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Feminisation Of Poverty And Women's Health

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Abstract
The phenomenon of poverty is historical in nature and the plight of the poor appears to be as old as human history. Poverty is the lack of resources and capabilities to fulfill the basic needs of life. Feminisation of poverty was coined by Diana Pearce in 1978 which posits that women compared to men have a higher incidence of poverty. Feminisation of poverty is due to relative poverty rather than absolute poverty. This paper seeks to examine feminisation of poverty in relation to women's health. While the health of both men and women is adversely affected by poverty, a higher proportion of women suffer from its effects because of increasing 'feminisation of poverty'. This study has utilised secondary sources of data. From the 'feminisation of poverty' lens, the paper highlights the status of women's health in the state of Meghalaya.
Keywords: *Feminisation, gender, poverty, reproductive health, health care.*

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I. Introduction

Poverty is generally considered to be a measure of deprivation of the basic needs that a person, household or community requires for maintaining a basic standard of living. Deprivation can be either in terms of a lack of resources, capabilities or both (Hagenaars & De Vos, 1988). There is ambiguity as to how the term poverty is described. Historically, poverty has been related to income, which still remains the core of the concept today. It has evolved from the 19th century idea about 'subsistence needs' – what a person needs to survive, to the mid-20th century conceptualisation of lacking 'basic needs', extending the subsistence idea by also including basic facilities and services such as healthcare, sanitation and education to the late 20th century understanding of poverty as 'relative deprivation', including of income and other resources, as well as social conditions (Ludi& Bird, 2021). The United Nations in the final declaration of the World Summit for Social Development in 1995, concluded that: 'Poverty has various manifestations, including lack of income and productive resources sufficient to ensure sustainable livelihoods; hunger and malnutrition; ill health; limited or lack of access to education and other basic services; increased morbidity and mortality from illness; homelessness and inadequate housing; unsafe environments; and social discrimination and exclusion. It is also characterised by a lack of participation in decision-making and in civil, social and cultural life" (World Conference on Women, 1996). Poverty, although commonly associated with the lack of income, is also characterised by the denial of opportunities and restriction of choices needed to enjoy a decent standard of living (Fukuda-Parr, 1999).

This article seeks to examine feminisation of poverty in relation to women's health. The first section of the paper analyses the discourse on the idea of feminisation of poverty, the second section explores the correlation between feminisation of poverty and women's health and the third section discusses the status of women's health in Meghalaya in relation to feminisation of poverty.

Feminisation of Poverty

The coining of the term 'feminisation of poverty' is traced to the work undertaken by Diana Pearce on gender and poverty in the United States between the 1950s and 1970s. However, the term reached a global status in 1995 at the Fourth United Nations Conference on Women (Chant, 2014). The concept was initially used to explain a phenomenon starting in the 1970s in the United States, where it was observed that the number of female-headed poor families with minor children increased, while the number of male-headed poor families (male only or both partners) decreased during the same period. Later on, the concept became common in relating poverty with gender inequality throughout the world. Feminisation of poverty thus means, specifically, the increase in the lack of financial resources in female-headed households in comparison to that in male-

headed households (Moghadam, 1998). Feminisation of poverty has been interpreted throughout the literature in a variety of ways. Most notably it has been associated with the following claims: women are the majority of the world's poor, the prevalence of poverty among women is increasing relative to men over time, and that growing poverty among women is linked with the 'feminisation' of household headship (Chant, 2006) .

For the last three decades, many women's advocates have been arguing that women are poorer than men. The most common empirical expression of this idea is the concept of "feminisation of poverty." This idea has been a vehicle for shaping analyses of poverty and poverty alleviation strategies. It has also opened a new way of understanding the experiences of women (Veeran, 2000).

Traditionally, poverty is defined in absolute terms. However, in recent decades poverty has been defined in relation to level of income, or social condition, accepted as average or normal for a society. A major distinction between absolute and relative poverty is not that both are matters of degree, but with the former the judgment of poverty is made with reference to man. In contrast relative poverty is seen with reference to a specific society or culture (Shaw, 1988). In other words, while absolute poverty refers to the set of resources a person must acquire in order to maintain a minimum standard of living, relative poverty is concerned with how well off an individual is in relation to others in the society. An absolute poverty line is a measure that could, adjusting for price fluxes, remain stable over time; a relative poverty line however is expected to shift with the overall standard of living in a given society (Mowafi, 2004).

