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How Gender Affects Our Health: The South Asian Context

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ABSTRACT: The research navigates the cultural anthropology and anatomy of the genders and their effects on their respective health statuses supported by demographic and empirical data. Through historical contexts and biological knowledge, it delves deeper into this concept while analysing known patterns and assumptions in the South Asian region. It is found that there is female excess in morbidity due to societal norms and restrictions, which have a direct influence on women's health. However, men suffering less is shown to be caused by shaped mindsets of not being seen as "weak" and coping in relation to society's expectations. The significant hormones, oestrogen and testosterone in females and males, respectively, have both positive and negative effects on their bodies which balance out, if present in reasonable proportions, and do not have much impact on anomalies in health.

KEYWORDS: Gender, Oestrogen, Testosterone, Female Foeticide, Anthropology.

I. INTRODUCTION

Relevant ethnographic and biological research have helped us in understanding how genders influence our mental and physical health. Contrasting lifestyles caused by societal and hereditary somatic differences have created respective gendered realities. As a result, there are likely to be differences between more and less developed countries. In the latter, health is still threatened by infectious disease and by unregulated environmental and occupational exposures. Also, the penalties of reproduction are higher because of pressures towards early and repeated childbearing (Macintyre, Hunt & Sweeting, 1996). In medical sociology and social epidemiology, gender differences in health are taken for granted when there is a focus on people with a specific diagnosis, structural inequalities amongst women or when we pursue explanations for these differences regardless of age. The research seeks to clarify assumptions and myths which relate to gender and health in the South Asian context.

II. GENDER DIFFERENCES IN HEALTH: ASSESSING GENERAL ASSUMPTIONS AND EXPLANATIONS

There is a conventional assumption of more significant female morbidity, which has been fortified by empirical research. Besides limitations set by women's bodies, gender roles associated with notions of female inferiority, substandard social conditions and higher stress exposure have contributed to this conclusion. The belief is that the division of labour by gender results in differential exposure and vulnerability to stress among women and men; women are in poorer health because their lives are more stressful than men's, and they are more vulnerable to the health consequences of life stressors because of their relative lack of material, personal, and social resources (McDonough & Walters, 2001). It has been suggested that one of the reasons for women's greater morbidity is researchers' tendency to focus on health conditions more commonly reported by women. In a direct challenge to the view of women's higher levels of ill health across all indicators, Aneshensel et al. (1991) argue that gender differences in health and effects of stress may depend on the specific health outcome of interest. For example, men appear to embody stress-related angst in substance abuse disorders that express anger and hostility, while women do so in affective and anxiety disorders indicative of depression (Umberson et al., 1996). More in-depth research is needed to clarify the patterns and explanations of gender differences in health.

As these differences are comprehended to be more complex than general assumptions and pragmatic reasoning, the explanations regarding such differences are sought out. McDonough & Walters (2001) believe that one of the most



common is the stress model of disease and illness. Fundamental to the base of the model is susceptibility to psychological or physical breakdown stimulated by inequalities in life. Susceptibility is counterbalanced by resistance—disease or illness results when the scale tips favour susceptibility (Gerhardt, 1989). In analyzing susceptibility to stress as a basis for gender differences in health, we narrow down two hypotheses: differential exposure and differential vulnerability. The differential exposure hypothesis suggests that women report more ill-health than men because of higher levels of demands and social obligations weighed on them because of their conventional gender roles. This can be resolved by allocating equal pressure of social expectations on each of the genders. The differential vulnerability hypothesis considers women's greater reactivity to life events and strains experienced by men. However, women's disadvantage in social roles and coping resources affect the nature of these stressors and ultimately harms their health. Suppose differential exposure is more of a contributor than differential vulnerability in the stress-health relationship. In that case, policy and social initiatives must focus on those sources that increase greater female exposure to risk. If instead, vulnerability turns out to be the leading cause, then there should be a greater focus on building up resistance resources. A 1994 Canadian National Population Health Survey (NPHS) indicated that differential exposure to chronic stress and life events accounts for some differences in distress. However, its role is negligible for the differences in chronic medical conditions and alcohol use.

