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Understanding the Socio-Cultural Factors Causing Aneamia among Women: A Case Study of the State of Punjab, India'

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Abstract

Even after seventy- two years of independence, more than fifty percent of women in India are still strangled in the chains of anemia. Punjab, known as 'Nations Basket', is characterized by strong patriarchal norms and gender discrimination which is reflected in the skewed sex ratio (895) and distressing prevalence of anemia among young girls and women in the state. Despite various programs and policies on maternal health, National Family Health Survey (2015) statistics reveal that there has been a fifteen percent increase in anaemia in the state over ten years (2006-2016). It is ironic that a state which is also known as the 'Grain Bowl of India' and is extremely significant for maintaining the national food security, is grappling with a problem related to nutritional intake. This paper tries to focus on elucidating the various socio-cultural factors affecting the cause of anemia among women and girls in Punjab and attempts in understanding these factors from a gendered lens. Primarily based on secondary sources, this paper tries to reiterate the fact that discrimination and gendered practices have a compound effect on the overall health status of women which further leads to serious issues such as anaemia. By taking an example of an issue like Anemia, this paper critically reviews the overall approach towards maternal health in the country and argues for a more comprehensive and holistic understanding of women's health.

Keywords- Anemia, Health, Public Health, Diet, Gender

JEL Classification- I120,I140, I180

Paper Classification- Research Paper

Introduction

Anemia among women and adolescents has always been recognized as a very serious concern both nationally and internationally. Anemia is a nutritional disorder resulting from reduced levels of hemoglobin or low iron level in the body. Reasons for anemia could be many, but lack of proper nutrition precedes the others. Many research estimates have proved that anemia could become one of the causes of morbidity if ignored. And implications of anemia are worse among specific groups such as early school-going children, adolescent girls, pregnant women, and women belonging to reproductive age. Estimates suggest that the incidence of anemia close to 40 percent should be categorized as a severe public health problem, as is the case with our country (McLean, 2009).

WHO data estimates that anemia affects roughly 25 percent of the world population and the population group of non- pregnant women is the worst affected (Bruno de Benoist ,Erin McLean, Ines Egli and Mary Cogswell, 2008). Data from the National Family Health Survey (NFHS-4) suggests that more than fifty percent of women in India are anemic (International Institute for Population Sciences, 2015-16). In such a scenario, universal health for all seems like a far fledged dream for our nation. It is a matter of serious concern because improving the health status of women is not only a national goal under National Rural Health Mission but also an international goal under Sustainable Development Goal-3 (SDG-3). One might raise a question that despite numerous national-level programs focusing on reducing the incidence of anemia in the country, why does it is still prevail in such huge numbers, especially among women?

Dominant scholarship in the area of reproductive health has argued that it is predominantly a social phenomenon that should be studied and understood at the intersection of many social, cultural, economic, and political factors. The reproductive health concerns of women might be rooted in biomedical measures but their genesis is located in social-cultural norms and human behavior. Patriarchal norms and cultural practices such as early marriage and motherhood, son preference, domestic abuse, quality of interpersonal relationships, etc have a cumulative impact on women's health and these factors are barely considered while framing policy and other health interventions. The fact is that gender and gender discriminatory practices accelerate the vulnerabilities of women and that emanates into adverse reproductive health outcomes such as anemia. It is equally important to understand that there is no uniformity to women's issues because women are exposed to different geographical locations, perform different kinds of works, and have diverse socio-economic backgrounds. And more often than not, the cure for women's issues lies in the socio-cultural context of their lives, rather than the conventional medical domain. Thus, there is an urgent need to understand and clarify the concept of health prevalent among women and how it might vary from woman to woman.

Review of Literature

Among the health practitioners and policy-makers, there is an inherent tendency to view reproductive health as only a medical or biological domain and that good reproductive health practices primarily revolve around the absence of any complications or dysfunction. With the tremendous growth of technology and the pressing need to meet international and national goals, reproductive health in India has become quite medicalized and target-oriented. There are defined parameters or rules for constituting which concerns are normal and which are not acceptable in the overall domain of reproductive health. The medical and technological advancements in the domain of reproductive health have proved to be immensely beneficial in terms of reducing the factors leading to maternal and infant mortality, innovating solutions for combating other complications and framing the pressing needs and concerns of reproductive health. Though these dominant approaches have helped in improving the status of reproductive health, the core of these strategies is based on the concept of universalization which assumes that reproductive concerns of all women can be categorized under a single umbrella and negates the diversity among human populations and women's bodies. By standardizing procedures and focussing on targets, it is presumed that women belonging to different social and cultural backgrounds, different economic situations and different reproductive health histories experience the same reproductive health concerns.

