Linking Gender, Class and Perceptions

Existing social realities

There is an attempt here to find an adequate framework for the inter-linkages between gender and health. The asymmetrical power relations that operates in many societies and which leads to the inferior position of women inside and outside the household points to the necessity of treating gender as an important parameter. In fact, it is complementary to, rather than competitive with the variables of class, ownership, occupation, income and family status (Sen, A. K.; in Irene Tinker ed.; 1991). The gender question has assumed a rather complex shape within such a context, intersecting with class, caste, regional and religious considerations. Attempts at framing the women's question cannot be examined, as Sangari and Vaid (1989: 2) have argued, independently of 'questions about the politics of social change; questions which have redefined the relations between patriarchy, cultural practices, social values and political economy (Sangari, K. and Vaid, S.; 1989). Nevertheless, a common belief that the women's space is private and, indeed, of the sanctity of this sphere has become entrenched. It is important to note here that Frederich Engels viewed women's subordination and oppression as deriving primarily from their exclusion from economically productive labour outside the home (Engels, F.; 1972). The ideology of gender – especially the assumption that women are (or should be) primarily housewives and mothers and secondarily workers – in fact permeates most policies of the modern state. This affects women's material situation in distinct ways – in justifying a discriminatory wage structure and a double burden of work that makes child rearing and economic careers incompatible.

Whether in socio-economic indicators such as education, health and work, or in mere subtle processes of power, decision-making and self-esteem, the inferior position of Indian women has been consistently documented. Indeed ideology plays a crucial role in the social construction of gender and in the process of women's subordination. The family, the community, the media, the educational, legal, cultural and religious

institutions, all variously reflect, reinforce, shape and create prevailing ideological norms – norms which may well conflict with and contradict one another, and usually vary in their specification and enforcement across classes and regions (Agarwal, B.; 1998). What is striking, though, is that the content of this ideological thrust reflects on singular preoccupation with particularly two aspects – the domestication of women and control over female sexuality. So, there is a growing recognition of women's oppression that has moved beyond, caste, class, ethnicity, race etc., i.e. reflected in their demands for control over sexual and reproductive choices, their access to assets, income and productive resources (eg. land), greater participation in decision-making and resisting violence within the domestic sphere. Therefore, the adverse health conditions are one of the manifestations of the low value placed on women and their powerlessness in patriarchal societies.

Women's health needs differ from those of men because of their biological differences, and also as a result of gender differentials in exposure to risk factors. However, women are affected disproportionately more than, and in different ways from, men. This is because women in every social stratum face the added disadvantage of gender discrimination, which results in a denial of equal opportunities and equal access to resources. Some manifestations of gender discrimination in our society is restricting the girl child's education, the pressure on them to get married at an early age, restrictions on women's mobility which constrain their income earning opportunities, and laws which deny women the same rights as men (Women of South-East Asia; 2000).

Therefore, these unequal opportunities, social norms and customs deny women autonomy and the right to take decisions concerning their lives. Four sets of factors have been identified as influencing women's access to health care: 'need', or the extent of ill-health among women; 'permission', which is the result of social factors determining whether women can seek health care outside the home; the 'ability', which is determined by economic factors enabling women to meet the costs of health care; and the 'availability' of health services for women (Ibid.). Even when women are able to recognize that they are suffering from a health problem, they do not seek health care services. Their workload may not allow women to seek medical assistance unless such

help is close at hand. It is also a factor that they may seek permission of their husband or senior members of the household before seeking services. Restriction in physical mobility is another factor that affects women's access to health services.

Thus, in order to attain a state of 'physical, mental and social well-being', all human beings need access to a range of basic resources. These not only consists of basic survival needs, but as well as capabilities such as literacy and access to information and also the power to make decisions concerning their lives (Ibid.). In fact, the combination of both poverty and gender discrimination increase women's risk of illness and limits their ability to take proper care of themselves when ill. However, the individual's access to service is basically determined by factors such as availability, accessibility and affordability, and also the appropriateness of services as perceived by users. While these factors affect both men and women, there are important differences by gender that cuts across the social groups. Nevertheless, gender is only one dimension of the many pervasive social inequalities in our society which threaten people's health and well-being. Other important inequalities include the gap between the rich and the poor, low and high caste, and the rural-urban divide.

Women in India are divided by class and caste and yet their different experiences are held together by the hierarchic norms defining and regulating their respective positions. There exists wide difference between the social classes in women's educational level, work quality and quantity, and work related life conditions (health, fertility, total availability of family care from household, community, and public sources). For instance, educated middle-class women tend to have higher marriage age and fewer pregnancies, and a substantial proportion of them now, at least notionally, have access to well-paid jobs with leave and other benefits. On the other hand, landless labourer women with very little of either food intake or rest, have to work at extremely low paid and strenuous jobs that offer neither leave as a matter of right nor regularity of earning (Bardhan, K.; 1993). Their low fertility rate, compared to land holding farmers, is at least partly due to poor nutrition and health. The number of live children per agricultural labour household is even smaller because of the higher infant mortality in their case, due to extreme poverty, material overwork and the disintegration of the extended family network under pressures

of landlessness, wage-labour, and migration (Krishnaji; 1989, cited in ibid.). In this and migration sub-proletarian labouring classes, children's health and quality of childhood suffer, along with young women's health and quality of life, because of their poverty of work options and lack of access to marketable skills and means for self-employment.

In this context it is important to point out that in both rural and urban India, regular salaried employees constitute a much smaller proportion of the female than the male workforce. Casual labourers at the lowest wages with little job security constitute a much larger proportion of the female workforce. Wages, especially, for women, provide barely enough for minimal nourishment, with nothing left over to save. The country's definition of the "poverty line" points out clearly to this economic reality for the labouring poor. A family is considered below the poverty line if by spending over 80 per cent of the total family income on the most inexpensive of foods (and cooking fuel) they are still unable to meet their minimum caloric requirements. Yet, it is precisely those who subsist on such an unbalanced diet who at the same time perform most of the strenuous physical labour in society (Zurbrigg, S.; 1991). Within the labouring families women also continue to bear a double, even triple, burden – of childbearing, child-care and household labour, in addition to labour outside the home. Such additional physical burdens play a major role in continuing ill health and higher mortality in women and children. Zurbrigg argues that the culturally determined lower status and oppression of women compounds their burden of ill health and therefore is an issue which demands to be specifically and clearly addressed in any social change effort (Ibid.).

Therefore, such studies tell us about the linkages between ill health and social structure. Not surprisingly the burden of ill health falls most heavily on a special group of people in society – on the poor. But, this does not imply that there are no health problems among the middle classes in urban areas. Though, within the middle class there are fewer resource constraints, it would be interesting to analyze their life conditions linking it with their access to health care, education and work pattern etc. So, this chapter makes an attempt to look into the concept of middle class and women's perception of health and well-being.

Against this background, I will be discussing the issues defining class, the composition of the middle classes, mapping its historical trajectory and its ideological hue. Further, I would be analyzing the gender inequalities within the "class" dimension; certain theoretical underpinnings underlying these inequalities, and women's position within the household/ family because, invariably, women's subordinate position is reflected in their poor health status. Finally, I will be exploring perceptions of health and well-being as perceived by women themselves, and analyzing it within the framework of 'autonomy' and 'agency'.

Issues in defining class

'Class' refers to a system of stratification that is economic in character. We are all familiar with terms like upper class, middle class and lower class. Sometimes these terms can be increased depending upon how fine one would like the categories to be. Therefore, it is often the case that one separates the upper middle class from the middle class or the lower middle class, and so on. We can have a class category depending upon the criterion of land, or one depending on the variable of money, as one on marketable yield, or one on disposable income. The important thing is that all of these criteria are convertible directly into money and that is why in class stratifications money or wealth is always central (Gupta, D.; 1991).

We can define a class as a large-scale grouping of people who share common economic resources, which strongly influence the types of lifestyle they are able to lead. Ownership of wealth, together with occupation, are the chief bases of class differences. It is important to note that class systems are typically more fluid than the other types of stratification and the boundaries between classes are never clear-cut (Giddens, A.; 1989). It has been contended that an individual's class is at least in some part 'achieved', not simply 'given' at birth as is common in other types of stratification system; that social mobility i.e. movement upwards and downwards in the class structure – is much more common. This is, however, a debated issue.

The most influential theoretical approaches are those developed by Karl Marx and Max Weber. We shall also analyze two later theories, those put forward by the Erik Olin Wright and Frank Parkin.

Marx's Theory of Class

Most of Marx's works were concerned with stratification and, above all, with social class, yet surprisingly he failed to provide a systematic analysis of the concept of class. Despite its centrality to his theoretical framework, class is one concept that Marx himself did not develop adequately. Thus, what we inherit from the Marxist corpus is an almost entirely 'historical' rather than a 'theoretical' discussion of class (Deshpande, S.; 2003). For Marx a class is a group of people who stand in a common relationship to the 'means of production' – the means by which they gain a livelihood (Giddens, A.; 1989). Before the rise of modern industry, the means of production consisted primarily of land and the instruments used to tend crops or pastoral animals. In pre-industrial societies, therefore, the two main classes were those who owned the land (aristocrats, gentry or slave-holders) and those actively engaged in producing from it (serfs, slaves and face peasantry). In modern industrial societies, factories, offices, machinery and the wealth or capital needed to buy them became more important. The two main classes are those who own these new means of production – 'industrialists' or 'capitalists' (bourgeois) – and those who earn their living by selling their labour to them – the working class or the 'proletariat' (Ibid.).

Thus, Marx's concept of class directs us towards objectively structured economic inequalities in society. Class does not refer to the beliefs people hold about their position, but to objective conditions which allow some to have greater access to material rewards than others.

Theoretically, the concept of class is located at the confluence of economy, society and polity. Thus, 'class' in Marxism is the theoretical principle by which society may be divided into distinct groups that: (a) are identified by their economic role or position, which; (b) shapes the social world they inhabit and the culture they fashion, which, in turn; (c) moulds their political consciousness and inspires their actions. It is in this sense that the three spheres (economy, society and polity) are seen as interpenetrating

and even integrated with one another. Therefore, the concept of class is the centerpiece of the core causal sequence proposed by Marxist theory wherein what you 'are' (at the economic level) shapes what you 'experience' (at the social level) which ultimately determines what you 'do' (at the political level) (Deshpande, S.; 2003).

In the Marxian notion of 'class', these three points are emphasized: - (1) 'Class' implies a group of people occupying a definite place in the system of production. For instance, workers do not own means of production and consequently, they work at the behest of those who own the means of production (2) Marx emphasizes that these groups have to compete for political power in defence of their economic interests. Since, each class is trying to assume power, a clash of interest is inevitable (3) There exists class-consciousness among these groups.

According to Marx, a class comes to be constituted, out of subjective awareness of objective conditions. This subjective element or class-consciousness implies the existence of hostility from one social group against other. So, Marx emphasized, that there are no classes without 'class-struggle'. Marx uses the notion of class in a collective sense, i.e. referring to the whole group.

It is significant to note that one of the problems of Marx's theory is, that, he is not able to see that there can be stratification among classes i.e. fractions of caste. There are different ways in which society can grade itself. But, Marx sees classes in a collective sense, i.e. in a homogenous form and no internal lines of divisions. Marx conceived of an essentially bipolar world with only two opposed classes, capitalists and workers. The intermediary classes were subsumed under these two core classes. Therefore, the most serious of these limitations is the inability to accommodate classes and groupings other than the two core classes of capital and labour. To the degree that such classes are socially and politically important, we need to go beyond the inherited Marxist corpus for meaningful class analysis (Deshpande, S.; 2003).

Weber's Analysis of 'Class'

Weber's approach to stratification is built on the analysis developed by Marx, but he modifies and elaborates it. Although Weber accepts Marx's view that class is founded

on objectively given economic conditions, he sees a greater variety of economic factors as important in class formation than are recognized by Marx. According to Weber, class divisions derive not only from control or lack of control of means of production, but from economic differences, which have nothing directly to do with property. Such resources include especially the skills and credentials or qualifications, which affect the types of job people are able to obtain (Giddens, A.; 1989). For instance, those in managerial or professional occupations earn more, and have more favourable conditions of work than people in blue-collar jobs. The qualifications they possess, such as degrees, diplomas and the skills they have acquired, make them more 'marketable' than others without such qualifications (Ibid.). Beyond this Weber also distinguishes two other basic aspects of stratification, i.e. 'status' and 'party'. According to Weber, class was determined by reward in the market place, status centered around the concept of social prestige; and the 'crucial' variable behind the party was power.

Erik Olin Wright has developed a theoretical position, which owes much to Marx, but also incorporates ideas from Weber (Wright; 1978, 1985, cited in Giddens; 1989). According to Wright, there are three dimensions of control over economic resources in modern capitalist production, and these allow us to identify the major classes which exists i.e., control over investments or money capital, control over the physical means of production (land or factories) and control over labour power. Those who belong to the capitalist class have control over each of these dimensions within the production system. Members of the working class have control of none of them. In between these two main classes, however, there are groups whose position is more ambiguous.

These people are in what Wright calls contradictory class locations, because they are able to influence some aspects of production, but are denied control over others. White collar and professional employees, for example, have to contract their labour power to employers in order to obtain a living, in the same way as manual workers do. Yet at the same time they have a greater degree of control over the work setting than most people in blue-collar jobs. Wright terms the class position of such workers 'contradictory', because they are neither capitalist nor manual workers, yet share certain common features with each (Ibid.).

Parkin developed an approach drawing more heavily on Weber than on Marx (Parkin; 1971, 1979, cited in Gidden; 1989). Parkin agrees with Marx, as Weber did, that ownership of property – the means of production – is the basic foundation of class structure. Property, however, according to Parkin is only one form of 'social closure', which can be monopolized by a minority and used as a basis of power over others. We can define social closure as any process whereby groups try to maintain exclusive control over resources, limiting access to them. Besides property or wealth, most of the characteristics Weber associated with status differences, such as ethnic origin, language or religion, may be used to create social closure.

Two types of process are involved in social closure. 'Exclusion' refers to strategies that groups adopt to separate outsiders from themselves, preventing them from having access to valued resources. For example, white unions in the USA have in the past excluded blacks from membership, as a means of maintaining their own privileges. 'Usurpation' refers to the attempts of the less privileged to acquire resources previously monopolized by others – for example, blacks struggle to achieve rights of union membership (see Giddens; 1989). Both strategies may be used simultaneously in some circumstances. For instance, trade unions may engage in usurpatory activities against employers, but at the same time may exclude ethnic minorities from membership. Parkin calls this 'dual closure'.

In this context it is significant to point out that the diverse character of the middle class as a whole is captured to some degree by concepts such as those offered by Wright and Parkin. Middle-class people find themselves in 'contradictory' situations, in the sense that they are caught between conflicting pressures and influences. It is important to note that those in the middle of the stratification system to some extent cast their eyes towards the top, yet are also concerned to distinguish themselves from others lower down. Many lower middle class people, for example, identify with the same values as those in more remunerative positions, but many find themselves living on incomes below those of the better-paid manual workers (Ibid.).

Concept of Middle Class

It is important to take into account that the founders of Marxism had little regard for the middle classes, or the 'petit bourgeoisie' in their terminology. The 'intermediate' or middle classes have arguably been the most important non-polar classes. Unlike the bourgeoisie and, of course, the proletariats, which were consider to be great classes with a historic mission, the intermediate classes were seen as impediments to the progressive march of history. The middle class has been a traditional blind-spot for both Marxist – left wing and liberal – mainstream social theory. The former has treated it as an acute theoretical 'embarrassment' (Wright; 1985: 13, cited in Deshpande, S.; 2003) or a 'swamp' of ambiguity (Lefebvre; 1976: 25, cited in Deshpande, S.; 2003), while the latter has tended to 'naturalize' it by uncritically adopting its world-view (Deshpande, S.; 2003).

How do we define the middle class depends on what we wish to do with the concept. It can be analyzed in the light of the Marxist definition of class – i.e. at the economic level with implication for the social and the political. The economic definition aims to identify groups with shared economic characteristics, such as levels or sources of income, ownership of particular kinds of wealth or property, place in the economic structure and so on. The social definition attempts to demarcate groups that share the same lifestyles, patterns of consumption, or social attitudes. The political definition tries to differentiate groups according to the political agendas or parties they support, or the leaders they identify with. Underlying such theoretical definitions, according to Deshpande (2003), is a larger analytical strategy or logic, some set of reasons why being able to identify groups of a given type would help us understand society better.

He has further argued that though the middle class is a notoriously loose term, it is striking that hardly anyone wishes to decline membership and even those who are ineligible wish to be included in it (Ibid.). So, it can be argued that majority of the people in a society aspire to belong to this social location.

It is important to note that there is little literature available on the middle class segment. For the analysis of the 'middle class', I have basically drawn upon B. B. Misra's classic survey (Misra; 1961), P. Varma's (1998) study on the evolution of the

Indian middle-class and S. Deshpande's (2003) work on middle class. Here he attempts to provide both a theoretical definition of the middle class and also tries to operationalize the concept of middle-class i.e. through available empirical indicators.

In common parlance – the middle class is projected as an 'average' class that best represents the whole of society. It is often referred as "the class that is everywhere represented as representing everyone" (Ehrenreich; 1989: 3, cited in Deshpande; 2003). Deshpande (2003) argues that the reasons why 'everyone' would like to belong to the middle class have to do with the various kinds of desirability that are attached to its middleness. The middle class is thought of (and more importantly, thinks of itself) as the stable center of society and polity, i.e. it occupies the position of a 'centrist' group avoiding extremes; there is a general sense of representing the majority; and also a full-blown assertion of moral legitimacy as the group most qualified to act or speak on behalf of society. This claim that the middle classes represent the major section of society, has been a more or less legitimate one in most Western countries. But, matters are starkly different in poor countries like India, and therefore it is necessary to enter into questions of definition in order to understand these differences (Ibid.).

However, there arise complications when this theoretical definition of middle class is operationalized (i.e. translating our definitions into concrete, observable criteria). Deshpande has further argued that the simplest of theoretical definitions runs into complications at the empirical level. Take, for instance, the most straightforward economic definition of class based on levels of income and wealth. If there were a list of all citizens that also told us about their income levels, we could 'classify' each person, determine the size of each class at the national or regional level, and so on. But, of course, no such list exists. So, he suggests the use of consumption expenditure data collected by the National Sample Survey Organization (NSSO). If we do so, it has to be clarified that we are moving away from the theoretical basis of our definition i.e. income and this involves certain compromises. For example, relying on consumption expenditure data tends to seriously underestimate the income of the rich and to (relatively) overstate that of the poor because a smaller proportion of income is spent on consumption as we go up the income scale (The rich get rich by accumulating income and wealth faster than

they can spend it, whereas the poor may often be spending their income faster than they can earn it, i.e., they may be living on credit) (Ibid.: 133).