Three issues highlight the complexity of people's lives in gender, stress, and health. First, the view that gender differences in health emerge because women experience more stress and react with greater intensity is challenged by studies demonstrating the contextual dependency of exposure and vulnerability to stress. For instance, women report greater workplace and social stressors while men are affected by economic stressors such as financial loss (Wheaton, 1990; Turner & Avison, 1989; Kessler & McLeod, 1984; Wethington, McLeod & Kessler, 1987; Bolger, DeLongis, Kessler & Wethington, 1990; Aneshensel et al., 1991; Thoits, 1987). Second, lack of conceptualization and measurement of stress. It is often merged with life events such as death, financial loss, marital breakdown etc. However, the patterning of exposure to life events by gender is inconsistent (Thoits, 1982) and many researchers conclude that differential exposure to life events is considerably less critical than differential vulnerability in contributing to gender differences in health (Thoits, 1987; Kessler, 1979; Kessler & McLeod, 1984; Turner & Avison, 1989). Thus, giving it more importance as a particular problem instead of associating incidents could lead to more efficient and effective solutions. Lastly, current research emphasizes interpersonal relationships in studies of gender differences in health. There is a tendency to focus on family-based data roles, excluding other essential life domains such as paid work.

We see abundance and diversity in the interconnected relationships between gender, stress, and health. This calls for a finer conceptualization of "gendered reality." Annandale & Hunt (1990) contradict the belief of gender as a fixed dichotomy, suggesting that gender roles may crosscut. However, most females and males restrict themselves to female and male gender roles, respectively. Increased "masculinity" led to better health outcomes for men and women, while "femininity" was correspondingly as disadvantageous. In a search for the causes of illness in gendered positions, we neglect the similarities in health and disease between men and women and the differences within men as a group and within women as a group (Annandale, 1998).

Macintyre, Hunt & Sweeting (1996) believe that if we are to make progress towards understanding the processes, whether social, psychological, or biological, which produce or maintain differences in health, it is essential to pay attention to the social and historical context of our observations and to take a more differentiated age-specific and condition-specific view of health when examining differences between the sexes. The challenge is to explore how gender continues to be a representation of inequality while recognizing the diversity of experiences within genders.

III. SOCIETAL PERCEPTION OF FEMALE INFERIORITY

Since societal expectations and inherited genes tend to differ between two communities, these differences are only heightened when comparing developed and developing countries. The situation is worse in the latter, particularly in the South Asian context, where men and elders in the family primarily take important decisions regarding women, financial and health statuses. Established norms and conservative societal beliefs glorifying the worth of men over women in South Asia have settled deep into the minds of the citizens of this region, changing their attitudes towards gender roles. It has led to the devaluing and neglecting of female health and health care. Sons are perceived to have economic, social, or religious utility; daughters are often felt to be a financial liability because of the dowry system



(Arnold F, Chloe MK & Roy TK, 1998). According to F Fikree & Pasha (2004), gender discrimination at each stage of the female life cycle contributes to health disparity, sex-selective abortions, neglect of girl children, reproductive mortality, and poor access to health care for girls and women. Research regarding the facets of women's health in South Asia is explained below:

Sex Ratio

Gender-related differences in health status have led to an unbalanced sex ratio for the past 100 years, declining further (Banthia JK, 2001). An estimated 60-100 million girls are "missing" worldwide, and the imbalanced sex ratios of South Asian countries contribute to a large proportion of this number (Coale H, 1991; Sen A, 1992; Watts C, 2002; Allahbadia GN, 2002). In the Indian subcontinent, this ratio has fallen to 770 females per 1000 males (F Fikree & Pasha, 2004).

Sex Preference

Selective abortion of female foetuses and prenatal sex selection of male embryos has become common. A surprising aspect considering this practice is that educated women are the most frequent to seek such sex-selective abortions. The most extreme form of sex selection, female infanticide, has focused international media attention towards specific communities in India (Singh J, 2000; Bindra S, 2003).

Neglect of Girls

Stimulated by more significant discrimination, Filmer D, King EM & Pritchett L (2004) say that gender health differences under five years of age are more considerable in South Asia than anywhere else in the world. For example, in India or Pakistan, girls have a 30-50% more chance of dying than boys.

Adolescents' Health

Early marriage, anaemia, sexual violence, and poor educational opportunities all contribute to ill health among female adolescents in South Asia (Tiwari BK et al., 1997). Adolescents, especially young women, are disproportionately affected by HIV infection worldwide; adolescence is also a time when vulnerabilities to injury, including motor vehicle crashes and suicide, as well as substance abuse, rise (Barker G et al., 2000). In most parts of the world, men bear the more significant burden of violence and injuries; however, suicide among young women may be more common in South Asia than in other parts of the world (Khan MM, 2001; Brockington L, 2001; Ronsmans C & Khlal M, 1999). This, combined with the distressing practice of "dowry murder," means that young South Asian women are at particular risk from violence (F Fikree & Pasha, 2004).