Further, to medicalize, reproductive health can also sometimes lead to discrimination towards the actual needs of women. For example, the process of birthing and pregnancy is being viewed as a medical illness or condition rather than a natural process. While the pregnancies with

complications require high-quality medical attention and procedures, the majority of cases do not. The health infrastructure of India is characterized by a lack of medical and para-medical staff, shortage of funds, and inefficient delivery of services, which results in inadequate attention and care required for women during their deliveries. Simultaneously, many research studies have reported that women countenance abuse, neglect, and disrespect during their birthing experiences in the institutions and that results in more number of preventable causes of maternal mortality. It has also been proved that the delivery experiences of women have a direct impact on their pregnancy outcomes as factors such as poor quality of care, abuse, and discriminatory practices are primary obstacles in women preferring institutional care (Meghan A Bohren, 2014).

There have been many arguments stating that access to quality health care services is one of the most crucial factors in improving the status of reproductive health in our country. But access to health care is never enough considering the fact the reproductive health is not merely a biological process, but it is located within the social-cultural, economic, and political context of women. The process of reproduction in itself is heavily derived from a conglomerate of social beliefs, cultural practices, and kinship norms. Therefore, while deciding the priority needs for reproductive health, it is equally significant to situate those needs within the social-cultural beliefs that are deeply embedded within the social fabric of our society. They have a substantial role in determining the reasons for many reproductive health issues and the way they are addressed. Like, issues such as lactation, miscarriages, post-patrum depression, infertility, etc are not prioritized as much as issues of family planning, birth control, and institutional deliveries. Furthermore, the way reproductive health is defined as a 'woman's concern' is also problematic even though men play a major role in determining the reproductive health of women as they are the main decision-makers. Yet, there are no serious efforts to educate, inform, and incorporate men in the larger domain of understanding the issues of reproductive health. The idea of reproductive health as solely a women's issue stems from the notion of biological vulnerability and is also indicative of the belief that women are the reproducers.

Differences between health indicators of men and women have always been acknowledged, but not the underlying factors and the reasons behind these differentials. Feminist scholars have contributed to the social construction of sex and gender in understanding the various implications of reproductive health (Jayasree, 2014). Researchers have debated that gender exacerbates the vulnerabilities of women and the expression of gender varies with changing socio-economic backgrounds of women which further translates into different health outcomes for different sexes. For example, the incidence of HIV, anemia, and occurrence of infant mortality is more pronounced in females than in males, especially amongst those belonging to disadvantaged communities. Thus, gender has a significant role in defining the reproductive health outcomes for women but this role needs to be understood at the intersection of caste, class, religion, and patriarchal norms.

It has been well recognized that high levels of anemia are found amongst women as compared to men. The rate of anemia among Indian women not only reflects their poor health status but also their state of vulnerabilities both within their families and society at large (Sharma H, 2018). The causes of health issues such as anemia have to be located and integrated within the socio-cultural lives of women, their economic status, their inter-personal relationships, discriminatory practices, early marriage,etc. Differentials in the rate of anemia among men and women indicate that apart from nutritional issues, these high incidences of anemia also reflect persuasive gender bias against women since birth. It has been well discussed in many studies that women have unequal and inadequate access to resources, including a good diet in the family. Women in patriarchal set up even have to struggle to ask for a nutritious diet, especially married women in rural areas. The fear of their mother-in-law and husband as well as the social conditioning often restricts them

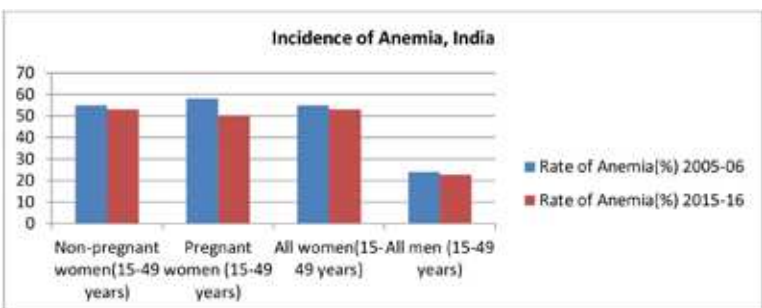
to prioritize their health. Gendered practices such as eating last at home or eating the leftovers are culturally and socially imbibed by women which are detrimental to the overall health and development of women.

A recent study was conducted by Sharma in 640 districts of India on the prevalence of anemia and it reported that anemia was highly prevalent in women belonging to the reproductive age group and it was more pronounced among rural women (Sharma H, 2018). The study also revealed that poor women were more likely to suffer from anemia as they were barred from access to good and quality resources. Another study carried out in rural Tamil Nadu to determine the level of anemia among 412 non- pregnant women and 341 men found out that roughly 60 percent of the women from the sample were anemic and that incidence of anemic was multifactorial including issues such as poverty, cultural practices, access to quality health services, nutrition intakes and poor awareness about health issues (Matthew Little, 2018). Due to a lack of knowledge, many women are completely unaware of the physical symptoms of anemia, and that further translates into worse health outcomes for them. A research study conducted on a tribal population of North Kerala reported sixty-seven percent of anemia in females while thirty-three percent of anemia among males from the sample size. The same study also concluded that the incidence of anemia was much higher among women belonging to low socio-economic groups (Imaad Mohammed Ismail, 2016).

