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GENDERING HEALTH: AN ANALYSIS OF WOMEN ISSUES IN ASSAM, INDIA

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INTRODUCTION:

Public health plays an important role in protecting and promoting the health of population. The activities of public health are complex, performed by multiple professionals. Gendering on public health is one of the new dimension, which needs more attention to discuss.Gender is a social construction, while sex is biological. B.K Nagla in his article, 'Sex and Gender:Cognitive Analysis', stated that the concept of gender as distinct from the biological fact of sex includes a complex of sociological,cultural and psychological associations with it[1].Therfore scholars from various disicipline tried conceptualize various issues through gendering perspective. Meanwhile such discussion have been developed in many feminist writing also. The Feminist introduced the concept of gender several decades ago to distinguish between biological sex and the social construction of masculinity &feminity. Now a days, gendering analysis in each and every sector is a matter of concern. Similarly Gendering in health is an important area of concern, because health disparities have been seen between the men and women's health. Health disparity can be defined as a 'marked difference or inequality between two or more population groups defined on the basis of race or ethnicity, gender, educational level or other criteria'[2]. Most of the time women health is being neglected by the family and as well as state machinery. The government policies on women's health have been designed in a way so that it gives priority concern to women reproductive health, while other health problems of women are automatically being neglected.The subject of health could not be studied alone. Research have showed that there are other important area, as for instance economy, socio-economic position, one's gender etc are also connected with health and these other areas are called in social determinants of health. Social determinants of health have a major role in terms one's health condition. In fact,

[1] Nagla B.K., 'Sex and Gender: Cognitive Analysis' in Avasthi A & Srivastava A.K (Ed) 'Modernity, Feminism and Women Empowerment',(2001), Rawat Publications, New Delhi.
[2]Pearcy J, Keppel K. A Summary measure of health disparity. Public Health Rep; 117 (May/June): 273-80

on the basis of various social determinants of health, one could determine the individual's social position. Meanwhile, on the basis of individual social position, social determinants of health is varies person to person. Therefore, it could be said that to improve health condition, one has to improve their Socioeconomic Position.However, socio-ecomic position is highly effected by the government's resource allocation system. Similarly equitable health distribution system has made an equality in terms of various social determinants of health(Commission on social determinants of health, final report 2008).Engendered by inequitable access to health determinants such as income, social support, good quality, housing and clean environments and the stress imposed by structural forces, multiple roles and discrimination health disparities reflect a gradient in socio-economic status and power[3]-[4].When health disparities are examined in terms of gender – Mathews, Manor and Power observe that relationship between health outcomes and social hierechy appears to be more linear in predicting men's health while the association to women's health appears to be more linear in predicting men's health while the association to women's health appears to be more complex[5].

There is a connection between poverty and women's health. In the year 1999, UNDP Report, it has been stated that although absolute poverty has reportedly declined in recent years, research suggest that relative poverty or the gap between the rich and the poor within and between the countries has been exacerbated over this same period[6]. Various survey or research have showed that poor women don't have adequate awareness as well as resources through which they can access better health care facility. These sections of women are struggling to get basic needs i.e. food, cloth and settler, where somewhere health is being missed. Health should have to include in their basic needs, without this no one can live properly. The World Health Organization in the year defined health as 'a state of complete physical, mental and social well-being and not merely the absence of diseases'[7]. But in the case of women in below poverty line, most of the time,

[3]Amaratunga C (Ed). Made to Measure:Women , Gender & Equity, Halifax, NS: MCEWH,2000.
[4] Hayes M. Man, Disease & Environment Association: From medical geography to health inequalities. Progress in Human Geography 1999; 23(2): 289-96.
[5] Mathew S, Manor O, Power C. Social Inequalities in Health:Are there Gender Difference? Soc. Sci.Med.1999;48:44& 60.
[6] United Nations Development Programme (UNDP). Human Development Report: Globalization with a human face. New York, NY: UNDP, 1999.
[7]World Health Organization. 2006. *Constitution of the World Health Organization – Basic Documents*, Forty-fifth edition, Supplement, October 2006.

such standard definition of health have not been seen as applicable. This pepar is dealing with the health of women who belong to socialiy, economically marginalized section, who most of the time have to victimized of the inequitable health services distribution system. Globalization does not help specially the poor women, basically who live in developing countries, rather it would creat huge political, social and economic burden on them. Therefore Meclean and others pointed out that women are not consistently benefitting from economic, political & social gains globalization can offer, instead it appears that poor women and girls, particularly those living in developing countries, are disproportionately burdened by the cost of their swift changes to the determent of their personal health and wellbeing[8]. However in terms of reproductive health , the rural poor women are more vulnerable and research showed that highest number of morbidity and mortality have been found among those women. Therefore an attempt has been made to see rural women health conditions through a gender lenses.