The Perils of Reproduction

Most South Asian women are either too young, receive minimal antenatal care, anaemic or malnourished at the time of reproduction. In addition, due to economic circumstances and spousal or familial opposition, women prefer to go through delivery at home rather than at a hospital. As a result, consequent reproductive health hazards are borne by them alone and inevitably the child progeny if surgery is not performed correctly.

Maternal deaths-most commonly from haemorrhage, sepsis, and eclampsia-continue to exact a high toll; unsafe abortions also contribute to deaths from haemorrhage and sepsis (F Fikree et al., 2002; Mari Bhat PN, 2001). In addition, home deliveries by unskilled attendants, a paucity of knowledge of intrapartum danger signs, and inadequate transport mechanisms to and lack of appropriate care at health facilities all contribute to this burden (F Fikree et al., 2002; Bhatia JC, 1993).

Health Care for Women

In South Asia, women are more likely to be unemployed, widowed, and dependent. The lack of support causes ill health as they survive into old age. As a result, as people grow older, diseases with equal prevalence in both men and women affect women more severely, ultimately concluding lower life expectancy. A finding of grave concern whose



explanation remains unclear is how South Asian women are more affected by diseases such as rheumatic heart disease and hepatitis C virus infection (F Fikree & Pasha, 2004).

It can be hypothesized from the given information that male superiority over women exists in the health sphere in South Asian countries. Decreasing fertility, preference for sons, and the spread of dowry and restrictions of women to agriculture-based work are the factors that originate from the societal devaluation of women in varied realms, particularly the economic one. The lack of economic utility of women is the underlying factor that has reduced their value in society's eyes. However, improved economic conditions and education will still be insufficient to change people's views, beliefs and practices that have been culturally, socially and in some places legally enshrined by society for centuries in the past. Among these countries, Sri Lanka has the best results. Here there are negligible differences between men and women in health status and rare female disadvantage. Moreover, education and employment levels are increasingly better, with life expectancy rates matching industrialized countries.

A rights-based approach must be looked at for improvement. Human rights activists, policy and programme-makers in South Asian countries should be aware of the influence of gender on one's health and responsive to making change.

IV. HORMONES AND SOMATIC RESTRICTIONS: A BIOLOGOCIAL PERSPECTIVE

Oestrogen and Female Health

The two main female hormones, oestrogen and progesterone, have imperative functions in women's bodies. While progesterone helps to regulate the menstrual cycle and get the uterus ready for pregnancy, by thickening its lining to prepare for a fertilized egg. Oestrogen is responsible for basic female characteristics as well as other essential bodily processes apart from tending to the reproductive system. Oestrogen contributes to the function of the cardiovascular system, cognitive and bone health. Both excessive and insufficient levels of oestrogen are injurious to female health. There is an increase in oestrogen to a healthy level during puberty and pregnancy which decline thereafter. At menopause, the level of the hormone is half as that of its peak, subjecting women to cardiovascular diseases, fractures, osteoporosis, and strokes. As suggested, oestrogen looks after general physical health. In terms of mental well-being, randomization to this hormone results in no significant effects on vitality, mental health, or depressive symptoms (Jennifer Hays et al., 2003).

Testosterone and Male Health

There is little evidence for the clarity of testosterone's effects on the overall health of men, as it has varying impacts both physically and mentally. The medical research community tends to view the relationship between health and testosterone as a positive one. In contrast to this belief, behavioural scientists find the hormone to be related to social and behavioural factors that are known to be related to poor health outcomes (Booth et al., 1999).

Testosterone improves sexual function (Aver et al., 1996; Billington et al, 1993; Davidson et al., 1979), mood (Wang et al., 1996) and enhances skeletal muscle mass (Brodsky et al., 1996). It also has been used to treat other ailments such as rheumatoid arthritis (Hall et al., 1996) and muscular dystrophy (Wells et al., 1992). Basal testosterone has a consistent relationship with dominant behaviour, sometimes accompanied by aggression and risk taking (Daltzman & Zuckerman, 1980; Kreuz & Rose 1972; Ehrenkranz et al., 1974; Dabbs et al., 1987, 1991, 1995; Lindman et al., 1987; Mazur, 1995). It is this link that may have strong potential for explaining health risk behaviour and some types of disease. Finally, the hormone is strongly and inversely related to obesity (Freedman et al., 1991), which in turn is related to increased morbidity.