Twenty-two percent of Indian men are found to be anemic as compared to fifty- three percent of Indian women (International Institute for Population Sciences, 2015-16). The table given below compares the data related to the incidence of anemia in India among different population groups from NFHS-3 and NFHS-4 reports. Statistics in the table reveal that there has been a decrease in the overall rate of anemia over ten years. The percentage of anemia slightly decreased from 55 percent in 2005-06 to 53 percent in 2015-16. Amongst pregnant women, considerable progress has been made with the decrease in the incidence of anemia from 58 percent in 2005-06 to 50 percent in 2015-16.

Thus, despite implementing a national level anemia control programme in the 1970s, fifty-three percent of Indian women are still anemic. On the contrary, only twenty-two percent of Indian men are found to be anemic and this percentage has decreased from 24.7 percent in 2005-06. A study conducted in 2018 explained the factors responsible for the fall in the incidence of anemia from 2006 to 2016 among pregnant women and as per the study, maternal education was responsible for 24 percent of the decline, socioeconomic status accounted for 17 percent of the improvement, improved sanitation facilities was responsible for 9 percent of the improvement and nutrition and health interventions accounted for 7 percent of the decline (Phuong Hong Nguyen, 2018).

Figure 1: A Comparison of the Prevalence of Anemia from 2006-2016, India



Source: Report of National Family Health Survey- 4, India

The incidence of anemia among men and women is also known to affect their productivity and hence their economic growth as a study conducted by Joesph H Hunt(2002) reported that there was a decrease in productivity among the workers employed in heavy physical labor by 17 percent (M.Hunt, 2002). A study conducted in Nepal reported that women's decision making power regarding health care and intimate partner violence was associated with the incidence of anemia among women of reproductive age group. The study revealed that more than forty percent of the women respondents were anemic, out of which 37.8 percent were not involved in the decision making and 23.9 percent had experienced intimate partner violence (Sujan Gautam, 2019). A similar study in India also reported the influence of domestic abuse on the nutritional access leading to increased levels of anemia among women (Leland K. Ackerson1, 2008). A study was conducted in 2019 in Maharastra to understand the relationship between women's empowerment in agriculture and the prevalence of anemia. The study revealed that there was a direct relationship between increasing levels of empowerment and the higher levels of iron status among women engaged in agriculture. As women with increased autonomy were able to make decisions for themselves which lead to improved access and consumption of iron-rich foods (Soumya Guptaa, 2019).

Differences between health indicators of men and women have been always acknowledged, but not the underlying factors and the reasons behind these differentials. Feminist scholars have contributed to the social construction of sex and gender in understanding the various implications of reproductive health (Jayasree, 2014). Researchers have debated that gender exacerbates the vulnerabilities of women and the expression of gender varies with changing socio-economic backgrounds of women which further translates into different health outcomes for different sexes. For example, the incidence of HIV, anemia, and occurrence of infant mortality is more pronounced in females than in males, especially amongst those belonging to disadvantaged communities. Thus, gender has a significant role in defining the reproductive health outcomes for women but this role needs to be understood at the intersection of caste, class, religion, and patriarchal norms.

Objectives and Research Methodology

This paper aims at elucidating the various social-cultural factors surrounding the cause of anemia among women in Punjab. It attempts at locating anemia within the social-cultural context of women and highlighting factors that go beyond just the availability of health care, safer pregnancies, reduced maternal mortality rates, and increased institutional deliveries. It tries to trace the reasons for the prevalence of anemia in one of the most developing states of our country. Through reviewing specific indicators related to women and their health from secondary sources, it attempts to understand the factors from non-medical perspectives by locating women's health within everyday occurrences of their lives, discriminatory practices, social beliefs, and patriarchal norms. Besides the secondary sources of information, the argument made in the paper is also authenticated by primary data which was collected from Village Kakrala of Patiala District, Punjab. In-depth interviews were conducted with 125 women of the village and those relevant are stated in the paper. By taking an example of an issue like anemia, this paper critically reviews the overall approach towards reproductive health in the country and argues for a more comprehensive and holistic understanding of women's health going beyond numbers and achieving national and international health goals.

Anemia in Punjab

Punjab, known as 'Nations Basket', is characterized by strong patriarchal norms and gender discrimination which is reflected in the skewed sex ratio (895) and distressing prevalence of

anemia among young girls and women in the state. Despite various programs and policies on maternal health, National Family Health Survey (2015) statistics reveal that there has been a fifteen percent increase in anemia in the state over ten years (2006-2016). It is ironic that a state which is also known as the 'Grain Bowl of India' and a leading producer of food resources and is extremely significant for maintaining the national food security, is grappling with a problem related to nutritional intake.

Punjab the 'land of five rivers' has always held an iconic status in the history of the country and is known for its rich and composite culture. It is one of the top income states of the country and has served as a role model of development for other Indian states. Green Revolution during the 1960s has been instrumental in accelerating the economy of the state and establishing it as one of the richest states of thecountry. The state is known to contribute more than 35 percent of wheat and 25 percent of rice to the overall grain pool of the nation (Economic and Statistical Organisation, 2019). The state has done quite well in terms of economic development as the number of people below the poverty line in the state is only 8 percent which is much lower than the national average (WorldBank, 2017). But there are paradoxes in the development in the state.

