Social Determinants of Gender Based Health Disparity: A Sociological Study of Radhemai Tole, Birgunj

Social Determinants of Gender Based Health Disparity: Suraj Kumar Kushawaha 2021

A Dissertation

Submitted to Faculty of Humanities and Social Sciences

Central Department of Sociology, University Campus,

Kirtipur, Kathmandu, Nepal

In Partial Fulfillment of the Requirement of Master of Arts in Sociology

By

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T.U. Registrations Number: 9-2-238-187-2012

Exam Roll Number: (283228)

December, 2021

TRIBHUVAN UNIVERSITY

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LETTER OF RECOMMENDATION

This M.A. dissertation entitled ***"Social Determinants of Gender Based Health Disparity: A Sociological Study of Radhemai Tole, Birgunj"***has been prepared by Mr. Suraj Kumar Kushawaha under my supervision and guidance. This dissertation has been prepared in fulfillment of the requirements for the ***Degree of Master in Sociology*** at **Tribhuvan University**. I believe this is his original work and has done decent efforts to complete it.

I hereby recommend this dissertation to the Dissertation Committee for its final acceptance and approval.

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APPROVAL LETTER

Thisdissertation entitled ***"Social Determinants of Gender Based Health Disparity: A Sociological Study of Radhemai Tole, Birgunj"*** has been submitted by Mr. ***Suraj Kumar Kushawaha*** for final examination to the research Committee of the Faculty of Humanities and Social Sciences, Tribhuvan University, in fulfillment of the requirements for the ***Degree of Master in Sociology***. I hereby certify that the Research Committee of the faculty has found this dissertation satisfactory in scope and quality and has therefore accepted it for the degree.

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DECLARATION

I hereby declare that this M.A. dissertation entitled ***"Social Determinants of Gender Based Health Disparities: A Sociological Study of Radhemai Tole, Birgunj"*** is submitted by me to the office of the Dean, Faculty of Humanities and Social Sciences, Tribhuvan University, Nepal is an entirely original work prepared under the supervision and guidance of **Prof. Madhusudan Subedi.** The result presented in this dissertation has not ever been presented or submitted anywhere else for the award of any degree or for any other purposes. No part of the contents of this dissertation has ever been published in the form or a part of any book. I am solely responsible if any evidence is found against my declaration.

…………………………

Suraj Kumar Kushawaha

ACKNOWLEDGEMENT

This study entitled ***"Social Determinants of Gender Based Health Disparity: A Sociological Study of Radhemai Tole, Birgunj"*** is an achievement of my serious effort of several months. The completion of this study encompasses various kinds of support, help, encouragement, sympathy and cooperation provided by a number of persons. The present study would not have been possible without these helping hands. These supportive roles which I received so far for the completion of this study have provided me an opportunity to appreciate them with warm respect. I would be indebted to all persons from whom I have received help throughout the course of this study.

The first person to whom I wish to express my heartfelt gratitude is my amazing supervisor, ***Prof. Madhusudan Subedi*** for his affectionate and valuable guidance to complete this dissertation. As a supervisor, he had always been sympathetic over me to provide his critical feedback and suggestions whenever I needed. His valuable guidance and creative time became a sound foundation for me on the path of the learning.

I would like to thank Dr. Youba Raj Luintel, Head of the Department of Sociology, for providing me the opportunity to conduct this dissertation on the topic of my own interest. Similarly, I am thankful to Dr. Tika Ram Gautam, Dr. Surendra Mishra, Prem Chalaune, Balaram Acharaya for their valuable suggestions.

In similar fashion, I would like to express my gratitude to my family members – my father Krishna Prasad, my mother Chinta Devi, my elder sisters Sosita, Babita, Kabita and younger sister Sarita. They were sensitive, inspiring and showing their great concern to my study, and providing me every possible help directly and indirectly. They are my pure source of inspiration for the completion of my masters in sociology.

At last but not the least, I would like to express my grateful thanks to all the respondents I interviewed with. I am very thankful to my friend DipendraYadav, Digambar Yadav, Pinku Kushwaha, Pooja Saxena and Sandeep Kushwaha who helped me gather information and made easy for me to interact with the respondents from the field.

Suraj Kumar Kushawaha

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ABBREVIATION

CSDH - The Commission on Social Determinants of Health

CVD - Cardiovascular Disease

DHS - Demographic Health Survey

DoHS - Department of Health Services

DVAG - Domestic Violence Against Women

HDR - Human Development Report

ICRW - International Centre for Research for women

MoHP -Ministry of Health and Population

NSSO - National Sample Survey Office

OHCHR - Office of the United Nations High Commissioner for Human Rights

SEWA - The Society for Education Welfare and Action

UNDP - United Nations Development program

UNICEF - United Nations International Children's Emergency Fund

UNODC - United Nations Office on Drugs and Crime

VAG - Violence Against Women

WHO - World Health Organization

CHAPTER - ONE
INTRODUCTION

1.1 Background

The term "health disparity" was coined in the United States around 1990, it was not meant to refer to all possible health differences among all possible groups of people. Rather, it was intended to denote a specific kind of difference, namely worse health among socially disadvantaged people and, in particular, members of disadvantaged racial/ ethnic groups and economically disadvantaged people within any racial/ethnic group. However, this specificity has generally not been explicit. Until the release of Healthy people 2020 in 2010, federal agencies of the USA had officially defined health disparities in very general terms, as differences in health among different population groups, without further specification (Braveman,2014).

Not all health differences are health disparities. Examples of health differences that are not health disparities include worse health among the elderly compared with young adults, a higher rate of injuries among professional tennis players than in the general population, or hypothetically, a higher rate of a particular disease among millionaires than non-millionaires (Braveman,2014). The term "health disparity" is almost exclusively used in the United States, while the terms "health inequity" or "health inequality" are more commonly used outside of the United States. A health disparity should be viewed as a chain of events signified by a difference in: (1) environment, (2) access to utilization of, and quality of care, (3) health status or (4) a particular health outcome that deserves the scrutiny (Carter and Baquet, 2002).One of the many issues in reporting on health disparities is determining how to appropriately describe inequalities linked with several variables.

Minnesota Department of Health,"…..difference in health status between a defined portion of population and the majority. Disparities can exist because of socio-economic status, age, geographic area, gender, race or ethnicity, language, customs and other cultural factors, disability or special health need."(Carter and Baquet, 2002, pp.430). The unequal distribution of health, affluence, poverty, and disease burden is characterized by differences in race, ethnicity, age, gender, location, and

socioeconomic factors impacting disadvantaged groups and frequently unnoticed populations.

Healthy People 2020 defined a health disparity as: "……a particular type of health differences that is closely linked with economic, social or environmental disadvantage. Health disparities adversely affect groups of people who have disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, or mental health; cognitive, sensory, or physical disability; geographic location; or other characteristics historically linked to discrimination or exclusion."(Breaveman, 2014, pp.6).

While it involves economic disadvantage, it also refers to an individual's or group's relative place in a social pecking order, which can be stratified based on economic resources, race, ethnicity, religion, gender, sexual orientation, and disability.

Among the various challenges of reporting on health disparity, one that is often overlooked is how best to report health disparities associated with multiple attributes. In healthy people 2020, the key attributes of health disparities are race/ethnicity, gender, sexual identity and orientation, disability status or special health care needs, and geography (Asada,Yoshida and Alyce, 2013). Health disparity occurs because of a number of factors like income and social status, culture, stressful living and working condition, inadequate access to essential health services, personal health practices and so on.

Whitehead has specified seven determinants of health disparities: (1) natural, biological variation (2) health damaging behavior that is freely chosen, such as participation in certain sports and pastimes: (3) the transient health advantage of one group is first to adapt a health promoting behavior (as long as other groups have the means to catch up fairly soon): (4) health damaging behavior in which the degree of choice of life styles is severely restricted: (5) exposure to unhealthy, stressful living and working conditions: (6) inadequate access to health services and other basic services: (7) natural selection, or health related social mobility, involving the tendency for sick people to move down the social scale.Social determinants are just one group of factors that shapepopulation health, alongside health care, genetics, behaviors, commercial influences, and more.Estimates vary, but most research show

that societal, economic, environmental and other non-medical factors play a greater role than health care facilities in affecting public health (Braveman and Gottlieb,2014).

The distribution of resources across society and the social status of citizens within it is influenced by underlying structural factors, such as a country's macroeconomic policy; public policies in education, housing, social security and other areas; and wider cultural and institutional contexts.In turn, these structural factors shape more downstream social factors, such as living and working conditions, and access to money for the purchase of food, clothing, and other fundamental resources that form the circumstances of the everyday life of people. Health and health inequities are formed by the interactions of these factors (Alderwick and Gottlieb, 2019).

To go through the gender health disparities, one should have understanding of how gender has been constructed over the years. The first thing to deal with is the distinction sociologists have made since the 1970s between sex (biological differences between males and females) and gender (socially produced differences between being feminine and being masculine). It is generally agreed that gender differences areto be understood as a central feature of patriarchy, a social system in which men have come to be a dominant in relation to women (Holmes, 2007).

Gender is so widespread in our culture that we take it for granted that it is ingrained into our genetics. Gender is continually produced and regenerated out of human contact, out of social life, and is the texture and order of that social life, which most people find difficult to accept.Yet gender, like culture, is a human production that depends on every constantly “doing gender” (West and Zimmerman,1987).

Gender construction begins with the designation of a sex category based on the appearance of the genitalia at birth. Parents do not want to be repeatedly asked whether their newborn is a girl or a boy, therefore the babies are clothed or ornamented in a way that reveals the category. Through name, wearing, and other gender indicators, a sex category becomes a gender status. Once a child's gender is established, others treat those of one gender differently from those of the other, and the youngsters respond by feeling and acting differently.

Medical and scientific discourses have been important in constructing gender. It is important to understand the part that ideas and meanings play in the social

construction of femininity and masculinity (Holmes, 2007). Sociologists of gender emphasize the social, rather than biological, processes that produce a person's gender. Focused on the interactional level, such theories illustrate how people sort particular genders (women wear skirts; men do not). Such visual cues act as proxies for biological criteria invisible in many interactions. This categorization process termed "gender attribution" (Kessler and Mckenna 1978) or "sex categorization" (West and Zimmerman, 1987) is theorized as an inescapable but typically unremarkable hallmark of everyday social interactions except in instances of ambiguity, which can create an interactional breakdown, generating anxiety, concern, and even anger (Schilt 2010; West and Zimmerman 1987).The social interest in gendered health inequalities stems from the undeniable reality that, regardless of how health is defined, men and women have different physical health profiles. In general, women have a higher life expectancy than males, although they are more prone to sickness. This result is extensively documented in the literature on health inequalities, and various reviews outline the breadth and depth of gender variations in health.

When it comes to mortality, gender inequalities in health are most obvious: women live longer than males in every industrialized country on the planet. It's also worth noting that, despite the fact that women outlive men, men and women are equally susceptible to the same diseases; for example, the top two primary causes of death for both men and women are heart disease and cancer (Read and Bridget,2010).

Gender itself is a determinant of health and is interlinked with biological and social determinants. If prominence is granted to social factors, then health must be considered within the context of gender roles, access to social and economic capital, the geopolitical environment, cultural values and the impact of racism, sexism and ageism (Moss, 2002;Splitzer, 2005).

Exposure to risk factors, health-seeking and risk-taking behaviors are affected by gender differences and inequalities; access to and use of health information and promotional, preventive, curative, rehabilitative and palliative health services; and experience with health care, including access to and control of resources and power relationships (WHO, 2005).

Gender differences in morbidity are not as straight forward as those for mortality, with the gap between men as women varying by specific disease out come and stage

of the life cycle (Crimminset al.2002, Gorman and Read 2006). At a younger age, males are more likely than women to participate in health-harming activities that have a negative impact on their well-being and raise their chance of mortality from accidental accidents and homicide. These habits also have a cumulative effect that harms men's health later in life by increasing their risk of dying prematurely from life-threatening diseases.

Women, on the other hand, are more likely to suffer from non-fatal, chronic conditions such as arthritis and disability, which do not necessarily lead to their death but depress their quality of life. The differential life expectancy of men and women is directly related to these health patterns. While women live longer than men without illness and disability, studies show that the elevated rate of female morbidity is related to their longer life span (Crimminset al.1996,2002). As a consequence, diseases with a weaker age relationship (e.g., asthma, bronchitis, /emphysema) vary less by sex than those with stronger age gradients. (example, heart disease, hypertension, arthritis) (Read and Gorman, 2010).

For females at all ages, several chronic conditions are more prevalent, including frequent headaches, arthritis, and depression. There is a higher prevalence among women for others, such as asthma, than among middle-aged men, but not at older ages.Yet others are more prevalent among women at younger ages, such as reproductive cancers and cardiovascular disease (CVD), but are more prevalent among men at older ages. For men and women at all ages, diabetes is equally prevalent. Hypertension and emphysema are equally prevalent among younger men and women, but are more prevalent among men older than 60 years of age.The view that women are not uniformly more likely to suffer from all types of ailments than men is confirmed by these various patterns.They also say, however, that women are more likely to suffer from conditions such as arthritis and chronic headaches than men, which are not life-threatening, but may lead to poor self-rated health and that men are more likely to suffer from diseases such as CVD and emphysema, which are risk factors for mortality, at least at older ages where most deaths occur (Case and Paxson,2005).

Using the 1997-2001(U.S.) National Health Interview surveys, Case and Paxson analyzed the relationship between records of chronic conditions and self-assessed

health. The analysis used 18 chronic conditions prevalence among men and women. This reflects the differences in the morbidity status of male and female.

Table no: 1Prevalence Rates of Chronic Conditions (percentages)

Condition	Prevalence, Women	Prevalence, Men	Excess prevalence in women (percentage points)
Headache	24.0	11.4	13.2*
Other pain	39.5	35.6	3.7*
Arthritis	28.0	19.2	7.2*
Bronchitis	6.7	3.2	3.3*
Emphysema	1.4	2.0	-0.8
Lung problem	2.0	1.4	0.5*
Asthma	10.8	7.8	3.1*
Diabetes	6.6	6.1	-0.3
Circulatory problems	0.5	0.4	0.05
Cardiovascular disease	13.3	12.9	-1.1*
Hypertension	26.5	23.3	0.5*
Skin Cancer	1.9	2.3	-0.5*
Stomach Cancer	0.1	0.1	-0.01
Respiratory Cancer	0.2	0.4	-0.2*
Vision problem	11.2	8.3	2.2*
Hearing loss	3.7	6.0	-3.0*
Depression	12.8	9.7	2.9*
Number of observations	81,704	66,292	147,996

Source: (U.S.) National Health Interview Survey (1997-2001)

Gender health relationship research has traditionally focused on the identification of individual factors that differently form health outcomes for men and women, particularly socio-economic status (e.g. poverty status, education level, and health insurance status) and health-related behaviors (example, body mass index, smoking,

alcohol consumption). The challenge with such an emphasis is that people are placed in wider socioeconomic, cultural and political environments that also influence their health status(Dadoo and Forst 2008; Read and Gorman 2010).

Violence towards women affects all aspects of the life of a woman: her freedom, her productivity, her ability to provide for herself and her children, her general health status, and her quality of life (Krantz 2002). Worldwide, domestic abuse is a problem that affects millions. Data shows that one of the most prevalent types of violence against women is domestic violence (UNODC 2018).Because of the domestic violence that women face affects their mental and physical health.

In general, morbidity or disease burden is assumed to accentuate mortality among individuals, and people with a higher disease burden are likely to experience higher mortality rates. The predicted pathway of a higher mortality rate through a higher morbidity level, however, does not always appear to be so.Compared to males, one of the most talked about facts, mostly observed in the developed world, relates to the higher survival chances of women, while afflicted with a higher burden of disease. In terms of mismatch between mortality rate and morbidity when examining gender difference in health outcomes, a similar picture has also been observed for India recently.Females in India experience mortality advantage with a higher degree of disease burden or morbidity, particularly from the age of 30, as compared to males (NSSO, 2006, Registrar General of India, 2007; Dhak and Mutharayappa,2009).