Therefore, the middle classes have been defined as a "consumer class". The simplest definitions of the middle class have been those that have conceived of it in purely economic terms as a specific segment of consumers. During 1990s, after the onset of liberalization and free market economy in India it was estimated that the size of this middle class ("consuming class") to be around 300 million, or 30 per cent of the Indian population. But, later it was clear that these were overblown estimates. Therefore, according to Deshpande (2003), we still have to determine where to draw the lines that distinguish the middle-class from other classes. It seems obvious that the middle class should exclude the rich and the poor, but it is not clear whether the middle-class should include everyone who is non-rich and non-poor. At this point, it becomes impossible to avoid discussing absolute levels of income. Here, Table 1.1 - (based on data from the NSSO's 55th Round Survey) provides a summary statement of the distribution of the monthly per capita consumption expenditure in India during 1999-2000.

Table 1.1: Estimated class composition of the Indian population

Based on Monthly Per Capita Consumption Expenditure Data, NSSO, 1999-2000

Description of Class	Rural India		Urban India	
	Monthly Per Capita Expenditure Class	Per cent of Population	Percent of population	Monthly Per Capita Expenditure Class
Below Poverty Line Population	Rs 329 or less	34.4	29.6	Rs 458 or less
Above Poverty Line	Rs 329 to Rs 470	33.8	36.9	Rs 458 to Rs 775
Less Poor Next 4 Classes	Rs 470 to Rs 775	24.7	25.9	Rs 775 to Rs 1,500
Non Poor Top 2 Classes	Rs 775 or More	7.0	7.6	Rs 1,500 or More
	All Classes	**100**	**100**	**All Classes**

Note: Rs 329 and Rs 458 were the official (Planning Commission) estimates of the Poverty Line for Rural and Urban India, respectively, in 1999-2000. (Source: NSSO 55th Round)

Source: Deshpande, S. (2003): "The Centrality of the Middle Class", *Contemporary India: A Sociological View*, Penguin Books India Pvt. Ltd., New Delhi.

However, it is clear that the "Below the Poverty Line" category is not in contention for inclusion in the middle class because this category will not be participating in formal markets in any significant way. Deshpande (2003) further argues that all the consumption of people in this category will be routed through informal markets tied to employers and/or creditors of various types. But here, everyone from the "Above the Poverty Line" category upwards is presumably participating in formal markets to a significant degree: the important question is who do we include and who do we exclude from the middle-class?

The solution (adopted by most market surveys) is to divide the spectrum of consumers into different levels or segments such as 'A', 'B', 'C'; or 'upper' – 'middle' – and 'lower-middle class', and so on. It makes sense to continue to refer these segments as belonging to a larger class called 'the middle class' only if they have more in common with each other than they have with groups outside the middle class. For example, a group that is actually part of the upper class (in terms of lifestyle, income level, attitudes, etc.) may prefer to conceal or play down this fact by insisting on calling itself the "upper-middle-class". On the other hand, a group that is actually part of the lower class may wish to pass itself off as "lower-middle-class", and so on.

For example, if we claim that the urban middle class includes the top 33 per cent, of the population of urban India. So, translating this claim into the figures available in Table 1 includes the top 2 categories in urban India (which together account for a little over 33 per cent of the urban population). Thus, Deshpande's definition of the present Indian urban middle class includes everyone with a monthly per capita consumption expenditure of Rs. 775 or more, or family of five spending Rs. 3,785 per month or more (Ibid.). Taking this definition, it needs to be reiterated that society is divided into classes of people grouped together with motives of common economic interest, common ways of behaviour, and common traits of character. Each such class forms a hierarchy of status according to the varying quality of social prestige and power expressed through the standard of living, nature of occupation and wealth.

Growth of the middle class in India

It is important to note that the Britishers transplanted into India their own form and principles of government and economic organization which they modified only to suit local conditions. They also attempted as part of their educational policy to create a class comparable to their own, so that it might assist them in the administration of the country and help in the development of its internal resources, necessary for the payment of the increasing imports of British manufacturers. In Macaulay's words, this was to be 'a class, Indian in blood and color, but English in tastes, in opinions, in morals and intellect (Misra, B. B.; 1961). Here, Macaulay did not use "class" as an economic category, but essentially referred to certain educational qualifications or skills, that was acquired by the Indians to assist the Britishers in their administrative endeavour. These ideas and institutions of a middle-class social order were imported into India. They did not grow from within. The Indian middle class, which the British aimed at creating, was to be a class of imitators, not the originators, of new values and methods. Therefore, the educated class of Indians who emerged as a result of British educational policy cared more for position and influence in the civil service and council than for mass education or economic development (Ibid.).

Composition of the Indian middle classes

The progress of education and the advancement of technology were tending towards the goal of a middle-class society. From the circumstances of their growth the members of the educated professions, such as government servants and lawyers, college teachers and doctors, constituted the bulk of the Indian middle classes. They form the rising classes, i.e. the advanced section of a middle-class bourgeois society. However, according to B. B. Mishra, the other social groups who belonged to the middle-class were "merchants, agents, and proprietors; salaried executives, such as managers, inspectors, supervisors; civil servants and other public servants, judges of high courts; students engaged in higher education at a university; well-to-do shopkeepers and hotel keepers" (Misra; 1961).

In the Indian context the middle-class society was formed due to the rise of commercial and industrial groups in Indian society. In the year 1991, when India moved towards the process of liberalization, opening up its market economy and inviting foreign investment, the Indian middle class came into new prominence. There was much debate about its actual size, its consumption patterns, and the pace of its growth in the years to come. The purpose here is to try and understand this class; not only to map what it buys/ consumes or would like to own, but to study how it has grown and evolved over the years. The work thus, analyses the growth of the middle class during the pre-independence years; post-independent era.

The creation of a native elite was the most spectacular and enduring achievement of British colonialism in India. The social segment from which these new beneficiaries came represented largely continuity: middle class Indians from an educated background, whose families had traditionally found employment in the government departments of revenue, police or justice. The baboos comprised of a very small number when compared to the large mass of illiterate people. The important point to note is that the members of the nascent Indian middle class of the 19th century didn't feel a sense of humiliation in collaborating with the agencies of British rule. It would be appropriate to say that they had acquired a stake in the perpetuation of British rule (Varma, P. K.; 1998). "It has been argued that the behaviour of such people is both imitative of and hostile to the colonial model before it. It is imitative, because it accepts the superiority of the civilizational values of the alien culture. But is also hostile because it incorporates rejection of the alien intruder and dominator who is nevertheless to be imitated and surpassed by his own standards, and rejection of ancestral ways which are seen as obstacles to progress and simultaneously also cherished as marks of identity (Ibid.).

The formation of Indian National Congress (1885) took place in this context. It did create for the first time an all India platform to give voice to the opinions of Indians, but it was essentially an upper and middle-class affair that didn't seek to challenge British rule. To quote Nehru in his autobiography: "My politics had been those of my class, the bourgeois. Indeed all vocal politics were those of the middle classes, Moderate and Extremist alike represented them and in different ways, sought their betterment" (Ibid.).

Gandhi brought about the participation of the masses in the freedom struggle; but he didn't seek to dislodge the middle and upper class leadership of the Congress. His way was to try and transform, through the force of his personal example and the corresponding moral pressure, the relations within the existing social structure; but not to change the structure itself. We see, therefore, that in spite of the politics of Gandhi and the intentions of Nehru, the middle class, and some elements of the upper classes remained at the helm of the freedom movement. The achievement of freedom and the end of British rule was a victory important in itself. But, above all it was the middle class, which enjoyed the crucial advantage of affiliation with a "world consciousness" thus having access to vastly superior ideological resources for running the machineries of a 'modern' state (Varma, P. K.; 1998).

After independence the nature of the entrenchment of the middle and upper classes under British rule ensured that the institutions built up during the colonial era remained largely intact. It had its unifying features, both in ideology and aspirations, but within this broadly defining framework it had its segmentations in terms of income, occupations and education. 'Education' was a common thread that bound together this pan-Indian elite. Income was also another distinguishing factor. Given the price levels and the perception of needs in those days, anything in a broad income band from Rs. 1200 - to Rs. 12,000 per annum was sufficient to entitle one to membership of the class. In the early years after the freedom movement the vision of the middle class was overwhelmingly urban (Ibid.). In keeping with the Nehruvian concept of progress, its goal was to achieve industrial and technological modernity. The influential members in the middle class had a lesser interest in the rural sector, and their priorities played a crucial role in the moulding and direction of state economic policy.

There were other areas – the health sector, for instance, in which the interests of the dominant coalition, of which the urban middle class constituted an important part, hijacked the policies of the state, to the enduring detriment of those for whom the policies were formulated. But during Independence, it was both Gandhi-Nehru legacy which helped to shape their ideological framework. Material pursuits were thus subsumed in a larger framework that never gave them the importance that they have acquired today. In

fact, social sensitivity towards the less fortunate was a natural extension of an attitude that saw purpose and meaning in life beyond mere individual gratification. After Nehru's death, (in 1962) there were certain noticeable changes occurring within Indian society. The first trend of importance was the visible retreat of ideology from public life and there was a quest for power among these classes (Ibid.).

According to Varma (1998) another factor to influence middle class attitude and behaviour was the legitimization of corruption as an accepted and even inevitable part of society. Throughout the 70s, the middle class had continued to consolidate its economic position. After the economic liberalization, there has been a resounding impact within the Indian society. The average middle class family today has, for instance, many more consumer durables than that of a generation ago. There is an endless rat race of wanting for more. Thus, in order to enhance family income, more and more men now seek out working brides; 'and yet, after marriage, miss their non-working mothers' single-minded dedication to the family. The contradiction is found with women too: much as they desire economic independence, they long for the securities their mothers enjoyed within the confines of the home. The institution which is under pressure is the home. The demise of the joint family has been replaced by the nuclear family, where traditional family values of support and a sense of belonging and togetherness has given way to individual pursuits and ambitions. Economic independence and education have made women more assertive, mostly for the right reasons'.

The economic reforms unleashed in 1991, this liberalization package, tailored to make India a player in the 'globalized' economy, suddenly put the spotlight on the middle class for an entirely new reason: its ability to consume. It altered the lives of a large section of India's burgeoning middle class. They have become far more international in their outlook and aspirations and more sophisticated and liberal in lifestyle and attitudes. The important point to note is that 'the current wave of liberalization has deepened the tendency which the wealthy Indian already had, to ignore the sufferings of the poor. So the truth is that the social insensitivity of the educated and privileged Indian is shown on the face of India, whether the ruling power is socialism or capitalism.

With increased economic opportunities and mobility the traditional support structures such as the joint family began to disintegrate. This consequently might have liberated the middle classes from the hold of tradition, and the compulsions of conventional religious practice. To some extent this did happen: the frequency of and familiarity with religious ritual was reduced, but, paradoxically, the need for the assertion of a religious identity increased (Varma, P.; 1998). In this context it is important to point out that for many middle-class families the degree and pace of change was tremendous. Thus, religion, by working the certitudes and simplicities of an idealized past, provided the most accessible crutch to stand up to the unpredictability of this rapid and demanding transformation. There was the tendency among these newly mobilized groups joining the middle class to assert their identity by appropriating the idiom they could best identify with. In this process, religious ideologies often have proved more accessible, meaningful and effective in the defence of interests than more abstract and less familiar secular ideologies of class, nationalism, or citizenship (Llyod and Susan Rudolph; 1987: 9, cited in ibid.; 140).

This appeal of religion created a psychological predisposition to support or condone the growth of organizations, which sought to reap political dividends on the basis of religion. It is necessarily this assertion of a Hindu identity, and a heightened sensitivity to any perceived threat to this identity, which created an enabling milieu for the Kar Sevaks to press militantly towards Ayodhya. The bulk of the middle class was not in favour of such an extreme act and though they disapproved of the final act of violence, large numbers in it were guilty of having supported the growth of communal sentiments that led to the demolition (Ibid.: 141).

According to the author, the "key issue that will determine the emergence of India in the 21st century as a united, democratic, stable and prosperous country – in conformity with the 'great power' vision of its middle and elite classes – will be the ability of middle class Indians to forge a national consensus, a strategy of progress and development that involves all Indians".

Gender and Class

It is very important to note that the class location, patriarchy, and the caste/ethnic hierarchy, religion etc. are interactive elements, which define and differentiate the condition of women. These hierarchies in society channel women into different sets of work options and constraints. Sexual and other social hierarchies have remained aligned with inequalities of material assets; of education, health, and of organizational assets – inequalities that structure most resource allocation, including that by the state (Bardhan, K.; 1993). Various studies have viewed that patriarchal institutions in the domestic arena are at the root of most forms of oppression of women, irrespective of their class location. Nevertheless, women's experience of oppression cannot only be confined to the private/domestic sphere of intra-family allocation; but it spans across all social relations as well.

Therefore, it will be incorrect to say that the only oppressive institution is the family, an undifferentiated, common denominator of women's oppression throughout the society (Ibid.). The inevitable fact is that women in India do not constitute a monolithic category, and so their experiences of exploitation or oppression cannot be generalized or assumed to be universal (Mohanty, C. T.; 1988). Thus, it should be emphasized that in the middle and upper socio-economic strata, women's oppression is largely generated within the family whereas, in the lower strata, women's oppression comes mainly from the operating socio-economic power hierarchy. So, women in general may be suffering more oppression than men, but it differs in nature and extent by their class location, and it is exercised by men as well as by women within and above their class (Bardhan, K.; 1993).

The conventional view of stratification theory argues, that women are marginal to the occupational structure and as their paid employment is conditioned by their familial responsibilities, their social class position is determined by the occupation of 'the bread-winner', the male head of the household (Abott, P. and Sapsford, R.; 1987). In other words, it implies that the social class inheres not in individuals but in households. This view also asserts that the women's class position is determined by the occupation of

someone with whom they live. So, it can be said that women's experiences and position within the family are derived through the status of the persons with whom they are living.

Goldthorpe (1983) has defended what he calls the 'conventional position' in class analysis. He argues that women can be ignored for the purpose of class analysis because their position is determined by that of the man with whom they live, either husband or father. He argues further that the position of the family is determined by that of the male breadwinner. He suggests that women do not bring resources of any significance to the family so do not need to be taken into account in determining the position of the family unit (Walby; 1990).

This position has many serious flaws. First, in substantial proportion of households the income of women is essential to maintaining the family's economic position and mode of life. In these circumstances women's paid employment in some part determines the class position of the households. Although women rarely earn more than their husbands, the working situation of a wife may still be the 'lead' factor in influencing the class of her husband. This could be a case, for instance, if the husband is an unskilled or semi-skilled worker and the wife, say, the manageress of a shop. The wife's occupation may set the standard of the position of the family as a whole (Giddens, A.; 1989). Allen (1982) points out that the wife doesn't acquire her husband's educational qualification on marriage, nor does she automatically acquire a socially or politically powerful background as a permanent right. A further problem in conventional class analysis is that it fails to deal adequately with the inequality and the social division of labour within the household itself (Cromptor, R. and Mann, M.; 1986).

It has been argued that a theory, which is not able to cope with the articulation of the major sources of social inequality cannot adequately explain inequalities based on only one source, because all sources combine to define social position. Feminists have thus asserted that an adequate theoretical position should be developed that would be able to deal with 'all' major sources of inequality – caste, class, gender etc. (Abott, P. and Sapsford, R.; 1987). The 'radical feminist' position has been developed by Delphy who asserts that women's oppression cannot be seen as secondary to, and therefore less

important than class oppression, and that women form who are exploited by men. According to 'Delphy',

> "While the wage-labourer sells his labour-power, the married woman gives hers away: exclusivity and non-payment are intimately connected. To supply unpaid labour within the framework of a universal and personal relationship (marriage) constructs primarily a relationship of slavery" (Ibid.).

Thus, according to her, patriarchal structures are fundamental to this form of social organization, it follows that the main axis of differentiation in our society must be gender. Walby (1990) is another who argues that housewives and husbands form two separate classes. "Within the patriarchal mode of production the producing class is composed of housewives or domestic labourers, while the non-producing and exploiting class is composed of husbands. The exploitation, or expropriation, which is taking place, is the expropriation of the surplus labour of the domestic labourer by the husband. A crucial aspect of the work of the domestic labourer, is the labour she performs on the exhausted husband in order to replenish or produce his labour power. Domestic work is productive: the housewife produces the labour power of her husband, herself, and her children" (Walby; 1990). Thus, the radical feminists generally go beyond immediate personal circumstances to the structural position of the gender as a whole and argue that all women, not just married women are oppressed by men and that patriarchal relations are dominant (Millet; 1971, cited in Abott and Sapsford).

However, Marxists argue that the radical feminist position fails to take into account the specific nature of class inequalities in capitalist society. The main development within mainstream Marxist theory to take account of gender relates very much to women's position within the bourgeois nuclear family (Crompton and Mann; 1986). It is based on Engel's argument that women's oppression can be seen to begin with the emergence of private property and hence with capitalist class relations, so that the struggle for a classless society logically subsumes the struggle for women's emancipation. Engels also in his book 'Origin of Private Property...' has emphasized that monogamous marriage largely in relation to bourgeois family led to the transformation of

the nuclear family into the basic economic-unit of society, within which women and children became dependent on the men. This transformation has led to the oppression of women, that has persisted till the present day and as a consequence the descent changed from 'mother right' to 'father right' (Engels; 1972). The core of Engels 'formulation' lies in the intimate connection between the emergence of the family as an economic unit dominated by the male and this development of classes. Therefore, the formation of the family as the economic-unit society was affirmed by the overthrow of mother right, the "world historical defeat of the female sex" (Ibid.: 120). He focuses on the emergence of the upper-class family as an instrument for the concentration of individual wealth. Therefore, the separation of public and private-spheres with the development of industrial capitalism meant that women came increasingly to be economically dependent on men. So, they were excluded from the labour market and thereby failed to have a class position of their own (Ibid.). Thus, the main thrust of the Marxist argument, is that the subordinate position of women can be explained by the means and relationships of production under capitalism.

However, Marxist feminists have challenged this conventional Marxist view arguing that we need to incorporate explanations of women's ongoing location in the family as the performer of domestic duties, that the theory must adequately explain the relationship between patriarchy and capitalism. 'Socialist feminists' such as Heidi Hartmann (1976) have furthermore, argued that the categories within which Marxist's operate are sex-blind. In order to understand the subordination of women in the capitalist mode of production, they argue, it is necessary to 'articulate' patriarchal with Marxist explanation. Socialist feminists go on to assert that gender and class inequalities have a mutual influence and cannot be analyzed in isolation from each other (Abott and Sapsford; 1987).