Punjab has been performing quite well as compared to other states as far as women's health and its specific indicators are concerned. Maternal Mortality and Infant Mortality rate for the state is 122 and 21 (SRS, 2014-16) respectively, both of these indicators fall much below the national average. Antenatal checkups (ANC) indicators for the state such as 3 ANC checkups, PNC visits, institutional deliveries, etc are better than the national average (HMIS-NHSRC, 2015-16). But there is a need to look beyond these indicators to have a nuanced understanding of the existing scenario of women's health and women's position in the state.

The occurrence of anemia among women and young girls in Punjab is very disturbing. According to NFHS-4, close to fifty-four percent of the women in the state are anemic and the comparison between NFHS-3 (2005-06) and NFHS-4 (2015-16) shows that the percentage of anemic women has increased by more than fifteen percent over ten years, as it is clear from Table 1, mentioning the incidence of anemia among women and girls in Punjab (International Institute for Population Sciences, 2015-16). The National Family Health Survey-3 data reported that close to fifty- five percent of Indian women were anemic and twenty-four percent were Indian men and the state that performed the worst throughout the country was Punjab. Data from the District Level Household and Facility Survey conducted between 2012-2013 suggested that anemia in the state was widely prevalent among all age groups and was particularly high among pregnant women marking the rate up to fifty-eight percent. NFHS-4 data also estimated that around fifty-four percent of adolescent girls in the state had anemia, which is a much serious concern for the state as young girls even before entering the motherhood phase are already anemic. More so, these numbers must be underreported.

Table.1 : Incidence of Anemia among women and girls in Punjab

Indicators	NFHS-3(2005-06)	NFHS-4 (2015-16)
Women who are not pregnant aged 15-49 years	37.9	54.0
Women who are pregnant aged 15-49 years	41.6	42.0
All women aged 15-49 years	38.0	53.5
Adolescents girls who are anaemic(15-19 yrs)	43 (DLHS 4)	58 (NFHS 4)

Source: Reports of National Family Health Survey (NFHS) 4, Punjab

Similarly, NFHS -4 data also suggested that around only forty-three percent of pregnant women consumed regular doses of iron-folic acid tablets during their pregnancies, which highlights the severity of the problem in Punjab. There has been so much pressure and focus on the consumption of the iron tablets by the government and yet less than half of the women in Punjab are consuming the tablets regularly. Furthermore, only 30 percent of pregnant women had full Antenatal checkups during pregnancy, which is one of the most critical indicators for combating high-risk pregnancies and maternal morbidity. Prevalence of anemia in such huge numbers is not only restricted to pregnant women in the state, but even young and adolescent girls are affected in severe numbers. The study conducted by Kaur and Kaur in the rural population of Patiala in 2011 reported that ninety-eight percent of young girls were anemic (Kaur, 2014). Similarly, the study conducted by Sidhu in one of the villages of Amritsar (1997) concluded that seventy-one of the girls in the sample size were anemic (Sidhu, 1997). Statistics mentioned in Table 2 about the occurrence of anemia in Patiala and Punjab among women shows a comparison of maternal health indicators of one of the better performing district, Patiala and Punjab for the year 2017-18. It can be comprehended from the table that out of the women registered for Antenatal checkups in Patiala and Punjab, more than ninety percent of pregnant women in Patiala and more than eight-five percent of pregnant women in Punjab were having hemoglobin less than 11 g/dl and thus were anemic. And around seventy percent of severely anemic women were treated in Patiala and sixty-three percent were treated in Punjab. These figures not only confirm the severity of anemia in the state but also marks a question on the overall situation of women and girls of Punjab.

Table 2 : A Comparison of Maternal Health Indicators of Patiala and Punjab, 2017-2018

Indicators	Patiala	Punjab
Women registered for ANC check-up	38,020	4,64,094
Pregnant women who received 180 IFA tablets	29,985	3,61,150
Percentage of women who were given IFA tablets to total ANC registrations	78.9	77.8
Number of pregnant women having Hb less than 11	35,157	3,95,119
Number of pregnant women having severe anemia treated at the institution	1,669	9,574
Percentage of women having severe Hb(less than 7)treated at an institution to women having Hb(less than 7)	70.5	63.3

Source: Health Management Information Systems(HMIS), 2017-2018

The above-mentioned data reflects the alarming situation of anemia among women in the state. It also highlights that the women in Punjab are not enjoying a 'good' health status, considering the development indicators of the state. One might raise a question that despite being one of the high- income state of the country and having better health facilities as compared to other states, why is it that more than half of its women are still strangling in the chains of anemia. There has been enough and more research on the effect of indicators such as maternal mortality rates, safer pregnancies, institution deliveries, access to health and presence of adequate health institutions on the overall health of women and how significant these indicators are in determining the health status of women of a particular region. But there is a need to understand women's health issues from a social and cultural lens and going beyond the specific indicators and numbers defining women's health. In the case of Punjab, albeit the importance of these indicators, it is also crucial to look beyond these developmental indicators for a real picture of the status of women and their health.