Testosterone has a circadian rhythm such that the highest level of the hormone is upon arising (Booth et al., 1999). It peaks at about age 20 and then slowly declines throughout the life course (Simon et al., 1992). Men with higher testosterone, though not necessarily excessive, are more likely to have sexually transmitted diseases, injuries, and depression and are less likely to have frequent colds, hypertension, heart attacks and cardiovascular problems, or be obese (Booth et al., 1999). Individuals with high testosterone have a 50% greater chance of being unmarried than low-testosterone men (Booth & Dabbs, 1993). The unmarried are largely susceptible to poorer health as marriage brings about an organized lifestyle, feeling of being loved and cared for and responsibilities which in turn limit subconscious reckless behaviour (Booth et al., 1999). As inferred, the greatest health benefits accrue to men with testosterone at the lower.



V. HORMONAL EFFECTS ON TRANSNGENDER HEALTH

In cisgender individuals, gender identity develops in line with the assigned gender at birth and is stable throughout life. On the other hand, transgender individuals may persistently or transiently identify with another gender different from the one assigned at birth. According to the Diagnostic and Statistical Manual of Mental Disorders 5th Version (DSM 5), we refer to “Gender Dysphoria” when the incongruence between the experienced or expressed gender and the assigned one leads to clinically significant psychological distress and impairment in the main areas of functioning. In some cases, this distress may lead to the desire for a social and/or somatic transition through a gender affirming hormone treatment and surgery (J Ristori et al., 2020).

Cross-sex hormones are commonly induced in transgender people to introduce changes they desire. Two groups of cross-sex hormones are used: oestrogen and less commonly progestogens which are androgen suppressors or male hormone blockers. The use of oestrogen has considerable positive impacts on cognitive health while aiding the process of feminization, such as, a sense of emotional well-being, emotional sensitivity, and improved impulse control (Tom Waddell Health Centre Transgender Team, 2006). Cohen-Kettenis & Pfafflin (2003) note that MtF hormone regimens may reduce aggression. They also remark on anecdotal evidence of increased emotional calm. However, Ashbee & Goldberg (2006) assert that oestrogen may (a) increase blood pressure, prompting a range of cardiovascular problems, including heart attack and brain damage; (b) increase the risk of blood clots, in turn leading to permanent lung or brain damage, heart attack, and/or chronic deep vein problems; (c) increase deep fat deposits around vital organs, leading to diabetes and heart disease; and (d) increase the risk of gall stones and a blocked gallbladder. In addition, it also may cause nausea, vomiting, headaches, and migraines. The use of oestrogen alongside other drugs, for example, tobacco-based nicotine is liable to undermine the effects of oestrogen. It also likely exaggerates the risk of cardiovascular disease which the hormones already promote (Winter & Doussantousse, 2009).

Thai research has found that cross-sex hormone-takers, as opposed to non-hormone takers, reported a lower quality of life (Suja et al., 2005). In the seven poorest countries in the South Asia region; Myanmar, Thailand, Vietnam, Laos, Cambodia, and Indonesia where oestrogen-based oral contraceptives and cross-sex hormone injectables are widespread and cheap. Large numbers of transwomen who use cross-sex hormones, repeatedly ingest high doses while following a “more is better” attitude. Excessive oestrogen is converted into testosterone, which retards the process of feminization, subjecting the consumers to cardiovascular diseases, strokes, osteoporosis, and fractures. The Philippines sells such contraceptives free to natal women. In Thailand, a progestogen; Androcur is available though less widely (Winter & Doussantousse, 2009). Oestrogen when consumed in quantities more than necessary can cause mental illnesses as well. In these low-middle income countries, not enough funds are available to be allocated towards mental health. In the view of Western Psychiatric Orthodoxy, a majority of trans people suffer from varied mental disorders. In Laos there is no place in the national budget for mental health as an issue of primary care. Trans people here must fund themselves and often go to the neighbouring country of Thailand seeking aid from professionals involved in surgical or hormonal transition for them.

VI. RESULT

While gender continues to change, with addition of others, cross-cutting of gender roles and alteration of society’s paradigm of ideal women. These changes have significant effects on the respective gender’s health. In South Asia, female excess in many forms of morbidity and structural disadvantages towards women in relation to the labour market and the family, continue (Doyal, 1995). This region has the minimal number of anomalies in female behaviour as expected from society and while fecundity for male and female infants remains equal, preference remains in favour of the male gender.

Societal perspective has often been limited to the view that gendered stress leads to poor health. However, poor health specific to genders can also be a stressor. From prior theoretical and empirical work, it was assumed that chronic stress and life events harm health, but it is also plausible that poor health leads to stressful experiences (McDonough & Walters, 2001). Research focused from this point of view can transform society’s outlook on the gender-health relationship. Age, condition and circumstantial specific views within the genders are necessary for more accurate and profound results. Policy and programme makers in the countries must take rights-based approaches to equate male and female gender differences originating from societal norms, and raise the level of health in South Asian countries to that of that of those which are industrialised.



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