Therefore, the socialist feminists even while critiquing the Marxists, have tried to integrate their understanding on class and gender hierarchies and premised patriarchy as an important form of oppression which according to them determined the nature of relationship between class and gender. Their strategy is to counter all forms of hierarchical structures and ideological formations, which undermined the importance of

women's role and women's consciousness in changing the existing social order. On the socialist feminist analysis, capitalism, male dominance, racism and imperialism are intertwined so inextricably that they are inseparable; consequently the abolition of any of these system of domination requires the end of all of them (Jaggar, 1983).

They claim that a full understanding of the capitalist system requires a recognition of the way in which it is structured by male dominance, and conversely, that a full understanding of the capitalist system requires a recognition of the way it is organized by the capitalist division of labour. To socialist feminists, however, the radical feminist concept of patriarchy is inadequate both as description and as explanation. The historical radical feminist conception of patriarchy does not describe women's situation adequately, insofar as it obscures differences between the experience of women in different societies, and between the experience of women in the same society who have different class, race, or ethnic backgrounds (Ibid.).

Women and the household domain

So, the gender inequalities exist and are sustained and reproduced in 'the wider society' and these inequalities feedback into and influence relationship within marriage and the family (Morgan, D. H. J.; 1985). According to Walby, family is also seen as an oppressive institution in the reproduction of capitalist or patriarchal structures (Walby; 1990). So, the family becomes an institution within which there is a whole nexus of inter-related interests and processes: the control over property, concern to produce male offspring, patriarchal control over women and children and also over women's sexuality, her labour etc. which influences her health and well-being. When we are speaking of women's position in the family or household, we do not intend to mean that the women's place is limited within the confines of the household but on the other hand trying to assert that the household cannot be treated as an isolated entity separable from the context in which it is embedded. As the intimate experiences of life are structured by wider social relations, so in order to understand the position of women it is necessary to examine intra-household relationships their dynamics and their historical, social, economic and political contexts. So, when we focus on the household in order to understand the

predicament of women, we emphasize the necessity of seeing the various inter-linkages between the individual household and the wider structures and processes of society (Krishnaraj, M. and Chanana, K.; 1989).

Therefore, in the present study it is essential to have an understanding of the lives of women and the role and significance of the household in shaping, sustaining and changing them. It is important to note, that when certain improvements come, women's subordinate position gives them inferior/ lesser access to these changes and thus disparities between men and women widen. For example, it can be illustrated with the working of the health care system, and also through the Family Planning Programmes (FPPs) of the state, which instead of providing a liberatory status to women, targeted them and held them responsible for fertility reduction. Thus, this discussion draws our attention to the substantial contribution that women make to the sustenance of the household, their burdens and their relative powerlessness and inadequate returns in concrete/material forms (health care and nutrition etc.). The assumption that a nuclear family gives more freedom to a woman may not be always valid because the strength of the ideology that confines women to restricted roles may still operate (Ibid.). A woman is good to the extent that she observes the taboos imposed on her and within these constraints fulfils any function assigned to her – be it housework, care of the husband, children, the old and the sick, and also simultaneously work for the household economy (Banerjee; 1996).

In this context, it is pertinent to note that decisions on most of the issues – like disease treatment, diagnosis etc. concerning women are not made by themselves but by others, mainly the intra-households authorities. In this sense, the crucial element missing in women's position in India is that of 'autonomy'. So the households appropriate the power for taking major decisions concerning women i.e., their age of marriage, childbirth, number of children, education and seeking employment. But such a picture drawn with broad underpinnings cannot be representative of all.

In fact (Bardhan 1993) has noted that women's position in one section of the Indian society is rapidly changing towards giving women more resources and more

autonomy. Among the educated, aware urban middle class, a section of parents with small families have responded partly to the general demands for women's equality and partly to the incentives offered by the obvious economic gains from a good education and professional training. They are increasingly giving their daughters such opportunities on par with sons. Girls are being allowed to choose their own careers and train for it. They are then being allowed to make their own plans for marriage and even given capital for setting up enterprises. This might lead to a growing polarization among women: the better-educated and empowered women would remain unaware of the controls imposed by the household-based patriarchy (cited in N. Banerjee; 1996).

Barriers in seeking health care services by women

Health is a state of complete physical, mental and social well-being and not merely the absence of disease. In this context, women essentially have the right to the enjoyment of complete physical and mental health. The enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life (Cecile, M. T. and Gijsbers, V. W.; 1996). However, health and well-being elude the majority of women. Despite, the importance of socio-economic factors, women's health is also greatly affected by the extent and quality of health services available to them. Women's health status is primarily affected by the environmental, social, political and economic factors that determine both the material circumstances of women's lines and their possibilities for self-determination in areas such as sexuality and reproduction (Zaidi, S. A.; 1996).

Thus, low levels of education, poor health and nutritional status, and lack of access to resources affect the quality of life of women and inevitably their health. According to Basu, "the lack of females in the labour force as a cause for lower health status amongst women, and argues that economically active women outside the domestic domain will have better health status compared with women denied economic independence. She also argues that norms and customs such as female seclusion and the lack of interaction with the outside world aggravate the health status of women (Basu cited in Zaidi; 1996).

Bina Agarwal has also pointed out that "the gender gap in the ownership and control of property is the single most critical contributor to the gender gap in economic well being, social status and empowerment" (Agarwal, B.; 1998). Thus, broadly it can be argued that women's ill-health in India is due to lack of resources and poor access to preventive, promotive and curative health care services, lack of prenatal medial care, insufficient nutrition, lack of basic infrastructural facilities like water, proper sanitation and better living conditions and above all few opportunities to earn income. These problems are further compounded by preferential treatment for sons that result in female foeticide and infanticide.

Thus, it is important to identify these factors that are deleterious to women's health, so that, we find way of removing these constraints which restricts women from improving the quality of their lives. Consequently, access to health care services is highly determined by one's social and economic position. So, women belonging to the higher socio-economic strata in even the poorest of underdeveloped countries do not face most of the problems highlighted by researches on gender and health. Not only are richer women better off than their poorer counterparts, but they are also far better off than poorer men (Zaidi, S. A.; 1996). But, at the same time, it is pertinent to point that here women's identity is usually linked to their husbands/ fathers/ sons, it is difficult to judge the social and economic position of women, for they are not independent entities. Thus, from this discussion it can be inferred that greater emphasis should be given to improving the role and status of women in society in order to increase their capacity to control their lives. Therefore, the effect of the social macro-structures upon the micro-structures, and the importance of these larger structures in determining health status needs to be realized.

Health perceptions of women

Perceptions of health and illness are determined by the social context in which the women live. Family norms and values, material resources, and social mores govern the recognition of their illness and their participation in treatment (Susser; 1979 cited in A. Sagar; 1994). Even when a woman knows that she needs treatment, someone in authority has to legitimize her illness. So, she is not the one to legitimize her own suffering but, it

is generally the father, husband, son or mother in-law those in authority, take decision here. As a result, the subjective or experiential health of women is completely ignored. Women's socialization into a mindset of self denial and the family's priority to needs of its male members doesn't allow early action on women's illness (Priya, R.; 2001). Thus, when we talk of perceptions of ill-health and particularly of women, we are in a way focusing on social factors of different kinds which play a central role in shaping individual's subjectivity. There is no doubt, various studies, which have discussed on health perceptions and treatment seeking behaviour of different social groups. But when speaking of women's health perceptions, their ill-health and sickness is explained in terms of their maternal reproductive health problems.

This narrow view tends to obscure the entire cultural, material constraints and the social environment which necessarily has an impinging effect on their health status. So, by completely separating issues of health from social structures and looking at individual's biology in isolation from the social environment, we fail to understand the inter-linkages that shape a person's health status. Consequently, this leads to an incomplete diagnosis of women's health problems. Thus, the social environment in toto is seen to be an important variable in affecting perception, recognition, and definition of disease (Sagar, A.; 1994). And there is growing literature to support the notion that women's experience cannot be subsumed under those of men, as there are specific issues, e.g. women's roles inside and outside the home, which influence a women's experience of illness. According to Lesley Doyal, "there are obvious difference between male and female patterns of sickness and health which can be attributed to the biological difference between the sexes and other social inequalities (Doyal, L.; 1995). But health and disease are still viewed within a reductionist model where the body is seen as a series of separate parts within a whole system. Within this model, the complex relationship between mind and body is rarely explored and individuals are separated from both the social and cultural contexts of their lives.

> "A study found the perception of medical care needs during the antenatal period of the women of a slum in Delhi and those of the medical/ public health definition of the ANC (antenatal care) package to be markedly divergent. The ANC services

ignored all self-perceived health problems of the ante-natal women (most of which related to their chronic ill-health and were perceived by them as arising from their social and economic context) which were outside the standard ANC package, thereby making the ANC services meaningless for them (Sagar cited in Priya Ritu, 2001). Thus, from this it can be inferred that women's health problems are often not correctly recognized – the genuine medical problems are not easily diagnosed and instead called 'psychosomatic' (cited in Priya Ritu; 2001).

In this context it is important to note that women's experiences of health care have all too often been affected by a climate of practice in which male physiology and behaviour have been taken as normative. So, it is important to have a holistic concept of health, in which mental and physical aspects are equally important, and the health problems of women are seen as "deeply implanted in the statuses that derive from their multiple social relations" (Dan, A. J.; 1994). This is reflected in women's perceptions as well – "the labouring Dalit women's conceptual framework suggests that while recognition of women's individual identity needed to be foregrounded, their other identities must not be lost sight of. The simultaneity of multiple identities is crucial to conceptualizing women's individuality, and that is the basic cornerstone of any attempt to enhance their access to health care" (Priya, R.; 2001).

This research work will make an attempt to understand, that, within complex webs of interlocking structures, women occupy diverse locations and identities, which shapes their experiences and their struggle. So it is important to understand women's health from their own perspective i.e. 'experiential' knowledge. Recent studies undertaken by Ford Foundation (1994) explains women's health from their point of view, their experiences, subjectivities and their own illnesses. But, it is essential to point out that these studies have a very narrow focus as they have basically emphasized on the reproductive health needs of women in India. Thus, what is delimiting about these studies is that it fails to bring a holistic and comprehensive understanding of women's health and connecting it to the larger structures of society and social inequalities that determines women's health, and their access to the health services. It has overemphasized reproductive health problems as being the major determinant of women's ill-health in

India. Nevertheless, these studies have made an effort to understand women's perceptions regarding their health, disease and treatment seeking behaviour, essentially the problems of women during pregnancy, childbirth and menstruation etc.

The studies have viewed women's health as an isolated category, and necessarily understood women's lives in a life-cycle approach neglecting their other basic survival constraints (Qadeer, I.; 1998). But there are other studies (Currer and Stacey; 1986) in which various authors have made an attempt to link the perceptions of health, illness, disease and treatment – seeking behaviour with the social structures of the society. It is important to mention here the work of Meg Stacey "who relates concepts of health and illness with the micro and macro level in which they are found, particularly to the division of labour, the position of members, their life experiences and their material and psycho-social interests. She suggests that the dominant concepts are those of the successful and powerful, whose interests they serve". Herzlich (1973) distinguished three ways in which lay people conceptualized illness: as destructive, as occupation and as liberator. 'Gilbert Lewis' study (1975) suggests that women's structural position in the Gnau patriarchal and patrilocal family leads them to think of health and illness somewhat differently from men and to behave differently. 'Kleinman' tries to explain the relationships between healers and healed in terms of their differing concepts as he sees them associated with different 'sectors' of medical system, namely professional, folk and popular. He makes an attempt to understand health, illness and healing as part of a cultural system and therefore which needs to be understood in relation to each other.

Another interesting study by Paul Unschuld also 'tries to explain the way in which illness is conceived, but he situates his search for explanation not only at the symbolic level but also in the nature of the society of which the ideas are a part'. Caroline Currer in her paper "Concepts of Mental Well and Ill-Being: The Case of Pathan Mothers in Britain" discusses of a minority ethnic group whose concepts of health and illness are at variance with biomedicine and whose illness behaviour is therefore unexpected in biomedical terms". She explains how women's illness behaviour and their health concepts can only be understood in their own terms and locating it within the structural positions they occupy (Currer and Stacy; 1986).

So, these studies draw our attention to the variety of concepts of health and illness that exist, over time and in different locations, and as well as to the variations which co-exist in any one time and place. A major theme, which emerged is the close association between concepts of health, illness, disease, and the social structure.

Conceptualizing well-being, autonomy and agency

Well-being, health and illness are three states with very nebulous definitions. They denote such dynamic phenomena that they may be visualized more as processes than states. 'Well-being' continues to be difficult to define clearly, being a very subjective component. However, it does have very definite evaluation and parameters for people within a given context. It could be said to be all-encompassing state that denotes quality of life with a positive hue (see Priya Ritu; 2001). World Health Organization (WHO) explains; "All indicators of well-being of an individual have objective and subjective components. The objective components relate to such concerns that is generally understood by the term "standard of living", which comprises – level of education, employment status, financial resources, housing conditions and comforts of modern living". As explained in UN documents (UN; 1961) "level of living consists of nine components: health, food consumption, education, occupation and work-conditions, housing, social security, clothing, recreation and leisure, and human rights. These objective characteristics are believed to influence human well-being. It is also believed that an individual's satisfaction/ happiness with his objective reality depends not only on his access to goods and services that are available to the community but also on his/ her expectations and perceived reality. It is this subjective component which links the concept of quality of life to subjective well-being, viz: 'as experienced by each individual' " (WHO; 1985).

In fact, I am also trying to understand well-being in order to link health to women's overall life situation within the context of our identities and perceptions. Each one of us have many identities. Being a man or woman and also a member of a family is one of them. Therefore, one's individuality co-exists with such diverse identities. And, consequently, our understanding of our own interests, well-being and behaviour is

influenced and shaped by the conflicting effects of these identities. And, according to Sen's analysis – it is seen that 'insofar as intra-family divisions involve significant inequalities in the allotment of food, medical attention, health care, etc., the lack of personal interest combined with a great concern for family welfare is, of course just the kind of attitude that helps to sustain the traditional inequalities'. And therefore, it is important to think along these lines in order to understand women's health status and well being by locating their position in the family (Sen; 1991 cited in Irene Tinker).

Further, Sen's paper explains – that "the well being of a person may plausibly be seen in terms of a person's functionings and capabilities: what he or she is able to do or be (e.g. the ability to be well nourished, to avoid escapable morbidity or mortality, to read and write and communicate, to take part in the life of the community, to appear in public without shame (Ibid.).

In fact, it is also possible to distinguish between a person's 'well being' and 'agency'. A person may have various goals and objectives other than the pursuit of his/her well-being. Although there are links between a person's well being and the fulfillment of his/her other objectives, the overall success as an agent may not be closely connected and certainly may not be identified – with that person's own well being. It is the agency aspect that is most influenced by a person's sense of obligation and perception of legitimate behaviour, but these perceptions must not be confused with the person's well being (Ibid.).

In this context it is important to point out that the perception of individual interests of women often merges with the notion of family well being in many households. Thus a woman is not necessarily concerned only with her own well being as she may have other objectives to pursue, therefore, in various studies it can be seen that a women's actual agency is often overshadowed by social roles and norms which gives legitimacy to their behaviour.

In this context, Naila Kabeer's paper on "Resources, Agency and Acheivements..." too provides us with analytical insights to understand women's autonomy and their agential dimension, which provides them the power to make choices

for themselves. She further explains that "some choices have greater significance than others in terms of their consequences for people's lives. And it consists of first – and second – order choices, where the former are those strategic life choices, which are critical for people to live the lives they want (in this context it can be explained as choice to make decisions whom to marry etc.). These strategic life choices help to frame other second-order choices, which may be important for the quality of one's life but do not constitute its defining parameters". At this juncture it is also important to point out Jeejebhoy (1997, cited in Naila Kabeer) study, which "explores the effects of a range of variables on women's autonomy. Measures of women's autonomy included their role in decision-making, mobility, incidence of domestic violence, access to and control over, economic resources, which both directly and indirectly affect woman's health status. And she further claims that since women are likely to be given greater respect within their communities for conforming to its norms, and to be penalized if they do not, their own values and behaviour are likely to reflect those of the wider community and to reproduce its injustices (Kabeer, N.; 2001).

Thus larger structures impinge on women's 'agency' and 'autonomy', which help to shape their interests and reflect their social positioning in society and also their health perceptions and treatment seeking behaviour.

II Emerging theoretical constructs for a research framework

In this chapter, I briefly discuss some concepts which provide us different lens through which we can understand how various factors play an important role in shaping women's health conditions and their perceptions of health, illness and well-being. These concepts provide us ways to look into the position of women in society and how it influences their health behaviour and illness perceptions. Before delineating the theoretical perspective I will discuss the importance of gender dimension in this study, the necessity of looking at middle class women's health and also analyzing certain other disparities, which has a negative impact on their health.

The gender dimension

Gender issues related to power and subordination cannot be ignored, since gender inequality is inextricably bound up with power relations. To understand the power and gender relations, we have to look into its multidimensional nature, the complex ways in which women experience subordination, and the ways in which they negotiate (by exercising their agency) this state of affairs. This formulation of power is concerned with ideology, and with the socio-cultural constructions and patterning of behaviours. Feminist analysis has shown how social rules, norms, values and practices play a crucial role in concealing the reality and pervasiveness of gender inequality and in defusing gender conflict. For instance, the reverence of mothers and motherhood conceals, and also serves as a rebuttal, of the evidence of the exploitation, devaluation and oppressions that women face. Further, the ideology governing gender relations of power and subordination in a society structures the construction of gender identity and consequently of self-identity too (Sonpar, Shobna and Ravi Kapur, 2001).

Therefore, gender represented through a depiction of "the inseparability and co-mingling of their various tasks that tends to differentiate women's lives from men" remains an important social determinant of health (Doyal; 1995: 21). Being healthy, Doyal suggests, goes beyond subjective well-being to being free from sustained

constraints on achieving one's potential and enjoying a satisfying life. Gender is shown to be a major axis of difference that affects health status, while 'class', caste, and race and nationality are also interrelated in complex ways with health inequalities.

Health status and experience are understood as gendered phenomena. Here, gender is not equated with 'sex difference' in this framework of understanding. Instead, it refers to the socially and culturally constructed meanings around biological sex, which inform notions of feminity and masculinity and associated norms of behaviour (Lafferty, Dyck, Lewis; 2001). Reliance on biological and physiological explanation of women's health and illness is challenged by documentation of the ways in which women's location in complex social, political, and economic relations affects the content and meaning of their lives, including their experience of health and sense of well-being (Dyck, I., Lewis, N. D., and McLafferty; 2001).