Reasons for the occurrence of anemia among women and young girls in Punjab in such high

numbers can be many. Lack of awareness on the nutritional understanding of the diets and iron deficiency can be defined as one of the main reasons for the cause of anemia. But many socio-cultural factors can accelerate the cause of anemia among women and girls. The state of Punjab is characterized by strong patriarchal norms and thus struggles with gender discrimination which is often reflected in the skewed sex ratio of the state. Sex ratio for the state stands at 895 (census, 2011) which is among the worst in the country and is much below the national average of 943. It is disturbing that the state of Punjab has been struggling with a skewed sex ratio for many decades now with a ratio of 844 in the year 1881 (Department of Planning , 2017). This number has drastically improved from 793 in 2001 to 875 in 1991. Even after this progress, the number does reflect a grim picture of the state of women and girl child and their low status in the state.

Table 3 reflects the pattern of sex ratio in Punjab and India. From the table, it can be comprehended that there have been improvements in the state in terms of increasing sex ratio every decade. The percentage difference in the sex ratio of Punjab and India has shown a decreasing pattern from 11 percent in 1951 to 5 percent in 2011. But still, the state lags in terms of the national average. There have been over 2 percent improvement over the last ten years in the state, which is a cause of serious concern. The girl child sex ratio (CSR), which is a cumulative indicator for gender inequalities and discrimination since birth, mortality at birth, and accessibility of the health services by the most vulnerable age group, stands at 846 while the national average being 919. Moreover, this number decreased from 901 in 1961 to 846 in 2011. Adverse sex ratio reflects the confluence of many socio-cultural factors: inherent gender discrimination, continuing strong son preference, and the combination of declining family size preferences and unchanging demand for sons, the easy availability, in practice, of technology that enables fetal sex determination and the apparent difficulty in enforcing laws prohibiting the revelation of fetal sex (Shireen J.Jejeebhoy, 2014). The girl child missing rate in Punjab is 11084 which is much higher than the national average of 3328 (Department of Planning , 2017, p. 353). Furthermore, the trend of a poor female work participation rate (FWPR) also highlights the inherent gender inequality in the state remaining at 13.9 percent, which is much below the Indian average of 25.51 and is amongst the lowest in the country. On the contrary, the male participation rate stands at fifty-five percent which is higher than the national average of fifty-three percent (Department of Planning , 2017).

Table No 3: A Comparison of Sex Ratio of Punjab and India

Year	Sex Ratio (Punjab)	Sex Ratio(India)	Percentage Difference [1](%)
1951	844	946	11
1961	854	941	9.2
1971	865	930	7
1981	879	934	6
1991	882	927	5
2001	876	933	6
2011	895	943	5

Source: Women and Men in India, 2018

Narratives from Women

The specific indicators regarding women in Punjab do reflect a griming situation as far as women's health is concerned and the situation is much worse in rural parts of Punjab. To have an insight into the extent of the incidence of anemia among women and reasons for so, in-depth

interviews were conducted by with women of village Kakrala in Patiala district, Punjab, who had delivered within the last three to five years. The reason for choosing young mothers was simply to ensure that the respondents have a clear remembrance of their hemoglobin levels during pregnancies and the overall situation they were in. During the in-depth discussions, questions about their understanding of anemia and its symptoms, their hemoglobin levels, their pregnancy experiences, and their fears, discrimination, and struggles were asked Out of the total 125 women respondents of the study, 52 women belonging to the age group of 21-35years were selected for this specific intervention with the help of ANM and ASHA workers of the village. 40 women belonged to scheduled caste and 12 belonged to the general category. The highest level of education attained by women respondents was graduation level and the lowest was no formal education.

According to the Indian Council of Medical Research, pregnant women with 10-11mg/dl of hemoglobin levels are mildly anemic, 7-10 mg/dl are moderately anemic and below 7mg/dl are considered to be severely anemic. Going by the national standards, out of the 52 women who were interviewed, 34 women respondents at the time of their pregnancies were moderately anemic as they stated their hemoglobin levels to be between 7-10mg/dl while 18 women reported having their hemoglobin levels below 7mg/dl and were severely anemic. The same reported information was also cross-checked with the ANM and ASHA workers of the village to ensure the accuracy and authenticity of data. Thus, the occurrence of anemia among the respondents was very high as 65 percent of the sample population was moderately anemic and 35 percent were severely anemic.

In-depth interactions[2] with women of this village corroborated the argument that health concerns of women are not always related to abnormalities or disorders, sometimes the issues originate from factors that the medical domain can not comprehend. During an in-depth interaction with a woman who had her first child when she was 20 years and was severely anemic, she stated that she was petrified of her husband and mother-in-law throughout her pregnancy and was wishing for the period to get over. She said, ' I came into a new house and got pregnant within two months. *Mainu pata hi nai chala ki mainu kuch hai*(I did not realize that I was pregnant*).* I used to feel very weak throughout my pregnancy. But this is normal for every woman. I used to cook , clean and do every thing in the house.' On further enquiring about her diet during her pregnancy, she replied, 'I used to eat proper food. Lekin mann nahi hota tha, rona aata tha(I did not feel like eating anything, used to feel like crying all the time). I used to feel where I have come. *Pehle pura kaam kar lo, phir khane baitho. Jo unhone khana hai , wohi banega(*First finish all household chores, then I used to sit to eat.I used to cook food as per their wishes only). I was nauseous all the time. I had to ensure that my mother-in-law and husband have eaten. I would just be quiet and listen to everyone. Had no one to share'.