Relative poverty locates the phenomenon of poverty in the society under study. From this perspective, a person is considered poor when they are in a clearly disadvantaged situation, either financially or socially, with regards to other people in their environment. This idea of poverty is closely linked to the notion of inequality. The classification between poor people and those who are not poor depends on the degree of development of the society under study and cannot be transferred to a different society (INE, 2007). The consumption or income approach to defining poverty has come under sharp criticism. It has been suggested that in the analysis of poverty, common property resources and state- provision of commodities should be taken into account and the concept of poverty should be broadened to include dignity and autonomy. From this perspective being non- poor implies a freedom from the necessity to perform activities that are regarded as subservient and (their) ability to choose self-fulfilling and rewarding life styles (Baulch, 1996).

From a relative poverty perspective, women are indeed poorer in most societies in many dimensions of capabilities such as education, health and employment. Gender inequalities in the distribution of income, access to productive inputs such as credit, command over property or control over earned income, as well as gender biases in labour markets and social exclusion that women experience in a variety of economic and political institutions form the basis for the greater vulnerability of women to chronic poverty (Godoy, 2004). Women are also relatively time poor and much of their work is socially unrecognized since it is unpaid. Even when women are in paid work, the return of their labour is lower than the return to men's labour. Men tend to have more command over women's labour so that in crisis situations they may be able to mobilise the labour of women, while women generally do not have the reciprocal right or ability to mobilise men's labour (Catagay, 2001).

The concept of multidimensionality of poverty makes it clear that poor people often face trade-offs between different dimensions of poverty in their struggle with deprivation. Women face many more such trade-offs compared to men as their economic choices are more socially constrained and as their work burden is almost universally higher. Although it is clear that poor women should not be viewed as passive victims and their agency should be recognised, gender relations and inequalities cause women and men to experience poverty differently within households (Catagay, 2001).

Linking feminisation of poverty with women's health

The topic on women and poverty is not new; it was discussed at the First World Conference on Women held in 1975 at Mexico City. According to Donner,"Poverty discriminates, striking women substantially more frequently and more severely than men" (Smith, 2009). Women still account for the majority of the poor; 70% of the world's poor are women in the developing world. More than 800 million people continue to live in poverty and that 'women are more likely to live in poverty than men'. Poverty has a 'female face' was established as a 'fact' during the Fourth Women's World Conference in Beijing in 1995, when it was stated that women constituted '70% of the world's poor, and rising'. This led to the understanding of 'feminisation of poverty' (Bradshaw et al., 2017). The Constitution of the World Health Organisation (WHO) maintains that "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political beliefs, economic or social conditions", yet many women throughout the world are being denied this basic human right. According to the WHO report, although girls are born with a biological advantage over boys, this advantage is often cancelled out by the social disadvantages girls suffer. Such social disadvantages are often related to gender differences (Cohen, 1994).

There is a link between poverty and health. Taking poverty as a primary determinant of poor health for men and women, the impact is more on women's health. Poor women face difficulty to access health care due to lack of adequate funds for transportation or for child care. Women engaged in low-level jobs do not have the time to visit the doctor. Poor women are unable to afford treatment when ill; suffer gender discrimination, time poverty and the burden of care; have low esteem due to socialisation, and therefore have less decision making power with regards their health. For instance, in terms of sexual and reproductive health, out of-pocket expenditure is one of the reasons for lack of utilisation of Emergency Obstetric Care services, which is critical to the survival of the mother and child (Awin, 2014).Poor women and poorly educated women have shorter lifespan, high rates of illness and death, and more limited access to health care services. They also experience financial limitations. For instance, lack of resources to pay for transportation to reach the health facilities where they access quality care at critical moments. Poverty hampers women's ability to use available maternal care services (Izugbara & Ngilangwa, 2012). Poverty is associated with reduced financial independence of one's ability to sustain pregnancy needs especially in terms of food and nutrition. Malnutrition is one of the common conditions found among pregnant women living in poverty. Malnutrition is either a deficiency or an excess of intake of nutrients which may result in under nutrition or being overweight respectively. Pregnant women living in poverty are also prone to developing nutrient deficiency related conditions such as anemia (Prakash and Yadav, 2015). Pregnant women with lower family per capita presented with anemia more than those with the higher one and that anemia was prevalent in women who were from rural areas. Melku et al.through their study on the prevalence and predictors of maternal anemia during pregnancy revealed that mothers with low monthly family income were three times more likely to be anemic as compared to those with high monthly income (Rapinyana et al. 2020). Women and children often suffer from lack of protein and energy, face health effects which are frequently worsened by deficiencies in micronutrients particularly iodine, iron, vitamin A and Zinc. Globally, among women of reproductive age, maternal mortality is the second leading cause of death, and women face a 1 in 180 chance of dying from maternal causes **(**Ngoma&Mayimbo, 2017).