In Nepal, there is a different kind of challenge in the health sector when it comes to gender. Women are treated as second-class citizens in Nepal's primarily patriarchal society (second class citizens). The family and society place little value on women's health, and the reproductive cycle is regarded as their fate. Women, particularly those from marginalized and backward areas, have limited access to education, health care, and information as a result of this familial and cultural discrimination; they fall behind in receiving general and maternal health treatments. Women's health has been harmed by fetal screening and differential treatment of boy and girl children(MoHP, 2009).

1.2 Statement of the Problem

Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. Every human being has the right to enjoy the highest standard of health. Health disparity among the population does exist which is a kind of threat in modern society.

The HDR 1990, the first in its series, recognizes very clearly that in many societies, gender disparities exist. As children, women have less access to education, including food and health care. When they become adults, they are given fewer opportunities to improve their education and training levels. Even though they work longer hours, they earn lower incomes than men do (UNDP 1990; Luintel,2018).Productive and reproductive tasks are regarded differently in most societies. In general, having a job gives you more autonomy, decision-making authority, and social respect. Men have more autonomy and social standing than women because of their larger participation in the paid labor force and better wages, even when domestic and other activities of women are included in. Men and women's health-seeking behavior and outcomes are affected by gender variations in economic position and purchasing power. This contributes to women achieving lower human capabilitiesthan their malecounterparts.

Women are presumed to be the most appropriate care givers for children, the infirm and the elderly and these responsibilities are presumed to be “natural”. Globalization has impelled the waves of health care restructuring that have resulted in a movement towards deinstitutionalization and abbreviated hospital stays (Spitzer, 2005). Hospital stays have been shorter because of the availability of women at home as a care giver.

Most of the societies still receive gender inequality and discriminatory act against women. Historically, there have been several social, political, and cultural causes that have shaped gender gap. Health is not only a biological phenomenon rather it is equally a social constructed phenomenon. Health is the real wealth of every individual. Most of the developing societies have health disparity by gender. In this 21st century, observing health disparity on any basis is something that must be noticed and efforts should be made globally for health equity.

The present constitution of Nepal (2015) in its part 3, article 35 right to health mentions that (1) every citizen shall have the right to free basic health services from the state, and no one shall be deprived of emergency health services, (3) every citizen shall have equal access to health services. Similarly, in act 38 right to women, it mentions that (1) every woman shall have equal lineage right without gender based discrimination, (2) every woman shall have the right to safe motherhood and reproductive health, (3) No woman shall be subjected to physical, mental, sexual, psychological or other form of violence or exploitation on the grounds of religion, social, cultural tradition, practice or on any other grounds. Such act shall be punishable by law, and the victim shall have the right to obtain compensation in accordance with law, (5) women shall have the right to obtain special opportunity in education, health, employment on the basis of positive discrimination. Despite of these provisions made under the fundamental rights in the constitution, women immensely lag behind in literacy status, health status, employment status etc.

Most of the literatures have drawn the attention towards the health disparity prevailing in different societies with major focus on the biological and socioeconomic status responsible for prevailing disparity on health status by race/ethnicity. However, research on gender health disparity has not been done enough with major focus on social determinants using sociological perspective in Nepal.Moreover, there has been very less attention paid towards womenfor suffering or reporting more illness/morbidity than their male counterparts. The reasons behind women suffering or reporting more illness than men have not been highlighted adequately in Nepalese context.Hence, this study has tried to address this gap.

In this study, I have tried to answer the following questions:

a) What are the social determinants that lead to gender-basedhealth disparity in Radhemai tole of Birgunj of Parsa district?
b) Who suffer more from illness males or females?
c) How do social determinants create gender based health gap in Radhemai tole of Birgunj?

1.3 Objectives of the Study

The objectives drawn from the statement of the problem have been given below:

a) To identify the social determinants that cause gender-based healthdisparity in Radhemai tole of Birgunj, parsa district.
b) To find whether males or females suffer more from illness.
c) To discover how social determinants of health create gender-based health disparity in Radhemai tole of Birgunj.

1.4Rationale of the Study

The knowledge that has beencreated through this study is supposed to be quite helpful for individuals, states, nations, readers, health workers and professionals,and policy makers. This study is expected to assist the health policy makers to deal with the social determinants of gender based health disparity and make provisions accordingly. It helps individuals to have a deeper understanding of causal relation between the social determinants of health and gender health disparity. This study is expected to enhance the better understanding ofhow health is not just limited to biology rather it is a social construct too and is influenced by a number of social determinants.

CHAPTER TWO
LITERATURE REVIEW

2.1 Theoretical Review

Social theory provides a context in which to interpret health patterns and how the social determinants shape the health of theindividuals and groups, and determine gender health disparity. This study has been linked with feminism as a perspective. Feminism is a broad theory, offering a variety of perspectives from which to understand women's position in society. Feminists argue that society disadvantages women by constraining them and limiting their opportunities.Feminist theories analyze women's experiences of gender subordination, the roots of women oppression, how gender inequality is perpetuated, and offer differing remedies for gender inequality.

Some major variation in feminist theories are: (a)Women's inequality is triggered by liberal feminism, which claims that women have unequal access to legal, social, political and economic structures, and promotes equal legal rights and inclusion of women in the public realms of education, politics and jobs:

(b)Radical feminism, which claims that women's oppression originates from sexuality, argues that women's bodies are controlled by violence, objectification, and social institutions such as medicine and religion and its promoters of remedies to increase women's control over their bodies, including sexuality, childbirth, and motherhood transformation:

(c)Marxist and socialist feminism, claimed by bourgeoisie and private men, abuses the unpaid reproductive function of women within the home and encourages the restructuring of family relationships by redistributing roles and changing access to education, health services, economic conditions and political power:

(d)Psychoanalytic feminism applies Freudian ideas of gender discrimination and claims that early childhood experiences form the psyches of women and create divisions between men and women, and its response is to advocate for an androgynous culture, likely created by dual parenting: (e)Postmodern feminism, which ignores overarching sources and remedies to gender discrimination and focuses

on diversity and disparities, and encourages the destabilization of patriarchal traditions that have contributed to gender inequality(Jones and Michelle J. Budig,2008).

However, among these diverse feminist theories, the study has been connected/linkedwith Marxist feminism in order to explore how social determinants of gender-based health disparity are supportive for such health disparity.

Marxist feminism: Marxist feminism is a form of feminist theory and politics that draws on Marxism for its theoretical underpinnings, particularly the critique of capitalism as a set of structures, practices, institutions, rewards, and sensibilities that foster labor exploitation, alienation, and debasement of freedom.Women's liberation and equality, according to Marxist feminists, cannot be accomplished within the context of capitalism.Marxist feminism is reluctant to treat “women” as a standalone group with similar interests and aspirations(Stefano,2014).

Marxist feminists attempt to identifygender relations in the context of production and reproduction as understood within historical materialism, where women were important in the struggle as workers and not as women.Marxist feminists attempt to distinguish the operation of gender relations from or in relation to the mechanism of creation and reproduction as known by historical materialism.The Marxist conceptions of exploitation, alienation, and the labor theory of value, with the implicit exchange principle, were worked into theoretical arguments to explain how the complex relationship between "the private" and "the public" was entwined through and based on material circumstances (Eeatherstone, 1991: p. 73-79). The undervaluing of women’s role as care giver is reflected in the occupational structure of capitalist patriarchal societies. Women are marginalized from the rewards of fulltime, technology driven, hard specialist professions, their caring wok is seen domestic work and sex relations, expanding simultaneously as part of work activities but not legitimate.

According to Marxist feminism, the interaction of patriarchy and capitalism has an influence on both women's health and the way in which women's caring and nurturing roles are presented as natural. The job of a woman as a caretaker ensures that she is built as an unrecognized laborer who reproduces both her husband and her children. Caring is defined as an emotional, physical, and social structure of the family and

child raising that is not labor or employment in the capitalistic system. Women labor at home, prepare required items for men, and occasionally massage them, but women are still excluded from the manufacturing process, and men are referred to as the sole breadwinner.Marxist feminists apply standard Marxist theory to unpaid don traditional Marxist analysis. Gender oppression is perpetuated by institutionalized inequalities and is replicated culturally. The working-class male is groomed into an oppressive framework that marginalizes the working-class woman by privileging men at the expense of women and continues to ignore traditional household labor as equally important.

Connecting this Marxist feminism theory with this study has provided a better framework for understanding of how societal determinants which are the product of exploitation of women through capitalism and unequal power relationsare responsible for gender-based health disparity.

2.2 Empirical Review

Both health and gender depend on biological circumstances; they are also socially constructed as suggested by Lorber and Moore (2002). Gender disparities in health are complicated and nuanced than suggested by biological or medical explanation (Moen and Chermack). In western society, women tend to report more physical illness, more psychological distress, and more psychiatric systems than do men (Kessler, McGonagle, Swartz, Blazer and Nelson,1993), yet women live longer than men.Gender influences derive from aspects of communities such as societies, cultures or nations, and they have the potential to createhealth outcomes at both the level of the group and the individual (Philips,2005).

Ottawa Charter (1986) recognizes nine social determinants of health as peace, shelter, education, food, income, stable ecosystem, sustainable resources, social justice, and equity. Similarly, WHO (2003) states eight (8) social determinants of health as social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, and food transport. Moreover, Center for Disease Control USA (2005) has recognized six (6) determinants. They are: socioeconomic status, transportation, housing, access to services, discrimination by social grouping, and social and environmental stressor (Bryant et al, 2003; Subedi and Dahal, 2015).

In a large number of countries, research into gender differences in health has brought to light an important paradox: women use more health services and report poorer self-assessed health than men, but women are less likely to die throughout their lives than men of the same age (Idler 2003; MacIntyre, Ford, and Hunt 1999; Molarius and Janson 2002; Verbrugge,1989).Women may be more likely to suffer from health problems such as arthritis or headaches than men, resulting in poorer self-rated health but contributing relatively little to mortality risk, whereas men may be more likely to have conditions such as cardiovascular disease or respiratory conditions that not only lead to poorer self-rated health, but also have relatively significant impacts on health (Case and Paxon,2005).The Canadian Institute of Advanced Research outline various determinants of health (some of which are social determinants): income and social status, social support networks, education, employment and working condition, physical and social environments, biology and genetics endowment, personal health practices and coping skills, healthy child development and health services. The U.S. centers for Disease Control highlights socio-economic status, transportation, housing, access to services, discrimination by social grouping (example, race, gender, or class), and social or environment stressors.

The Meikirch Model of Health suggests that health happens when individuals use the biological capacity provided and personally acquired to handle life's demands in a way that promotes well-being. This process persists throughout life and is rooted in social and environmental health determinants that are linked. All three dimensions - human, social, and environmental determinants of health - constitute health (Bircher and Kuruvilla, 2014). Health is undoubtedly associated with a number of factors. The influences of the factors determine the status of health.

According to the Commission on Social Determinants of Health(CSDH) in March 2005, the social determinants of health inequality act through a collection of intermediate determinants of health to form health outcomes.The conceptualization of the social determinants of health by the CSDH reflects recent thinking in the literature on social medicine, whereby the role of social determinants is seen as a feature of the society as well as a factor affecting individual health status (Diderichsen, Evans, and Whitehead, 2001). Social determinants have powerful impacts on each member of the societies. Social groups observe different level of exposure to social determinants of health and that may cause health disparity.

Closing the gap emphasizes that the ill health of the poor, the social health gradient in countries, and the major health gaps between countries are caused by....(difference) in the immediate, observable circumstances of the lives of people, their access to health care, schools and education, their working and leisure environments, their families, neighborhoods, towns or cities, and their chance of lead a flourishing life(CSDH).Structural determinants or structural drivers are often implicated in health disparities and inequities by the CSDH. It proposes that, within a given society, social, economic and political structures give rise to a series of sociopolitical roles whereby societies are stratified by wealth, gender, schooling, profession, race, ethnicity, and other factors.These socioeconomic positions, in turn, influence particular health status determinants that represent the place of people within social hierarchies.According to the CSDH,there are fundamental disparities in the distribution of the social determinants of health due to the unequal distribution of power, income, goods and services in each society.

Research suggests that greater social participation, mutual efficiency, andtrust are associated with better health outcome (Kwachi,2001).Social factors may be beneficial or detrimental for the well-being of people, both by improving or inhibiting the growth of their capacity and by affecting the demands of life and the resources available to individuals to meet these requirements. The WHO Commission on Social Determinants of Health concluded: “The poor health of the poor, the social gradient in health within countries, and themarked health inequities between countries are... caused by the unequal distribution of power, income, goods,and services, globally and nationally”(Bircher and Kuruvilla, 2014).

In determining the public's health, social determinants arguably play the largest role. The policies and practices in place in our homes, schools, workplaces, and communities determine our public health.Many of these determinants are difficult, if not altogether impossible, to control, such as economic standing, genetic predispositions or proclivities, and the customs, traditions, norms, and attitudesof the community in which we are raised (Dingake, 2017). Social norms and policies remain

in practice throughout our lives. Some of the norms may not be good for sound health, though they are practiced.

Multiple variables decide health directly or in a complex mix. The precise method of the development of health is beyond our comprehension. Yet wellness is the end product of how culture distributes various health determinants(Asada;2005). The term "social determinants of health" arose out of researchers' quest to define the basic mechanisms by which various levels of health and disease are experienced by members of different socioeconomic classes.In the United Kingdom, the publication of the Black Study and the Health Divide follow-up sparked interest in how the material conditions of life work to assess health status. People with various socioeconomic positions all over the world display profoundly different levels of health and disease incidence(Raphael, 2006).

A number of studies have attempted to assess impact of social factors on health.An analysis by McGinnis et al. reported that only 10 percent - 15 percent of preventive mortality in the U.S. was responsible for medical treatment, although Mackenbach'sstudies indicate that this figure could be an exaggeration, affirming the overwhelming significance of social factors.McGinnis and Foege concluded that half of all deaths in the U.S. include causes of behavior, other evidence showed that social factors, including income, schooling, and employment, are highly affected by health-related behaviors (Braveman and Gottlieb,2014).

Whitehead (1992) found that, due to age, disability, race, gender, and socio-economic status, there can be measurable variations in health experiences and health outcomes between various demographic groups. If these disparities arise, then gaps in wellbeing are likely to occur. Such disparities may either be preventable or inevitable.Dahlgren and Whitehead’s (1992) social health framework, commonly known as ‘multi-level rainbow model’ are five levels where different factors contribute to disease(s) which impact our health(Dahal and Subedi,2015).

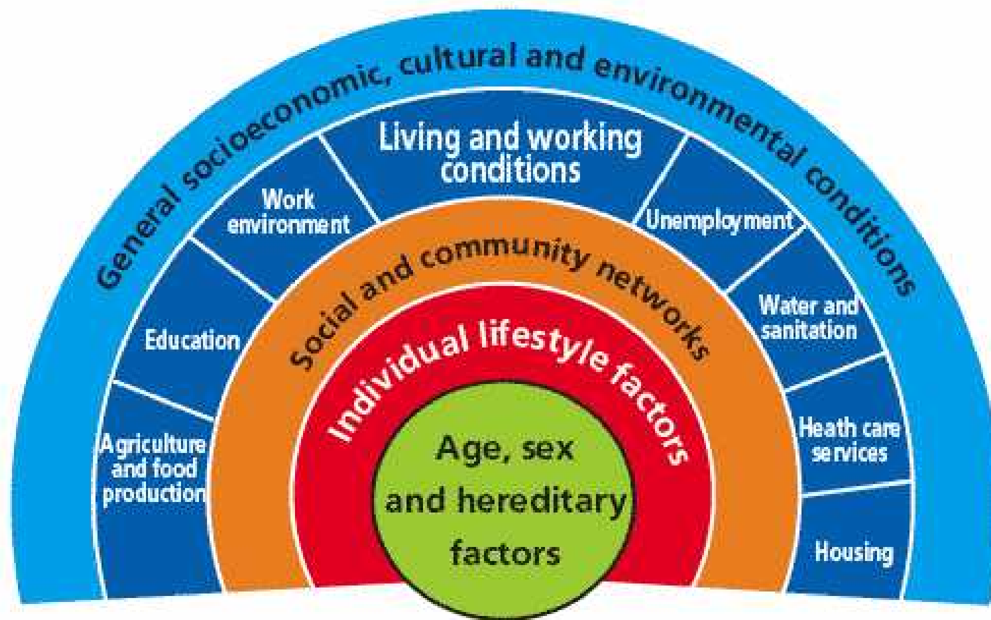

Fig no. 1: The determinants of health set out by Dahlgrem and whitehead (1992).