There were many enriching responses from the women such as, 'Every woman with whom you will interact here will want a son. My hemoglobin was below 7 g/dl. I was taking the tablets which I got during my checkup at the Primary Health Center (PHC). Throughout my pregnancy, I was under stress with the fear that what will happen as my family will not let me survive if this time I did not deliver a baby boy'. Many women in the village were so scared of their mother-in-law to ask for food, as one of the women said, 'I can not openly ask for food, it is just the not right manner to be constantly eating. Not good for women.'

During an in-depth interview[2] conducted with one of the community health workers of village Kakrala in Patiala, she highlighted that anemia is one of the most common issues existing among women of this village. She said, 'Almost seventy percent of the pregnant women who come to us during the checkups have hemoglobin below 7g/dl and are severely anemic'. On further asking

the reason for the occurrence of anemia in such huge numbers, she explained, 'We tell them to have iron tablets regularly and have a good diet. Some listen and some don't. But that is not the only reason for this. Women have so much going on in their homes, they are in full stress throughout their pregnancies due to the fear of their mother-in-law, some have alcoholic husbands and you know what these husbands do, they harm them. But the most common tension they have is whether they will have a son or not. This is the biggest problem existing among women and that leads to concerns like anemia'. Thus, the issue of anemia in the villages of Punjab is severe and the issue is not only related to women consuming IFA tablets, or having a good diet. It is also located within the intricacies of women's lives, their every-day struggles, and their hopes to provide a son to their families.

Discussion

Despite major strides made in several parameters related to women and their empowerment, India's obsession with a male child and their significance has not diminished. For decades, female subordination and gender discrimination have regrettably remained as impediments to women's social, cultural, and economic growth. Research studies have shown that lack of gender equality translates to outcomes such as poor health, poor education, and limited access to resources for women. India has a history of more women and girls dying than men through childhood and their reproductive age. Gendered practices and norms are deeply embedded within the social fabric of our society and they not only subjugate women in every sphere of their lives,but also condition them to internalize these practices and norms. It is considered to be the prime responsibility of the women to impart these roles and practices to their daughters and daughters in law. In the patriarchal family set up, young girls while growing up are often encountered with phrases such as ' You are a woman, you are supposed to do this' or 'You are a woman, you are not supposed to behave like this'. Women are taught to be submissive and tender right from their childhood so that they are properly 'adjusted' in their families once they are married. And that is how women are socially conditioned and their gendered identities are constructed around them so much so that more often than not, women themselves become torchbearers of patriarchy.

Though the situation of women in our society in recent years has improved due to numerous awareness drives and social campaigns such as 'Beti Baccho, Beti Padho', achieving gender equality still seems like an illusion for our nation. At the center of gender discrimination discourse, is the phenomena of son preference. Despite major strides made in several parameters related to women and their empowerment, India's obsession with a male child and their significance has not diminished. Son preference in India is ancient and universal. It is an indicator of social development (Radkar, 2016). There are a plethora of social, cultural, and economic factors that contribute to this skewed preference. There has been enough and more research on understanding the cause of this preference and the main reason emphasized by social scientists has been the patriarchal social set up and its implications on the position of women in our society. Many studies carried out since the 1970s have shown how cultural practices have always undervalued daughters or women in Indian society (Ahlawat, 2016). Cultural norms and rituals celebrating the birth of son are practiced and observed across all sections of our society. There is the social and economic value being assigned to a male child. Birth of a son is supposed to give a higher social status to the family, especially the mother, as well as it is considered as a step forward towards economic prosperity. A boy in the family is viewed as an investment and future breadwinner of the family while the daughters, on the other hand, are seen as a liability and are eventually married off to their 'real' families on paying heavy amounts of dowry. There is always a feeling of remorse associated with the birth of a girl child, especially for second or third daughters. They are

even less breastfed than their brothers and have limited or little access to good food, medical care, and education as compared to their male counterparts. Moreover, a family is never 'complete' unless they are blessed with a son. It is often considered as a burden to raise young girls as the concept of shame and honor are associated with them. There is a strong emphasis on their purity and virginity and girls are told to behave in preconceived and socially constructed ways. A lot of importance is attached to the onset of menstruation in young girls because it is an indication that the girl is not barren and will reproduce once married hopefully, sons.