Equitable distributions of social determinats of health have important relations between the gender and health, and which has serious relation with poverty also. If the SDH are equally distributed among both the men and women, then it would help to reduce gender disparities in health.But UNDP(1995, 1996, 1997, 1998 1999) has shown that there is no necessary relationship between the level of economic development of a country and its level of gender equity. The Human Development report 1995- 1999 (UNDP) provides a comprehensive global review of the 'gender gap' in health, social, political and economic status. The 1997 Report proposed a six –point plans of action to eradicate poverty , which included urging nations to commit themselves to gender equality in order to unleash the energy and protective capabilities of women around the world. The report suggested that priorities for closing the gender gap should include 'equal access to education and health, to job opportunities and to land and credit and actions to end domestic violence[9]. The Human Development Report 2011, emphasized on sustainability and equity for a better future of all. This report offeres important new contribution

[8]Meclean H, Sicchia SR, LoboneR(eds). Globalization, Gender & Health. Final Report prepared for the Canadian Institutes of Health Reasearch Institute of Gender & Health. Ottwa On, November 2004.
[9] UNDP: 1997, The Human Development Report 1997 (Oxford University Press, oxford.

to the global dialogue to show how sustainability is inextricably linked to the basic questions of equity[10].

THEORETICAL PERSPECTIVE & METHODOLOGY:

The theoretical perspective of socialist feminism is quite relevant in this context. Socialist feminist believe in two system theory of women's oppression i.e. patriarchy and capitalism. Socialist feminism tried to understand women's subordination in a coherent and systematic way that interest class and sex, as well as other aspects of identity such as race/ ethnicity or sexual orientation[11]. Here women health can be studied through this theoretical perspective.Because women health is related with some other area i.e. patriarchal structure, class and caste position also . A secondary analysis in the context of Assam , i.e. NFHS 3 data and Annual Health Survey (2011-12) have been used. However with some region specific empirical data is also being discussed. In this paper, an attempt has been made to critically analysis government's approach in terms of women's health in Assam. However, it has been tried to analyse how patriarchy hegemony portraits its influence in terms of defining women's health.Moreover, the paper will try to give an overview on how inequitable health disparities are related with poor women. Generally women are poorer unlikely than men, therefore health has a close relation with feminization of poverty.

SOCIAL DETERMINANTS OF HEALTH: GENDER AS AN IMPORTANT COMPONENT OF IT:

Social determinants of health has a very close relationships with one's health.The social determinants of health are the economic and social conditions and influence individual and group differences in health status(commission of social determinants of health 2008). The World Health organization commission on social determinants of health(CSDH) embedded the goal of universal health care in strategies that include daily living conditions, tacking the inequitable distribution of money, power and resources as well as measuring and understanding health inequalities[12] [13]. The commission's 2008 report defines health inequalities as " systematic

[10] Human Development Report 2011: Sustainability and Equity: A Better Future for All., United Nations Depelopment Programme.
[11] Tong, R (2009) Feminist Thought: A More Comprehensive Introduction, Westerview Press, California.
[1212]Birn A., Historicing, Politicising and Futurising' Closing the gap in a generation. In Bhattacharya, S., Messenger, S.Overy, C, Editors Social Determinants of health : Assessing Theory, Policy and Practice. Hyderabad: Orient

differences in health that are 'avoidable by reasonable action and are quite simply unfair"[14]. It proposes to terminate these systematic differences i.e. close the gap in generation the space of 30 to 40 years, through action on the social determinants of health[15]. The CSDH defines the social determinants of health (SDH) as "the conditions in which people are born, grow, live, work and age including health system"[16].However Social determiants of health again has close connection with gender. In fact, gender is itself is one of the important component of SHD. Gender is playing an important role in terms of distribution of health care system also.Connell(1987) stated the relationship between gender and health is basically based on four traditions: biomedical, psychosocial, epidemiological and society & health[17]. Because, apart of women reproductive health, government gives less concern on other health problems of women. And basically other health issues have been merged as health for all. And within health for all, women health issues are somehow being neglected .