Interactions between these various layers are illustrated in the model. Individual lives, for instance, are rooted in social and community networks and living and working environments, which are in turn connected to the larger cultural and socio-economic setting.Socio-economic health disparities represent unequal exposure to risks associated with socio-economic status from before birth and throughout life. In explaining health disparities that exist according to ethnicity and gender, these differential exposures are also essential (Purdy and Banks, 2001).

Individual level variables that impact health outcomes differently for men and women, such as socioeconomic status and health-related activities, have usually been the focus of research on the gender health relation.This focus is appropriate, as studies have consistently established robust links between these elements and physical health. The challenge with focusing on people is that they are embedded in larger social, cultural, and political circumstances that influence their health (Dodoo and Frost,2008). According to Macintyre and Ellaway (2003), people's neighborhoods can have direct and indirect effects on their health status (through cognitive and emotional processes), but there's no reason to believe that these effects are consistent across health outcomes or demographic categories.Socioeconomic status is the most common and widely quoted factor shaping contemporary disparities in men's and women's health. In general, as reported by Marmot (2004), people of higher social

status have better health because they have greater access to the services required to prevent and cure disease can generally cope with stressful events over their lifetime better.The literature on health determinants is full of evidence that social factors such as wealth, occupation, culture and social connectivity have a powerful influence on the well-being of individuals and populations (Marmot and Cummins; Philips, 2008).

Women have often tended to shift in and out of school, careers, and community positions, often in combination with shifting responsibilities in family care and/or accommodating the job-related movements of their husbands. As a consequence of a variety of institutionalized cultural frames, the responsibilities and resources of women and men are socially constructed: the feminine mystique, believing that the roles of being wives and mothers are essential to the happiness of women (Friedan,1963).

Gender matters for welfare in the social fabric of institutionalized obligations, wealth, relationships, and hazards in various locales for men and women. Gender has obvious implications for the occurrence, timing, and duration of roles, as well as the combination of roles held by individuals, all of which have health implications.Home making, for instance, has a position occupied by women in different ways. Studies suggest that women who are home-makers appear to have stronger signs of depression than women or men working in paying jobs (Repetti,1998). Women get more responsibility to perform household works and they are not given enough opportunity to engage with market-oriented work. They get limited interactions with other people than their family.

Two decades of study in social science and public health indicates that discrimination is associated with various poor mental and physical health outcomes, including anxiety, depression, and cardiovascular disease, with great consistency (Kessler, Mickelson, and Williams 1999; Paradies,2006; Williams and Mohammed 2009). Women are more likely to experience high levels of depression and anxiety (Caroli and Webber-Baghdiguian 2016; Marchand et al. 2016) but men are more likely to experience anti-social personality and substance-abuse dependence disorders (Simon 2002). There are similarly diverse gender disparities in physical health, with men more likely to develop life-threatening ailments, such as emphysema and heart

disease, and women more likely to suffer from less extreme yet chronic illnesses (Gorman and Read 2006; Read and Gorman 2010).

Gender-based health inequalities often differ across regional and historical backgrounds and are further reliant on the individual social classes considered (Bambra et al. 2009; Brown et al. 2016).The unequal distribution within and between communities of internalized, behavioral and systemic modes of inequality gives rise not just to individual health and disease disparities, but also to chronic and broad disparities related to health.Stressful incidents, such as injustice, have an emotional and neurological effect on people and are often correlated with higher levels of cortisol that have a further impact on the health of individuals (Harnois and Bastos, 2018).

Women tend to report more physical illness, more social trauma and more psychiatric systems in western culture than men do, yet women live longer than men. Many believe that these gender differences occur through time and society and have biological origins regularly and exclusively. The sex gap in cancer incidence, however, is caused by cultural and socio-economic causes, as expressed in the rates of female versus male cancer incidence and life expectancy disadvantages in different countries (Benigni, 2003).This reflects that sex difference in morbidity and mortality are not determined exclusively by biology.

Social determinants of health can also be understood as the circumstances in which people are born, grow, live, learn, work, and age, which are shaped by a set of forces beyond the control of the individual. These are the intermediate determinants of health, downstream from the structural determinants.The root causes of health inequities are structural determinants, because they shape the quality of the social determinants of health that individuals experience in their neighborhoods and communities.The governing mechanism, economic and social policies that control pay, working conditions, housing, and education are systemic determinants. Structural determinants determine whether the services needed for health are distributed equally in society, or whether they are unjustly distributed according to race,gender, social class, geography,sexual identity, or another socially defined group (Dingake, 2017).

Economic status and social integration are widely recognized as social determinants of health because health, morbidity and mortality are stratified along these

dimensions, and it is these factors that contextualize health and illness. Research on the social determinants of health has identified differential effects on morbidity and mortality rates of women and men.The causes of such differences are studied by an increasing body of study, focusing on gender differentiated roles, wellbeing behaviours and help-seeking(Popay, Bartley, Owen;Ballantyne,1999).

In daily life, women are more likely than men to encounter stressful life events and chronic stressors that increase their risk of depression in turn. Depression by reduced immune functioning and elevated blood pressure is directly associated with poorer health;depression is indirectly linked to poorer health through increased participation in unhealthy behaviors such as excessive drinking, lack of exercise, and smoking and research has demonstrated that women have higher rates of depressive disorders than men(Gorman and Read,2006).

Diderichsen, Anderson and Manuel (2012) have identified five (5) mechanisms behind social inequality in health. They are:

a) **Social stratification:**Societies establish a variety of social roles that human beings strive to fulfill through schooling and in other ways. Education, ancestry, gender, age, ethnicity, and health play a central role in this social stratification. Some people have considerable difficulty reaching or retaining such a role and become socially marginalized.Circumstances during infancy and early development that are affected by the family's economic, social, and psychological condition, and later by day care and schooling circumstances, have a strong effect on the prospects of the child in the stratification process and thus on his wellbeing later in life.Early social determinants can affect the life of the individual through their effects on personality and cognitive growth, among other things. Some factors may also produce psychological susceptibility to the health consequences of later crises, such as a lack of social interaction with parents during the first years of life.

b) **Differential exposure:**Depending on the social position of adults in society, they are to a varying degree exposed to a wide range of risk factor through their work, economic circumstances, and thereby residential conditions and

physicalenvironment. The individual background is also of great importance to health behavior and a range of biological risk factors such as blood pressure, blood lipids, and overweight.This can be expressed as a situation in which the influence of the social status on health is mediated by this form of determinant.While the figure shows only one such mediating factor, we also speak of long chains of causality in real life, where social determinants in the organization of labor or social relationships, for example, assert their impact through physiological mechanisms, psychological processes, or behavioral health.

c) **Differential vulnerability:**By definition, causes of illness have an impact on the risk of falling victim to disease or injury. However, the extent of this impact is also contingent on the presence of other risk factors for the same disease. Smoking, for instance, if high blood pressure is also present, has a greater absolute impact on heart disease. Several different physical, psychological, and behavioral risk factors for disease are often exposed to lower social classes. The impact of one of the risk factors given is therefore likely to be greater in lower social groups than in higher groups. Accordingly, they are considered more vulnerable.

d) **Differential disease consequences:**Survival, functional capability and quality of life are impacted by diseases and accidents as well as the opportunities for people to engage in work life and social life in general.The social status of the person affects these consequences because social position can affect access to care and recovery, as well as employment and other requirements, both of which, despite a diminished functional capability, are vital to the individual's chances of returning to work. There is a third form of determinant relating to fiscal, cultural and other obstacles to access to treatment and to the job market, including lowered working capacity, and to the provision of economic losses due to illness by social insurance schemes.

e) **Disease consequences for the individual and for society:**The social consequences of illness have an effect on the further course of the disease at

the individual level and will thus also increase social disparity in health. In society, the effects of illness have a bearing on the aggregate cost of illness and the supply of labor.There are varying degrees of ill health and lowered working potential among the many working-age individuals who are now outside the labor force. The social effects of disease can be so extreme, not least for those with significant mental illness and drug abuse, that they can become very marginalized and alienated.

According to Davidson and Kimberlee J. Trudeau the five major areas to gender differentials in health outcomes are as follow:

a) **Personality:**Several personality traits were recognized as possible health predictors (Smith and Ruiz,2002; Weibe and Smith,1997). There are also several personality variables that predict wellbeing and have major gender variations, such as happiness, frustration, and aggression (Example, Stoney and Engerbretson, 1994).Personality constructs were found to predict reactions to illness, adherence to suffering-relieving regimens, and the onset of physical illness itself (Wiebe and Smith,1997).

b) **Social support**: There has been considerable evidence to suggest that social support influences health status, health behavior, and use of health services.Social support is a complex construct encompassing various dimensions, including sources, types, and assessment of social support, each of which has been sold to be evaluated. Social characteristics (for example, the number of people from which a person may draw support types) have been shown to have a positive effect on the immune system and to boost morbidity and mortality-related factors. The positive effects of social network structures, social integration and support have been demonstrated for general mortality in prospective population studies, and for mortality and morbidity from various chronic diseases including arthritis, tuberculosis, and asthma; for psychiatric morbidity, infant health, adaptation tohearing loss, recovery from illness, for life transitions such as pregnancy outcome, adaptation to mothering, unemployment, bereavement, retirement, and for other events such as suicide and accident rates(Wilkinson; Ballantyne,1999).For example, in a 3-year longitudinal study of participants with mild hypertension, higher

marital adjustment (i.e. Happiness, solidarity, agreement, affectional expression; Spanier,1976) at baseline was associated with a decrease in left ventricular mass index (Baker et al, 2000).

c) **Health related behaviors:**Several gender-based variables, including exposure to abuse, burden of treatment, and maladaptive health patterns, impact actions related to health. For example, intimate partner violence against women and children can have a dramatic effect on health (example, chronic pain, gastrointestinal problems, sexually transmitted disease, depression; Campbel,2002). Gender based violence is a serious human rights violation and public health concern that affects the individual survivor and her children's physical and mental health and carries a social and economic cost to society.The United Nations (UN) Declaration on the Elimination of Violence Against Women (1992) defined gender-based violence as “violence that affects women that is directed against a woman because she is a woman, or violence that affects women disproportionately.It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty.”The gender roles and unequal power ties between genders in society are inextricably related to them. One of the manifestations of this gender imbalance is brutality against women and girls (DoHS,2075). Sexual abuse often has adverse physical and mental health consequences. The burden of treatment is a substantial social expense that women frequently bear to the detriment of their wellbeing (e.g. depression, anxiety, and reduced satisfaction with life; Yee and Schutz, 2000), but is often not measured again.Finally, the position of women as home primary care caregivers also ensures that women neglect their own personal preventive health practices in order to enhance those of other members of the family.

d) **Coping skills:**Although others have indicated that less research focus has been paid to coping skills and health outcomes than to the correlation between personality determinants and disease, multiple studies indicate a link between coping skills and quality of life, including adjustment to disease (Weibe and Christensen,1996).In order to understand the lives of women, it has been suggested that both stress and coping mechanisms are specific to the

socialization of women (Tom, 1993). Coping skills are easily modifiable frequently differentiate men and women and are predictive of many physical and psychological health outcomes (Penley, Tomaka and Weibe,2002).

e) **Attitudes and values:** There are a multitude of gender attitudes and beliefs that have a significant effect on wellbeing. For example, their general health satisfaction, their relationship with health providers, and their use of alternative health services are likely to influence the importance of individuals attached to health (Pittman, 1999).Indeed, the perception of women when they are sick or well depends on their health significance and attitudes, according to a review study including women with chronic disease (example, interpretation and management of symptoms: O'Neill and Morrow, 2001).

Most of the literatures suggest that despite enjoying a longer life expectancy, women are generally expected to live few years in good health than men. The shorter life expectancy of men results from both biological disparities in vulnerability to disease and gender-based behavioral activity and risk-taking patterns. The weaker self-perceived health of women, on the other hand, represents a higher prevalence of a significant number of non-fatal, debilitating physical and mental illnesses.The poorer health status of females has been viewed as unequal. As a result of a patriarchal gender order, gender inequality is seen as avoidable due to the inferior power status of women in society (Palencia, Mortel, and Artazcoz; 2017).

2.3 Conceptual Framework

There have been a few literatures that suggest different approaches or frameworks to measure health inequality by various academicians and professionals.

However, this study has not aimed to draw out the health disparity among the population. Rather this study has gone for the social determinants of gender-based health disparity. A variety of approaches to the social determinants of health exist, and all of these are concerned with the organization and distribution of economic and social resources.

Peace, housing, education, food, income, a stable eco-system, sustainable resources, social justice, and equity were highlighted as requirements for health in the 1986 Ottawa Charter for health promotion. Dahlgren and Whitehead proposed a rainbow model of health determinants in 1992, in which the "living and working conditions" arch highlighted agriculture and food production, education, work environment, unemployment, water and sanitation, health care services, and housing as contributions to health.

Raphael (2006) presents the three dominant frameworks that have emerged to explain the role that income inequality may play in health are also relevant to understanding the influence of other social determinants of health. These are the materialist, neo materialist and psychosocial comparison approaches.

Materialist Approach: *(Conditions of Living as Determinants of Health:* Individuals experience varying degrees of positive and negative exposures over their lives that accumulate to produce adult health outcomes. Within nations, socio-economic position is a powerful predictor of health, as it serves as an indicator of material advantages or disadvantage over the life span.Material conditions predict likelihood of physical, developmental, educational and social problems.Material conditions of life lead to differences in psychological stress. Individuals of lower socio-economic position experience a range of psychological status that threatens health. Materialist arguments outline the sources of health inequalities among individuals and nations the role played by various social determinants of health.

Neo-materialist Approach:*(Conditions of Living and Social Infrastructure as Determinants of Health):*Differences in health between countries, regions, and cities are linked to the distribution of economic and other resources throughout the population. More low-income persons and wider income disparities exist in American states and other places with more uneven income distribution and poor quality of various socioeconomic determinants of health. They spend less on public infrastructure that influences social determinants of health, including as education, health, and social services, as well as jobless and disabled people's supports and libraries. The health characteristics of such unequal jurisdictions are significantly worse.The neo-materialist view directs attention to both the effects of living

conditions on individuals' health and the societal factors that determine the quality of the social determinants of health.

Psychosocial Comparison Approach:*(Hierarchy and Social Distance as Determinants of Health):*It is argued that health inequalities in developed nationsare strongly influenced by citizen's interpretations of their standing in the social hierarchy. The establishment and spreading of hierarchy at the community level impairs social cohesiveness, which is a factor of health. Individuals grow increasingly agitated and distrustful of others, eroding support for community systems like public education, health, and social services. This method focuses on the psychological consequences of policies that decrease social determinants of health. It also raises the question of whether material features of society, which are the emphasis of materialist and neomaterialist views, are the primary drivers of these psychological processes.

There is no doubt that health status of people from the developed nations differs from those of under developed or developing nations. It is mostly because of the distribution of health resources, practices and environment.