Hunger and undernutrition are closely associated with poverty. Undernutrition adversely affects the health of a woman during pregnancy and childbirth, as well as the child. Deficiencies in micronutrients such as iron, vitamin A, iodine and zinc lead to undernutrition. These adverse effects can also be transmitted to the next generation. Children of under- or malnourished mothers often suffer malnutrition in utero, leading to low birth weight (LBW). The relatively high burden of reproductive ill health among poor women, combined with their generally lower access to preventive and curative reproductive health services, results in significantly worse reproductive health outcomes, including morbidity and mortality (Coll-Black et al., 2017).

Feminisation of poverty and women's reproductive health in Meghalaya

Situated in the North- Eastern Region, Meghalaya was initially part of Assam and became the 21st full-fledged state of India in January 1972. Known as the "abode of clouds" Meghalaya is predominantly tribal and is home to the three tribes, viz., Khasi, Jaintias and the Garos. The state on the North and east is bound by Assam while on the south and west it shares its borders with Bangladesh. Meghalaya is spread over an area of 22,429 square kilometers and lies between 25° 01'N and 26°07' N latitude and 85°50' E and 92°48'E longitude (Ryngnga & Sarma, 2016). Meghalaya being the Schedule VI state under the constitution, has many legal and constitutional provisions, and is divided into three divisions with Autonomous Hill Councils (ADCs), namely, Jaintia Hills, Khasi Hills, and Garo Hills. The State has 12 districts, 6 municipal councils, 22 towns and 6459 villages. According to the 2011 Census, the population of Meghalaya is 29, 66,889 with a sex ratio of 989 females per 1000 males (Meghalaya Statistical Handbook, 2022).

The social system of the three indigenous communities of Meghalaya is different compared to many other identities in the Northeast. The three tribes, viz., Khasi, Jaintia and the Garos practice the matrilineal system whereby lineage is traced from the woman. Property and wealth were also passed down through the matrilineal line.It may be said that the system of matriliny operates within patriarchal ideologies which allow room for deprivation and inequality with the developmental changes of the society. The effective control of women by the men through the roles of the father or husband only explains why even in matrilineal societies, where women play an active role in contributing to the family and the economy, yet it is the men who exercise control (Tariang & Thomas, 2018). In Meghalaya, the number of female- headed households, on account of divorce and abandonment, has been increasing leading to increasing feminization of poverty. Since children live with their mothers in a matrilineal society, the burden on women is unimaginable. With growing poverty, many of these women slip further below the poverty line. Therefore, persistent gender inequality and poverty are the root causes of many health concerns in Meghalaya. According to the Meghalaya Health Policy (2021), health is a subject that is closely linked to other societal and environmental determinants and stresses the importance to address issues such as gender inequality and poverty which inadvertently results in poor education and can cause a vicious cycle of poor health among its citizens.

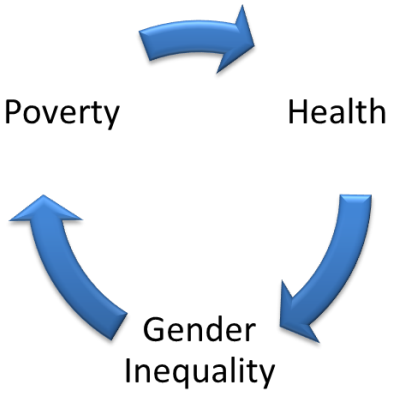

Fig 1. A cyclical relationship between poverty, health and gender inequality. From*Meghalaya Health Policy, 2021,* by Health and Family Welfare Department, March, 2021. (https://meghealth.gov.in/docs/Meghalaya/202021.pdf)