Women position is somehow determined by socio-economic position. The term socioeconomic position (SEP) refers to the position occupied in a social hierarchy by an individual or family . People occupying lower socioeconomic positions may have difficulty accessing resources that are necessary to enable them to live lives that are considered appropriate or decent within their society. Social economic position is directly proportionate with one's health. If one's socio-economic condition is good, he or she could easily access better health care facility, and if he or she belongs to low socio-economic postion , then eventually his or her capacity to access better health care facility would be less(Adler Nancy.E n others , Socioeconomic Status and Health,January 2014). Therefore various scholars like Broom, 1998, Horpole, Mort, Freud,

Blackswan, 2010. & Smith GD, Krieger N. Tacking Health Inequalities. British Medical Journal 2008 (227): 529-530.

15.World Health Organization commission on Social Determinants of health. Closing the gap in a generation: Health equity through action on the social determinants of health. Final Report of the commission on social determinants of Health, Geneva: WHO 2008:2.

[15] In 2009, the 62nd session of the World Health Assembly approved resolution WHA 62.14 Reducing health Inequalities through action on the social determinants of health, exhorting member states to move forward with their own effort to 'close the gap in a generation' monitoring measuring and equalizing the social gradient of health along axes of age, ghender, ethnicity, race, caste, occupation, education, income and employment.

[16]World Health Organization. Health Sector Reforms in India:Initiatives from states II (Internet) n.d (cited 2011, May 26) Available from: http://www.whoindia.org/.../Health_sector_reform_HSR_VOL_II_Chatishgarh

[17]Connell, RW. (1987). *Gender and power.*Stanford, CA: Stanford University Press.

Ornav& Brennan, 2000 etc. have emphassied on gender sensitive health care and in their writing, they also initiated about redefine of exsisting health model[18]. Therefore through out the world, concerning on women health issues become an important area of matter. Eventually various policies and programs have also refeclted it's gender concern nature through out the world. In this context, various women international conference has significant role. It helped to bring the awareness among the women issues through out the world. Since after the independence, Indian government has also tried to implement varios women oriented programs through various five year plans. And finally in the year 2004, Ministry of Women and Child development introduced recognized Gender Budgeting as an important tool for women's empowerment and as an important tool for women empowerment. The MWCD adopted, 'Budgeting for gender equity' as a mission statement, and framed a strategic framework of activities to implement this mission, which it disseminated to all ministers and department of the Government of India. The Ministry of Finance mandated all ministries to establish a gender budgeting cell by January 2005 and in the same year the Ministry of Finance initiated the process of creating an institutional mechanism for gender budgeting cells (GBSs) in all ministries and departments. Similarly a special concern has been given to the department of health, so that all the health policies and programs could be gender sensitive.In a larger level, Ministry of Women and Child development has formulated various policies for women and children. The main goal of these policies is to provide equal health opportunities so that women could also equally participate in the mainstream development activities as like their male counterparts.

In the year 2005, Government of India introduced NRHM (National Rural Health Mission) model to bring the change of health development scenario of India. Under the NRHM, the Empowered Action Group (EAG) States as well as North Eastern States, Jammu and Kashmir and Himachal Pradesh have been given special focus. The main goal of the mission is on establishing a fully functional, community owned, decentralized health delivery system with

[18]*VissandjdeBilkis.,Weinfeld Morton .,Dupdrd Sophie &Abdool Shelly.,* 'Sex, Gender, Ethnicity, and Access to Health Care Services: Research and Policy Challenges for Immigrant Women in Canada' in JIMI/RIMI Volume 2 Number/num6ro 1 (Winter/hiver 2001):55-75.

inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality. Institutional integration within the fragmented health sector was expected to provide a focus on outcomes, measured against Indian Public Health Standards for all health facilities.