As these contributions have opened up ways of exploring women's health, the limitations of biomedical approaches in understanding health and illness have become evident. It is important to note that in these accounts women are not always viewed/ represented as 'victims', but also seen as exploring and using active strategies in managing health and illness and also seeking health care services. The importance of these issues to the future direction of health-care delivery as well as to the quality of life of the female population mandates a fresh approach to the analysis of women's health issues, one which places them in a broad societal context (Lewin, Ellen and Olensen, Virgina; 1985). So, there are certain important questions that need to be raised in this context. If the issues of health are embedded in the societal context then what are the factors that are significant in determining women's health? What are the macro and microstructures and the social processes that create and perpetuate ill health among women? How do we understand the role of the household, community, class, caste and the state in determining health?

Social status and women's health

In the Indian context, society is stratified on the basis of caste and class. It has been treated as a comprehensive system of social relations, that represents both a

structural system based on occupation and a cultural system based on ritual hierarchy and the status of occupational groups. The three basic characteristics of caste, typified as 'jati', a birth-status group, and exclusion or separation (rules governing marriage and contact, which maintain distinctions of caste), hierarchy (the principle of order and rank according to status), and interdependence (the division of labour which is closely tied to hierarchy and separation) (Dube, L.; 2001). According to Dube (2001), when we turn to the material bases of caste, the most important form of inequality in the caste system – the unequal distribution of resources and the exploitative relations of production – can be understood only through an enquiry into the principle of kinship governing allocation of resources, devolution of rights to property, rights to services, and entitlements. It is not the 'jati' as a whole but the lineages or familial units, which hold material resources. This has crucial implications for gender since, within these units, there are clear distinctions in respect of the rights and entitlements of their male and female members (ibid.). The household, which is the basic unit, is located in the social structure according to its caste and class status. Dube, further argues, that the principles of caste inform the specific nature of sexual asymmetry in Hindu society, the boundaries and hierarchies of caste are articulated by gender.

All the features of caste have negative and worse implications for gender equality and justice. The increased constraints on women are an essential part of a rise in caste hierarchy. Ruth Manorama (1995) emphasizes that the concepts of pollution, purity and provide prescriptions and prohibitions about social interaction. Furthermore, she argues that, within a patriarchal joint family, women are considered as part of man's property in the same way as a piece of land belonged to the men of the family. Only sons are valued and inheritor of immovable property, the daughters are not valued and therefore taken as dowry in the form of goods... to their marital family. Thus, cultural explanations of caste hierarchy had its material basis. Therefore according to her, gender division reinforced the caste division and gender ideology legitimated not only the structure of patriarchy but also the organization of caste (Massey, 1995 cited in Manorama, R.; 1995).

Women are considered to be unequal and inferior to men. They are considered as possessions of man and thus have no independence in exercising their agency for

decision-making within the household, marriage, reproductive freedom and health care treatment and thereby less access to resources, which has a negative impact on their well-being and health status and aggravates the problems of women. The principles of caste involve a clear distinction between the domestic sphere/ home and the 'outside'/public world. And women play a key role in maintaining the sanctity and purity of the home. Marriage and sexual relations too constitute a central arena in which caste impinges on women's lives. A woman's role in biological reproduction makes her primarily responsible for maintaining the purity of caste and its boundaries and calls for proper control over her sexuality (Dube, L.; 2001). All these values and norms are internalized in the process of socialization and also in the opportunities for education and employment to women. Thus caste has an impinging impact on the process of growing up as a female. The importance of the purity of caste affects women in all life stages (ibid.). It is significant to note that the difference in the levels of purity/ impurity between men and women is much less among the lower castes than among the high castes. However, among these castes women's substantial contribution to the process of earning a livelihood along with the sharing of impure tasks by both men and women makes the gender division less unequal (ibid.).

Since caste incorporates class and class incorporates caste, neither the "caste" alone nor the "class" alone can explain the entire gamut of India's social reality. Thus, both caste and class are real dimensions of India's social formation, and seem to be inseparable from each other. Class is not simply a conceptual abstraction, but a construct based on certain attributes or operational indices; it is a concrete reality. In simple terms, caste is the ascribed status of an individual (i.e., initiated by birth) whereas class can be called as the achieved status (i.e., individual's economic status, income, occupation). Thus, class represents economic status in terms of ownership of land, assets, resources and type of occupation (for instance doctor, engineer, teacher, artisan or domestic servant) (Lingam, L.; 1998).

People are inserted differentially within the social relations and uneven distributions of power operating over space, so that some women will have greater control over their local conditions – and their health – than others (Massey; 1993 cited in

Dyck et. al.; 2001). Perhaps the single most important reason for the low health status of women in our society is that they are not valued as much as males. A women's identity is still tied with their husband's social status and position in the society and the family. This factor of social status is important irrespective of the economic group to which the women belong. In the case of women from the poorer families the risks due to being female are added to the already present risk of poverty (Sathyamala et. al.; 1986). Nevertheless, it is very significant to point out that gender discrimination prevails in the middle classes, which has an impact on women's health status. There may be greater female seclusion and more rigidly defined gender roles even as the family prospers (Mukhopadhyay and Sudarshan; 1997 cited in Sonpar, Shobana and Ravi Kapur; 2001).

However, their health status and educational achievement would be relatively better than women belonging to the lowest social class. There is also lesser work burden for the women belonging to higher socio-economic strata but that cannot assure her greater access and mobility to the public sphere, e.g. employment, greater sexual reproductive freedom or decision-making within the household or family. Thus, the general belief about women enjoying a better health status in the middle-class, and having the power and agency to take decisions in seeking health care services, or enjoying greater economic dependence and taking important decisions for their own life and including their children's or husband's lives, can be debated and needs to researched upon. Gender disparity cuts across all classes, castes, religion and regions. For instance, while education and income may be high, there may still be a great degree of violence against women.

Therefore in the urban middle classes, while there may not be overt gender disparities in provisioning for basic needs, various other constraints of subtle/ covert nature exist. Like other systems of difference and inequality, such as class and race the gender system is multilevel, involving cultural beliefs and distribution of resources at the macro level, patterns of behaviour and situational structures at the interactional level, and selves and identities at the individual level i.e. micro level. Doyal (1995), suggests that women experience both material discrimination and cultural devaluation that, respectively, affect their access to the resources necessary to maintaining a healthy life

and threaten their emotional health. This holds, Doyal points out, despite the wide variation in women's situations, within their own societies and between countries. Drawing on international research, she shows that what women do as mothers, daughters, or wives, whether in domestic, waged, or unpaid community work, affects their health and how they manage health problems detrimentally.

Understanding women's health issues

In fact, health cannot be compartmentalized as a separate issue in women's lives; rather it is integral to their everyday life, which is invariably linked to their position in the society. So, this study basically focuses on the women's own perspectives of health and illness and ways of managing health. Our perspective is – that women's lives are inextricably linked to a set of social relations in the larger social organization, and the circumstances shaping their illness experiences. Hence, women's experience cannot be subsumed under those of men, as there are specific issues, e.g. women's roles inside and outside and house, which influence women's experience of illness. There is increasing evidence that men and women use health care resources differently. For e.g., one study, comparing how men and women use the same health care system, found that "men of higher social classes were more likely to use medical care, whereas among women those in higher social classes were more likely to use lay consultants" (Anderson, J. M. Blue, C.; Lau, A.; 1991). Therefore, there is a need to examine the context in which belief systems are constructed and the inequalities within the society that infringes upon health and illness management.

Women's lives are largely lived within familial parameters. Therefore, the centrality of the family and the household in their lives has to be recognized. And since the household can be considered as a basic unit in present society, it is relevant to look at the dynamics within the household, which affect health status. The household is undoubtedly the "immediate health environment of its members who share (whether equitably or not) a common water resource, sanitation facilities, breathing space, a hearth, and other facilities. This has important implication for the acquisition, transmission, prevention, and treatment of disease" (Chatterjee; 1989: 166 cited in Thapan, Meenakshi;

1997). It is equally important to look at the way of life of the individual or what according to D. Banerji (1982) is called the 'health culture'. This includes the food a person eats, his/her access to clean water and hygienic living conditions, the environment, the meaning and significance given to sickness and disease in the community, and access to health facilities. And these factors are determined by an individual's status in the household and community, which in turn depends on the variables such as age, sex, kinship, occupation, caste and class.

It has to be taken into account that households adapt to external pressures by frequently adjusting the allocation of domestic work, resources, goods and services. External pulls and pressures determine the kind of changes that are induced in the production, reproduction, consumption and allocation behaviour of the domestic group, referred to as family strategies (Bardhan; 1980-90, cited in Lingam, Lakshmi; 1998). So, women's health is directly affected by certain factors, like how resources are to be spent within the household, and whose sickness is articulated and treated- is a function of the person's role and position in the family. Their health is inevitably linked to the household structure, the class position of the household, and the intra-household distribution of work, resources and food and the age, sex and kinship position, a wife, mother, mother-in-law, daughter-in-law, etc. Therefore, this negative social value attached to a woman/ daughter needs to be countered.

Sen tries to understand the causes of intra-family disparities. He finds that, often enough, individual welfare is pitted against collective well-being, though the former cannot be looked at independently of the rest of the family (cited in Karlekar; 2000). Karlekar argues that women contribute substantially to the domestic economy either in terms of a wage or 'invisibly', and it is also the case that their roles go largely unrecognized by themselves as well as by other family members. This results in their ignoring illness and food intake and accepting a large burden of mental and physical wear and tear. Therefore, the large majority of Indian women combine a multiplicity of roles, each leading to different health implications.

Differentials in health-care utilization

It is significant to point that there is over medicalisation of women's health on one hand and lack of access to much needed health care services on the other. It has been documented that women of all ages have not only poor access to the health care system but are also less likely to use it. Studies from several parts of India indicate that there is a gender bias in accessing and using health care, which starts early in life. For example, both hospital and community data reveal that more boys are brought to clinics for treatment than girls. They are likely to be brought early in their illness and given the full range of treatment. On the other hand, girls may be withheld medical care or provided with poorer quality care (see in Rao, S. R. and Townsend, J. W.; cited in Das Gupta, M. et. al.; 1995).

Small studies across India do indicate that more men than women seek treatment for illness. Access is usually determined by 'need', 'permission', 'ability' and 'availability' (Chatterjee; 1990 in Impact of Work and Environment cited in ibid.). Social and economic norms determine 'permission' and 'ability'. Often women need permission to seek health care for example, as in this study in Agra district where women were questioned on the lack of treatment for their gynaecological problems – among the prominent reasons given, by women is that, they didn't seek treatment as family members considered it unnecessary. Some of them also responded that their conditions were not serious enough to merit treatment (The Population Council and Mode 1995 cited in ibid.). Thus, both individual and community perceptions of health are important determinants of health-seeking behaviour.

Research on gender differences in malnutrition does not find richer households less discriminatory. For e.g., during famine in Bangladesh, Bairagi (1986) finds the gender difference in malnutrition to be greater among children of the higher socio-economic status group (S. Kishore, in Das Gupta, M. et. al.; 1995). In research in West Bengal, Sen and Sengupta (1983) report that male-female differentials in under-nourishment were greater in agricultural labourer and Harijan households as compared to the households of higher socio-economic status where there was no external food

supplementation; but, where there was food supplementation, the gender difference was larger among children from the more economically well-off households. He further argues that the economic and cultural worth of females is likely to be greater in landless and lower caste households rather than in landed and upper caste ones, and in most empirical analysis, either the relative mortality (or malnutrition of females is found to be greater in higher caste and landed households, or else it is found not to differ significantly by socio-economic status (ibid.; 1995). The economic cultural value of women is also likely to differ by caste; and women of lower castes having greater economic and cultural value since there are fewer restrictions placed on their autonomy and their mobility in the productive sphere. From these arguments we can conclude that the socio-economic status of the household, whether measured in terms of caste, occupation, education or land-holdings, is, in general not found to increase the survival chances of females compared to those of males of same class and caste.

Sen (1995) emphasizes the important role that play in making objective health assessments, pointing out that various actors may perceive 'health' differently. Perceptions of women's health – its dimensions, its importance, its causes – vary widely among women themselves, family members, the community, health professional, researchers, and policy makers. Thus, perceptions could play a vital role in making us understand particular health problems and influencing policy decisions (Germain, A. cited in Das Gupta et. al.; 1995). According to some scholars, however, there has to be research to know more about women's perceptions of their own health, their utilization of the full range of health services (from ayurvedic to allopathic) and their service preferences. This would make an effort to sensitize and change certain male-centered social attitudes of family members, and policy makers as well resulting in the overall improvement of women's position in the society and ensuring better health status (Karlekar; M.; 2000 cited in Shifting Sands).

While the idea of holistic health is the preventive, curative, and promotive aspects, the actual implementation of policies shows how this idea falls far short of people's needs. Karlekar argues it is mostly the women and children belonging to the marginalized sections of society who are the victims/ sufferers of inadequate delivery

systems and outreach programmes. *Veena Shatrugna* found that women's access to and use of facilities are dependent on their class position. A study of records at medical institutions (Batliwala; 1983) reported that there was only one woman user to every three men who use hospital facilities. Further, only one woman to five men would make her way to a PHC. It is also the case that women tend to use traditional non-institutional remedies in large numbers (Ibid.: 92). Data from five states in the 80's on awareness and utilization of Government health services concluded that while about 35 per cent of those who visited a health facility were women, many came on account of their child, or other family member's illness. Other studies also indicate that women seek help very late in their illness as 'a women's illness is apparently not a pressingly 'felt need' for seeking health care till she is really sick' (Mathai; 1989: 261, cited in karlekar; 2000). *Karlekar* also emphasizes that violence within the home also affects the girl child's health and sense of well-being. So, she hypothesizes that while a sizeable percentage of women's health problems lie rooted in familial dynamics and tension-ridden relationships, more often than not they tend to get treated for physical disorders (Ibid.).

Over-medicalisation of women's health

According to *S. Batliwala*, the national health system is geared towards viewing women as mother and reproducer. Thus, the health system has yet to awaken to the fact that there are a large number of women in need of health care who are neither pregnant nor lactating. This attitude finds expression in inadequate sensitivity training in non-maternity health care issues as also in ill-equipped facilities and programmes (Karlekar; 2000).

For instance, women have been identified in their reproductive role as primarily responsible for limiting the size of families. However, recognition of the links between women's autonomy over their own lives and fertility control is not widespread and women continue to be treated in an instrumental manner in population programmes. The lack of satisfactory birth-control methods, and the introduction of more invasive techniques (such as IUDs and hormonal implants) is making birth control even more 'women centred'. So, it can be argued that men are let off the hook in terms of their

responsibility for birth control, while increasingly placing the burden on women. Women's groups and health activists in India have opposed these contraceptives on several grounds. They have commented on the dangerous side effects (such as disturbed menstruation, hypertension, nervousness, vomiting, dizziness, etc.). It has been further argued that the administration of such contraceptive technologies depends on ill-equipped health-care systems. Existing public health facilities in India are nowhere near adequate for screening potential users, inserting and removing implants, and providing continued monitoring of user health. They warn of the risks involved in using drugs not developed or standardized for women in India (Tharu, S. and T. Niranjana, 1989).

These hormonal contraceptives, thereby, should not be introduced before conducting epidemiological and biochemical studies that take into account differences in weight, diet, and so on, between Indian women who will use these contraceptives and the 'average' Western woman. In this context, it can be said that no attempt is made to reinforce or envisage more egalitarian relationships or place responsibility on the man. No questions are asked about the nature and quality of existing health care systems and the complex factors that mediate different women's access to them. The use of these contraceptives is promised on the notion that wise planning and scientifically developed products can fulfill women's demands for liberty and self-determination (and catapult them into modernity) without changes in existing family relations or in society at large; in other words, the promise is of a technological fix that can bypass sexual politics and indeed the network of relations in which women are gendered and subjugated (Ibid.).

With the development of the contraceptive pill in the early 1950's, and later, other contraceptive methods, fertility management through modern technology became more reliable. Then came sophisticated technologies such as ultrasound for pregnancy management, followed by technologies for the management of conception. As these advances took place within a profit-oriented economic system, health care became an enormous industry and with it came the control over individuals by medical scientists, pharmaceutical companies and the state. The contradictory possibilities of reproductive technologies became visible (Gupta, Jyotsna, A.; 2000). Proponents of Norplant and Net-Oen in India argue that long-acting implants or injectables that do not interrupt

intercourse and do not require women to do anything on a regular basis are particularly suitable for an illiterate and backward population. These hormonal injectables/ implants were intended for 'less desirable' demographic groups, the teeming millions of the third world.

The agendas of the Indian state and international agencies have moved away from the strident population control agenda of the 1960s and 1970s to the more expansive notions of reproductive health and reproductive rights. But, this reproductive health agenda has limited the issue of women's health to one of service delivery and quality while evading the structural issues of inequality and discrimination (Qadeer; 1998). The population establishment has appropriated the language of rights and choice but without situating it within the political context of structural inequalities. The promoters emphasize that women need contraception that they can use without knowledge of the rest of the family, including their partners, and consequently the injectable is ideal. More so since women are rarely in a position to decide about their own bodies, given the nature of power relations in families. Women's activists, however, argue that technology cannot be a solution to social problems. For example, technologies designed for pre-natal sex determination have been used to further reinforce son preference and have not in any way led to women's empowerment. And this is a serious problem if the preliminary results of the 2001 census are any indication, with the 0-6 child ratio coming down to 927 from 945 in 1991 and 976 per 1000 in 1961 (Viswanath, K.; 2001).

Women's groups have also challenged the nature of informed consent, in different trials for contraceptives, claiming that women have never been given complete information on the nature of the contraceptive. Neither were they appraised of the various side-effects or the experimental nature of the technology. Most women who are enrolled as part of trials are poor women who seek the services of government health care centers. And even today counselling is simply reduced to convincing women to put up with the side effects, as they are seen as 'non-serious' (Ibid.). Therefore, the state as the primary agency for effecting population control, has to work out carefully its policies and plans for implementation.

Theoretical approaches: emerging pathways to understand women's health issues

Social science research is now commonly, but not universally, acknowledged as an essential ingredient in understanding women's health, one that must take into account the various dimensions of "context" in which women live (Dyck, I., Lewis, N. D., and McLafferty, S.; 2001). It can be argued that the social science scholarship have opened up ways of exploring women's health that emphasize the importance of the "interconnections" between the biological, psychological, social, cultural, economic and political dimensions of health and illness (ibid.; 2001). In fact, social science scholarship has focused on a broader understanding of health rather than a narrow biological (reductionist) focus. The narrow bio-medically based models of women's health are being replaced with broader social models of health. The underlying philosophy of the social model of health is that the health of individuals and communities is the result of complex and interacting material-structural and behavioural-cultural factors, whereas, the focus of the medical model is on pathologies, clinical interventions and patient behaviour. Therefore, this social model of health situates women's and men's health in a particular social, economic and political context.