According to the NITI Aayog, 2023, Meghalaya ranks as the third poorest state in India. The National Multidimensional Poverty Index (MPI) measures simultaneous deprivations across the three equally weighted dimensions of health, education and standard of living that are represented by 12- Sustainable Development Goals aligned indicators. The issue of women's health in the state is also best looked at through the lens of family planning and reproductive health, which is one of the core challenges that the state has been dealing with. Maternal health is an important aspect for the development of any country in terms of increasing equity and reducing poverty. The survival and well-being of mothers are not only important in their own right, but are also central to solving broader economic, social, and developmental challenges. Maternal health care services are essential for the health and wellbeing of mothers, as well as their children, affecting the overall population and its health and nutritional status (National family health survey (NFHS-5, 2021).

Meghalaya has been a poor performer across critical health indicators such as maternal mortality, infant mortality and several aspects of nutrition according to the National Family Health Survey- V. Meghalaya's Total Fertility Rate (TFR) adds another layer of concern. TFR denotes the average number of children a woman gives birth to during her reproductive years. As per National Family Health Survey (NFHS) - 5, Meghalaya's TFR is a striking 3.1, a figure that stands in sharp contrast to the national average of 2.2. This glaring difference signals a gap in the state's family planning initiatives. According to the National Rural Health Mission, the MMR of Meghalaya in 2015–2016 is 211/1, 00, 000 live births which is higher than the national average, i.e., 130/1, 00,000 live births. A recent study in Northeast India by Das and Guha (2017) showed that in case of maternal mortality rate, Meghalaya is one of the worst performing states compared to the national average. The study also revealed that coverage of vaccination and nutritional status are less than the all India level. According to the NFHS- 5 (2021), only 54% of women received antenatal care during the first trimester of pregnancy. 52% of mothers had four or more antenatal care visits. It was also observed that urban women were more likely to have four or more antenatal visits than rural women. The antenatal visits also vary in accordance with the years of schooling as indicated by the table below.

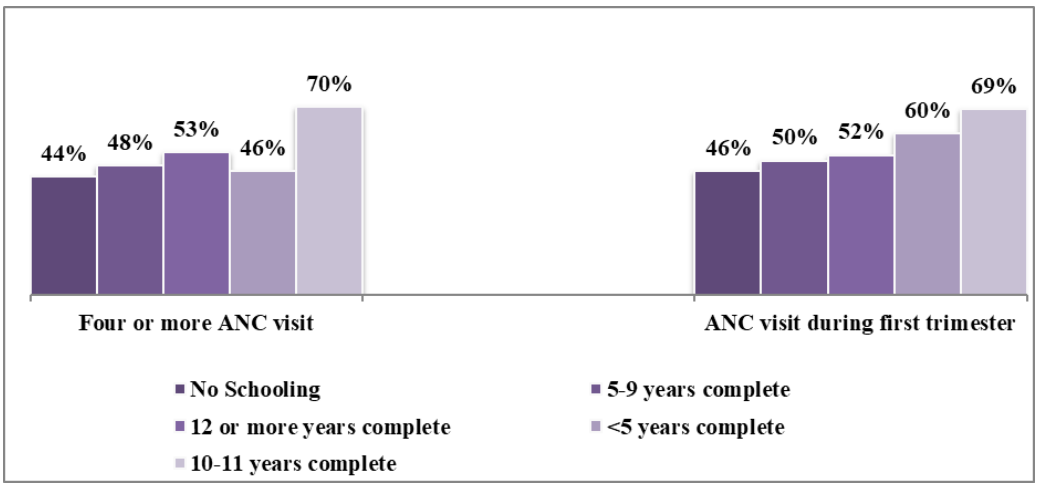

Fig 2: Antenatal visits vary with schooling. From *National Health Family Survey, 2021.*