ANALYSIS OF EXISTING WOMEN HEALTH POLICIES IN ASSAM:

Assam is called 'The Land of Rising Sun', because it is situated on the North Eastern sentinel on the frontiers of India. With an area of 78,438 sq. kilometers Assam represents 2.39 percent of the land area of the country. According to the 2011 census, the total population of the state is 3,11,69,272. The economy of Assam is mainly agriculture based. Health is become a state subject and therefore Assam Government has also implemented a number of health policies since a last decade. But after coming the NRHM model, an increasement in terms of policies have been seen in Assam. Meanwhile, during the year 2005 the approach of gender budgeting has come in the national context and as a result of this government has to execute each and every policy through a gender lens. The process of gender budgeting in Assam has been introduced in the financial year 2008-09.Thirteen departments in the state at present have been covered under gender budget approach of the government.Gender Budgeting examines the resource allocation through a gender lens and stress on re prioritization rather than an increase in public expenditure. In the following some of the major present health policies and programs of Assam which focus basically on women's health are discussed.

a) **Assam Public Health Act :2010**

Assam is a pioneer state in the country to enact Assam public health Act 2010, which seeks to gurantee people's right to appropriate and efficatous health care – especially towards effective measures of prevention , treatment and control epidemic and endemic diseases[19]. This act has also mentioned some serious clause on women health. This act is the direct outcome of right to health act. This act passed unanimously in the state assembly recently, and coming into effect from January 2011, makes it mandatory for all hospitals and nursing homes, government and private, to maintain appropriate treatment protocol for the first 24 hours to an emergency patient. The Act guarantees people the right to appropriate medicines and the right to effective measures

[19] Collusive Behaviour in Health Delivery in India: Need for effective Regulation.(COHED Project): Collusive Behaviour in Health care and Impact on consumers evidence from Assam.

of prevention, treatment and control of epidemic and endemic diseases. It also empowers the state health department to fix accountability and responsibility in cases of recurring outbreaks of viral, communicable and waterborne diseases. Not just that, the law makes it mandatory for all new development projects in the state to pass a health impact assessment (HIA) test. In this women health is also being included and women also get benefitted from it.

b) **Janani Surkhya Jogana(JSY)**

JSY is an Indian Government scheme and it was launched on 12th April 2005 by the Prime Minister of India. It aim to decrease the neo-natal and maternal deaths happening in the country by promoting institutional delivery of babies.

c) **Mamoni Scheme:**

The Assam government introduced the Mamoni scheme in the state under the National Rural Health Mission. The aim of the scheme is to reduce Maternal Mortality Ratio.Mamoni scheme encourages the pregnant women to undergo 3 ante-natal checkups so that any danger sign could be detected during pregnancy at earliest and proper treatment could be offered. The scheme provides very pregnant woman a booklet on the tips of safe motherhood and new-born care. Afterwards, the pregnant women receive an amount of 1000 rupees in the second and third ante-natal checkups for expenses related to nutritional food and supplements.

d) **Majani Scheme:**

Through this schemes government has inspired the parents having female children. An amount of rupees 3000 has been fixed during the birth of the female children and whenever she will attain 18 years, she will get this rupees.

e) **Janani Sishu Surkhsa Karyakram(JSSK)**:

The "JananiSishuSurakshaKaryakram (JSSK)" also provides for free transport from home to institution, between facilities in case of a referral and a drop back home. Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Rural Health Mission (NRHM) being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women. The Yojana, launched on 12 th April 2005, by the Hon'ble Prime Minister, is being implemented in all states and UTs with special focus on low performing states.

Some of the upcoming government schemes that will be introduced by the state government, such new schemes are mainly Iron plus initiative for young girls, MCTS programs, etc. Under iron plus initiative schemes, the government will provide iron tablets for the young girls so that they can prevent themselves from the anemic kind of diseases. The second one is introduction of Mother and Child Tracking System (MCTS).This will primarily be a telephone-based facility to monitor the health condition of pregnant ladies. However, there are other important programmes that government introduce. These are mainly village health outreach programme. According to the data from 1st Mar 2011 to 21st oct 2014, VHOP covered 6204126 population. Such programee is basically dealing with various health realted issues of village person.