Such kind of social conditioning often leads to bad health outcomes such as anemia among young girls and women. Gendered practices such as want of a male child results in ignorance and neglect of girl child which further translates into inadequate nutrition right from their childhood (Kaur, 2014). Even breastfeeding practices are discriminatory against girl child. Marriage entails a heavy pressure on the women as her social status is heavily dependant upon her capability to produce more sons. Socio-cultural beliefs such as putting family first, offering their husbands the best of everything including food and the practice of eating last often result in deterioration in women's health. Most women are discouraged to make decisions for them, including the kind of food they want to consume. Also, the idea of good nutrition revolves around only ghee and milk in Punjab neglecting other important dietary intakes. Furthermore, lack of knowledge and education about the necessary nutrition requirements has acted as a catalyst in worsening the status of anemia in the state. Despite government health and nutrition programs such as THR, Kishori Shakti Yojana, etc women are still ignorant about their own health needs. They are often hesitant to consume the ration being available to them at Anganwadi centers arguing that such foods are for poor and marginalized people and that they can afford to consume much better foods. One might want to raise a question here that despite the state being the largest producer of food grains, why is it that anemia among women over the years has accelerated?

Punjab has been performing better as compared to the national average in most of the indicators such as growth rate, literacy rate, MMR, IMR, birth rate, etc which are often the parameters defining the prosperity, well being, and development of a particular region. However, there is a need to look beyond these indicators and understand the scenario in the state socially and culturally. People in Punjab are known to cherish efficient roads, good schools, one hundred percent rural electrification; schools, and health centers provide basic amenities to the people of the state which are still not available to large areas of the rest of the country (Department of Planning, 2015). However, it would be problematic to analyze the state of development in Punjab solely based on specific indicators and parameters. There is a need to look beyond these numbers and understand the scenario that has been brewing in the state from the past two decades through a sociological and cultural lens.

On one side, the state 'Punjab' is synonymous with rich culture, tradition, folk music, fertile lands, and great food, on the other side; it is also synonymous with skewed sex ratio, gender imbalances, an alarming rate of anemia among women and drugs. In today's day and age, there is enough and more discussion around women's empowerment and achieving gender equality. India is hoping to achieve Sustainable Development Goals (SDGs) by 2030 and SDG -5 that aims to achieve gender equality in all aspects has much more far-reaching implications on all other 17 goals and is undoubtedly the most significant indicator to be achieved. The question here arises that is it possible to achieve gender equality and achieve the numbers where the most basic right of life and birth is still a challenge? Can we talk about achieving national and international goals of eliminating gender discrimination and ensuring better health for women when one of the most developed states of our country is struggling with a skewed sex ratio, accelerated numbers of anemia, and deeply rooted patriarchal norms?

Conclusion

Reproductive Health(RH) forms a very significant area of development. In India, as elsewhere, women's development is related to national development (Kasturi, 2016), and RH forms an integral part of women's development. Reproductive health in India witnessed a variety of phases before it got its way into the larger policy formulations and discussions. Until the nineties, reproductive health and rights were mirrored by the agenda of 'population control' as combating a growing population was the much needed and definitive goal of policymakers. For decades, maternity health was given low preference as compared to family planning. The introduction of the Child Survival and Safe Motherhood Programme in 1992 gave thrust to maternity care services during the nineties (Leena V Gangolli, 2005). International Conference on Population and Development that happened at Cairo in 1994 embarked on a significant phase in the domain of maternal health and this phase brought a major shift in the health policies from the contraceptives target-oriented approach to target free approach. Thus, 'Reproductive Health' as a term was introduced during the nineties to accommodate diverse and varied issues surrounding women's health. Reproductive and Child Health(RCH) program was launched in 1995 that promised an integrated approach towards women's health but its focus remained contraception. National Rural Health Mission(NRHM), launched in 2005, was a strategic approach to provide effective health care to the rural population. NRHM did scale up the maternal health care in the country, but its implications weren't far-reaching.

Considering the way RH has emanated through the various phases in the health history, there are no doubts that the country has tried enough to put it as a relevant issue in the development and empowerment of women. If the health history is traced, it is evident that significant shifts have happened for the enhancement and improvement of women's reproductive health, like shifting of maternity services from the general services during the seventies, replacement of the term 'maternity health' by 'reproductive health' during the nineties, the shift from the 'method-specific approach ' to 'target free approach' and the vital shift from the 'midwives' in ancient India to 'CHW's, ASHA workers and ANM's'. This paradigm shift, although, was a result of the ongoing global conflict, marked a noteworthy change in the framing of future RH services in our country. Thus, there was an effort of moving from the strategy of 'population growth' and viewing RH issues and services at par with the rest of the general health services.

Though this shift brought a significant change in the domain of RH in India, somehow, it failed to mark its effect on the overall health status of the country. The so-called' improved' health services for women, now, moved from 'reducing population' to 'reducing MMR' and 'increasing the institutional deliveries'. Initially, all the policies that were framed for women's health, aimed at controlling women's sexuality and her capability to reproduce, in short, aimed at reducing 'over -population' because reducing the population was the most promising approach that our country followed for attaining development. With the shift happening, the approach shifted to 'reducing MMR' to achieve MDG's by 2015 and now SDGs by 2030. The Government seemed to overlook other aspects of these goals related to RH, like access to RH services, adolescent health, use of contraceptives, etc on the aid of 'institutional deliveries' and 'reducing MMR'. NRHM, with the help of ASHAs and ANM's, is trying to achieve the highest numbers of institutional deliveries in rural locations. These women are trained to motivate rural women to undergo institutional deliveries. To accelerate institutional deliveries, monetary assistance is also provided to every woman who delivers at public hospitals. ASHA workers are constantly pressurized to meet their targets of maximum institutional deliveries from their respective areas. In a way, it is a good effort from the government for reducing the MMR and saving women from, morbidity.