However, the major focus of this study was to find out the social determinants of gender-based health disparityand explore the causal relationship between gender - based health disparity and its social determinants. The variables that have beenconsidered for causing gender-based health disparityare: access to health care,domestic violence against women, gender roles, domestic violence, education, gender discrimination, early marriage and pregnancy. The conceptual framework for this study can easily be understood through the given below figure (2)

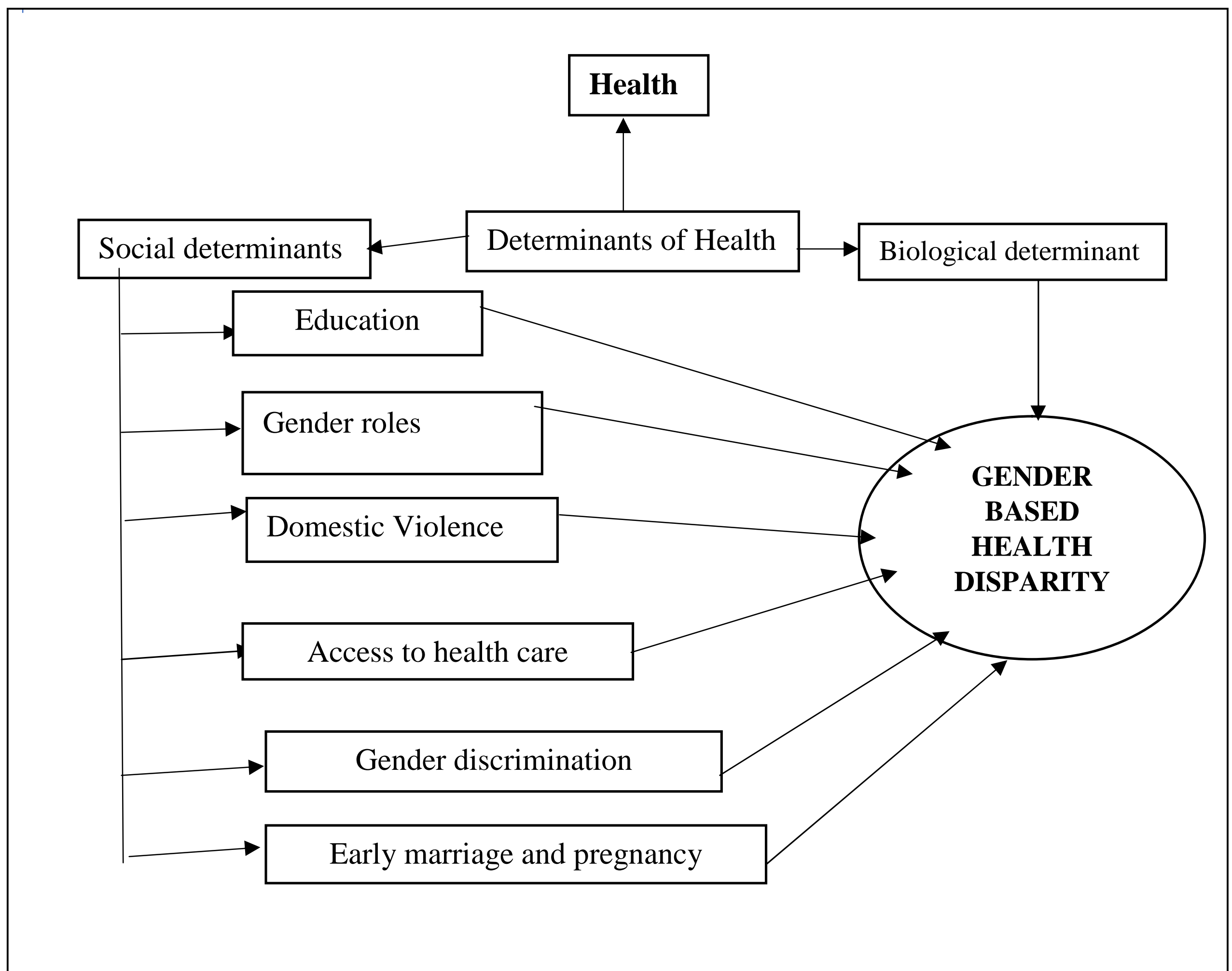

Figure no: 2: Representation of Conceptual Framework through Diagram

It is well known to all that there have been biological and social determinants of health. Health is directly or indirectly associated with the distribution of a variety of resources. Health disparities do prevail on several basis such as gender, race and ethnicity, geographical location and so forth. Generally, health disparity occurs due to inequitable distribution of resources. However, there have been a number of other societal factors that lead to different health outcomes of a particular group. Women as a group do observe health disparity compared to their male counter parts. This study particularly focuses on social determinants of gender-based health disparity. For this study, a number of variables were taken into account such as education, gender roles, domestic violence, gender discrimination, access to health care, early marriage and pregnancy. After considering these variables, the study has been able to figure out social determinants of gender-based health disparity.

CHAPTER -THREE
RESEARCHMETHODOLOGY

3.1 Rationale of the Site Selection

The study requires data, and for the data, the researcher has to locate the field from where the data have to be taken. For this study, the site for the data was Radhemai tole (ward 13), Birgunj (Parsa). It is a metropolitan city in Parsa District in Province No. 2 of southern Nepal. Birgunj lies 135 km (84 mi) south of the capital Kathmandu, attached in the north to Raxaul in the border of the Indian state of Bihar.As an entry point to Nepal from Patna and Kolkata, it is known as the "Gateway to Nepal". It is also called "Commercial capital of Nepal". The town has significant economic importance for Nepal as most of the trade with India.Tribhuvan Highway links Birgunj to Nepal's capital, Kathmandu. Birgunj is one of the largest cities in Nepal and largest in Province no. 2 [Madhesh Pradesh]. Birgunj is the sixth most populated metropolis of the nation.

Birgunj being the metropolitan city, it has total of 32 wards. Out of which Radhemai tole is the 14th ward. It lies towards the north of the central market area and west of the sugar mills factory [not in operationthese days]Radhemai tole has been named from a temple named[RadhemaiMandir] that lies in that tole.People residing in tis area are mostly the Hindus. A small community of muslim also resides here.The reason behind selecting this site as the site for my study was quite clear because this place rarely receives any researches and I had a few good friends staying over there who could assist me for raport building with the respondents. Moreover that place observes rich cultural diversity which would help to open more about the variety of responses from the respondents.

3.2 Research Design

A research design is a strategic framework for action that serves as a bridge between the research questions and execution or implementation of the research. Research designs are plans that guide 'the arrangement of condition for collection and analysis of data in a manner that aims to combine relevance to the search purpose with economy in procedure (Sellitz, Jahoda, Deutsch, and Cook,1995; Durrheim,2006).Research design can be thought of as the structure of research – it is

the “glue” that holds all the elements in a research project together.It is designed and plan nature of observation that distinguishes research from other forms of observations.

There have been a very few researches carried out on health disparity in Nepal (especially in case of gender based health disparity). This study, therefore, has been exploratory in its nature. Exploratory research is flexible and can address question of all types (what, how, and why). Since, exploratory research “tends to tackle new problems on which little or no previous research has been done”,this study has followed exploratory research.

3.3 Nature and Sources of Data

For this study, primary and secondary sources of data were the main sources. The primary data has been collected from the field using in-depth interview guide. Some open ended and some close ended questions were asked to obtaingood piece of data. The secondary data have been collected from different sources such as census, demographic surveys, and published related books. The primary data was collected via in-depth interview and was qualitative in nature. Theprimary data had played the major role while the secondary data had played a supportive role.

3.4 Selection of the participants

Since this study is a qualitative study, the research followednon probability sampling process and usedpurposive sampling. The data was collected from 20 womenaged 30-60 years old from different social backgrounds. The reason behind selecting women of aged between 30 to 60 years was that they would have ample experiences and dealings of life to share. The sample size was 30 but the data were saturated when found that the responses from the respondents were of similar kind.

3.5 Technique of Data Collection

The secondary data was collected from the census, demographic surveys and other related books. And apart from the secondary data, the following technique was used while collecting data:

Interview

Interview is one of the most used and suitable techniques of data collection in social science research. This is an extremely useful method for developing an understanding of an experience, or setting. It allows researchers to focus the respondents' talk on a particular topic of interest, and may allow the researchers the opportunity to test out their preliminary understanding. The purposeofinterviewing is to find out what is there in someone's mind. The purpose of open ended interview is not to put things in someone's mind but to access the perspective of the person being interviewed (Patton, 1990). Patton further states that interview data can easily become biased and misleading if the person is being interviewed is aware of the perspective of the interviewer.

However, interview is the one of the most common and powerful methods and instruments for understanding an individual or group perspective. It is widely used to gather information regarding an individual's experience and knowledge; his or her opinions, beliefs, and feelings in qualitative researches. It is not only an effective tool for data collection but also it is something that provides space for active interactions between two or more people leading to negotiated, contextually based results. It is very useful tool for studying everyday lives of people.

The presence of an interviewer to help respondents interpret and understand the questions can be critical to the success of the study.Interviews help the researchers uncover rich, deep insight and learn information that they may have missed otherwise. The presence of an interviewer can give the respondents additional comfort while answering the questionnaire and ensure correct interpretation of the questions. Conducting interviews can help the researcher overcome most of the shortfalls by allowing him/her to build a deeper understanding of the thinking behind the respondents' answers.

Hence, the significance of the interview as an effective tool prompted me to choose this tool for my study. Whileapplying in-depth interview to obtain information for my study, I followed the following stages:

On the completion of the selection of the informants, first of all, I visited them one by one and requested for their cooperation during my research period. I asked their

permission for the interview and clarified them about my purpose of research. Then I inquired the informants for their most convenient time for our meeting. These preliminary works helped me to become familiar with them.

On the scheduled days, I visited them individually at their residence. I then described my topic and purpose of the interview with them again and asked their permission to begin. I repeated the same process until I finished interview with all of them because I had to conduct couple of interviews with everyone. I went through the issues which were developed out of the research questions. While conducting every interview with the informants, I acknowledge full respect of their valuable presence and provided full freedom to respond whatever they felt reasonable from their part. On completion of every day session with each informant, I did debriefing shortly regarding the areas covered in the interviews and expressed warm appreciation for their valuable time and their cooperation.

3.6 Process of Data Analysis

Data analysis is a process of inspecting, cleaning, transforming and modeling data with the goal of highlighting useful information, suggesting conclusion and supporting decision making. It is a practice in which raw data is ordered and organized so that useful information can be extracted from it.

This study has followed thematic analysis.Thematic analysis (TA) has a less coherent developmental history. It first arose as a "method" in the 1970s, although it was applied in a variety of ways and with varying degrees of consistency.TA provides a toolset for academics who want to conduct strong and even advanced qualitative data analyses while also focusing and presenting them in a style that is understandable to others outside of academic societies. Boyatzis (1998) laid out clear specifications and principles in a significant publication centered on "code and theme creation," which moved away from grounded theory (Braun& Victoria,2008).

This analysis requires more involvement and interpretation from the researcher. The issue of reliability is of greater concern with the thematic analysis. This issue is even more pronounced when working in teams with multiple analysis. Despite the issue of reliability, thematic analysis is still the most useful approach in capturing the complexities of meaning in a textual data set.

Data analysis provides the meanings of the research. After obtaining all the data, I moved towards data analysis procedure. At first, the recorded data was transcribed and translated. Then the data was codified and categorized and then was given theme. At last, but not the least the data was interpreted.Data has been presented in the descriptive form. Then only, the findings of the research have been made after detail analysis and interpretation of data.

3.7 Limitation of the Study

This study was conducted at Radhemai tole (ward 14), in Birgunj, Parsa District of Nepal. This study is solely based on the experiences of women of that particular tole. I have presented the findings brought up via interview of 20 women. This study has not such grounds to fully represent the situation of gender based health disparity of whole Birgunj and beyond. So the socio determinants of health that cause gap between the male and female's health status may differ from the other places and time periods.

CHAPTER – FOUR
PERCEPTION OF THE RESPONDENTS

This chapter presents the findings of the study taking into account of its aim of exploring social determinants of gender based health disparity solely based on the experiences of women. In the similar fashion, this study also gives emphasis on how those social determinants have been pushing women towards their vulnerable situation, surrounding with patriarchy embedded long influences.

4.1 Background Characteristics of the Study Population

The study participants belonged between 35- 49 age group of women. The average age of the participants was 40 years. This age group of women had ample experiences of their pre-marriage and post -marriage life. Regarding their marital status, all the participants were married. The participants were from different ethnic background. They were particularly from Kanu (8), Kurmi (6), Chamar (Dalits) (2),Godh (1), Dhanuk (1) and Ahir (Yadav) (2) ethnic groups. Majority of the participants (12) were illiterate. Merely, two of the participants had completed their schooling i.e. SLC and intermediate respectively. Two of the participants had completed their lower secondary level i.e. 8 class and two of the participants had completed their primary education and remaining of the participants never went to school and remain illiterate. The given below table shows the detailed background characteristics of the study population regarding their current age, marital status, caste/ethnicity, number of children and education.

Table no 2: Background characteristics of the study participants

ID Number	Current Age	Marital Status	Caste/Ethnicity	Education
A	43 years	Married	Kurmi	5 class
B	45 Years	Married	Kanu	7 class
C	38 years	Married	Kanu	Illiterate
D	46 years	Married	Kanu	Illiterate
E	39 Years	Married	Kanu	Illiterate
F	42 years	Married	Ahir	SLC
G	36 years	Married	Godh	Illiterate
H	38 years	Married	Kanu	Illiterate
I	37 years	Married	Kurmi	10+2
J	39 years	Married	Kanu	Illiterate
K	36 years	Married	Kurmi	Illiterate
L	37 years	Married	Chamar	Illiterate
M	45 years	Married	Chamar	Illiterate
N	40 years	Married	Dhanuk	8 class
O	36 years	Married	Kurmi	Illiterate
P	44 years	Married	Yadav	Illiterate
Q	36 years	Married	Kurmi	8 class
R	40 years	Married	Kanu	3 class
S	37 years	Married	Kurmi	7 class
T	49 years	Married	Kanu	Illiterate

All the participants had got married quite early. Early in the sense that it does not match the standard set by the government. Only one participant has got married at the age of 18 years and remaining of the participants (19) had got married before they could reach 18 years. Among the participants, the lowest age of marriage is 12 years and the highest age of marriage is 18 years. Similarly, each of the participants has had their first pregnancy before they could reach 20 years old. Each of the participants has at least 3 children and more of 6. Regarding the occupation of the participants, only one of them was a job holder i.e. a primary teacher and rest of the participants (19) were housewife or assisting in the farming activities. The given below table shows the detailed background characteristics of the study population regarding their age of marriage, age at first pregnancy, number of children and occupation.

Table no 3:Age at marriage and first pregnancy, number of children and occupation of the study participants

ID Number	Age at Marriage	Age at First Pregnancy	Number of Children	Occupation
A	16 years	17	3	Farming
B	15 years	16	4	Housewife
C	15 years	16	3	Housewife
D	12 years	16	3	Housewife
E	14 years	17	4	Housewife
F	17 years	19	3	Housewife
G	17 years	18	3	Housewife
H	16 years	17	4	Housewife
I	18 years	18	3	Teacher
J	15 years	17	4	Housewife
K	16 years	17	5	Housewife
L	15 years	17	4	Housewife
M	14 years	16	6	Housewife
N	16 years	18	4	Housewife
O	17 years	18	3	Housewife
P	12 years	17	3	Housewife
Q	15 years	17	4	Housewife
R	14 years	16	4	Housewife
S	15 years	16	3	Housewife
T	12 years	16	5	Farming

4.2 Perception about Gender-wise Illness

The participants claimed that women are more vulnerable towards illness. The participants stated that female body is weaker than male and females have to work a lot from early morning to late night which make them more prone to illness. Giving birth to child and having more household responsibilities also make them prone to be affected by illness. Except one participant, each agreed that females have more chances of getting ill more often than the males.

Women have many problems. They do more works at home and they are weak too. So they are more prone to illness than men [ID-B].