ASSAM GOVERNMENT MODEL OF HEALTH CARE:

The overall organization model of Assam health care system is quite similar to the health care system that followed across the state of the country. In Assam Health and Family Welfare Department comes under the supervision of the Ministry of Health and Family welfare. The Ministry of Health and Family Welfare has a commissioner and a secretary, officer on special duty (OSD), Senior Financial Accountant, under secretary and senior Research Officer assist the secretary. There are two departments that come under the immediate purview of the secretary. Department A includes the general Directorate of Health Services (DHS) and DHS of family welfare (FW). Directore of Medical Education(DME) comes under the department B. Each of these departments has their own hierarchical structures from the state capital down to the district level. Assam lauched the National Rural Health Mission (NRHM) in April 2005 and it trying to give support to provide effective and adequate health facilities specially in the rural area. The state Programme Management Unit (SPMU) is headed by the mission Director who works of the same level as that of the directorate level, the district Programme manager heads the district Programme management unit. Under NRHM, at the district level, there is a district health society headed by the deputy commissioner as chairman and the joint director of health services as member secretary. The society is responsible for the overall management of the programme. The joint DHS is the officer responsible for the programme and is assisted by additional chief medical & health officer(CM & HO). A team of members comprising of District Programme Manager, District Account Manager, Data Assistant & Media expert (Dutta. I & Bawari. S 2007).

The health care delivery system in India can be grouped into 5 types. These are mainly 1. Public Health Sector, 2. Private Health Sector 3. Indigenous Systems of Medicine 4. Voluntary Health Agencies & 5. National Health Programmes. Primary health centers are important institutions as per nation's health scenario is concerned. In India Primary Health Centers were established in 1952 after India got Independence. In the year 1977 GOI launched a rural health Scheme based on the principle of 'Placing people's health in people's hands'. The National Health Policy stressed the provision of preventive, promotive and rehabilitative health services to the people. Primary health cares are integral part of the health system of a nation. In the rural areas health services are provided through local institutions. There are some levels of such institutions. These level are mainly based on village, sub centers, Primary Health Centre level and Community level. In the various research and survey report, it has been found that Assam does not have enough community health centers to meet the demand of the rural population (CBHI 2006). Assam is the most populated state among the north east India. Therefore the demand of health facilities are also more in comparison to other states of the north-east India. But the unfortunately the numbers of Government hospitals are also small in comparison to the whole population. In Assam 78% of the rural population uses public health facilities as their main source of health care, while only 22% rural people access the private sector (Dutta. I & Bawari. S 2007). Therefore a large portions is still depens on state's health care system where women occupying a significant role. This paper is basically dealing with the women health issues of assam, so government's intiative on women health also has been discussed in earlier sections . State government has introduced various policies and programmes but many of them assistance for reproductive health care system. In this juncture , women's other serious health issues seem to be neglected. This kind of negligence towards another section of health stands as a hindrance to inclusive development. In this study an attempt has been made to see how reproductive health is neglecting other area of women's health and by this how inclusive health development is getting affected in the context of Assam. In the following, on the basis of NFHS 3 (2005-06) data, and Annual Health Survey (2011-2012) women's some serious health issues have been discuseed.

HEALTH PROBLEMS: SOURCE :NFHS 2005-06

Number of women at age 15-49 per 100,000 who reported that they have diabetes, asthama or goiter or any other thyroid disorders, by background characteristics, Assam, 2005-06.

Background chracteristics	Diabetes	Asthama	Goitre or other thyroid disorder	Total Women
Age				
15-19	255	1,190	851	699
20-34	118	972	708	2021
35-49	1,004	2,341	798	1,120
Residence				
Urban	812	1,542	731	721
Rural	307	1,380	767	3,119
Education				
No Education	307	1,593	668	1,161
<5 years complete	437	1,636	762	548
5-9years complete	341	1,116	817	1,387
10 years or more years complete	637	1,513	798	743
Wealth Index				
Lowest	0	3,787	583	615
Second	429	1,124	1,124	1,116
Middle	132	524	527	908
Fourth	616	1,233	529	673
highest	1,003	998	892	527
Total	402	1,411	760	3,840

From the above table it has been seen that a large number of women reported of having various kind of diseases. Meanwhile education is an important factor of it. Those women who have 10 or more years education, they outlined as less number of diseases than the women who have less education. Yet age is also playing an singinificantrole in terms of health, therefore the aged group of women have more diseases in comparison to younger one.