Therefore, a person's experiences and his/her conceptions of illness and disease cannot be separated from macro-social phenomena. Though observed at the individual level and through interactions with the members of the family or physicians, they cannot be fully understood without being placed within the macro-structure. So, it's important to give a strong meaning to Blaxter's statement that a person's conceptions of his/her illness and of its causes 'may be very individual but... they will be to some extent socially patterned' (Herzlich, C. and Pierret, J.; 1985).

In this context, it is important to point out that our study on middle class women's perception of health where women give an account of their own understanding and experiences of health and well being can be analyzed along two theoretical approaches – *the macro level* pertaining to the social structures like caste, class, religion, patriarchy, gender, etc. which play an important role in determining women's health and well being (here the emphasis is on social structure). *The micro level* is concerned with the way in

which women perceive and interpret or give meaning to their own illness and well being, and in the process negotiating and acting out strategies in their everyday life (i.e. for a better health condition).

Therefore, the *macro-level* emphasizes the role of the social structures in shaping women's subjectivity, whereas the *micro-level* emphasizes the actors (women's) capacity both to attach meaning to different social situations and to act accordingly. In fact, though there exists a difference between these approaches, it would be interesting to note that women's accounts constitute a double indicator: they express subjective experience of health and illness while at the same time they also index the social structure of which they are a product (Castro, R.; 1995).

It is important for us to theorize the link between social structures and subjective experience of health. Therefore, the basic postulate arising out of this discussion is that women's experience of health and illness must be understood in connection with the central features of both the social structure and women's view of them (or the subjective context). But, often the macro theories (structural approach) and micro theories (interpretive approach) have faced the problem of taking into account either the features of social structure, or the interpretive ability of the individuals as a starting point to study the perceptions of health and illness (especially the subjective experiences) of women. Therefore, if we take into account any one of these perspectives, it will consequently lead to the under-theorization of the other. However, instead of strictly drawing upon either the macro or micro theories this study emphasizes the importance of taking into account both the social structure influencing women's health and the women's perception or subjective views of their own understanding of health, illness and disease, as both being considered equally important levels of reality. This is the main conceptualization of my study.

In fact, this paradigm helps us in understanding analyzing middle class women's perception of illness and well being within a social reality. So, the women's experience of health and illness is a complex phenomenon that draws upon both the objective and subjective social realities. Unless, these two levels are addressed simultaneously, the

study of these issues will render results that emphasize either a too mechanistic or a too spontaneous subjective experience of health and illness (Castro, R.; 1995).

In this context, it is important to refer to *Meg Stacey's* (1986) study, where she relates concepts of health and illness to the structure of the society in which they are found, particularly to the division of labour, the position of members, their life experience and their material and psycho-social interests. She uses examples of field-studies to work out her arguments, seeing the prepositions as ones, which can be found at the micro level and related to the macro (Stacey and Currer; 1986). Another study which also moves beyond the micro-level and tries to understand women's illness behaviour and their health concepts with regard to the structural positions they occupy: is *Caroline Currer's* work on the "Concepts of Mental Well and Ill-Being: The Case of Pathan Mothers in Britain" (ibid.; 1986). In this study, Currer found that Pathan women viewed both health and illness as part of the natural order, as a part and risk of living. The definition of an illness was linked to the ability to work. The women's value in their own eyes and those of their community lay in their ability to care for their husbands and children and manage the home. Furthermore, Currer saw that social position and religion emerged as the factors, which most powerfully influenced concepts, particularly responsibility for becoming ill. Social life was in all matters emphasized over individual well or ill-being (ibid.; 1986).

Therefore, the social structures operating in our society has led to the existence of certain inequalities that each of us experience in our daily lives, both within the public and private/domestic sphere. These structures, more or less gives legitimacy to the inequalities present in the society (for example, the power relations operating between men and women, rich and poor, and a person belonging to a higher caste and a that of a marginalized section of society). Often, these structural inequalities, to some extent have been deeply entrenched in the minds of the people. This has led to an all-pervasive unequal relations among the people in the society. However, these structural constraints bears more negative impact on women. Because, it's not only the caste, class and gender inequalities that operates against them but all these forms of inequality are also linked up with the patriarchal structures that oppresses and exploits women. Thus, when we study

middle-class women's perception of health, we have to contextualize our study within these oppressive forces that act against women, and which also in the process shapes their consciousness and makes them understand their experiences of health and well being in accordance to it. That is to say, a woman may often neglect her illness and mayn't seek any treatment until she is very serious, but would be overcautious in maintaining good health of her husband, children and other family members. So, the patriarchal forces operating in the society have made her internalize has low social status and a devalued position in the family and society. Thus, the social structures act as a constraint/deterrent for a woman both in the society and the family.

In this context, it is important to invoke Marxist theory (the structural/materialist approach i.e. at the macro-level) for providing us an analysis of these social structures. But, it is significant to put out that except providing an analysis of "class", the Marxist theory cannot address any of the other structures like caste, gender, religion and patriarchy. Therefore it can be said, that Marxist theory is delimiting because other than the materialist analysis of class, or giving primacy to the economic structure, it falls short of taking into account the other structures, which are equally important forces that play a key role in creating inequalities and sustained unequal, oppressive and exploitative conditions for women. For Marxists, the notion of class is the key to understanding all social phenomena, including the phenomenon of women's oppression. The good society is the classless society (Jaggar, Alison; 1983). So, women's subordinate role in the family cannot be accommodated within Marxist theory. One aspect of women's lives, such as domestic labour, may submit partially to economic analysis, but the more wide-ranging dynamics of women's oppression are untouched (Nye, Andrea; 1989).

Nye (1989) has further argued that Marxist theory cannot give an account of the dynamics of familial relations because in Marxist theory relations are a result of the mode of production (ibid.; 1989). As Marxists are concerned primarily with the critique and overthrow of capitalist society, their interest in women focuses particularly in women's situation under capitalism, in which productive activity is organized around the division between the working class and the capitalist class. To understand women's nature under capitalism, therefore, it is necessary to investigate it through the lens provided by the

notion of class. Because they see capitalist society as being split by a division that cuts across sex lines, Marxists do not assume that the nature of women in the capitalist class will be identical with the nature of working class women (Jaggar, A.; 1983).

Marxist theory provides no explanation about why women are subordinate to men inside and outside the family. Thus, Marxist categories are sex-blind (ibid: 72). According to Jaggar (1983), Marxist theory was not designed primarily to provide an account of women's nature and women's oppression. Therefore, what Marxism has to say about women is peripheral to the central claims of the theory. Women's procreative labour is not part of the commodity production, i.e., it is not part of the mode of production that defines capitalist society. Consequently, women who work at home do not have an independent place within a Marxist analysis of capitalism; they take their husbands and fathers (Ibid.: 77).

The structural inequalities — caste and gender that work as social forces, which oppresses women have been briefly discussed earlier. Here I will analyze how patriarchy as a social structure is important for understanding women's subordination and unequal power relations in society. Walby (1990) argues that the concept of 'patriarchy' is indispensable for an analysis of gender inequality. According to her, theory of patriarchy is essential to capture the depth, pervasiveness and interconnectedness of different aspects of women's subordination, and can be developed, as to take account of the different forms of gender inequality over time, class, caste, race, and ethnic group (Walby, S.; 1990).

However, it is important for us to ask, as to what kind of understanding and strategies regarding patriarchy/gender relations have to be evolved in the context of the Indian society. One could define patriarchy as "a system of social structures and practices in which men dominate, oppress and exploit women. The use of the term social structure is important here since it clearly implies rejection both of biological determinism and the notion that every individual man is in a dominant position and every women in a subordinate one" (Walby; 1990: 20 cited in Anandhi, S. and A. Roy Chowdhury; 1994). The structures, which mediate the various forms of patriarchy could be the state,

community and the family and the configuration of all these forces which ultimately defines women's subordination and articulates the ideology and social construction of gender. Therefore, what is needed is a total change of social structure.

Today the performance of *state* in perpetuating patriarchy has assumed complex, multifarious and often pernicious forms (Agarwal, B.; 1991). The health care policies, developmental policies, various legislations, and technological breakthroughs etc. have characterized the Indian state to be a site of patriarchal force. It is also significant to note that in the recent years the state has also emerged as the explicit supporter of particular religious, ethnic, communal interests, and particular form of patriarchy (Anandhi, S. and A. Roy Chowdhury; 1994).

In fact, the health-care policies of the government for e.g. Family Planning Programme, promotion of various contraceptive methods etc. have always tried to control and regulate women's sexuality, which has clearly infringed upon women's right over their life and body. Walby (1990) tries to argue that the state represents both patriarchal as well as capitalist interests and furthers them in its actions (Walby: 5; 1990). So, it is important to analyse the relationship between the state and the position of women. In this context, it is important to note that Mc. Intosh (1978) suggested that the state upholds the oppression of women by supporting a form of household in which women provide unpaid domestic services for a male. And therefore, the state should be seen as capitalist, as, in this manner, it is acting to maintain the capitalist mode of production (see Walby; 1990). Therefore, the household/family is a microcosm of the exploitative relations that exists in the society. Here, the wife replenishes the labour power of her husband over, which she has absolutely no control. The housewives/domestic labourers, within this patriarchal mode of production is the producing class, and the exploiting class is composed of husbands. As in capitalist mode of production in the workplace where, there is the expropriation of the surplus labour of the worker by the capitalists, the same prevails in the private sphere of the family too. The exploitation, or appropriation, which is taking place, is the expropriation of the surplus labour of the wife/domestic labourer by the husband. Within the patriarchal mode of production, the husband does not use the

proceeds of his labour power to compensate the domestic labourer fully for the work she puts into producing it.

At the *Meso-Level*, I have focused on women's working conditions in and outside the home. Here, we have referred to women of all classes. I have discussed both the household and workplace, and also in a way tried to establish certain linkages between them. Women's position in the household, their reproductive roles and associated sexual practices all contribute to their experience of health.

Housework in its current form came into existence with the separation of the home and workplace (Qakley; 1974 cited in Giddens; 1989). The home became a place of consumption rather than production of goods. Domestic work became 'invisible' as 'real work' was defined more and more as that which receives a direct wage. The movement of production into mechanized factories was probably the largest single factor. Women came to be associated with 'domestic' values, although the idea that 'a women's place is in the home' had different implications for women at varying levels in society. Affluent women enjoyed the services of maids, nurses and domestic servants. The burdens were harshest for poorer women, who had to cope with the household chores as well as engaging in industrial work to supplement their husbands' income (Ibid.).

As men and women have different relationships to the capitalism and patriarchy that structure the division of labour in housework, by and large men are not likely to share the burden of housework with women. The patriarchal authorities not only enforce a given pattern of intra-household sexual division of labour: they also create an image through which even women come to accept this as their 'natural responsibility (Barrett; 1985 cited in Banerjee, N.; 1996).

The division between sexes in general, and specifically those within the household may be deeply influenced by the pattern of gender division of work. In particular, the members of the household face two different types of problems simultaneously, one involving 'cooperation' (adding to total availabilities) and the other 'conflict' (dividing the total availabilities among the members of the household). Social arrangements regarding who does what, who gets to consume what, and who takes what

decisions can be seen as responses to this combined problem of cooperation and conflict. The sexual division of labour is one part of such a social arrangement, and it is important to see it in the context of the entire arrangement (Sen; 1991). The specific patterns of sexual divisions (and female specialization in particular economic activities) even 'outside' the household can be seen as being partly reflective of the traditional 'within-household' divisions related to established arrangements, which differentially bias the cultivation of skill and tend to sustain asymmetry of opportunities offered for acquiring 'untraditional' skills (Ibid.). In understanding the inferior economic position of women inside and outside the household in most societies, the hold of these social arrangements has to be clearly identified and analyzed.

Women's studies have particularly challenged the assumption that the family is a homogenous unit or that all the members of a household derive equal benefits. They have highlighted the role of household dynamics in women's overwork, deprivation and new forms of oppression in the struggle of the urban and rural poor for survival (Krishnaraj; 1989). In this context, the notions of expectations and entitlements are particularly important. An entitlement (Papanek; 1990, Sen; 1981, 1985) represents the right to a share of resources such as health care, nutrition, education and material assets as well as to parental attention and interest (cited in Irene Tinker; 1991). The degree and nature of this distribution depends on a range of socio-economic as well as psychological and emotive variables. Data (Das Gupta; 1987) indicate a definite bias in feeding boys milk products and eggs while both boys and girls have equal access to cereal and vegetables. Harris came to certain interesting findings, in her study that adult men are better cared for and eat relatively more because of implicit assumptions that they are the major breadwinners. The CWDS study also found that while most women and girl children were vegetarians, the same was not true of men and adult sons (Karlekar; 2000: 109). Thus women, within the household play an important role as distributors of food. Often enough they are reflecting a world-view based on preferential feeding and caring for those perceived to be the primary, if not sole breadwinners, or family supporters.

Thus women's ability to gain access to resources, to labour and to income is dependent upon the composition and organization of the household. Providing education

or employment to the women may change the situation to certain extent for some, but for the rest, a change in the inherent cultural traits of the society, reflected in the family norms, is necessary.

According to Walby (1990) the control of women's access to paid work is maintained primarily by patriarchal relations in the workplace and in the state, as well as by those in the household. The kind of work that women do in a particular economy and the characteristics that are usually associated with women's work there, are very much a social construct which fits in with the general image of women that is sanctioned by the patriarchal ideology prevailing there (Banerjee; 1996). This image and consequently, the work that women do can vary widely between different societies. Within India, we find that in some areas like Kathiawar, women are expected to carry out strenous activities like pulling loaded handcarts; in other areas, on the other hand, they are expected to do work that needs not so much physical strength (Ibid.). In the labour market, the private sector has not been a major employer of women but only in 'women-oriented' types of jobs as typists, nurses and teachers. Whatever women require such as work, housing, and other resources, are systematically denied to them by the norms of the patriarchal family and society (Nandita Shah et. al.; 1999).

Within the completely unorganized sector, women are employed only in jobs which are seen as women-oriented such as garments or food processing. Small-scale plastic units prefer men, giving the usual rationale that hard manual work and night shifts disqualify women from these jobs. In India, Banerjee has pointed out that there is an all-embracing ideology shared by employers, men workers and even accepted, by women workers, which sees the male worker as a 'superior worker'. The jobs that women have got in industry has little to do with skill or capacities but 'went to women ... entirely at the discretion of male workers reflecting the power position men occupied in society (Banerjee; 1991 cited in ibid.).

Some scholars have argued that 1980s is both the decade of 'labour deregularization' as well as a period marked by a 'renewed surge of feminization of labour activity'. According to Standing (1989) when low wage jobs spread, it is women

whose employment in them increases. There is a disproportionately high representation of women in the unorganized sector, where they are paid a small fraction of the wages, which would be paid for the same jobs in the organized sector (cited in Hensman, R.; 1999). The unspoken or explicit assumption behind all these practices is that women are less effective as wage earners than men and have less need of money (Ibid.). On the other hand, they also have to spend more time in domestic labour. The combination of this with the pre-existing discrimination in food allocation to women and girls will result in a serious health to illness, disease and pre-and post-natal complications (Nandita Shah et al; 1999).

The reality is that for millions of women who have to combine wage labour with household tasks, the working day is punishingly long sometimes as long as eighteen hours or more – leaving them no leisure at all and, indeed, insufficient time even to recover from the day's exertion, so that chronic exhaustion and ill-health are the result (Hensman, R. 1999). Of course, it may be possible for women in exceptional circumstances (for e.g., single women without children, or those who can afford to pay for home help and child care) to perform as well as men in paid employment over their entire working lives, but for the majority of them this option is not possible. 'Shramshakti', the Report of the National Commission on Self-Employed Women and Women in the Informal Sector, appointed in 1987, provides the most comprehensive and up to date status report on India's working women. It states quite unequivocally that 'among the poor, all women work; further as most 94 per cent work in the informal or unorganized sector, unprotected by labour laws and other regulatory mechanisms, they are 'steeped in drudgery, doing arduous work for long hours, generally in unhygienic conditions, thus affecting their health adversely'. State intervention is limited and unscrupulous employers work to keep their enterprises out of the ambit of regulation and control. Thus, 'protective legislation in the critical area of wages, maternity benefits, childcare, and social security have not benefited a great majority of women in poverty' (Shramshakti, Summary Report 1989: 19 cited in Karlekar, M.; 2000).

Even in the formal sector, employers evade legislation by simply refusing to comply with it, or by not recruiting women at all. The 'bidi' industry in India is a case

where employers have avoided the obligation to provide workplace crèches by dispersing workers to do the work in their homes – i.e., by transferring production from the organized to the unorganized sector (Hensman, R. 1999). It is important to note that these facilities are only available to women in the large-scale organized sector. Women prefer home-based piece rate work as it saves on commuting time, and allows them to combine several roles without too much dislocation. As it confines them to their homes, it does not invite social or familial sanctions. It is also significant to note that women in the unorganized sector cannot get married or have children, while she is working or, if she does, her health and family life may suffer serious strain resulting from the absence of any allowances for domestic commitments. Lack of child care has another undesirable side-effect: it usually means that girls are kept away from school to look after young siblings at home, thus extending deprivation and exploitation to the next generation (ibid.). Thus, if a women's burden of the housework cannot be renegotiated, then she will be significantly worse off under the double burden of combining it with wage work.

There are many feminist scholars who have consistently seen the family as the centre of women's oppression even though the form and content of the familial structure and ideology would vary cross-culturally and historically. The form of women's oppression within the family is a result of constant interaction and mutual strengthening of both the material structure as well as the ideological formulation of the households. To this entity has been attributed not only qualities and attitudes, but also feeling and perceptions and even different forms of consciousness (Anandhi, S.; 1994). Feminist studies can be classified according to the experience of health – structural approach or interpretive approach. The former rest on the concept of patriarchy, but tend to assume, rather than to explain, women's actual subjective experience of health and illness. The latter, on the contrary, explains many aspects of such a subjective experience but often remain silent about the central features of the social structure where women live. Other interpretive studies have emphasized that individual's subjective experience of health and illness cannot be completely understood unless they are analyzed in the context of 'individuals' lives as a whole (Castro; 1995).