Females are more prone to illness because they are weak and have to work from early morning to late night. There are no rest days for females. Males also fall ill but not as female. Female's biology is also not strong as male. So females have more chances of falling ill than males [ID-S].

A few respondents also added that women are weak because they give birth to their babies and have more responsibilities of household works that makes them more vulnerable.

Obviously, female are more prone to illness. They are weak and have to deliver child which makes them much weaker. Men are strong so they fall less ill than female [ID-N].

It is quite clear that women have more chances of falling ill than males. It is because male's body is strong and female's body is weak. Females have to work from early morning to late night. This causes us physically and mentally tired everyday [ID-J].

Absolutely, it is female. Example, I usually think about household problems like cooking, and maintaining cleanliness inside home and outside too. Apart from that I cannot bear tension, tension of making marry of my daughter. Females have more things to worry about [ID P].

They mostly focused on women being much weaker than men and have more responsibility which causes female to fall sick, they were clear about female observing more sickness than men due to weaker body and responsibility.

Two of the females added that along with doing more works, they eat late than others and have to go through many sleepless nights because of their kids respectively. The exact words were:

I think females have more chances of getting ill more quickly than the males because females are weak, do more works and eat lately after everyone takes meal [ID -L].

In my opinion, female are more prone to illness because they are weak. Their body is not as healthy as males. Women do more work and have many sleepless nights because of their kids. So, females have chances of falling ill more often [ID -Q].

Another woman added that women are less immune than men but have more tolerating power. The words were:

Obviously female are more prone to illness. Woman's body is soft and is less immune than the males. Men are stronger. But, yes women have more tolerating power than men [ID-E].

It was absolutely interesting to note that only one participant out of 20 participants stated that males suffer from more illness than the females and rest of all undoubtedly stated females suffer the most. According to her..

In my view, everyone suffer from different sort of disease. But what I have noticed is that male fall sick more often. Because they work physically hard, they work outside mostly and they have more pressure to run the family. As a female we have to stay at home and do household things which are much easier than that of males work. So male suffer more [ID-R].

It is quite clear that the participants claimed that females are more prone to illness than males. They presented a variety of reasons for this. They mostly stated that the female body is weaker and is biologically weak and less immune. They also put the notion that giving birth to the babies makes them even much weaker. Moreover, they also claimed that their family responsibility and late eating habit after feeding everyone also causes problems. Merely one respondent stated males to have been more prone to illness.

4.3 Gender Wise Discriminatory Practices

Generally when the participants were asked about the equal treatment within the family, they simply stated that they were treated the same as the male ones. But gradually with the follow up questions they accepted that they have not been treated the same way as of male. Particularly in context of education and health practices, they found themselves lagging behind the male ones.

Mostly the participants stated there has not been any discrimination. But later they themselves clarified they do have been discriminated.

Yes, we do not discriminate…….male members are more educated than the females…..we usually go to government hospital because private clinics charges a lot but in case of my son, we often take him to private clinics for better and immediate treatment [ID-A].

Yes, everyone is treated equally. My son goes to private school and my both elder daughters go to government school [ID-G].

Two of the respondents stated that everyone is treated equally now but a few years back it was not the same especially in context of education and work.

These days everyone is treated equally, but when I came here after marriage, there was not equal treatment. It is always the men that got more freedom of things or the opportunities. Like education, my sister-in laws are illiterate but the brothers have got certain level of education. Even my mother in law sent my only daughter in government school and my both sons were sent to private school.[ID-D].

Yes, everyone is treated equally. But few years back, the situation was something else. Female always got lesser resources. But now everyone get equal resources like getting education, going out for work and fun [ID-J].

The only teacher among the participants stated that there has been still discrimination in the family but have to go according to the society like sending male child for late tuition classes and not to the female child.

We can say yes that there is no discrimination but deep inside still there is a bit of discrimination in every family. As a literate person I accept it there is still discrimination in the family. But sometimes it is not in individual control. We have to go according to our society like letting male child to attend late tuition class but not the female child [ID-S].

A couple of participants added that males and females are not treated equally and they cannot compare themselves with the males because males have been always treated in a special way and have got more rights and opportunities.

No, we male and female are not treated equally. We cannot compare ourselves with male because they are male and have all the things from many years. Male always

gets more rights and opportunities. They have got all the freedom and are the breadwinner of the family [ID-Q].

No, we cannot compare ourselves with the males. They are always treated in a better ways. They have more responsibility when they grow up. So from early childhood, they are treated in a special way [ID-R].

The participants clarified that males had always the more opportunities. Males were treated in a special way. They were engaged in household works from their early age whereas their male counterparts were sent to school to get education. They also stated that men had always the opportunities to a lot more things than the females for many years and still males get such environment. Females have not been given much importance. But these days, the new generations are treated mostly the same. Less discriminatory practices are observed in present context, this is what the respondents conveyed.

4.4 Gender, Education and Drop-out situation

The participants clearly stated that male members of their family were more educated than that of female members. They did not get such opportunity to get education as their male counterparts. At their early ages, their brothers were sent to school whereas they were engaged in household works including feeding cows and grazing goats. They undoubtedly made sure that male members of their family had opportunity and freedom for their education.

One participant added that she had never been to school but she had been able to give education to her children. She had sent her both male and female children to school but only her younger son went to private school. And she also stated that males were more educated than females in her family. Her words were;

I have never been to school but my each child has completed their schooling and they are in college now. My elder son and daughter have studied in government school and only my younger son has studied in private school. We could not afford to pay all of them to send in private school. Males are more educated because they have to earn more money for the family. Apart from that, female had to complete all the household works including feeding and cleaning dung of goats and buffaloes. I was also never sent to school to during my early days. Hence I remain illiterate [ID P].

Two of the participants who had studied till grade 8 stated that they could not continue their education because of their marriage. Their children had completed their schooling and have been married. They stated that during their times female used to have lesser opportunities to get education but these days everyone gets sufficient opportunities to get education

I have studied till class 8. While I was studying I was married and there after I did not get opportunity to continue my education. Two of my children (total children) still go to school. Two of the remaining children have been married and have completed their school education. They all have studied in government schools. Obviously males are more educated because they are given more opportunity for education. And females lag behind in this aspect. Males have to work out side also. So they have to study more. And we females have to stay at home. But these days, girls and boys are equally getting opportunities to education. We are also providing education to our children [ID N].

I have studied till grade 8. While I was studying in grade 8, I got married. My family members did not allow me to go for further education. Otherwise my aim was to become a teacher. When it comes to education males are more educated because they have got those opportunities to everything. Even after their marriage, they continue their education if the family is well to do of. Every male child is given more exposure to good things. They get all possible environments to enhance their potential whereas the female lacks these opportunities in many aspects [ID – Q].

A respondent stated that she was illiterate but her children were able to get education. However two of her daughters got married while they were studying in grade 8 and rest of the two daughters were married after they had completed their schooling. They started marrying their daughter a bit early so that they could give lesser dowry and could collect certain amounts for other daughters' marriage. Despite of that they allow their only son to complete bachelor degree

I am illiterate. However my children have completed their schooling. I have four daughters and all have been married. And my only son is also married. He teaches in a boarding school. Two of my daughters got married when they were studying in class 8 and two of them were married when they completed their schooling. Marrying daughters requires a lot of money. So we started to marry them after collecting

certai6n amounts in 2/3 years of interval. And their age had also become adequate for marriage. But we allow our son to complete his bachelor degree [ID T].

A respondent who was illiterate stated that she never went to school but want her children to be educated. Her son goes to private school and daughters are sent to government school. She said if daughters were sent in private school too, they could not afford for any of their education.

I am illiterate because I was never sent to school. However we send our children to school. My son goes to private school and my both elder daughters go to government school. We have to pay more for our son in private school. If they (daughters) also go in private school then we have to pay a lot more. At least they are going to school. I have not been to school. I am illiterate but I do not want my children to be like me. However, my daughters have studied up to class 10 and they will get marry soon [ID - K].

Another participant stated that she was not sent to school during her time. But her children have got education. However her daughters are sent to government school and sons are sent to private school. She clearly mentioned that it was her mother in law decision to send the children in government and private school. Moreover, she said that male members were more educated than the females.

I am not educated. I was not interested in education neither my parents forced me to go to school. But my children have got education. They have completed their schooling and they are now college students. My son has studied in boarding school and my daughter in government school. Every family's decisions are taken by my mother in law. She did send my both sons and to private school and my only daughter to government school. However, she is studying H.A in a private college on scholarship. My both sons are also studying in Pokhara. Definitely, male members are more educated because they have got those opportunities that female did not get such opportunities. But these days everyone is getting opportunities for education. I am also insisting my all children for better education so that they can get various opportunities for good job [ID- D].

A respondent stated that she was married while studying in grade 7 and then never went to school back. Her both sons were studying engineering in Bangalore and her

daughters were married after they completed 12 class. She also stated that women do not become engineers so they did not go for her daughter engineering.

Yes, I have studied till grade 7. I was married while was studying then I never went to school back for my education. Yes, my elder daughter has studied up to n grade 10 in a government school and my other daughter has studied up to grade 12 and they both got married and stopped their study. Their age was for marriage because females get married a bit earlier than the boys. After all women do not become engineers and if they also studied engineering, we could not have afforded for everyone's education. My both younger sons studies in Bangalore. They are studying engineering [ID- B].

The respondent who was also a teacher stated that she has completed intermediate and her children have also got good education. Each of the children has studied in private school but her daughter goes in a government school so that she can get scholarship for higher education. She also said that males were more educated but the trend has been shifting and everyone has been getting opportunities to get education.

Yes, I have studied and completed intermediate level. My children also study and my both sons go to private school and my daughter goes to government school. We are not discriminating here. Actually if she takes exam from the government school, then she will receive certain scholarship for her higher education as she is in grade 10. She has also studied in private school up to grade 8. Males are more educated. But the trend has been changing. Everyone is getting equal opportunities to get education. In past males were only given priority for education. So they occupy the top spot [ID-S].

As per the respondent, they were the males who were more educated than the females. Even if females were sent to school, it was likely that they had to drop out of the school because of the early marriage practices on the other hand the males were able to continue their education even after their marriage. After their marriage, females were not allowed to go out and continue their education. Instead they had to do the things for the rest of the family members like cooking, washing clothes for all, cleaning the rooms, taking care of elderly people at home and so on. Due to dowry practices, girls were married early which resulted in school dropping out. As males were more educated, they were able to occupy the top spot in the society.

4.5 Gender and Work

Mostly the respondents were either engaged in household works or were working in field on daily wages. Since, women were not educated they did not have ample opportunity to have job in different sector. So either they had to work as labor in the field or stay at home and take care of kids and elderly. Male members had the opportunity to work outside because of their freedom and choices of job allowed by their level of education. Staying at home and serving kids and taking care of elderly people had caused some psychological stress among the women as they stated.

A few respondents stated that they work in the field which includes a variety of works like planting paddy, picking up grass, planting vegetables etc. and they are paid 5/8 kg of paddy for their 8 hours of work. Apart from working in the field, they take care of household works. They also stated that their nature of work also cause illness. They also like to have a comfortable life but they accept it as their destiny.

Yes, I work in the farming field. Working in field contains a variety of works like planting paddy, vegetables, picking up grass from the planted vegetables etc. they pay me 5/8 kg of paddy/wheat for the works. Apart from that I have to take care of my house hold work. I am not satisfied with my work because I also like to do safe and comfortable works and I think everyone likes that. I think my works make me ill. [ID-L].

Sometimes I go out and work in someone else field on daily wages. They pay me 5 kg of paddy for my work. Nobody likes to work in someone else field and for 5 kg of paddy for 8 hours of work. Everyone likes comfortable works. But what to do, we are not from that well to do family. This has been written in our destiny and we have to do this [ID- A].

There have been majority of the respondents who did not work anywhere on wages. They were limited to household works including feeding and managing domesticated animals and taking care of kids and elderly people at home. However they were not satisfied with their works. They wished to have better work which could pay a decent amount of money.

No I do not work on wages. I have to feed my buffalos and goats. Moreover, I am engaged in household works including taking care of elderly people and little kids. No

I am not satisfied. Everyone loves good work with lots of money. Earlier I was thinking it is okay. But I now I think I would be also doing other works if I had got certain level of education [ID- J].

No, I do not work on wages. I am engaged in household works including taking care of elderly people. I am not satisfied with my work. I also like to work out side like teaching, or working in banks etc. I would have been happy if I were a teacher [ID-F].

No I do not work for someone else. I just do my household stuffs. I take care of two old family members i.e. my father in law and my mother in law. Yes I am happy that I stay with my in-laws and take care of them. There should be someone around them to take care. Since my husband remains busy in his work, I am the only one to take care. My sons also are not here. I also think that if I were more educated, I would also work in bank office. But it is okay [ID-B].

A few respondents also added that they do not work for others but they contribute for the family by taking care of the household things and elderly people. And they feel happy doing those stuffs because that allows their children to achieve good career.

No I do not work for someone else. I just do my household stuffs and take care of my old mother in law. Yes, I am happy with my work I feel happy see my daughter and son doing some great works for society and they are on the way to make their career bright [ID- P].

No I do not work on wages. I am engaged in household works including taking care of elderly people and my children. I am happy with my household works [ID- Q].

Out of all the participants, only one had government job. She was a primary teacher. She stated that she was happy with her job.

Yes. I am a primary level teacher in a government school. Yes I am happy with my job [ID-S].

The respondents mostly were the housewives. Few of them were also involved in farming activities on daily wages. They were limited to their household works. Male members had the opportunity to work outside because of their freedom and choices of job allowed by their level of education. Females had to take care of domesticated

animals. They were not directly the economic earner and holder. Staying at home and serving kids and taking care of elderly people had caused some psychological stress among the women as they stated.Most of the women desired to work as men do in offices but their illiteracy does not allow that.

4.6 Gender and Health Care Discrimination

Majority of the respondents suffered from asthma, arthritis, blood pressure issue and gastric problems. The respondents had some experiences regarding the discrimination they had felt during seeking health care. Not only had they observed, they too were among those who had practiced health care discrimination. They seek for better treatment for their sons where as they sometimes ignore the condition of their female child. The women also stated that when they fell ill, their family members waited for three/four days to see whether it would be all fine without treatment. When they couldn't get over their illness, then after couple of days, they were taken to health clinics. When males suffer, quick action was taken for their treatment.

Yes, I suffer from asthma and arthritis. It is very problematic. Yes I have observed late treatment. It used to happen when we were living in joint family. I was only taken to hospital when it was so serious. Otherwise they waited for the recovery to happen itself or by the local tablets prescribed by someone else. It has happened many times. But now this does not happen. When we were in joint family it was a bit difficult. I was not given good care during my sickness [ID- K].

I quite often suffer from blood pressure issue, arthritis and asthma. At earlier stage I used to get late treatment. I have felt ignorance at time of illness. When the family was big i.e. we were staying in joint family. There was not the economic control with my husband. He was not earning that much money. There was dependence on the big brother of the family. He used to control and take decisions of the family. That time there were several occasion I received ignorance when I used to fall ill or it was pregnancy time [ID –T].

One of the respondents had multiple health issues like asthma, arthritis and gastric. She stated that she had observed late treatment on many occasions. Her mother in law was the decision maker and she hardly assisted to take her to hospital. Because of late treatment she had get lots of injection.

Yes, I suffer from asthma, arthritis, gastric. I have observed late treatment on many occasions. I often get asthma attack and since my mother in law was not that soft to me, she often did late to insist my husband to take me for treatment. Then I have been injected a lot. Because of late treatment, injection was only possible so that it would work a bit quicker than tablets and capsules. No I am not happy with the approach. My mother in law hardly assisted to take me to the hospital. I lacked proper care during such times. I have experienced ignorance. When I had arguments it my mother in law, she used to tell "let her die. She is useless. Why to spend money on her.'' What to tell more. [ID–D].