In the rural areas of Meghalaya, the fear of out of pocket expenditure, financial constraints and lack of proper knowledge of available government schemes were some of the reasons why women do not opt for institutional delivery (Sarkar et al, 2017).Momin and Dutta (2021) study indicated that women who are financially unstable face the problem of visiting long distance hospital for maternal care hence they often opt for home deliveries. The non-availability of functioning maternal care health- care facilities at the village level, inadequate health equipment, and human resources are the major reasons for which women have to travel to the central hospitals situated in town areas. While accessing central hospitals for better treatment, they have to travel long distances with difficulties such as poor road conditions and transportation facilities and financial hindrance. However in the urban areas, despite the close proximity of government-run Urban Health Centres and the availability of health insurance, women from lower income background reportedly hold back from seeking health care for fear of tallying up out-of-pocket expenses. The researchers found that women often deprioritise their own health in favour of supporting the needs of others. Many internalise notions of being second-class citizens, which prevents them from asserting their rights (Oosterhoff et al., 2015). Despite the matrilineal family structures, some women are subordinate to spousal decision making when it comes to reproductive health. The National Family Health Survey- 5 (2021) reports that 90 % of women are more likely to participate in decisions about visits to their own family and friends than decisions about their own health care visits which accounts for 87%. Participation in decision making with regards to health is higher among women employed for cash (87%), compared with 81% of women who are not employed.

Malnutrition has an inter-generational impact, particularly on girls and women. It is directly and indirectly related to high mortality and morbidity rates. Maternal nutrition is important in determining obstetric outcomes. A girl child that has been born of a malnourished and sick mother is at a great risk of underdevelopment not only in her physical but also in social life. She will tend to be ignored due to her poor health or be left at home to tend her siblings while she should be going to school like any child of her age. Hence, the vicious cycle continues of that child to bear sickly children and be herself at risk of all morbidities and mortalities associated with women. In Meghalaya, 11% of women are too thin. Under- nutrition is particularly common in the younger age groups (especially age 15-19), in rural areas for women (National family health survey (NFHS-5), India, 2019-2021: Meghalaya, 2021)

Anaemia is a major health problem in Meghalaya, especially among women and children. Recent studies in India have shown poor education, poor socioeconomic status, and faulty dietary practices as major bio-social factors of anemia among women (Panigrahi&Sahoo, 2011; Khan, 2015; Sadeghian et al., 2013). 54% of women in Meghalaya have anaemia, including 24% with mild anaemia, 28% with moderate anaemia, and 2% with severe anaemia. Anaemia is particularly high among rural women. It has been reported that the overall prevalence of anaemia in children has increased from 41% in NFSH-4 to 45% in NFSH- 5.Children of mothers who have anaemia are much more likely to be anaemic. Although anaemia levels vary somewhat according to background characteristics, anaemia among children is widespread in every group. Over one-third (35%) of children in Meghalaya are anaemic even if their mother has 12 or more years of schooling (National family health survey (NFHS-5), India, 2019-2021: Meghalaya, 2021). Sharif et al (2023) study on the prevalence of anemia among reproductive women in different social group in showed that economic status dominantly controls the anemia level in all social groups. It is observed that multiple socio-demographic factors ranging from poor economic and educational status, rural residence to higher childbearing of women are responsible for predicting anemia levels among the social groups of women in India.

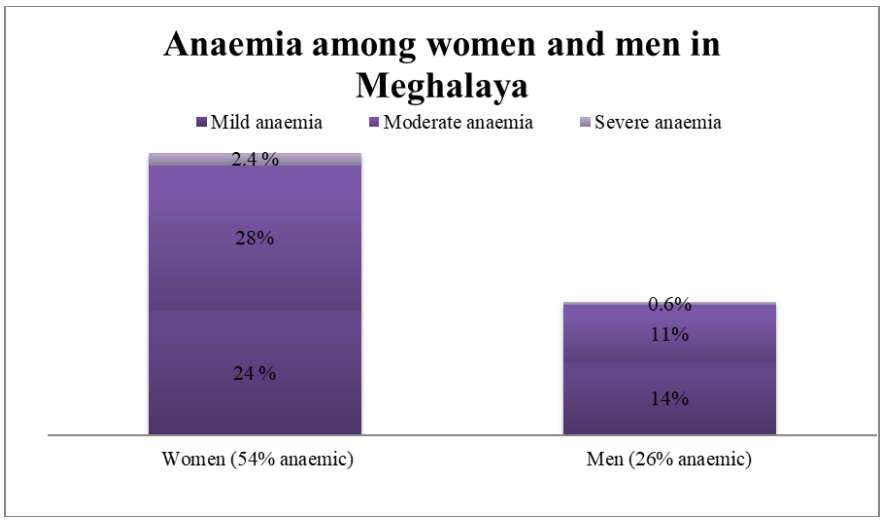

Fig 3: Anemia among women and men of Meghalaya. From *National Health Family Survey, 2021.*