At the *micro-level*, I emphasize on the interpretive approach, i.e., it is concerned with understanding how people themselves see and interpret or (attach) meaning to their social world. Here, in this study of women's health perceptions, this perspective is necessary because it is more descriptive and intuitive. Instead of engaging in quantitative analysis of social facts, the emphasis here is to observe and carefully record the quality of human experience – people's ideas, thoughts and feelings – rather than impose the researcher's own categories of meaning. The feminist perspective has also adopted an interpretive approach. For instance, *Popay's* findings show that women do not perceive themselves as having the freedom to get sick. The responses of mainly husbands; to women's experience of disease (i.e. tiredness) is also crucial: men do not tend to consider housework to be strenuous enough for women to feel tired. And as the adoption of the sick roles requires the approval of others, women are indeed constrained from feeling tired (cited in Castro, R.; 1995).

It is important to note Cornwell's study here. She has compared individual common sense views of health, with the views of other areas of everyday life, such as family & work. Her work advances our understanding, in a sense that she seeks to link social structure and common sense together, and on this basis then to explore the subjective experience of health and illness (cited in Castro, R.; 1995).

Thus, in this study of middle class women's health perceptions, an attempt has been made to take into account the three dimensions discussed here. Although, social science scholarship concerned with women's health has not always employed feminist theory, nevertheless, feminist inquiry has made important contributions in two main ways. First, through centering women's experiences and locating these experiences in wider social relations and political economies, conventional ways of conceptualizing women's health issues have been extended. *Second,* feminist scholarship has been influential in prescribing research methods that are appropriate for investigating gendered social relations and their impact on where and how women live. Feminist analyses emphasize the influence of structured inequalities based on caste, class, gender, race, sexual orientation and age on women's health (Dyck, McLafferty, Lewis; 2001).

It is also important to note that qualitative methods have been privileged in feminist research, to gain a full perspective on the many dimensions of social differences that has an impact on women's health, and which also takes into account their own voices and concerns about this experiences of health and illness. However, this does not mean that quantitative methods are unimportant. Rather, it can be used to document the broad contours of difference in women's health and well-being and their access to resources and services (ibid.; 2001).

Therefore, this study on middle class women's perception of health is concerned with listening to women's diverse experiences, understanding the everyday lives of women and through examining economic, social and cultural influences it identifies the major obstacles that prevent women from optimizing their health. The interviews and case studies have focused on eliciting women's health concerns from their own perspective (i.e. valuing women's experiential knowledge).

This inquiry into women's perceptions of health and well-being in their own perspective – can be understood from the standpoint of women. According to Smith (1987) this is not necessarily a general attribute of women as a class of persons, but a mode of experience that is distinctive to women and in important ways an experience that has marked us off from men and still continues to do so (Smith, D. E.; 1987). Following the line of analysis derived from Smith, it is important to ask how women's experiences of illness are organized, how they are determined and what are the social relations that generate them and develop an inquiry "which explores the everyday world not in itself but as it is articulated to the social relations of the larger social and economic process" (cited in Anderson, J. N. Blue, C... ; 1991). Therefore, these theoretical and methodological perspectives help us in providing a detailed analysis of women's experiences and their health status.

III Understanding middle class women's perception of health and illness: analyzing data from the field

This chapter is divided into two parts where the first part gives an account of the background of the locality where the study has been undertaken and the second part consists of the analysis of case studies.

Profile of the colony

The study was carried out in one middle class unauthorized colony in South Delhi. Hence, it is necessary to provide a brief note on the unauthorized colonies. Unauthorized colonies are those set up by private developers in violation of the Land Use Plan of the Master Plan of Delhi. They develop through illegal sub-division of agricultural land, which is sold as residential plots to individuals. "The sub-division is illegal either because it violates zoning and/or submission regulations, or because the required permission for land subdivision has not been obtained. Land may be privately owned, under notification for expropriation, urban fringe agricultural land or common land of a village engulfed by city growth. The sale or transfer of land and hence ownership of the plot may have a legal or quasi-legal status, but because of the illegality of the subdivision, plot holders cannot get permission to build. In addition the area is not eligible for an extension of infrastructure services" (Banerjee, B.; 2002).

The illegal subdivision of land in Delhi began with the partition of the country in 1947. With large number of migrants coming to Delhi, the growing demand for residential land was only partially fulfilled by the formal supply. Private colonizers took advantage of the unsatisfied demand and subdivided large parcels of land without any formal approval and sold them to needy and desperate buyers. When the interim General Development Plan come into force, the intention to acquire vacant land on a large scale for development purpose become known to the people. A large number of structures were built hastily on vacant plots. By 1962, there were 110 unauthorized colonies housed 2,21,000 population which formed 9 per cent of the urban population in 1961. Out of

these, 76 colonies were covered by the General Notification for Land Acquisition of 1956. The remaining 42 colonies were not covered by the above notification.

Between 1967 and 1974, there was a further increase of another 260 unauthorized colonies. The DDA undertook a detailed survey of all the colonies. About 71 per cent of the structures had come up in the areas earmarked in the Master Plan for district playgrounds and open spaces. The area occupied by these colonies was about 3000 hectares housing about 8,00,000 population. There was also substantial variation among these colonies in terms of layout patterns, level of infrastructure and plot sizes. The better ones have proper road widths, standard level of infrastructure, and some community facilities, open space, etc., and plot sizes of 200 to 300 sq. m. On the other hand, some of the poorest colonies have plots less than 21 sq. m. with 2 to 3 m wide winding streets and almost a total absence of community facilities (Sajha Manch; 1999).

Thus, the groups served by illegal subdivision belong to higher and middle-income group. In spite of the lower entry costs and hardships brought about by inadequate infrastructure, families actually pay more for housing in unauthorized colonies over a period than in the public housing scheme.

The Master Plan of Delhi supported by the policy of socialization of urban land saw the proliferation of unauthorized colonies at a much faster rate than before. Many factors have contributed to this development as discussed below:

Inadequate formal supply: Probably the most important reason for unauthorized development pertains to the inability of the Delhi Administration to cope with population growth and household formation in the capital. On one hand, the process of land acquisition development and disposal has been very slow. On the other hand, the high standards of development adopted by the Master Plan have effectively excluded a larger proportion of households from this limited supply.This limited supply has further escalated actual market prices. As a result, a parallel land market has developed in Delhi.

The land acquisition process has generally taken a very long time. There is a gap of several years between the notification for acquisition and actual acquisition of the land.

The landowner, whose land is notified can neither invest in his land, due too uncertainty, nor is allowed to sell. This uncertainty, which in many cases lasted for 10-15 years, tempted the landowners to dispose off their land in the parallel illegal land market on power of attorney. The illegal sale is profitable because the compensation amount would have been very low (based on date of notification) as compared to the market price discounted for illegality.

Up to 1974, none of the surveys had physically identified the area under these colonies. Taking advantage of this ambiguity, many unauthorized colonies have developed as extensions of existing authorized colonies. Unauthorized colonies have also come up outside the urbanisable limits in the agricultural green belt. It has not been possible to restrict urban growth up to the urbanisable limit as identified in the Master Plan. The urban limit was an arbitrary limit and did not provide any physical barrier to prevent further extension. Colonies have also developed in anticipation in areas proposed for urban extension in the Master Plan for 2001 (Ibid.).

The difference in land price between the regularized and unauthorized developments is much higher than the associated costs borne by the residents or plot holders. Further, over time, the real increase in land price is also high. This had encouraged speculative activity so that a large number of buyers purchase the plots for resale. The costs of improvement in these situations are borne by either the society (through outright subsidies or ineffective cost recovery) or the true residents. However, the capital gains largely accrue to the speculators. Investment in the property market by this group has proved to be very profitable.

These areas also attract industrial, commercial establishments and warehouses, as space is available at a much lesser rent than in formal industrial areas and in practice no controls are enforced. The non-residential uses grow without inhibition as the settlement densifies over a period.

Section 29, 30 and 31 of the Delhi Development Act of 1957 and Section 343 and 344 of the Delhi Municipal Corporation Act provide the legal basis for the demolition of unauthorized structures and levying of penalty on those who develop or sub-divide land

without permission. Despite this, unauthorized colonization has continued unabated due to lack of vigilance, negligence and loopholes in the administrative procedures. Connivance of politicians and officials responsible for land protection from police, revenue and local bodies have made colonization possible. Precedence of regularization policy with ever changing cut off dates and lack of punitive action against slack officials have encouraged such developments (Ibid.). Thus, over a period of time the unauthorized colonies have now become an important pressure group. Their residents are largely those middle class people who have not been lucky enough to get a DDA built flat, which is backed by high state subsidy for its development. Nor can they afford the high costs of houses in already established residential colonies.

Infrastructure provision in unauthorized colonies

Most of the colonies are deficient in infrastructure provision. The predominant source of water for most unauthorized colonies is ground water and individual hand pumps are extensively used. In most cases, the water is not potable and residents have to depend on municipal taps existing in nearby localities for drinking water needs or illegal connections from existing water pipe. Municipal water supply system, which is high priority amongst residents exists in some of the regularized unauthorized colonies. Dry conservancy latrines are most common. Each household pays to sweepers for cleaning latrines. Sewage sometimes get disposed off in open drains. Some plot owners have constructed soak pits. Municipal sewer lines are available in only a few colonies. People's priority for sewer line is not very high. In most colonies, drainage is very poor. Water accumulates in low-lying areas and it has become difficult to improve drainage once houses have been constructed. In some cases, plinth of individual houses in lower than the road level. Environmental conditions deteriorate especially during the monsoon. Though some of the regularized settlements have lined surface drains, there is no direct cost recovery for drains. Garbage removal is also non-existent in such colonies. Most of the refuse is dumped on vacant plots or on the periphery of the settlement. Garbage bins are provided in regularized colonies but frequency of removal is very poor. A list of 1,071 unauthorized colonies, which had come prior to 1993, has been prepared. However, these have yet to be identified/ verified from the aerial survey conducted in 1993. Many

of these colonies are on private land, some are on government land, and a few are on land notified for acquisition where the compensation has already been announced and deposited by DDA.

The real estate operators, of different scale, constitute an inalienable part of power politics in the capital. No political party would like to ignore them and many of them are integral part of different party organizations. Thus, the political debate in recent years regarding 'regularizing' the unauthorized colonies reflects the primacy of politics, for there are several competing interests, over principles of sound urban governance.

Area of study

The place where the study has been undertaken is called Vasant Kunj Enclave, an unauthorized colony located in South Delhi near to the Vasant Kunj police station and the 'Spinal Injuries Hospital'. This was also located in between two main markets i.e., Masoodpur and Mahipalpur.

This unauthorized colony now stands on the agricultural lands of Rangpuri village, which had belonged to the Jats in 1920's and 1930's. The area was marked as Rangpuri village, which was located then, in the outskirts of Delhi. But as the city gradually developed, it also started expanding due to which large tracts of village lands were lost in the developmental process. Twenty to thirty years earlier these agricultural lands were sold by the villagers to the government authorities and other private enterprises. Even today some wells (belonging to the Rangpuri village) can be seen on our way to the colony. Besides the residential area, there are farmhouses; a central school; government quarantine plant and a sewage pumping station on the Rangpuri village land. The colony is situated around one and a half km from the main road. The radius of the area is approximately two kilometers.

The colony is not well developed, as the roads are dusty and during rains it becomes muddy. As there are no proper drainage facilities the entire area is flooded with

water. The road leading to this colony has no streetlights. There was a hotel located near to this colony and most of the residents used it for marriage purposes.

The colony has been divided into two phases – A and B. There are fifty-five built plots and besides it, six plots which are under construction. The colony also comprises of three plots, which have temporary rooms and were under the supervision of caretakers. The settlement patterns was scattered and somehow three to four houses were also being built near to the fields that surrounded this colony. There are near about 20 households in phase A of the unauthorized colony. Phase A also comprises of large farmhouses which are usually under the supervision of caretakers. Though some houses had been built, they were rented out by the owners. There is also a mosque and a temple in this part of the colony. In addition to this, there are a large number of jhuggis located in Phase A. There are around 1,000 jhuggis and more than 4,000 people are living here. The basic amenities like proper drinking water and sanitation is better in these jhuggis, when compared to those located in Phase B of the colony.

Phase B of Vasant Kunj Enclave comprised of 35 households and also 300 jhuggis. Earlier, this unauthorized colony had no provision for municipal water and other basic amenities like electricity connections, proper roads, sewage and drainage disposal for its residents. But, now with the setting up of a welfare association in the colony (since 1995), has made matters different. This committee was responsible for making provision for certain basic necessities required in the colony like electricity connection (with metres), streetlights and water supply to the residents. So, this committee was responsible for the upliftment of the colony. All the residents in the colony have their own personal boring for the water supply and for the sewage disposal. They have constructed septic tanks in their houses. The residents too avail electricity connection and separate metres are fixed in each of these houses. The committee members take the metre reading and also pay the monthly electricity bills of the colony in lump sum. But, the roads in this area is 'kacha', it is not made of concrete and as a result is filled with potholes. There is also no proper garbage disposal bins installed by the committee members or the residents of this colony.

This association, therefore, has been trying and making efforts for the authorization of the colony but the DDA (Delhi Development Authority) created problems as, it wanted to acquire this land for its housing project. So the titleholders of the land were the private owners. In phase B of the colony almost all the residents have built their own houses. All of them chose settling here due to the low land-price. It was difficult for these residents to purchase land in any part of South Delhi as, the land prices were usually exorbitant. The residents of this colony liked its location because it was more or less a pollution-free area as compared to other parts of Delhi. They also had other advantages, as the colony was located near National Highway (8) i.e., (Gurgaon-Delhi highway) and the international and domestic airports were also quite close. So, the residents emphasized that there were chances of this colony being developed soon and gain authorization.

Besides, the middle-class families in Phase B of the colony, there are also around 1500-2000 people living in the 300 jhuggis located in this area. Some of the people in these jhuggis have been residing here for the last 15-16 years, as they were engaged in the quarrying work. In those days, there was absolutely no habitation here, except the workers having put up their own tents and jhuggis. These workers were mostly from Bihar, UP and Rajasthan.

Recently there has been an influx of people from Bengal. The quarrying stopped within 5/6 years of its inception and the workers were rendered jobless. But, they still continued living here and are engaged in some or the other jobs. The land occupied by these slum dwellers is within the (Van Vibhag) and therefore their dwelling is not recognized as a government Jhuggi-Jhonpri cluster. The Bengali women are working as domestic servants or maids in the colony. The men too are engaged as daily labourers, and also in other jobs like car washing, pulling rickshaws, selling vegetables and some of them owned auto-rickshaws. The slum dwellers are also engaged as mistris or labourers in any undergoing construction work of this colony and even work as plumbers or dhobis.

The health of the people in these jhuggis is affected due to their living conditions. They did not have provision for the basic facilities, which is required for a decent and

humane living. There is no toilet and sanitation facilities and the people had to defecate in the open. They availed electricity by hooking from the main electricity pole. There is absolutely no provision for the garbage disposal and the regular cleaning of drains. Twice a year, the people from the Malaria Eradication Department visited these jhuggis and sprayed insecticides. The Jhuggi dwellers not face water-shortage especially for drinking purpose as tube wells had been installed by the local MLA.

The jhuggi dwellers complained about lack of health facilities. There are no government hospitals located near this colony. They mentioned that a government medical van visited them once every week. Besides, there is also a homeopathic doctor who has been practicing in this colony for past three years. According to the jhuggi dwellers there existed a stark contrasting picture in this colony. Here the people residing in big house had all the facilities from good school to the best private hospitals, but it was far beyond their imagination to access these facilities.

Since this study attempted to explore and understand the health perceptions of middle class women within limited time, only one phase (phase B) of the colony was selected. This was to make it possible to have access to the middle class women within a manageable study population.

Interpreting Data

Socio-demographic characteristics of women

The socio-demographic profile is taken in to account in this study to have a sense of who the women were. It is not intended that statistical inferences be drawn from them. The profile comprised of certain basic information about the middle class women- i.e., the age of women, marital status, education, employment status, family income, living arrangement/ type of family, religion, caste and class background, and their length of time in Delhi and whether permanent residents or migrants. The following table provides a summary of the socio demographic data of the thirty middle class women.

Table 3.1: Socio-demographic characteristics

Age of Women	
Under 25	0
26-34	17
35-39	3
40-44	3
45-49	3
50-54	2
55-60	1
60 and Above	1
Marital Status	
Unmarried	1
Married	27
Widowed	2
Divorced	0
Education	
None	1
Class 1-5	1
Class 6-8	2
Matriculation	7
Class 11-12	5
Graduation	11
Post-Graduation/ Technical Degree	3
Employment Status (of women)	
Employed	4
Family Business	3
Retired from work	1
Housewife	22
Nature of Employment (of the women)	
Executives	2
Teacher	2
Clerk	1
Self-employed	1

Grocery Shop	1
Private Tuitions	1
Nature of Employment (of the men)	
Executives	10
Engineers/Doctors/Lawyers	4
Government Service	6
Business	8
Retired from work	2
Household Income (monthly)	
Under 5,000	0
5,000-9,999	3
10,000-14,999	14
15,000-19,999	8
20,000-24,999	1
25,000-29,999	3
30,000 and over	1
35,000 +	0
Per Capita Monthly Income	
Under 500	0
500-999	0
1,000-1,499	0
1,500-1,999	0
2,000-2,499	1
2,500-2,999	7
3,000-3,499	8
3,500-3,999	2
4,000-4,499	4
4,500-4,999	2
5000-5,499	5
5,500-5,999	0
6,000-6,499	0
6,500-6,999	1
> 7,000	
Type of Family	
Living Alone	1
Nuclear Family	14

Joint Family	9
Widow (Living with dependant Children)	1
Extended family	5
Religion	
Hindu	24
Muslim	1
Christian	3
Sikh	2
Caste Status	
Upper Caste (Joshi, Bengali Brahmins, UP Brahmins, Pandits-Sharma)	7
Middle Caste (Jats, Ahirs, Yadavs, Rajputs, Bania, Khatri)	21
OBCs	2
SCs/STs	0
Length of Time in Delhi	
Born	4
Less than 1 year	0
1-5 years	4
6-10 years	5
11-15 years	5
15 years or more	12
Resident Status	
Permanent Residents	8
Migrants	22

Most of the women in this locality considered themselves as migrants, who are now settled in Delhi due to various reasons. In fact most of them had settled in Delhi after their marriage. Out of the thirty women, fifteen of them came to Delhi immediately after marriage because their in-laws or husbands had been settled here. Seven of them had come later when their husbands had found jobs here. The rest eight of them were residents here i.e. considered themselves as permanent residents who were born in Delhi.

Data was also collected regarding the caste, class and religious background among the middle class women. Most of the women residing in this locality belonged to the middle castes – Jats, Ahirs, Yadavs, Rajputs, Bania. Seven belonged to Brahmin castes. The majority of the women interviewed were Hindus, though six of them did follow Christianity, Sikhism and Islam.