A respondent stated that she had experience of having late treatment that resulted into tuberculosis. She had been suffering from fever and she was not given care. Nobody took her for treatment after 1 week she was taken to hospital when she was so serious. She was found to catch tuberculosis. She stated it all happened while they were in joint family.

Yes, I have suffered from disease like typhoid, tuberculosis. I have received late treatment and it often happens. Everyone waited so that the suffering would be cured within 2/3 days. When it became serious then only they took me for check up. It happened when I was suffering from fever and they kept waiting for my recovery without proper treatment. After 1 week I was taken for check up, I was found suffering from typhoid. There have been other instances too. No I am not satisfied with the treatment approached by my family members. If I had been in other family, I would have got proper care during my tough times. May be we are poor so this happened to me. While we were in joint family, nobody really cared. But after living separate we care each other [ID-L].

Four of the respondents had the health issues as well but they were happy with the approach their family members had shown during their tough times. They got the best possible care and treatment their family members could provide.

Yes, I suffer from asthma attack. I think this is genetic because my mother had the same problem. My family cares me a lot. I am happy and I have not felt any ignorance [ID-F].

Yes I suffer from high blood pressure. I am happy with the approach my family has shown to it. I get treatment from the best possible way [ID-P].

Yes, I do suffer from arthritis. I have pain in my several joints. I am satisfied with the treatment approached by my family. Wherever they heard about the treatment of arthritis, they possibly brought medicine from there. In context of care given, it is this way that I stay with my elderly in laws. My husband remains outside and my sons too. When I completely become sick, like not able to perform my daily works, my sister in law comes to assist me. When my any of the sons will get marry, there will be someone who could take care of me properly during tough times. I it is the situation that shows ignorance because of my sons' education as they stay out of our city. When they will be here, everything will be okay. But from health perspective, there seems a little carelessness [ID-B].

Majority of the respondents suffered from asthma, arthritis, blood pressure issue and gastric problems. The respondents had some experiences regarding the discrimination they had felt during seeking health care. Not only had they observed, they too were among those who had practiced health care discrimination. They seek for better treatment for their sons where as they sometimes ignore the condition of their female child. The women also stated that when they fell ill, their family members waited for three/four days to see whether it would be all fine without treatment. When they couldn't get over their illness, then after couple of days, they were taken to health clinics. When males suffer, quick action was taken for their treatment.Most of the patients had experienced late treatment or not given appropriate care when they suffered from illness. The most common thing among them was during the time when they were staying joint family. Their health was not taken that seriously. They were given medicine without the prescription and without medical check-up.

4.7 Gender Roles

At first, the participants did not know what exactly gender roles mean. They were clarified about gender roles. Most of them accepted that their health is associated with their roles. Gender roles have made them restless. The women who were working outside they also had to complete all the roles at home. Among them, I came across to

the only teacher of them, and she stated that even after coming back to home after a full tiring day, she had to do all the stuff that all other women do like cooking, washing, serving food to everyone, washing clothes for all, giving massage to her mother in law and so on. These sorts of regular acts used to create mental stress to them. Despite not liking to do these all everyday, they had to do it unwillingly. The only teacher among the rest of the respondents stated that gender roles do play role in sickness.

Yes, gender roles make me suffer from illness. It is because I have to do all the household works along with my professional work. On the other hand my husband is also a teacher but he does not do all the cooking stuff. There is difference between male and female. That time gender roles play a role. It does create a lot of tiredness mentally and physically. Males have freedom in this aspect [ID-S].

A respondent stated that gender roles cause illness and anxiety but there is nothing that can be done against it and that is what they are taught from the childhood and are trained of doing that

This is true that gender roles do cause illness and anxiety. But there is nothing we can do against it. This is what we are taught from our childhood. And we are trained doing that [ID-B].

Another respondent stated that gender roles do create a bit pressure on mental health. Sometimes they do not remain in the condition to perform their gender roles, despite of that they unwillingly had to do. They do not get any rest days.

Yes. Sometimes it really makes us suffer. Some works are only meant to be done by us like cooking, cleaning, and other stuffs when you become tired for works at day. You have to do the things at night. Unwillingly, I have to do at any cost. This really creates pressure on mind [ID-L].

Another participant also agreed that gender roles make her suffer too. But also stated that there is nothing wrong in it because women are meant to do that and are for that.

Yes I think gender roles make me suffer. Because as a woman one does not have any rest days. I have to perform all the works. But I do not think there is anything wrong in it. Women are meant to do that and are for that [ID-A].

A respondent added that if gender roles were not there it would have been my much easier for them in one hand and on the other hand she did not want her husband to cook or do other basic cleaning of their home.

Working in field and completing all household works till late night does make feel problematic. If there would not have been gender roles, it might have been easier. But we cannot ignore this also. I do not want my husband to cook or do other basic cleaning of our home [ID-R].

A respondent stated that gender roles have role in their weakness and illness. As a woman, one never has off duty. She added that gender roles increase when a woman becomes a mother and one has to do a lot more works.

Yes, gender roles play role in illness. Women are never off duty. Especially when one becomes a mother, it brings a lot of works. Even some works can be carried out by males too but they do not do it. I had to perform a lot more works but now my daughter in law does all [[ID-T].

Another respondent accepted that gender roles cause morbidity but she also added that there is nothing women can do against it. So she did not want her husband do those works and therefore she feels good doing all those stuffs.

Yes, this is true. But there is nothing we can do against it. This is what we are taught from our early childhood. And I absolutely do not want my husband to do these works. I feel good doing this [ID-P].

There were a few respondents who believed that gender roles do not harm that much because those things are being done from childhood. However, they also accepted that it causes irritation sometimes.

No, I do not say gender roles make me ill but it does create anxiety sometimes. I do not like to confine myself to household works. But what else I can do. I do not have any other option [ID-F].

I do not think gender roles make me ill because there are the things we have been doing since our childhood [ID-D].

No I do not think so because these things are done by every woman. But more work load of the women may lead to sickness [ID-J].

No, I do not think so. Because it is what we have been doing since our early childhood. Sometimes irritation is felt but that does not make me ill [ID-N].

No, gender roles does not make ill but sometimes it makes irritating. Doing same thing every day without any rest days and when you make any mistake, you have to listen a lot from your senior members of the family [ID-G].

The respondents stated that they could not anything against the gender roles. Some respondents also stated that they would love to work outside or in offices but were not capable of doing that in one hand and on the other hand they had to stay home to take care of kids and old in laws at their home because males had stay out normally to earn bread for the family. Despite of their wishes to our outside, most of them had to stay and perform gender roles which also affect their psychological aspects.Gender roles create a lot of tiredness mentally and physically. The addition of gender roles makes a woman restless. Males get more freedom and females keep doing all household works even though they work outside too.

4.8 Battered Women and Health

Most of the participants had stated that they have been beaten up by their husband couple of times. Mostly, it used to happen when they used to live in a joint family. Anything spoken against their in law or not giving regular massage to in law or not making food tasty or giving their opinion while decision making resulted in verbal abuses and beaten up. When they were beaten up, they had certain physical injuries and had to go through mental stress a lot. Almost everyone who had been beaten up in front of certain people had gone through suicidal thoughts, which is absolutely understandable. Few women also showed certain scars on their body that was resulted from those beaten up, a few years earlier.

Yes, I have been scolded and slapped for a couple of times. It does happen in the family. It happened in the past. Now everything is alright. It does not happen now. Once I was beaten when I had said something against my mother in law and my brother's wife (Dewar kobudi). It was all about family issues [ID-N].

One respondent who could not make tasty food and unable to complete work on give time, was beaten up by her husband and her mother in law.

Yes, I have been beaten. It was when food was not tasty, it became spicier. When I did not follow the instructions of my mother in law, I was scolded and beaten up by my husband. Even my mother in law has beaten me for not completing the work on time. Yes, I have gone through suicidal thoughts. I often fall sick when it was taking long time to cure, I was thinking about it. Even I was not getting proper treatment. I was totally hopeless and was completely broken [ID-D].

Another respondent stated that she was beaten up and targeted time and again in the family during the arguments in the family. The family was large so the arguments were more frequents.

Yes, I remember I have been beaten and scolded by my husband for being argued with my mother in law. There are certain family issues that bring arguments and then being the wife I have to suffer. Yes I have gone through suicidal thoughts. When you are mentally drained and feel unwanted, it is obvious that such thoughts hit the mind. This happens when you are in a large family and arguments occur frequently and you are targeted again and again [ID-J].

Two of the respondents stated that they were beaten and scolded because of a variety of the reasons like late in cooking, certain work remain uncompleted and not gone for body massage of their mother in law and argued against the decision of their mother in law

I have been scolded a number of times by my mother in law and my husband. This happens when there is a large family. I have also been beaten up. And I think this is quite common with most of the wives. There are a variety of reasons like late in cooking, certain works remain uncompleted, not gone for body massage of my mother in law and argued against the decision taken by the in laws. Having suicidal thoughts is common. When you are mentally disturbed, there is nothing to do. This occurs when you are abused and you cannot utter a word against it. It is so disturbing. My husband was also not that understanding those days [ID-T].

This is very uneasy question to answer. I have not been beaten up but yes I have been scolded a number of times by mother in law and my husband. And I think this quite common with most of the wives. There are a variety of reasons like late in cooking, certain work not completed on time, not gone for body massage of my mother in law and so forth. Yes, I have gone through suicidal thoughts. When we feel so much depressed, such thoughts come to mind. When you are mentally disturbed there is nothing to do. This occurs when you are abused and you cannot utter a word against it. It is so frustrating. Now I cannot say more [ID-A].

A respondent she was beaten because she had arguments with her sister in law and once she tried to convince her husband to try other work in the city.

Yes, I have been beaten by my husband couple of times. When I had arguments with my sister in law, I was beaten. Once I argued with my husband to try other works in the city area, he started abusing and beating. Yes, I have felt suicidal thoughts many times. I think all the poor women who are beaten up by their husband might have thought about this. We could not do anything. These things were quite frequent those days but now everything is okay [ID-L].

A respondent stated that she had been scolded a lot due to arguments in the family for some internal things which she did not share. She had suicidal thoughts too but because of her children she did not commit.

When I was newly married, there were a lot of arguments in the family. And I have been scolded a lot by my husband and my mother in law for many things like some internal things which I cannot share here. This was in the past. Now everything is alright. I had suicidal thoughts many times. But I did not commit because of my children. When things were not right in the family, there were a lot of arguments on several issues. My opinion was not valued, I was harsh spoken. But these days everything is okay [ID-B].

Yes, I have experiences of being beaten up. My husband has beaten me for a few times. It was due to arguments on family issues. It has become nearly 15 years of that incidence. I have gone through suicidal thoughts when I was mentally disturbed [ID-R].

The majority of the respondents stated that they had gone through physical assault. They were scolded and beaten up by their life partner and mother in law many a times. They were beaten for a variety of reason like not making tasty meals, not going for giving body massage to mother in law, giving certain opinion in the family's decisions etc. Most of the respondents had gone through suicidal thoughts but they did not commit because of their love for their children. They had suffered from physical and psychological problems because of the violence they suffered.

4.9 Early Marriage, Pregnancy and Health Care

Each of the participants had gone through early marriages. They have been married before they could reach appropriate age of marriage. Early marriages have resulted into early pregnancy. They all become mother in their teens. Each of them had got least 2 children and most 6 children. Some of them had gone through miscarriage as well. They also did not receive appropriate rest and care during their pregnancy and post delivery.

Three of the participants stated they were married at 12 years and had the first baby at the age of 16. They had not been given proper care during and post pregnancy. They kept working before 1 month of delivery.

I got married when I was 12 years old. I got my first baby when I was 16 years old. I have not got proper rest during such time. Since the family was a large one, I had to cook and serve for them and then do the rest of the activities. The trend in the family is that after everyone is eaten and then the server has to take the meal. Just before I month of the delivery, I was given rest only. Since pregnant women take healthy food with proper nutrition with fruits, I rarely got such things [ID-D].

I got married at the age of 12. I got my first baby when I was 16 years old. That time medical facilities were not the same as it is today. However, I was given proper care during my first pregnancy. After that because of family arguments I was not given that care [ID-T].

Another participant stated that she was married at the age of 14 got first baby at 17. She was given care at first pregnancy and for the next couple of pregnancy she was not given that care and health check-ups. She had to work before two weeks of delivery.

I was married at the age of 14. At the age of 17, I got my first baby. I was treated quite well during my first pregnancy, since I was a new bride. But after that, for my second, third and fourth pregnancy I did not got such treatment. I was not really given regular health check up during the pregnancy which is very important for a pregnant lady. I still used to perform household works even before 2 weeks of delivery which is slightly disappointing. But I could do nothing against it [ID- J].

A few respondents stated that they had lost the babies in the womb. They were not given proper rest and care. They stated that everyone in the family loved the new born baby but not the mother who gave the birth.

When I was 15 years, I was married and 2 years later I got my first pregnancy. Actually when I see other women treatment during pregnancy, I think I was not given such support and care during my times. I had to do all the works even during such situation. But actually women of such conditions should be given extra care and rest [ID-L].

I was 15 years old when I got married. I got my first baby at 16 years old. During my first pregnancy, there used to be a lot of arguments in the family. The care given to a pregnant woman was not that great. However I was given proper care during my last month of delivery and post delivery. I have lost a baby in my womb. That was so frustrating. When I remember that incidence, I see myself too weak. Everyone in the family loves baby but not the one gave birth to the baby. I was not given enough care during my first two pregnancies [ID-B].

There were some respondents who were happy with the treatment and care during their pregnancy and post delivery. However, they also got their baby before they could reach 20 years old.

I got married at the age of 16 and I got my first baby at 17. Everything was normal and my family members treated me well [ID-C].

I was 17 years old when I was married. I got my first baby at 17 years. Possibly I have been treated well [ID-K].

Each participants were married before they could reach 20 years. Mostly they were married between 12 to 16 years. Early marriages had resulted into early pregnancy. Most of the respondents did not get the proper care and treatment during pregnancy and post delivery. They kept working to their last month of the delivery. They did not receive proper rest and care. Few of them also went through miscarriage.

In a nutshell, the respondents agreed that females were more vulnerable to illness more often than the males. Females were the ones who were more illiterate. They had faced more discriminatory practices regarding access to education, health practices and social interactions. Females were mostly involved in household activities including taking care of children and elderly at home. Even few of them who were working in field were less paid (wages) than their male counterparts. Early marriage seems to be significant since they all were married in their early teens which had resulted into early pregnancy which had also challenged their good health. The participants had also faced several domestic violence. They were beaten up by their husbands and their mother in laws. Moreover, they did not get appropriate health care services, care, love and pampering from their family members during and post pregnancy. All these factors seems to be responsible for the vulnerability of females that help in obtaining ill health among the females and these factors created health gap in the status of male’s and female’s health.

CHAPTER – FIVE
SOCIAL DETERMINANTS OF HEALTHFINDINGS AND DISCUSSION

This chapter contains the findings and their discussion. The findings have been derived on the basis of analysis and the interpretation of the data collected through the research tool. Each finding is followed by discussion in the paragraphs below:

5.1 Gender and Literacy Status

Education is what everyone needs. It is such a weapon that brightens our world. Education is an important resource on the road to health since it is a resource in and of itself, and the human capital it implies helps individuals produce additional resources (Mirowsky and Ross 2003, 2005;Catherine, Masters and Hummer,2012). A resource is something that aids in the achievement of one's objectives. The majority of People place a high importance on good health. Because it demonstrates resourcefulness, or the capacity to handle situations effectively, education has attributes that go beyond those of other resources that assist attain goals. Education is associated with multiple facets of life. It determines a lot of things in life. Education makes people aware about many aspects of life including health related behaviors.

Though the informant's thought has improved that education is one of the prominent basic rights and necessities of each member of the family and each one should get ample opportunities to get proper education, as education is associated with various aspects of the life. Still the female members were lagging far behind when it came to their educational status in the study site. Males were found to attain more education than their female counter parts. Out of 20 female participants merely 2 were found to have completed their schooling (up to class 10). However, their children including female child were provided opportunities to education.