Meghalaya has one of the highest unmet contraceptive needs and the lowest contraceptive prevalence rates in India. According to NFHS V, Meghalaya records the use of any type of contraception at 27.4% and a total fertility rate of 2.9. These statistics highlight the state's dismal performance in meeting the objectives outlined in the National Health Policy, 2017 (Shullai et al., 2023).Though women in Meghalaya have greater decision making power with regards to other family matters, however this does not extend to making independent decisions about contraception. Some studies showed high income women were more likely to use modern contraceptives than poorer women. This could be owing to their social level, which includes access to modern health care and education. Additionally, low awareness, distrust of modern contraceptive technologies and a preference for natural contraceptives derive at least in part from inadequate and insensitive healthcare delivery mechanisms. The contraceptive choices offered by health workers, especially IUDs and pills, are regarded with suspicion as 'foreign' objects that may harm women. Some of this suspicion may be due to a lack of information about these technologies (Oosterhoff et al., 2015).

The increasing 'feminisation of poverty' and its effect on the health of women in Meghalaya paint a dismal picture. The underlying reason of health issues in Meghalaya is due to gender inequality and poverty. Women's health is not a standalone issue and needs to be dealt with in a holistic manner in order to remove societal gender barriers. The initiation of the National Rural Health Mission of the Village Health and Sanitation Committee (VHSC) formed at the village level consists of essential stakeholders from the village and act as a platform for planning, supervision and information dissemination at the local level. This participatory form of health governance ensures that services reach every segment of the village population. Members of the VHSCs oversee the availability of health service professionals during immunisation or Village Health and Nutrition Days (VHND) and communicate with higher authorities if there are any unforeseen changes to these schedules. VHSCs are also largely contributing to the steady reduction of Maternal Mortality Rates (MMR) in the state due to the immediate primary steps that are available. From 241 deaths in 2020-21, the MMR of Meghalaya has now come down to 158 in 2022-23.The Government of Meghalaya introduced the Meghalaya Health Policy, 2021 which seeks to address the issue of gender inequality and poverty which inadvertently results in poor education and can cause a vicious cycle of poor health amongst its citizens. It also aims to bring about empowerment of women by ensuring health rights such as birth spacing and other reproductive rights. There is a need to create awareness about women's rights which will improve their healthcare and thereby empowering women by facilitating their economic independence which will strengthen society as a whole (Meghalaya Health Policy, 2021).

In addition, the state has launched the Chief Minister's Safe Motherhood Scheme to address critical gender and poverty issues to ensure safe labour and delivery. The spouses of high-risk pregnant mothers are given wage compensation to ensure they are brought to their nearest healthcare institutions. This intervention is also designed to leverage the trust of traditional birth attendants who can play a key role in reducing the high rate of MMR in remote villages. MOTHER App has been developed to record the data of all expectant mothers and predict high-risk pregnancies, allowing healthcare professionals to bring them to health facilities before an emergency arises (Meghalaya Health Policy, 2021). The State Government's main objective with regards to this policy is to save the lives of mothers and infants with a larger objective of improving the life expectancy of people in the State while attempting to break the social stigma associated with use of birth control measures as well as the taboo surrounding discussion of teenage pregnancies. Such steps, both at a macro and at a micro level are the need of the hour in Meghalaya. Comprehensive interventions, including awareness campaigns tailored to the cultural nuances of the region by the State and the local *DorbarShnongs* as well as the involvement of the women's wing (*Seng Kynthei*), infrastructural development to ensure easy access to menstrual products, and sex education programs to demystify reproductive health, are some of the steps that are slowly setting pace, but needs to be scaled eventually.

II. Conclusion

In Meghalaya, the female- headed households seem to be more trapped in poverty much more than the male- headed households (Tarian g& Thomas, 2018). Hence there is a need to acknowledge that if women are constantly struggling with poverty, then our society as a whole cannot be at its healthiest. Poverty restricts women's decision- making when it comes to their own health and in using services that enable them to live a healthy life. Since women's health status is a reflection of the cultural, political, and socioeconomic context in which they live. It is therefore imperative for appropriate policies to be designed that would be gender- specific, thereby empowering women to challenge and change discriminatory practices and gender biases.

Declaration of Conflicting Interests

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