For determining the class position of the women, household income was taken into account. This size of income determines the status and prestige of the household and thereby of the individual in the society at large. It was important to collect information concerning the caste and class position of the women to see how these factors shaped women's perception and beliefs of health and treatment seeking patterns. In this context it is interesting to note that mostly the income of the male members of the family was taken into consideration by women while assessing their position in the society. Though, women were working, their income was always seen as an add-on or subsidiary to the husband's income. This was especially in case of woman who manage grocery shop and gave private tuitions. Therefore, the class position of women was determined by the income or job security of the males in the family.

Income of almost half the households (14) was within the range of Rs 10,000-15,000. These people can be grouped under the service class working as engineers in private companies, accountants, executives in MNC firms, teachers in private schools or owners of small businesses and some of them were also engaged in government jobs like army personnel or state department jobs etc.

People within the income range of Rs.15,000 to 20,000 also belonged to the service class of senior managers and professionals; like lawyers, media analyst or secretaries in government departments etc. Out of thirty, in seven of the families both husband and wife were earning members. The families belonging to the income range of Rs. 15,000 to 20,000 comprised of two households where the women were employed as teachers. Two of the women, managed grocery or a stationary shop; and also gave private tuitions. Women's income was not equivalent to what their husbands earn. But, they made an effort to contribute to the family's income. Women were able to save this

amount and use it in times of financial crises or managed their personal expenses. In one case, children too contributed to the family's income. There are four households between the income range of Rs 20,000-30,000. Out of which in two of the households both husband and wife were earning members and each of them earned around Rs 15,000. Here both the husband and wife worked as executives in private firms. In other two households, the husbands were the only earning members i.e. employed as engineers or having their own business. They also had other sources of income i.e. agricultural landed property.

Those having an income higher than this range had other sources of earning i.e. family business or income from the agricultural property in the village etc. In this colony people belonging to a higher income category (Rs. 30,000 and above) was only one family. Only three households had monthly income between the range of Rs 5,000-10,000. In one of these families an unmarried woman was employed as a government servant i.e. as a clerk. In other two families, husbands were retired government employees.

So, it can be argued that this colony comprises of mostly middle class families in the context of Deshpande's definition of the urban middle class. According to Deshpande's definition the urban middle class includes everyone with a monthly per capita consumption expenditure of Rs 775 or more, or families of five spending Rs 3,875 per month or more. In the context of this colony, we can see that the per capita monthly income of all families exceeds Rs 775. Fourteen households have a per capita monthly income above Rs 3,500. And the rest of the sixteen families per capita monthly income ranges from Rs 2,000 to 3,500.

Here, it is mostly the male members of the family who are employed while; the women play the role of housewives. It is only a negligible number of women engaged in jobs i.e. they work as teachers, accountants, clerks in government offices etc. out of thirty middle class women, six of them also mentioned that they had been working prior to their marriage. But after marriage, due to various constraints they had to quit their jobs. In most of the cases, the husbands did not approve that their wives should work after

marriage. Men believed that their income was sufficient to run the household. So there was no necessity for the women to contribute to the family income. Further, men were also of the opinion that the women's work after marriage was to manage the house and take care of the children. Women also mentioned that after marriage, some of the decisions were taken by their in-laws. So they had no choice than to abide by their father-in-law/mother-in-law's decisions regarding their work even while their husband was supportive. Out of thirty women, three of them were planning to take up jobs after a few years.

The educational status of women in this colony varied. It is important to note that almost half of the women (14) had graduated, of which three also had a technical/professional degree like diploma, B.Ed., computer training etc. Some of them, who did not receive higher education after schooling, had some constraints and family pressure. Out of thirty women, seven of them had to discontinue studies after the matriculation or post-secondary education due to their marriage. Though the women did want to continue with their studies, their marital family was not supportive. But, the case was different for men. Men had received higher education in majority of these families. It is important to take account of these socio-demographic characteristics, as it provides us with certain facts that are necessary to be analyzed in the context of women's lives.

Perceptions of Health, Illness, Well-Being and Treatment Seeking Patterns

Perceptions of Health: Links with Well-Being

The middle class women perceived 'health as both physical and mental fitness'. According to women health did not mean physical strength but also a positive attitude and a 'state of mind'. Mrs. Trishila Jaswal, though recuperating from breast cancer, she considered herself to be healthy. She had a positive bent of mind and was convinced that she would recover soon. Mrs. Harjinder Kaur also believed that health was a state of mind *(agar man khush rahe to sehat to apne aap hi acha hoga)*. Thus, health was for them closely linked to the notion of well-being. For instance, Mrs. Susheela Solanki, aged 55 years explained that though she had good health referring to physical fitness, she

did not enjoy a sense of well-being. The demise of her grandson had shattered her life. She now felt a sense of 'loss', 'despair' and 'helplessness'. Some women perceived health more as a state of subjective well-being. So the perception of health among middle-class women cannot be explained only in terms of objective parameters.

It can be argued that the women's perception of health was linked to their circumstances in life and experiences. Women also said that health could not be explained in terms of specific indicators.

The perceptions of health varied among women. Some of them responded that their way of life determined their perception of health. For instance, the women's perception of health and well being was closely linked to their various situations in life within the family, their relations with the family members and their identity vis-à-vis other male members in the family. To substantiate this argument we can draw upon another case study of Mrs. Kamala Sharma, aged 55 years. Her life experiences provide us a picture of the nature of problems and difficulties she had to undergo in her marital family. In her opinion, well being emerged from women's condition in life, the social relationships, and the emotional and social support from the family. She mentioned that her life had been a struggle in the marital family. She did not receive any kind of emotional support from her husband or her in-laws. Her husband had an illicit relationship with another woman. He never respected her and also went to the extent of abusing her physically. She had to do all the household chores with no co-operation from anyone in the family. This led to deterioration in her health condition due to work burden and she developed persistent back pain. She also believed that these worries and tensions had a detrimental impact on her overall health condition. Added to this the recent death of her son and daughter left a deep sense of shock and grief. Thus it is important to note that well being was necessarily the subjective concerns and experiences of women and therefore can be understood in relative terms.

Women understood health in its positive dimensions, arising out of an overall assessment of life as functioning smoothly and joyfully. So the term health more or less reflected a feeling of happiness and a sense of fulfillment in the middle class women's

lives. Some of the case studies discussed above clearly brings out the inter-linkages between health and well being, as perceived by the women. Most of them understood health not only as the absence of disease but also a positive state of mind. Though some of the women were not affected by any kind of disease, still this fact did not generate in them a sense of well-being and 'being healthy'.

Most of the women believed that their health was affected due to the 'tensions' and 'worries' in their lives, due to which they did not perceive a sense of well being either. For example, Mrs. Sanpa Chatterjee's (33 years) sense of well-being was necessarily linked to her daughter's health condition. She had a seven-year-old daughter who suffered from a rare form of epilepsy. The often-recurring epileptic fits, resulted in the deterioration of her daughter's mental condition and had also affected her speech. Her daughter's health was a matter of serious concern among all the family members. It was very difficult for her to accept this fact about her daughter's incurable form of disorder. It was difficult for her as a mother, to see the pain, her child had to undergo everyday. Her daughter was seeking treatment from a neurosurgeon specialist and every week she had to undergo all kinds of tests and diagnosis. The doctors had also recommended steroids for her health condition. But, the doctors believed that these tests and medicines could never completely cure her daughter's abnormality. Since the treatment expenses were quite high, Mrs. Sanpa too had to work. Now, as both she and her husband had to stay away from their daughter for a longer duration, this made them feel all the more 'restless' and 'disturbed'. Therefore, her life experiences and circumstances determined her state of well-being. Her daughter's health condition had an overbearing impact on her realization of a general feeling of happiness and satisfaction in life. She also mentioned that she had no control over the circumstances of her life.

The middle class women perceived their health to be better than that of the slum dwellers. Women mentioned that the poor living conditions affected the health of the slum dwellers. They believed that the concern here was more with the issue of survival rather than good food and better living conditions. The slum dwellers did not have basic facilities like water, electricity and sanitation etc. which had an impact on their health

condition. Therefore according to middle class women, the slum dwellers suffered from various kinds of diseases like diarrhea, cholera and malnutrition etc.

To a great extent, what made women think they were healthy or unhealthy is how they were able to live their daily lives, the quality of the food they ate and the air they breathed; their access to health care; how much rest they got and also how much stress they lived with. Mrs. Jaswal believed that a healthy life depended on proper diet and exercise. Mrs. Indira Joshi mentioned that the stress she had to undergo in housework affected her health. Women also mentioned that the resources available to them, especially the financial resources, greatly influenced their health. They perceived that in this unequal society, some people could afford to take care of their health more than others. It is interesting to note that women believed that their emotional well-being cannot be separated from their physical health.

For instance, Mrs. Sona Alick emphasized that 'good health' is closely linked with person's happy and contended life. She was physically healthy in the sense she did not suffer from any kind of illness, but was constantly worried about her family life. According to her, this necessarily affected her health. Her husband was settled in Dubai, and she had to manage the house and children. She did not enjoy her life as a whole, as she had lost her peace of mind. She took up the entire responsibility, as there was not much support from relatives and friends. Mrs. Mini Khanda also emphasized that (*aap agar 'man' se khush nahin hai, to iska asar sehat pe padega hi*). She said that when she felt happy in her daily life circumstances, it gave her a sense of well-being. She felt her life as worthwhile and this made her feel healthy and joyful. This necessarily arose out of her relationship with her husband, children and elders in the family. So, the emotional support she received from family members and the closeness within family shaped her health condition. Thus, here, the majority of middle class women perceived that their health and well-being was affected by their social relationships within the family.

Thus, it is important to argue that the perception of health of middle class women was deeply implanted within the concept of well-being. And that well-being was understood as an 'all-inclusive' term, which related to women's experiences and

circumstances in their life. The women provided a holistic concept of health, in which mental and physical aspects were equally important; the health problems of women seem to be derived from their multiple social relations. In this context Allan Young's model i.e. the internalizing and externalizing systems of concepts of disease and illness, is important in theorizing our findings. This can help us in understanding the women's perception of health and illness. Women may view their health and illness basing on the 'objective examination' of physical signs of disease as well as subjective feeling without any obvious ill-health.

In this study, it can be seen that many women were consciously or unconsciously affected by sexist discrimination. Women also perceived that men's needs took precedence over their needs. They also mentioned that they were fitted into certain roles that completely negated/ crushed their identity.

Perception of Illness

The women perceived illness to be a part of the natural order or a way of life. Mrs. Kamla Dhaiya had persistent back problem but she considered herself to be normal. Ms. Suman though was affected with polio was able to manage her life on her own. She was unmarried and was in service. She never perceived herself to be anything different from a normal person. Women believed that their illnesses in various ways reflected the world in which they live and what do they do in it. Women perceived 'illness' – as a state of ill-being. Out of thirty, ten women viewed illness as 'weakness'; 'being functionally unfit'; 'giving in to diseases', and a 'sense of uneasiness'. Twelve of them perceived ill-health to be pain in various parts of the body, feeling overworked and tired to easily. Rest eight of the middle class women perceived ill-health in the sense of having a disturbed sleep and unable to carry on with the housework, not perceiving a sense of physical fitness.

However, women's illness perceptions were shaped within the structures of the society. When ill, some women experienced inactivity while, some of them carried on with their day-to-day household chores and denied its existence. Many of the minor illnesses that occurred did not interrupt or disturb their daily work schedule. Most of the

women, though suffering from 'back pain', 'headache', 'cold', 'fever' etc. did not consider themselves to be ill enough to stop working or go for treatment. Some would try home remedies. However, even when they did perceive an illness which required resort to a doctor or necessitating rest, they would ignore it since as the women mentioned, they were more concerned about the health condition of their family members. Therefore, the women did not value their health; in relation to that of their husbands and children. Their foremost responsibility was to take proper care of their husbands and children and manage the home. The definition of an illness was commonly seen to be linked to the ability of managing the home. The social life i.e. their role of caring and fulfilling the obligations within the family took precedence or was emphasized over individual well or ill being. Women felt that their life was worthwhile to be able to care for their husbands and children. They considered themselves responsible to maintain the health of their family members. They enjoyed performing the role of caregivers in the family, as it gave them a sense of satisfaction and fulfillment.

Most of the women viewed health and illness as a part of life. For instance Rita Nahata (45 years) perceived 'health' as physical and mental fitness. She also added that an attitude in life is also important in order to achieve good health. To feel healthy was more a state of mind. Though, she was unwell, (i.e. she suffered from kidney problems) and had to undergo regular check-up and treatment this did not disturb her daily schedule. She also mentioned that medicines had become a part of her regular diet. But, since she was working, it was difficult for her to follow any kind of strict regimen. She did not believe that maintaining the health of the family members was her priority at the cost of neglecting her own health. In fact, she and her husband had their own responsibilities, work schedules and functioned according to it. However, this illness had become a part of her normal life. She was engaged in her daily routine of work, managing both the house and her work. Therefore, she did enjoy a sense of well being though ill.

Mrs. Beena Singh too perceived her illness condition as a way of life. She suffered from diabetes and high blood pressure. But, this did not detract her from continuing with the regular pattern of life. She believed that the perception of illness varied among women. Some of them considered 'illness' as weakness condition, and

'losing their ability to work'. But, in her case, she was actively involved in her day-to-day work engagements, like cleaning, cooking, marketing, etc. She believed that a person's attitude towards life was very important during his/her state of illness. A cheerful and tension free attitude towards life, kept her going. She also emphasized that a physically fit women cannot be called healthy, if she constantly kept worrying over here life and her family's health. Therefore, concepts of health and illness was closely linked to the subjective state of well-being.

Accessing treatment

In this context it is important to cite the illness experiences of Mrs. Priti Ahuja (27 years). She mentioned that after a few months of her marriage, she had developed a cyst in the stomach and was hospitalized for nearly a fortnight. It was then that she realized her importance and worth in the maternal family. Her in-laws and her husband were not concerned about her health and illness condition. She survived because of her parents who took care of her during the period of her illness. Initially, she had neglected the illness symptoms – like giddiness, and severe pain in the stomach. She thought that the pain was caused due to an upset stomach. It did not disturb her daily schedule of work, i.e., she was able to manage the cooking, cleaning work in the house. But, after a few days, her condition deteriorated, and the pain was so severe that she was unable to move. At this point of time too, no treatment was sought. And her mother-in-law told her, that she was pretending to be sick because she did not want to do the housework. None of the other family members also took care of her. In fact, they decided to send her back to her parents, as she had become a burden on them. She emphasized that she survived because of her parents' support and care. They were the ones who had borne the treatment expenses. She believed that in her marital family much importance was given to the health of the male members and that of her mother-in-law or sister-in-law.

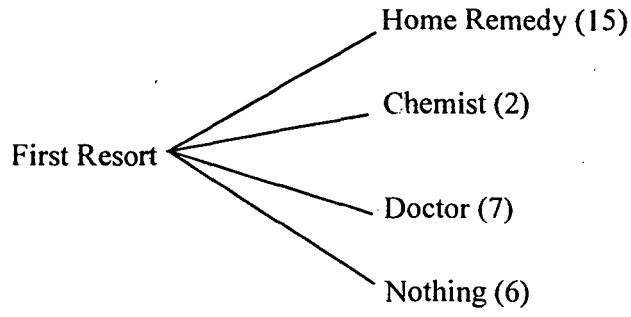
Mrs. Shashi Gupta. She too perceived that her family members were not concerned about her health and well-being. When her husband or children were affected with any illness, treatment was sought immediately. But, in her case things were different. She was forced to do all the housework even when she was unwell. She said

that during her illness, when she suffered from appendicitis, treatment was sought only when her condition became severe.

Women too neglected their illness symptoms, until it interrupted their regular pattern of life. It was only when they were unable to manage the home and take care of their children and husband that they perceived themselves as ill.

Initially they tried to deal with the problem at home itself, whether through self-medication or home remedies. Out of thirty women, thirteen of them initially resorted to home-remedies, if unwell. It was only during some form of severe illness/ disease that a doctor was consulted or other kinds of treatment were sought. In cases of cold or cough, they had ginger tea or 'tulsi'. And sometimes during fever, back pain etc. they had medicines like Dispirin, Crocin, or also applied Iodex, Moov etc., with the doctor's consultation. Most of them in cases of severe illness, also sought treatment from an allopathic medical practitioner, private health care services and government hospitals. Women believed that proper diagnosis of the disease was done in private hospitals, though, the treatment cost was higher. For instance, Mrs. Rini believed in allopathic treatment and mostly preferred private hospitals. Mrs. Trishila Jaiswal who was undergoing treatment for cancer believed in allopathic medical practitioner. Though the medicines had side effects, she recovered well with these medications.

First Resort Taken by Women During Ill-Health



Issues of identity

Women's identity in the family/ society was closely linked to her autonomy and freedom, in taking her own decisions in life. Exercising her own 'agency' to negotiate with issues in her daily life determined her status in the house. Women's ability to take decisions in certain matters of their life helped them to have control over their own situation and circumstances in life. Within these households it is generally seen, that most of the women had a devalued status due to unequal power relations. Out of thirty women interviewed, twenty of them said that they had no freedom to take certain important decisions that greatly affected their lives and their health. For example, in matters of pregnancy/ childbirth, the men were the sole-decision takers of when and how many children to have. These matters were never considered important to be discussed with women. Men never bothered to seek their opinion, about how they had wished to plan their life. So, if a woman was not prepared for a child, she had to bear it, as there was no other 'choice' for her. She had to give in to the demands of her husband. In some of the cases, as noticed in this study, a woman had to undergo an abortion because her husband and in-laws did not want a girl child again. She already had two daughters and her family members now wanted a son. She had to undergo pre-natal sex-detection test and again it was a female foetus. Though, she had refused to undergo an abortion, her husband forced her into it. In another instance a woman had to undergo an abortion in her first pregnancy, because her husband was not prepared for a child within a year of their marriage. He was in the army and had to stay away from his family for a long periods.

Majority of the women in this study took decisions only in matters regarding the routine household purchases, the ration, buying vegetables or shopping some small accessories for the house, like some kitchen set, bed sheets etc. According to the women, their husbands took all the major decisions in the house – like the childrens' schooling, building a house, where to live etc. But, the women were not consulted prior to taking these decisions. Out of thirty middle class women, fifteen of them had taken it for granted that their husbands should do the decision-making in the important matters of the house.

The women's identity in relation to other members of the family was also determined by their access and control over family resources. In this study, it was seen that most of the women did not have access to the family resource and it was mostly controlled by the elders or male members in the family. These people were considered to be responsible and were also the sole decision makers, who were consulted in each and every matter. Out of thirty middle class women, twelve did not handle the income of their husbands. But the women believed that the control over resources would in some way enhance their status in the house. They would be able to take decisions regarding their own health and illness, where and when to seek treatment.