The positive association between education and health is well established. Well educated people experience better health than poorly educated, as indicated by high levels of self-reported health and physical functioning and levels of morbidity, mortality, and disability. In contrast, low education attainment is associated with high rates of infectious disease, many chronic non-infectious diseases,self reported poor health, shorter survival when sick, and shorter life expectancy (Morris 1990; Pappas, Queen, Hadden, and Tunstall-Pedoe 1992: Ross and Chia-Lung Wu 1995). Evidence

accumulated over the past two decades suggests that health literacy, defined as an individual’s ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions (Seldon, Zorn, Ratan, and Parker, 2000), may be a stronger factor than educational attainment in explaining and predicting individual health behaviors and use of health services (Clement, Ibrahim, Crichton, Wolf, and Rowlands, 2009; Commission on Social Determinanats of Health, 2008;; Wolf, Parer, Ratzan, and Kris, 2008). It is well known that the educated ones can seek for more proper health ca re than the non- educated. The interaction with the health experts is important and the literate once have more command exposure with the health experts. According to Präg, Wittek& Mills, (2017) differences in the doctor–patient interaction might have a variety of consequences for the health of various educational groups. Regardless of the doctor–patient interaction, higher-educated persons may command stronger psychological resources and have more experience negotiating with high-status actors such as physicians than the less educated.Education is an essential indication of socioeconomic position, and a lack of it is a significant risk factor for poor health. In terms of self-rated health or mortality, the less educated have a worse health status than their more educated counterparts. Education is a key predictor of future life chances, despite being relatively steady throughout one's life. It has a strong link to having access to resources that are critical to one's health, such as material resources and social relationships.

Education-based disparity divides people into separate groups, each with its own set of risks and rewards. The ongoing stressors to which people are exposed, the services available to help them cope with stressors, and their lifestyle are all influenced by where they are in the stratification system(Pearlin 1989; Ross, C., & Wu, C. (1995).Ross & Chia-Lung (1995) contend that the advantages of well-educated people in terms of job and economic conditions, as well as social-psychological capital and lifestyle, enhance health. Hence, the gap between the males and females regarding educational attainment is regarded as a social determinant of gender based health disparity.

5.2 Gender Discrimination

Discrimination refers to the process by which a member, or members, of a socially defined group is, or are, treated differently (especially unfairly) because of his/her/their membership of that group. Any action that excludes or disadvantages persons based on their gender is referred to as gender discrimination. It includes both planned and unintentionally unjust actions. When a particular gender is given much importance at any particular place or in any activities, neglecting another gender is simply understood as gender discrimination. United Nations (1979) defines Gender discrimination as: "Any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on the basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field." Gender discrimination can take place at any level, be it at home, school, working place, and so on. Gender discrimination is a source of stress, and it can have a direct impact on mental health, just like any other stressor.

Participants accepted that they have not been treated the same way as of male. Particularly in context of education and health practices, they found themselves lagging behind the male ones. They were engaged in household works from their early age whereas their male counterparts were sent to school to get education and had a lot more freedom. They also stated that men had always the opportunities to a lot more things than the females for many years and still males get such environment. Females have not been given much importance.

Gender discrimination takes place in each country of the world in different forms. There has been a long history of gender discrimination in multiple aspects of our life. Women have been controlled for a long from patriarchy.Discrimination based on gender has a profound influence on mental and physical health across the world. It has the potential to restrict people's access to healthcare, raise rates of illness, and reduce life expectancy.Gender discrimination may also result in a person's living situations deteriorating and them having less access to the resources they require to survive and flourish. First discrimination starts from the family. When female children are not provided with education and proper nutrition as male children get, their health remain

at greater risk. The prevalence of anemia in girls and women reveals the degree of under-nutrition in these groups. Millions of women in third-world nations are dealing with the larger health effects of poverty, infectious disease, and malnutrition.According to estimates, at least 44% of all women in third world countries are anemic, compared to around 12% in developed ones (WHO,1992;Purdy & Banks,2001). When women are discriminated, their physical and mental growth somehow is negatively affected. The uneven distribution of internalized, interpersonal, and structural forms of discrimination both within and between populations gives rise not only to specific patterns of health and disease but also to persistent and large healthrelated inequalities. Stressful events, such as discrimination, take an emotional and psychological toll on individuals and are also associated withincreased cortisol levels, which take a further toll on individuals' health.Gender discrimination, sexual harassment, and other types of workplace maltreatment, according to studies, have a negative impact on various aspects of women's health (Harnois and Bastos, 2018). Gender discriminations do restrict economic opportunities to women.

Gender discrimination is also observed at work place and wages. Women are significantly less paid for the same nature of work at most of the work places. Because women are frequently paid less for the same occupations as men, they have fewer resources to fall back on when they get sick, and their ability to control their own wages is often limited (Fischbsck& Herbert,1997; Vlassoff,2007). When impoverished women in developing nations become ill, they often delay seeking medical help until their symptoms become too severe to ignore, visiting a traditional healer or a local pharmacy in the meanwhile. As a result, they take longer to heal and frequently return to work before fully recovering. When males become unwell, others urge them to seek medical treatment, and as a result, they are identified and treated more quickly than women. They also get more care from their spouses and aren't expected to do anything else till they feel better. When their husbands are unwell, women typically fill in for them in agricultural labor, but households seldom do so, and only the most basic responsibilities are taken on by other family members. In addition to their regular job, as women recuperate, they are confronted with several unfinished chores (Vlassoff,2007). Moreover, there has been the history of subordination in modern medicine and treatment of women. In patriarchal medicine,

women's bodies are defined in contrast to the good, healthy, male body and found wanting. Hence, women are, by definition, inferior, sicker and more at risk of biological disorder than men. Gender discrimination is found prevailing in multiple facet of life and as a result women are found lagging behind.

5.3 Gender and Access to Health Care

The prevention, diagnosis, treatment, recovery, or cure of disease, illness, injury, and other physical and mental disabilities in individuals is what health care is all about. "The timely utilization of personal health services to achieve the greatest possible health outcomes" is what providing health care services entails. Family members are the first who provides immediate care and services. The first and foremost health care starts from the family. They are the family members who approach for the one who has ill health. Health care services immensely vary across the countries, communities and individuals influenced by social and economics and the health policies too. Family members have a significant role in the care of patients, including aiding the health-care team in providing treatment, increasing patient safety and quality of care, assisting with home care, and fulfilling the expectations of the patient's family and society at large.

Majority of the respondents suffered from asthma, arthritis, blood pressure issue and gastric problems. The respondents had some experiences regarding the discrimination they had felt during seeking health care. Not only had they observed, they too were among those who had practiced health care discrimination. They seek for better treatment for their sons where as they sometimes ignore the condition of their female child. The women also stated that when they fell ill, their family members waited for three/four days to see whether it would be all fine without treatment. When they couldn't get over their illness, then after couple of days, they were taken to health clinics. When males suffer, quick action was taken for their treatment.

Females are discriminated in a number ways. And in access to health care is not an exception. Women, often regarded as second sex, are always overlooked. When both genders are not offered equal quality treatment and care for the same medical complaints or when different manifestations of disease are not considered based on sex, we can expect patient outcomes to suffer.How illness affects men and women, as

well as health-seeking behavior, the availability of support networks, and the stigma associated with illness and disease, are all examples of gender variations in the social repercussions of health and illness. (Rathgeber and Vlassoff,1993; 2007) states that when men and women become unwell, they react differently in terms of how long they take to admit they are sick, how long it takes to recover, and how their family and society treat them.Men are more likely to seek treatment from established health systems in poor nations, but women are more inclined to self-treat or utilize alternative remedies. This has been attributed to reasons such as women's numerous responsibilities, which confine their activities primarily to the home realm and make it impossible for them to visit clinics during business hours. Traditional healers or community stores, on the other hand, are more accessible and would often accept delayed payment or payment in kind. In contrast to the more scientific explanations of clinic personnel, traditional healers also give easy-to-understand explanations.

While health maintenance and treatment services may not guarantee good health, they can avoid, halt, or ameliorate the progression of many diseases. Differences in access to care by men and women, whites and minorities, and rural and urban dwellers all have been examined, as have differences in the way the health care system responds to women. Some research indicates that women are treated with less respect and dignity, that male physicians may be less sensitive to women's needs, and that psychotherapeutic medications are disproportionately prescribed for women(Kirschstein and Merritt,1985).

Women are less likely to seek appropriate and early care for disease. Yet the frequency with which such care is required- burden of disease, maternal mortality, and morbidity aside- and the quality of care provided to women has not been well documented in South Asia (Fikree and Pasha, 2004). Decisions aboutseeking care during their illness are made largely by the husband or the elder members of their family. Lack of decision-making, freedom of movement and time can restrict visits to health centers, even where a health problem has been recognized.While poor quality of care can inhibit women from seeking health care, women's lack of autonomy in decision-making or movement is also an important constraint on women's health seeking. Women are, by and large, taught self-denial and modesty from an early age and are hence unlikely to acknowledge a health problem, and particularly a gynecological problem, unless it is very advanced[SEWA-Rural

1994;Jejeebhoy,(1997).Women have a lack of autonomy and control over household resources - both material and knowledge especially in developing countries. As a result, even for their own health, the decisions are made by their husbands.

5.4 Gender Roles

Gender refers to the socially constructed characteristics of women and men, such as norms, roles, and relationships of and between groups of women and men. It varies from society to society. In general terms, sex refers to a person's physical characteristics at birth, and gender encompasses a person's identities, expressions, and societal roles. One's sex, which might be male, female, or intersex, is physiologically determined at birth. Gender roles of a'man' or a 'woman,' on the other hand, are socially and individually determined; gender norms determine these classifications.Gender norms differ significantly between cultures (Nobelius, 2004; Dahal&Subedi, 2015). Gender norms are the spoken and unspoken rules of the societies about the acceptable behaviors of girls and boys, women and men – how they should act, look and even think or feel. Gender norms are perpetuated and challenged in the families, communities, schools, work places, institutions and the media. These expectations start early and powerfully shape individuals' attitudes, behaviors, experiences, and the behaviors, with important health consequences throughout the life course.

The women who were working outside they also had to complete all the roles at home. Among them, I came across to the only teacher of them, and she stated that even after coming back to home after a full tiring day, she had to do all the stuff that all other women do like cooking, washing, serving food to everyone, washing clothes for all, giving massage to her mother in law and so on. These sorts of regular acts used to create mental stress to them. Despite not liking to do these all every day, they had to do it unwillingly. Some women also stated that they would love to work outside or in offices but were not capable of doing that in one hand and on the other hand they had to stay home to take care of kids and old in-laws at their home because males had to stay out normally to earn bread for the family. Despite of their wishes to work outside, most of them had to stay and perform gender roles which also affected their psychological aspects of health.

Women are the main providers of informal care for children, disabled and older people and men as well. The effects of this role can include reduced sleep, less leisure time and increased risk of poverty for women who are full time care givers. All of these can have serious negative consequences for both physical and mental health. Indeed, it has been suggested that the potential impact of the caring role on mental wellbeing may explain the higher rates of depression in women of childbearing age (Bebbington, 1996).

Because of two key factors, the WHO (2010) recognizes gender as a significant determinant of health: first, "gender disparity contributes to health risks for women and girls around the world; and second, addressing gender norms and roles leads to a deeper understanding of how the social construction of identity and unbalanced power relations between men and women affect risk, health seeking actions, and health outcomes (Men et al, 2011; Dahal, 2008; Dahal and Subedi, 2015).Women's unequal and unjust treatment is a source of long-term stress for them, as well as the development of risk factors for various illnesses, disabilities, and premature death.

In general, women's gender responsibilities entail a disproportionate amount of domestic labor, cultural transmission, and socialization of children, as well as kin work that involves caring to familial social interactions. In many areas of the globe, women work in subsistence agriculture and may also work in the labor market.Women's many responsibilities leave them prone to role conflict between home and job obligations, which can lead to a range of severe health consequences (Noor, 2002; Spitzer).

Male gender norms, for example, may have negative health consequences that contribute to male mortality. For example, masculine ideals that value risk-taking, aggressiveness, and stoicism are linked to an increased risk of injury and mortality. Males often involve in risk taking behavior and have more hazards at their work place. Males as they work out of the home, they are involved in the road accident and have multiple injuries.

Productive and reproductive tasks are regarded differently in most societies. In general, having a job gives you more autonomy, decision-making authority, and social respect. Men have more autonomy and social prestige than women because of their larger participation in the paid labor force and better incomes, even when domestic

and other activities of women are included in (Vlassoff, 2007).Men and women's health seeking behavior and outcomes are affected by gender disparities in economic position and purchasing power. Many forms of non-market or reproductive work are fruitful, according to recent schools of thinking. Rosenfield used measures of power in work and home, demands on time and personal control, and symptoms of sadness and anxiety to compare men and women from the United States in a study on gender, employment, and mental health.Psychological discomfort levels were similar in men and women with equivalent demands on their time in the family and at work. Women in high-demand settings, such as housewives or professional women with major household obligations, have greater rates of sadness and anxiety than males. Gender inequalities in economic positions have a significant impact on mental health (Rosenfield, 1998; Vlassoff, 2007). This is what gender roles does to women i.e. restrict the opportunity to economic welfare and adds anxiety to them.

5.5 Domestic Violence against Women

Violence is defined by the WHO as intentional use of physical force or power, threatened or actual, against oneself, another person against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal development or deprivation. The term violence against women means any act of gender based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. VAW is now widely recognized as a serious human right abuse, and an important public health problem with substantial consequences physical, mental, sexual and reproductive health. Domestic violence against women is a global issue that exists in all nations and is a key factor to women's poor health.

Most of the participants had stated that they have been beaten up by their husband couple of times. Mostly, it used to happen when they used to live in a joint family. Anything spoken against their in law or not giving regular massage to in-laws or not making food tasty or giving their opinion while decision making, resulted in verbal abuses and beaten up. When they were beaten up, they had certain physical injuries and had to go through physical pain and mental stress a lot. Almost everyone who had been beaten up in front of certain people had gone through suicidal thoughts which

are absolutely understandable. Few women also showed certain scars on their body that was resulted from those beaten up, a few years earlier.

Physical violence has been encountered by 22% of women aged 15 to 49 since they were 15, with 9% having experienced it frequently or occasionally in the 12 months prior to the study. Six percent of all pregnant women have suffered violence during their pregnancy (DHS, 2016).Abuse has a wide-ranging influence on women's physical health, according to a large body of evidence. Injuries of different sorts, chronic pain syndromes, gastrointestinal problems, and fibromyalgia (pain all over the body) are among the effects. Women who have been abused have repeatedly been proven to function at a lesser level than women who have not been abused(Tjiaden&Thoennes, 2000,Nelson& Zimmerman, 1996; Caracci, 2003). Domestic violence victims are around twice as likely as other women to have poor health, according to the report, with symptoms including dizziness, pain, gynecological issues, depression, and other mental health issues. They're much more likely to have considered or attempted suicide, as well as miscarriage or abortion.Even if the violence occurred years ago, the risk of abused women having health issues was found to be 1.5 to 3 times greater than for women who were not abused. If women lived in developing or developed countries, there was a connection between poor health and domestic violence (Verma, P., Hafiz, A., Douglas, C., Mantilla, K., Harris, J., & Simpson, J., 2005).Women who have been victims of violence as adults are more likely to be diagnosed with anxiety, depression, phobias, and post-traumatic stress disorder, according to Roberts et al.

Suicide is a significant danger for women who have been victims of violence(Murray & Lopez,1996;Stark & Flicraft,1996; Caracci,2003).In Asia and Africa, there is evidence of significant suicide rates among mistreated women. Adolescent females who have been mistreated have been proven to be more susceptible to suicide ideation and conduct. Women’s stressful situations may further hamper child care in a household, which may impact children’s nutritional as well as psychological wellbeing.