While discussing gendering health, women's capacity on decision making activities is an important area of concern. Therefore **NFHS 3 (2005-06)** data have shown married women decision making capacity on various household activities, where her decision on her own health care is also being incorporated. Here **NFHS 3 DATA** on women's decision making activities has been discussed.

Urban context: As per reported by married women

Decision	Mainlywomen	Womenhusnd	Husband	Someoneelse	Other	Missing	Total

Own health	17.2	65.8	16.2	0.9	0.0	0.0	100.0
Majorpurchasing	7.1	70.9	18.3	3.0	0.7	0.0	100.0
Purchaseondaily	17.1	60.8	18.3	3.2	0.6	0.0	100.0
Vist relatives	9.1	76.5	12.5	1.7	0.2	0.0	100.0
howmanychildren	na	na	na	na	na	na	na

Rural context :As per reported by married women

Decision	**Mainlywomen**	**Womenhusnd**	**Husband**	**Someoneelse**	**Other**	**Missing**	**Total**
Own health	16.4	63.0	19.1	1.0	0.3	0.2	100.0
Majorpurchasing	5.7	65.0	23.0	4.7	1.3	0.2	100.0
Purchaseondaily	13.4	54.9	25.5	4.8	1.2	0.3	100.0
Vist relatives	9.1	70.8	16.4	2.7	0.8	0.2	100.0
howmanychildren	na	na	na	na	na	na	na

Na = not applicable.

From the above table, it has been seen that urban based women have more decision making quality in compare to her rural counterpart. In the rural set up, husband decision is quite dominant. However both urban and rural context, maximum decisions have been taken with the help of both husband and wife. Indeed, the number of rural women who could able to take decision on her own health is less than urban women. Here, former represent 16.4 and later stand for 17.2 .

As discussed earlier, state has followed a women health care system, which put more emphasis on reproductive nature of health care. Meanwhile, a large number of policies and programs have been indroduced every year, but majority of these policies are in favour of reproductive health. Women's maternal health is an important area of concern, therefore giving the importance on it is commendable step of government. But on the other hand, the women's other health issues also should not be forgotten. Every year a large number of women, have to die in non maternal causes. However a large number of below poverty line women has been suffering various communicable and non communicable diseases, which needs extra government concern. In the following with the help of Annual health survey of Assam (2011-12) maternal and non maternal female death have been discussed.

Age group	Sample female death	Maternal death	Proportion	95% confidence interval		Non maternal death	Proportion	95% confidence interval	
				Lower Limit	Upper limit			Lower limit	Upper limit
15-19	342(310)	32(28)	8(7)	4(2)	13(11)	310(282)	11(11)	10(10	12(13)
20-24	417(386)	101(112)	26(26)	22(22	31(31)	316(274)	11(11)	10(10)	13(12)
25-29	486(424)	110(117)	28(28)	24(23	33(32)	376(307)	14(12)	12(11)	15(14)
30-34	417(376)	68(81)	18(19)	13(15	22(23)	349(295)	13(12)	11(11)	14(13)
35-39	466(459)	42(50)	11(12)	6(7)	16(17)	424(409)	15(17)	14(15)	17(18)
40-44	468(406)	21(24)	5(6)	1(2)	10(10)	447(382)	16(15)	15(14)	18(17)
45-49	559(536)	12(11)	3(3)	0(0)	6(6)	547(525)	20(21)	18(20)	21(23)
Total	3155(2897)	386(423)	100(100)			2769(2474)	100(100)		

Source of the table :Annual Health Survey 2011-12, Assam.

Data within brackets ( ) pertain to the corresponding estimates of baseline survey.

The above data has clearly mentioned about the maternal and non maternaldealth rate in various age group. The data are clearly showing that non maternal death rate is higher than maternal death rate. In the age group of 45-49 , the non maternal death is the highest, while between the age group of (25-29) maternal mortality rate is relatively high. Meanwhile, the overall picture of thetable refected high non maternal death among the women of the Assam.

On the basis of some field work, which was done in Nalbari district of Assam, three case study have been incorporated which represt minority , tribel and general category women respectively.