Women also mentioned that if they had access to resources, they could plan their lives in their own way. In this context, women also mentioned the pros and cons of working. Most of the women believed that the working women enjoyed more freedom within the household. So, the economic independence of the women determined her position in the family. Women who were working had a better status, because they also took the major decisions of the family along with their husbands.

Out of thirty, two middle class workingwomen perceived that there were certain disadvantages of working. Though the women had a better status, which was determined by their income earning capacity they had a double workload. The women also perceived that this workload had a detrimental impact on their health. They tried to maintain a balance in their daily life. It was difficult, because they had to straddle both worlds, the workplace and the home. Women also mentioned that after working long hours in the office, they also had to manage the household chores and take care of their children. So, they often felt tired and also had a sense of 'guilt' for not being able to cater to the needs of their family members.

But on the other hand they also had a feeling of satisfaction, for contributing to the expenses of the family, and so, in a way women were able to lessen the burden of responsibility on their husband and also manage the household during any financial crisis. The most important fact to note is that due their economic independence they were able to exercise their agency, take their own decisions, i.e. regarding purchase of any

assets in the home, (TV, refrigerator etc.), decide when and how many children, which school for children, and also in the matters of the family. Women too believed that all the members of their family consulted them before taking major decisions. But the women who were not employed did not enjoy this kind of freedom due to their dependent status.

Three of the working women also mentioned that their husbands were very supportive and helped them in their housework. It is also important to note, that most of the workingwomen did not neglect their health condition. In fact, they took decisions concerning treatment of their health and that of the family members. Therefore, women perceived that they could exercise their agency in negotiating issues in their day-to-day life because of their independent status.

The women also narrated experiences of their workplaces. Two of the women, who worked as executives in private firms, said that the work atmosphere was good. People were very professional and their colleagues were also co-operative. The women responded that the company provided them with all facilities – like travel and holiday allowances and bearing medical expenses etc. Two of the women who worked as teachers also said that they did not face any kind of discrimination and the workplace was conducive. But, another woman who was employed as clerk in government service faced problems at her workplace. Her male colleagues used to crack jokes and pass lewd comments at their female counterparts. So, she perceived that the sexist attitude of men, led to harassment of women.

Further, we have also tried to analyze the division of household duties in the family because the nature and burden of work determined the women's health condition. Most of the women mentioned that they had to do all the housework on their own. They did not receive any help from other family members. Some of them said that it was the 'duty of the wife' to see to the cleanliness of the house, washing, cooking, marketing, looking after the husband's and children's needs. Out of thirty in twenty-three of the families, the husbands never cooperated or helped the wives in their daily tasks. In twelve cases, the women refused to accept any help from their husband, in performing the chores of the house. They believed that their husbands were tired after the office-work and

needed to take rest / relax in the house. Few of the men did buy the monthly ration, pay the phone and electricity bills, and purchase other accessories for the house. In this context, it is important to cite the study by Arlie Hoschild (1990). It is interesting to note a particular case-study in this book where a couple to avoid conflicts concerning the housework and so had made certain arrangements. The husband had to manage the 'downstairs work', which included cleaning the car, taking the dog for a walk and purchasing the household accessories while on the other hand, the wife had to manage the 'upstairs work', which again included cleaning up after meals, doing laundry, cleaning the house etc.

In our study it was seen that the men mostly did the 'downstairs work', which involved getting the children from school, buying vegetables etc. However, most of the women perceived that certain health problems, like backache and pain in the joints and various parts of the body were due to the limitless tasks in the house. Most of the women also perceived that they suffered from headaches due to lack of sleep. From early in the morning till late hours in the night they were involved in some or the other work.

Overall assessment of women's life within the society/ family

Here, we have tried to see whether the woman perceived any change in her position within the marital and maternal family, their views regarding issues of national development and changes in the society.

Out of thirty, four of the middle class women perceived their life to be miserable, the circumstance of their life were beyond their control. There was a feeling of helplessness about these life circumstances. Five of them perceived that a sense of unhappiness crept in their lives, as they did not have any freedom to make their own choices. This was the view of women as they believed that their importance was marginal in the family, in comparison to other members. It can be argued that there were some contradictions in the view of these women. Out of thirty, eight women did believe that the women's responsibility was to manage the home and men were necessarily the breadwinners.

Women mentioned that they had a subordinate status in relation to men and faced differential treatment all through their lives. Women also faced discrimination in their maternal family. Most of the women said that they could not continue with their education because their parents pressurized them for marriage. They also did not have the freedom to decide who and when to marry. It is important to note that Sunita Sharma perceived her status to be better in her marital family. She said that her parents showered all their affection on her brother. She also mentioned that her parents restricted her movement, after she passed her high school, i.e., she was not allowed to pursue further studies, and also mingle with her friends. Now in comparison to her life earlier, she felt better in her marital family. She was able to take certain decisions, concerning her children's schooling, household expenses etc.

Therefore, most of the women believed that they had limited ability to control their own lives. The personal experiences of the women differed. Some of them experienced ill treatment in their marital family. In most of the cases, women mentioned that their family members restricted their freedom; they did not permit them to work and there was no freedom of spending their own money. Many women also had no control over the family resources, which was mostly controlled by their in-laws or husband. For instance, Mrs. Santosh Manocha did not receive any support from her marital family after her husband's death. Her brother-in-law also tried to take control of her husband's property.

Therefore, the picture, which emerges from experiences of women, is quite complex. Perceptions about changes in women's situation in the family and society were discussed at length. There was agreement overall, among the women that they were better off now than they were before. More of them were educated, more of them were employed, and their prospects were bright. It is interesting to note, that there was a positive attitude to educating girls especially among the women. They would like their daughters to study and get jobs and earn a salary, unlike them. Women's employment was seen as necessary to be able to meet the increasing expenses towards the children's upbringing. On the other hand, according to the middle class women, there was still

discrimination, violence and harassment towards women in our society. Women were burnt to death for dowry, sexually harassed within homes and workplace and subjected to other forms of violence. They also discussed about the safety issues of women in Delhi. Some of them also raised the issues of Gujarat carnage and how women had been subjected to violence, brutality and rape. Therefore women mentioned that the only solution was to change the attitude and mindset of the people in our society.

Discussion

In this study we can see how women's health problems are largely determined by the subordination in gender power relationships even among the educated urban middle class. Women's perceptions of health are important to take into account because women's lives are inevitably linked to certain system of relationship that denies them access to information and resources. It is important to study the concrete mechanisms through which these systems work. We have attempted to develop a theoretical framework that includes not only gender hierarchies but also the linkages between different kinds of hierarchies of class, caste, etc. since they are closely interlinked and form the basic structures which shape the lives; health and perceptions of the women just as they do of men. These power relations are not easy to change. Gender relations, caste and class relations are intertwined in systems that have very efficient self- perpetuating mechanisms (Carmen Barroso cited in Alice J. Dan, 1994). Women's perceptions, in this study are examined within the environment of social control imposed by their position in the society and the family. It is important to note that the hegemony of patriarchy continues even today, despite the changing roles of women.

It is evident through various other studies that the socio cultural and economic realities that women face in India complicate their access to health services. Indian women are conditioned to tolerate suffering and are therefore slow to respond to their own medical needs. Women are subjected to conditions which allow them only to reproduce existing patterns with little ability or means to modify the economic and social structures around them (Ford Foundation, 1994).

In this study of middle class women, it is interesting to see that though there are fewer resource constraints to access health care services, women often prioritized the health of the male family members and children. These women had entrenched the idea for being responsible to provide care for their family members.

Family and societal customs dictate the extent to which a woman is permitted to seek health care. They are forced to fulfill the obligations imposed on them as wives. Societal norms and family requirements, in particular, determine when and how many children they should bear. In case of taking decisions regarding childbirth, it was found that majority of the middle class women had absolutely no choice, than to give in to demands of their husband. The husbands never bothered to seek their opinion, about how they had wished to plan their lives. Thus the wide range of sexual and familial relations that exist in the country and the variety of subject-positions that are therefore available to a woman are, in the process, homogenized and naturalized in a conservative mode (Susie Tharu and Tejaswini Niranjana; 1989). For instance, women have no control over the conditions in which they get pregnant; and they have no freedom to take decisions regarding childbirth. In this context, it is interesting to note a widely publicized statement by Werner Foros, President of the Washington-based Population Institute. While Foros does cite resource shortage in third world countries as an important factor in population planning, he seems far more distressed that a majority of women in such countries had no control over their fertility, that the important right of choice was not available to them. In the same statement, he quotes a survey in which three hundred million women worldwide had said that they had not wanted their last child; "women today do two-thirds of the work, earn only one- tenth of the money and own less than one percent of the property" (Ibid; 1989).

From the case studies discussed earlier we can understand how middle class women's health perception was closely interlinked with her position in the family. The women perceived their health condition within the context of their day-to-day life. While subordination continues their perception show that they recognize the subordination and also recognize that it is less than that of previous generations. They wanted to get out of these conditions and further linked their own situation to that of women in society in general. The middle class women differentiated their life conditions from women of other classes. The middle class women saw their living conditions (especially economic) better than that of working class women but few of them argued that though belonging to the middle class they enjoyed lesser freedom than the women of working class. This can be explained in matters of taking decisions, exercising their agency and being able to step in

to the public sphere and gain their own economic independence. The findings also demonstrate that even within a class the women's perceptions are not homogenous. It was found that the working women in the middle class could exercise their agency in matters of their own health, if they perceived themselves to be yield they sought treatment immediately. They also took decisions in household matters like children's education, how many children to have, and where to live etc. The middle class women perceived that the position of an employed woman in the family was better than that of a woman who was not economically independent. The unemployed middle class women often had to abide by the decisions of their husbands and mothers-in-law in everyday matters like what to cook, when to take rest, and in the case of going to the market etc.

In fact, in this study we also become aware of the operating social structures that are responsible for undermining the health status of women. These structures make the circumstances or situations unfavourable for women to optimize their health. An important issue that emerges from this study is the lack of power of women in most of the different contexts that has been studied. This research on middle class women has attempted to explore their health beliefs; understand what women can and cannot do to alleviate their burden of ill health; examine women's health-seeking behaviours; and assess social and cultural constraints to using health services.

However, there is a need to examine the context in which belief systems are constructed, and the social inequality within the society that impinges health and illness management. In this study we can see that a complex set of factors influence how a woman perceives and manages her illness, within her daily life situation. The case studies are illustrative – because through these narratives it has been possible to examine how women's subordinated position prevails in their relations with men, and how this domination, in turn, is a key element that partially shapes their subjective experience of health and illness.

In this context it is important to note, that in the Indian situation where women are chief producers of health care within the household, they are also the most neglected as far as their own health is concerned even within the middle class where resources are not

as much of a constraint as among the poorer sections. Even in the better-off households where low status of women is combined with their own low self-esteem, women often practice 'self-denial' or self-control, when it is time to take action against ill-health (Soman; 1998). Women's ailments are usually ignored at initial stages and medical help is sought only when the illness is either chronic or serious (ICSSR 1977 cited in Ibid.; 1997). Thus, women's low self-esteem also acts as a barrier in improving their education and income earning capacity. In this study we can see that women's lack of recognition of their right to health results in their not knowing or ignoring symptoms of illness. Sen in his study has emphasized that intra-family divisions involve significant inequalities in the allotment of food, medical attention, health care, and the like (often unfavourable to the well being – even survival – of women), but also the lack of perception of personal interest combined with a great concern for family welfare is, of course, just the kind of attitude that helps to sustain the traditional inequalities (Sen in Irene Tinker ed.; 1991).

This study demonstrates how women's perception of health, involving notions of disease, symptoms, normal functioning illness, etc., are closely linked with the structure of the society concerned. It also tries to show how they are all socially constructed. Understanding of the lay views on causation of health and ill health is also important for the design of those health education and health promotion programmes aimed at making people change their behaviour in a way likely to improve health, and for understanding some of the basis for individual use or non-use of health services and patient 'compliance' with treatment regimes (Curtis and Taket, 1996). It is important to note that this study examines the concepts of health implicit in women's definitions of themselves as 'healthy' or 'ill', and in perceptions of the causes of ill health.

Such an interpretation is suggested, for example, by Stacey (1988: 152 cited in Curtis and Taket; 1996: 34) "the beliefs of lay people have their own logic, a logic which can be seen when the believers are located in their social context... Certainly a good deal of evidence suggests that aspects at least of lay concepts vary from one social class to another in ways that appear to relate to the material difference between the classes..."

In this study the middle class women saw health as being the absence of illness or the absence of serious illness. They tended to integrate mental and physical health into their concepts of health. Here, it can be seen that women's health depended on other characteristics, like socio-economic position or family composition. In middle class extended families women had a more subordinate position as the elders or the male members controlled the resources in the household and were the major decision makers in each and every matter. They had absolutely no space for taking decisions regarding their own life. Thus, from our study it can be understood that women's perceptions of health and illness beliefs are intimately linked to power structures operating within the household.

In this context, it is important to note Cornwell's study (Currer and Stacey; 1986) where she has emphasized that 'it is not enough to know that health is interpreted as "functional ability" or "capacity to work" without knowing something about the nature of the work people do and of their relation to it.' Therefore, it is important to understand the context in which the perceptions are shaped, and their social construction.

The large majority of Indian women combine a multiplicity of roles, each with different health implications. Women have a vital role to play as producer, either of material goods and a wage, or services such as child care and care of the elderly, and cooking, cleaning etc. In this context their perceptions of ill health and discomfort vary: women do not often have the privilege of reporting 'sick'. In this study on middle class women it was found that most women had no rest at all. Cooking, washing and cleaning occupied their time, and men rarely helped.

A standard feature of this intra-family division of work is that women's responsibility for the entire housework is considered non-negotiable. Even when entrusted with additional tasks, she cannot abrogate her responsibility for the former. Through time, as a woman ages she can expect to share it with her children and her daughter-in-law: but at a given juncture, she cannot expect to shed any part assigned to her (Banerjee; 1996). In our study of thirty middle class women it is important to note that majority of women's function was to serve the various needs of the household

without imposing their own preferences anywhere. Their training and socialization too mainly aimed to develop this ability to combine several tasks and carry out these functions effectively without any complaints. Households also strongly induce women to closely identify themselves and their well being with their marital families. In this study I have also argued that an important component constituting middle class women's overall position in society is the degree of autonomy that they enjoy over their own lives. It has been argued, here, that the households appropriate the power for taking crucial decisions concerning women.

We have described the inner life of the household and how a complex interplay of factors determines women's health conditions. Middle class women's status is further related to many other factors and therefore the study included information on socio-economic status, education, caste, family composition and contact with the natal or maternal family. Therefore, this study has given voices to various middle-class women. In some respects the women are similar, particularly in their limited ability to control their own lives. Still, their personal experiences of health and illness beliefs differed.

The women's narratives betray the conflict between prescribed gender roles and changing realities and expectations. Few of the middle class women saw it fit to enunciate a number of qualifications for a 'good' wife, or a 'good' woman. A 'good' wife for them was one who took good care of the house and children. She had to be thrifty; she did not buy things for herself unless her husband asked her to. The picture, which emerges from the experiences of the middle class women in this study, is quite complex. On the other hand, the middle class women were also aware of their right to be treated as individuals in their own right. Few of them perceived that they were consulted in family matters more than before. Yet again, the middle class women were denied autonomy especially in the 'private' sphere. They could be managing the household finances but without having the freedom to spend money on themselves or on their maternal family. And while their physical mobility is not usually restricted in terms of not being able to step outside the house, these middle class women rarely have the freedom to move around, without their husbands or in-laws' knowledge and consent, even if it is in the company of other women.

However, nothing that would dislodge the male authority and cause imbalance in the current gender power equation is tolerated. Although majority of the middle class women were dissatisfied with their situation, they were still far away from challenging the established norms. The middle class women wanted greater personal freedom in their lives, i.e. how many children they will have and when, and to be consulted in household matters. In this context it is important to cite N. Kabeer study (2001) where she has argued that some choices have greater significance than others in terms of their consequences for people's lives. We therefore have to make a distinction between first and second-order choices, where the former are those strategic life choices, which are critical for people to live the lives they want (such as choice of livelihood, whether and who to marry, whether to have children, etc.). These strategic life choices help to frame other, second-order, less consequential choices, which may be important for the quality of one's life but do not constitute its defining parameters.

It is against this background that the perceptions of health and illness have to be viewed. In this study, majority of the middle class women viewed health and illness as a part of life. Their life experiences and circumstances determined their state of well-being. The health condition of the family members had an overbearing impact on the women's realization of a general feeling of happiness and satisfaction in life. The majority of the middle class women also mentioned that the resources available to them, especially financial resources, greatly influenced their health. They also perceived that men's and children's needs took precedence over their needs in the family. Therefore, women's health or, illness ailments were not of much concern for their family members. When ill, majority of the women carried on with their day-to-day household chores and denied its existence. Women ignored the ailments like back pain, headache and fever as minor illnesses that did not disturb their daily work schedule. It is also important to point out that majority of middle class women believed that their health was affected due to tensions and worries in their day-to-day life context and so they did not perceive a sense of well-being. In this study it is important to note that though women suffered from ailments most of them resorted to home remedies and self-medication. They sought treatment only when these did not help.

If these are the perceptions of the middle class, it is not difficult to understand why our health policies and programmes are so gender insensitive (Qadeer; 1998). They also point to the need for a more holistic approach to health where societal conditions, social structures and social relationships are geared to improving quality of life. More equitable power equations within social relations would be significant contributors to health.

The recent gender inequity approach to health (Standing 1997) considers the gender-skewed allocation of resources and power in the household as among the critical factors responsible for women's disadvantageous position within the health-care system (Maya Unnithan-Kumar, 1999). As feminist scholarship in the 1980s anthropology and more recently in economics have shown, the household, far from being a 'natural' (biologically determined) unit of members with homogenous interest, is in fact a sight of continuous negotiations, with decisions made through both consensus and conflict (Harris, 1980; Sen, 1990; Agarwal, 1994 cited in ibid, 1999). Therefore as gender roles and relations within and between household vary from one material, social, cultural and ideological context to another, decisions regarding matters of healthcare become at once both complex and challenging to understand. Instead of looking at inter and intra household relationships as two distinct sets of relationships as Dasgupta and Chen (1995) do, we need to understand power relationship between sexes within the socio-economic context which constantly impinges and alters power relations within families (Adams and Castle, 1994 cited in Qadeer, 1998). This social level of intervention is one which calls for social and political mobilization to create conditions that make recognition of women's needs and women's assertion of their needs within families easier. At the policy level again, debate on health can be meaningful only if it addresses the socio economic and political context of health.

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