Domestic violence exists in all communities and civilizations across the world, although it is more prevalent in developing nations. In Nepal, it has fully developed

into a serious and hot topic.DVAW(Domestic violence against women) has increased in Nepal as a result of the patriarchal society's acceptance of women as second-class citizens, as well as the societal value that places husbands at a higher social standing and permits them to dominate their spouses. Cuts, bruises, or pains are the most prevalent injuries described by women who have ever suffered physical or sexual violence (32%), followed by eye injuries, sprains, dislocations, or burns (12 percent). Deep wounds, shattered bones, broken teeth, or any other significant injury are reported by 9% of women who have suffered spousal violence (DHS, 2016).Women of all ages, backgrounds, classes, castes, religions, and societies have been victims of domestic abuse. Any sort of VAW let women suffer on different level. DVAW restricts women's holistic development including their physical and mental health.

5.6 Early Marriage, Pregnancy and Health Care During and Post Delivery

Marriage is a legally and socially sanctioned union, usually between a man and a woman that is regulated by laws, rules, customs, beliefs and attitudes that prescribe the rights and duties of the partners and accords status to their offspring. UNICEF defines child marriage as a formal marriage or informal union occurring before the age of 18 (UNICEF, 2014).Early marriage or Child Marriage is a marriage of a girl or boy before the age of 18 and refers to both formal marriages and informal unions in which children under the age of 18 live with a partner as if married.Early marriage is commonly linked to an early age at the time of the first childbirth, typically before the child's physical growth and development is complete. Early marriage and parenthood had negative impacts on the health of both the mother and the child more than the father. Females are married a bit earlier than the males.As a result they tend to be mother at a very tender age which has immediate and long term effects on their health.

Each of the participants had gone through early marriages. They have been married before they could reach appropriate age of marriage. Early marriages have resulted into early pregnancy. They all become mother in their teens. Each of them had got least 2 children and most 6 children. Some of them had gone through miscarriage as well. They also did not receive appropriate rest and care during their pregnancy and post delivery.

Marriage is associated with both social and biological needs. There are different types of marriage taking place across the world. However, early marriage or child marriage has always negative consequences on the life of the female in many aspects. Marriage is commonly seen as a barrier to education, since women are expected to quit school to care for their new house or to dedicate their time to childbirth and childcare. Finally, the age of the woman at the time of marriage, as well as the age gap between married couple, may have an impact on the relationship between husband and wife (Jensen and Thornton, 2003).As of 2018, over 650 million living women have married before the age of 18, with 12 million women marrying as children every year. South Asia is home to more than 40%, or 285 million, of women who married before the age of 18. For men, child marriage is significantly less prevalent than for women (UNICEF, 2014). Women in Nepal marry about 4 years earlier than men (DHS of Nepal, 2011).Adolescent pregnancy was found to be substantially more prevalent among girls from poorer households and lower social classes (52%) than among girls from wealthier families and higher social classes (26%) (Shrestha, 2002).The negative consequences of early marriage on girls' health indicate that females who marry before the age of consent, which is 18 years, have an earlier sexual debut and give birth to more children who are vulnerable to neonatal and childhood illness.

Early marriage can have a variety of negative consequences for a female child who is not mentally, psychologically, emotionally, or physically ready for a material life. An early marriage denies her the opportunity to begin or complete her education, as well as any chance of her establishing her own personality and professional growth. She is expected to take on the duties of wife, daughter-in-law, housewife, caretaker, and mother once she gets married. For a young girl, this shift may be both mentally and emotionally stressful (Plan Nepal, 2012).According to research from the International Centre for Research on Women (ICRW), girls under the age of 15 are five times more likely than women in their 20s to die during delivery (Walker, 2012). A pregnant woman requires special care, nutrition, proper rest and decent medical care. When she is not provided with required amount of care and love, she may face much complication during pregnancy and at time of delivery. Most of the family who are under poverty line or are illiterate not only lack medical facility a but also they cannot give proper care and rest to the pregnant women as a result, the pregnant has to go through several pains and even miscarriage. Working women and their families are

more vulnerable throughout pregnancy and motherhood. Expectant and nursing women require particular protection to protect their own and their children's health, as well as enough time to give birth, recover, and nurse their babies. When they lack services after their delivery, their health and the new born baby's health may badly deteriorate. Early marriage has negative impacts on both males and females but female experienced more. Hence, early marriage and pregnancy makes women more vulnerable to illness.

CHAPTER - SIX
SUMMARY, CONCLUSIONS AND THEORETICAL REFLECTION

6.1 Summary

This thesis is about the social determinants of gender-based health disparity solely based on the experiences of the women of Radhemai tole of Birgunj. Twenty women of different caste or ethnicity shared their experiences and the findings are completely based on their responses. This study has been exploratory in its nature and has been able to address question of all types (what, how, and why). The primary data was collected via in-depth interview and was qualitative in nature.

The objectives of the thesis were to find whether males or females suffer more from illness and to identify the social determinants that causes gap in the health status of male and females. This study also has tried to link and explain the findings from the feminist Marxist perspectives.

This thesis has tried to explore the determinants of health first and then correlated how those socio-determinants have been creating gaps among the health status of males and females. The world in 21st century is advanced and developed than the past centuries. Despite that, inequality in health status among the different groups is noticeable. Women as a group have a long history of struggle, unequal power relations and exploitation which have affected women's life in a variety of ways.

This study does not focus on diseases suffered by any of the groups rather, it has tried to figure out the social determinants that brings gender based health disparity in the same settings or locality from the women's perspective. Hence, the findings of this study may differ from other researchers and their researches on similar issue but in different settings and time period.

Woman as a group has a long history of negligence and discrimination across the world. Because of the several movements and protest in 20th and 21st century, the level of discrimination and domination has come down but not completely and not everywhere. Patriarchy has dominated both private and public domain resulting women to play second fiddle in life.

Good health requires a safe and healthful physical and social environment, an adequate income, safe housing, good nutrition, access to preventive and treatment services appropriate to the persons to be served, and a population that is educated and motivated to maintain healthful behaviors. Thus, when a certain group of population gets discriminated or is deprived of the health resources, it is obvious to observe health disparity.

Sex differences might be observed in epidemiological tendencies. Men have higher rates of mortality in earlier stages of life and women live longer, but this does not mean that women enjoy better health. This phenomenon is known as ‘gender paradox in health’ and it ignores the fact that women suffer more health complications i.e. morbidity at all ages, in most cultures, and in all socioeconomic groups (Sen, George, and Ustlin 2002;WHO 1996).

Women noticeably lag behind in many aspects. They as a group observe greater illiteracy in many parts of the world which let them to remain backward when compared the males. Their knowledge and awareness, the capability to hold a decent job, better decision making ability, raising voice against their subordination etc are pushed back when they do not get the proper education.The positive association between education and health is well established. Well educated people experience better health than poorly educated, as indicated by high levels of self-reported health and physical functioning and levels of morbidity, mortality, and disability. In contrast, low education attainment is associated with high rates of infectious disease, many chronic non-infectious diseases,self reported poor health, shorter survival when sick, and shorter life expectancy (Fledman Ross and Chia-Lung Wu 1995).

Gender roles have huge impacts on women’s health issue. Women are the primary givers of informal care for children, the disabled, and the elderly and men as well. For women who are full-time caregivers, this duty can result in less sleep, less leisure time, and an increased risk of poverty. All of these things can have major physical and mental health implications. Indeed, it has been proposed that the possible influence of the caring role on mental wellness might explain why women of reproductive age have greater incidence of depression (Bebbington, 1996).It becomes difficult to the job holder women who work outside. They not only have to perform their duty at job but also complete other roles associated with gender roles at home.

Females are more illiterate across the world. Education is absolutely associated with one's health. Education is associated with multiple dimensions of life that are linked to health status. Moreover, females' economic opportunities are restricted by their illiteracy which ultimately block their other require resources for the good health.

Men are provided with more appropriate health care services than the females. They are given extra rest and care, more comfort zone and appropriate environment for a better life. Comparatively women these days achieve lesser gap in these aspects for the last few couple of the decades.

Women across the world suffer from domestic violence which has both short term and long term effects on physical and mental health. Especially from the developing nations where illiteracy is more, violence against women is frequent. Women are hit by suicidal thoughts when they are physically and mentally tortured by their partners.

Marriage is a social phenomena which generally ties two opposite sex into one. This helps two opposite sex to live together, and reproduce their new generation. However, the problem is with the early marriage or child marriage followed by teenage pregnancy. Females have to suffer from major complication during the pregnancy and at time of delivery. Child mortality and maternal mortality is also found high among the teenage mother and their new born. Teenage mothers have to face lots of health issue during their whole life. Pregnant mothers require sufficient nutrition and proper rest and care and when they lack such resources, their health remains on high risk.

6.2 Conclusion

This thesis has dealt with the key social determinants that bring disparity in health status of males and females. This study has been carried out at Radhemai tole in Birgunj of Parsa district. This thesis has tried to explore how social determinants of health have been creating gap in health status of males and females.

I have tried to explore the determinants of health first and then correlated how those socio-determinants have been creating gaps among the health status of males and females. The world in 21st century is advanced and developed than the past centuries. Despite that, inequality in health status among the different groups is noticeable. Women as a group

have a long history of struggle and have suffered from multiple discriminatory acts and domination. Women's life chances have been restricted by the influence of patriarchy. They have been restricted to household activities including taking care of elderly at home.

When the females are married, they come under control of their husband. Their education and economic opportunities are crunched down. The males remain the bread-winner of the family and that makes them dominant over females. Women lack most of the freedom that males enjoy.

Even the decision regarding their own health issues are taken by their husbands. When males are ill, others encourage them to seek medical help and treatment as a result they are appropriately diagnosed and treated earlier. Men also receive greater care from their wives. But when women are ill, they are less likely to seek medical help unless it becomes very serious. Females tend to suffer from more mistreatment and receive late medical treatment.

Gender roles do have impact on ones' health.A gender role is a social role encompassing a range of behaviors and attitudes that are generally considered acceptable, appropriate, or desirable for a person based on that person's biological or perceived sex. Because of the gender roles, women lack freedom, restrict their economic growth, weaken their social networks and so forth. Gender roles do create negative impact on the mental health of the females.

Early marriage leading to teenage pregnancy is another social determinant that creates gap in the status of males and females. Teenage girls when they are tied the knot with their male counter parts are more likely to have babies soon putting their health at risk. Most of the women lack proper nutrition, medical help, adequate care and love during and post pregnancy. Because of which they have to suffer from disease like anemia. Moreover, because of early marriage, their education, their career and their holistic development is pushed miles back. After they are married they have to perform multiple roles in the family where they have to devote themselves for the other members of the family.

Despite of their multiple roles, they have to go through harsh words from the family members mainly with their own husband and mother-in-law. In some cases, when they respond to those harsh words, they are physically harassed. This marks some injury to

them. It certainly affects to their mental health and physical health. A woman suffers from several violence's which also lead her to have suicidal thoughts.

Women have been the sufferers for a long. The subordination from the patriarchy has been enormous and its effects fall a lot on multiple facets of women’s life. The holistic development of women won’t be possible unless they are given the required resources as males often get.

6.3 Theoretical Reflection

In this thesis, I have described the social determinants of the gender based health disparity. This thesis has been linked with a Marxist feminist social theory because it provides a context in which to interpret health patterns and how the social determinants shape the health of the individuals and determine gender-based health disparity.

This thesis has dealt with how women has been dominated and discriminated, misbehaved, mistreated, exploited which has resulted in achieving their ill-health. Male and female are regarded as the two wheels of the same cart. However, when it comes to the discrimination, females are mostly found the sufferer. They have been discriminated in many aspects of life and as a result they are found to be lagging behind in main stream of the society. The long deep injected patriarchal thoughts are dominant in the society. Females remain playing second fiddle in the family and the society which results in domination of males in both public and private domain of live.For centuries, women have been regarded as the "other" in medical discourses, the "ill" or "incomplete" version of men: as weaker, more unstable, infection-prone, impure, carriers of venereal disease, or the source of psychological harm to their offspring (Ehrenreich,1974). Women are more exploited in capitalism. Power in the family is possessed by the breadwinner and males the bread winners but women are those who prepares basic for the males. Women work at home, make necessary things ready for the males, give them massage at times but still they are alienated from the production and the males are called as sole bread winner.

The intersection of patriarchy and capitalism, according to Marxist feminism, impacts both women's health and the manner in which women's caring and nurturing responsibilities are presented as natural.Females do not lag behind in most spheres of

our life themselves rather they are forced to become so. They are subordinated through different means such as not providing equal level of education, not giving equal opportunity and freedom, not giving equal pay for the same work, not letting them take decision for their health or anything regarding their own life, letting them feel unwanted, treating like inferior and so forth.Much of the literature on women's care and femininity portrays such traits as inherent in their biological makeup. Caring is a highly flexible behavior that may or may not be the responsibility of women in different situations. The fact is that women's caring role is a direct result of capitalism and patriarchy's interactions. In the first place, a woman's role as a caregiver assures that she is constructed as an unnoticed laborer who reproduces both her husband and children.In capitalistic system, caring is described as an emotional, physical, and social arrangement of the family and childrearing that is not labor or work.Gender oppression is perpetuated by institutionalized inequalities and is replicated culturally. The working-class male is groomed into an oppressive framework that marginalizes the working-class woman by privileging men at the expense of women and continues to ignore traditional household labor as equally important.

When women are not given the same resources as of males, it is obvious that they will be in spot of vulnerability. Family as an institution plays an important role for the condition of its female family members. The discrimination starts from there. Males are always given the first priority as a result males remain ahead every spheres of life.

Activities that are productive and those that are reproductive are valued differently. Earning a living gives more liberty, decision-making authority, and social respect. Men have more autonomy and social standing than women because of their greater participation in the paid labor force and better wages, even when domestic and other activities of women are included in. Men and women's health seeking behavior and outcomes are influenced by disparities in economic status and purchasing power.

Hence, this thesis explores the social determinants that bring gap in the health status of males and females and it concludes that most of the social determinants are the gift of the exploitation of women through capitalism and in equal power relations and other cultural discrimination between males and females. The long run dominations and exploitation ,along with discriminations over females have not been over yet. Health disparity between males and females is also the consequences of in equal power relations, and the social structures that are shaped by patriarchal influences and practices in capitalism

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ANNEX: I

DEMOGRAPHIC INFORMATION

NAME	AGE	CASTE/ETHNICITY	EDUCATION	OCCUPATION	MARIEATAL STATUS	AGE AT MARRIED	NO OF CHILDREN	AGE AT FIRST PREGNANCY

DATA COLLECTION TOOL

1) Who do you think are more prone to illness, male or female members of your family? If female, then why?
2) Are male and female member of your family treated equally? If not, why?
3) Who are more educated male or female members of your family? If male, why?
4) Why didn't you continue your education?
5) Do your children go to school/college? If yes, where?
6) Do you work anywhere on wages? If yes, which work and where?
7) Are you satisfied with the work? If no, why?
8) Does your working place and nature of work lead you to your ill-health?
9) Have you ever suffered from any sort of disease? If yes, which?
10) Are you satisfied with treatment approached by your family members? If no, why?
11) Do you get the type of care given to the sick people when you suffer from any abnormality by your family members?
12) Have you felt any sort of hatred or ignorance during your tough times/ illness by your family members?
13) Have you ever suffered from menstrual exclusion? If yes, how?
14) Does gender roles make you suffer from disease/ illness? If yes, how?
15) Do you go for health check-up yourself or you are taken for it?
16) Do you decide for your health check up or your other family members do? If other, who?
17) Where are you taken for health check up? Private or government hospital/clinic?
18) Where are the male members of your family taken for their health checkup or treatment?

19) Have you ever been beaten up and scolded by your family members? if yes, why?
20) Have you ever gone through suicidal thoughts? If yes, why?
21) How were you treated during and post pregnancy? Were you given enough care and support?