Maternal Mortality rates (MMR) and reducing its number have always been the main agenda of all the programs and policies. But are the main causes of Maternal Mortality seriously ever considered? Women die in the country not only while giving birth, but also because of many other diseases or problems like back pain, anemia, etc. The main question that arises is that how often is the context of these problems ever discussed and how does one locate them in the domain of reproductive health. For example, women in varied regions of the world experience varied kinds of problems, depending upon the kind of work they do or the kind of environment they are exposed too and such problems might not relate to RH, then why to universalize all the problems of women under the umbrella of 'RH'. There is no uniformity to women's issues, considering the fact women are exposed to different geographical regions, perform different kinds of work, and have different reproductive histories. We need to understand the silence of the women behind various RH issues and try to locate the underlying reasons, not in the conventional medical domain, but the social and cultural domain of life

Also, various policies like RCH 1 and 2 and NRHM have tried to incorporate social angles to health too, but it is not very clear how these policies will be operationalized in a male-dominated, hierarchical and patriarchal societies of the country. In a country like India, especially in rural settings, all matters related to child-bearing, pregnancy, and child-birth are majorly taken by men though these issues are very conveniently known as women's issues. So, women's sexual and reproductive health decisions are made by men in their lives. Not only that, decisions related to use and non- use of contraceptive methods is also taken by men.

So, there is a need for a broader reproductive health approach that aims at major changes in the content and delivery of services, awareness, and education and communication programs. There is a need to realize that reproductive health is a broader theme and many times, issues of reproductive health are far apart from the medical domain and apart from mere diseases and sterilization procedures. They might not be solved by applying the core strategies or conventional methods of the medical domain. No doubt, the social and cultural domain of health is being taken into account and there have been good efforts in that direction, but there is more to this approach.

Healthcare and its services play a vital role in determining the development and economic growth of a nation. It is often believed that good health status is directly proportional to the level of economic advancement of a region. Economic advancement translates into a better standard of living and better health outcomes. Therefore, the importance of health care increases in such populations where poverty is more pronounced. Provisioning of health care services is also challenging in areas that are remote. There is no doubt that the establishment of efficient and accessible public health institutions is significant and much required in achieving the desired results of maternal and child care, especially for disadvantaged populations in the country. Though the public health system has improved over the years, especially after the implementation of NRHM, there is much more that needs to be done. The effectual functioning of public health institutions has a tremendous impact on the health of women, especially in rural areas. Non-availability and lack of access to public health institutions are one of the many reasons responsible for ill health and morbidity cases among rural women. World Health Organization (WHO) argues for an effective and efficient public health system for each country by increasing more funds and improving access to health care (Singh, 2010). But the question here arises that access to health is enough in determining the reproductive health status of a region?

Reproductive health is a very much public health issue and is the state's responsibility (Qadeer, 1998).

Despite the wide research on reproductive health policies and their implementation still, there

is a need to understand and clarify the concept of 'health' and how it might vary from woman to woman depending on their social and cultural situation. The concept of reproductive health still revolves around fertility regulations and achieving targets of maternal mortality numbers and institutional deliveries. The problem here is not that achieving these numbers is not vital, it is, but to prioritize specific dimensions of reproductive health is a problem. Reproductive health is a complex interplay of social positions of women within their families and societies, their perceptions about themselves, inter-personal relationships, domestic violence, and their silence about many health issues. Deeply rooted patriarchal norms and gender practices are instrumental in determining the reproductive health status of the women in the country. Thus, the official concept of reproductive health in the country is not necessarily 'pro-women'; it is only women-centric (Qadeer, 1998, p. 12). Therefore, a multi-prong approach is required that aims to broaden the scope of reproductive health by incorporating the various social and cultural dimensions of women's lives and their social and mental well being and then only issues like anemia can be effectively addressed and reduced.

Scope For Further Research

This present study allows discussion on the concept of reproductive health and how it might vary from woman to woman depending upon their social-cultural lives, their economic conditions, and political context. It provides a platform for further study through understanding issues such as anemia at the intersection of gender, health, access to resources, nutritional intake, and patriarchal norms. This study also provides a scope to broaden the framework around which health policies are formulated and implemented in India and argues for a comprehensive approach around women's health issues.

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Footnotes

1 Percentage Difference manually calculated

2. Primary data was collected by author while conducting an ethnographic work for her doctorate research on reproductive health and in depth interviews were conducted with ASHA workers, ANMs and 125 women of Kakrala village. Only the relevant interviews have been discussed in this paper.

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