CASE STUDY : 1

Saribha Begam , 32 is the resident of Sariahtali village. She is the follower of Islam. With her husband and two children she has been residing in the village since last 20 years. She has two son respectively 15 and 13 years old. During the time of interview, she revealed many of her personal experience towards her health. She even admitted that the health care system 10 years ago was less accessible or inclusive for poor common people. That's why she had to experience home delivery . Meanwhile she also added that in earlier time, health awareness level among the people was quite low in comparion to present time. Saribha has experienced many diseases , as for instance diareah, eye related problem, chest pain. While talk to her, it has been asked her to say in detail of her experience in these diseases. As a response to this question, she said "

Diareah is common problem to mine, often I experience of it. Probably my digestive system is not so good, and there fore repeatedly I fall in sick". Her another problem is chest pain. Very often she has to go through this kind of pain, and that impede her daily activities in her household. Moreover one important point she expressed that the oral pill that she consumed earlier had make an serious impact on her health. She said, " Earlier I used regularly oral pill, and now I feel that these pill make me physically encumbrance". Again she is looking for a girl child but due to weak health she could able to think further on it.Later, to know about her decision making qualities, some questions have been raised. In response to that she replied that mostly husband takes all major decision in household, including her health related issues also. While she is having any kind of illness, she could able to go to hospital with taking prior permission from her husband. Therefore it has been seen, in her case, husband is quite more dominant. Further to know about her awareness over her health issues and rights over her body a single questions was raised, i.e. whether she could able to take decision over her body?She replied that to some extent she could able to take decision over her body but her husband decision is full and final specially in the case of reproductive health. Indeed she also enjoys some kind of freedom in case of family planning matter. In fact she also regretted about extra expenditure in government health care centres . In her words, "In government hospitals also, we often have to buy medicine and extra accessories from the private medicine store ,hospital authority didn't provide us these facilities". Again she added, "a huge amount also has been spend from the pocket in name of transportation".

CASE STUDY 2:

Mamoni Bodo, 30 another habitant of Kotakuchi village. Her husband is working as a service man in Assam Police . She has two child, where one is boy child(14) and another one is girl child(10). Her economic condition is relatively good in comparison to other neighbor of her locality. Mamoni's maternal house is at Dhemaji district. She has been living in this village after her marriage. She expressed her problem in earlier time to comprehend the lower Assam dilect, which is quite different from the Upper Assam. Mamoni stated that her family usually go for private health care facilities, because she pointed out some shortcoming of public health care facilities. In her words, "*the treatment in public health care system is quite lazy and we don't have even so much of trust on it".* Meanwhile coming to her cultural- religious point, she said

that her family is not yet assimilating with mainstream culture, rather they are purely following bodo culture. While asking about her decision making ability, she expressed that she could also equally participate in decision making activities in the house hold. She is fully aware of her own body and therefore, while she fall in sick she immediately rush to the nearest hospital. Earlier she took contraceptive pills and now she did operation. In fact she also having back pain related diseases, stomach pain etc. Although she usually goes for private health care facilities, but she regretted Government's insufficiency in terms of women health. Generally, government merge women health in to reproductive health and has kept little attention towards other issues on women's health.

CASE STUDY 3:

Weaver **Nilima Kalita , 45 year old,** has been residing in Kotakuchi Village since last 20 years. The religion she follows is hindu and she belongs to general caste of the society .She herself is engaging in income generating activities and tried to help her family in financially also. Her husband is a small cultivator and monthly income of her family is about rupees 3500. During her interviewing , it could come to know that she is carrying on various number of disease.And in spite of this, she continuously tries to help her family in a best possible way. Meanwhile her decision in the household domain is quintessential. But it does not mean that husband don't have any voice, rather it could be said that both are equally participate in decision making activities. Indeed, she enjoys the adequate amount of rights over her bodies and her husband never keep forcing on her in terms of reproductive related issues. It is her own decision to take or not to take family planning measurement. In her words, "*earlier I took oral pills for preventing unwanted pregnancies, but later I feel due to regular use of it, my health is adversely affected. Now a days I stop using of it."* She also added that she is thinking about operation but due to her illness , she could not able to take final decision on it. Apart of reproductive health, he opined on government's attitude towards women health. She said, "*Every policies and programmes are only for pregnant women, then what about us, we are very poor women and having many more diseases in my body. Can government listen to my agony"?* She also put questiong on the role of ASHA. She said , "*At the role of ASHA, we are not at all satisfying. She even don't inform us about necessary health information".*

CRITICAL ANALYSIS OF EXISTING HEALTH POLICIES OF GOVERNMENT OF ASSAM ON WOMEN HEALTH:

With the help of gender budgeting paradigm a number of health policies are coming up to National and as well as the state context. To reduce gender equality and establish an equitable health care distribution, such gender budgeting approach has been taken in the health sector. In the new development discourse, special attention to gender is an important area of concern. Women along with the men are integral part of national development policies and programmes. Gender justice and equality are not the mere outcome of development policy, but are simultaneously instruments of balanced development for both gender-male and female. In the context of Assam, especially in the rural area, most of the women are unaware about these kind of policies and programmes and as a result, many few of them are able to get benefit and rest are untouched by the policies and programmes. Moreover specially poor and illiterate women are basically unaware of government policies and programmes. A gap has been noticed between the marginalized and affluent women. Here marginalized women mean those who are economically, socially backward and belong to various tribes and minority categories. These portions of society are completely detached from mainstream development. Therefore a structural discrimination is seen in this context. Meanwhile comparatively thepatriachic dominations among these sections are also very strong. The major criticism for existing policies is that they are mainly giving importance to reproductive health. Most of the policies are targeting pregnant women, and as a result the other women's health issues are completely neglected. In this context ImranaQadeer wrote in her article '*Reproductive Health: A Public Health Perspective'* that how reproductive health stands as a hindrance in the overall women's health . Moreover the writer has portrayed that reproductive health is becoming a part of primary health care and therefore state's responsibility has been increased to improve on it. In the context of Assam, although the government of Assam has given a special attention to women's health, but most of them could not touch the poor marginalized women. Choosing the actual target is another important lacking in Assam's context. Assam is a land of multi-ethnic diversities. Here a large number of different caste, class, racial differential people reside and therefore a large number of health disparities have been seen among them. So policies should have to address the different health disparities and provide a sustainable solution through which specially poor marginalized women could get

the benefit. Moreover, in terms of proper inclusiveness of the health care system, three things are considered as important. These are mainly availability, affordability and quality. Similarly, proper gender inclusiveness is also offering these three things. But in the context of Assam, most of the Primary Health Care Systems are starting from the far away of the remote village. As a result of it, women of such area may not able to come and access the health facilities. In the context of Pregnancy related issues, the government generally provides vehicles, so that beneficiaries could come to the nearest P.H.C. But in terms of other diseases these types of transportation facilities are not available. Indeed, another serious problem that has been seen that the poor people have to pay a huge amount from their pocket in terms of getting medicines or other laboratory tests. As a result, their Out Of Pocket expenditure(OPE) is going on and on. These OPE has serious impact on women. Because of this, women's health has been neglected in most of the household domain, as women are occupying secondary role and having lack of economic independence, they themselves usually prefer not to go to health care centre. Gender equitable health care facilities mainly depends on social determinants of health. Here, social determinants means income, education, social support network, health literacy, etc. Without proper addressing social determinants of health no policies or programmes could establish proper gender inclusiveness in terms of health. Meanwhile, although the government has introduced ASHA workers to distribute the health facilities at people's door step, but in most of the cases, the role of ASHA is not being played as it expected to be. In a nutshell, here, it can be said that the government is following a universal model of the health care system, which most of the time fails to touch local women's health problems.

CONCLUSION:

Health is an important area as far as national development is concerned. Meanwhile emphasing gender on health sector is an outcome of gender budgeting approach. Without giving proper attention on gender, it leads inequality between male and female in every sector. Meanwhile Women are considered as one of the vulnerable sections of society. The Patriarcal hegemonic system prohibits women to participate in mainstream development activities as like men. Their approach like gender sensitive or gender neutral are very much important to enhance women's position in society. Government of Assam has introduced many policies which address women's

health, but in the real terms a gap has been seen between the implementation level and practicality of them. The gender sensitive paradigm which has been used in health policies in Assam needs more holistic attention, so that it could touch the socially, economically backward women of Assam. Instead of giving single attention towards reproductive health system, Government should have to extend it's attention on women's other health issues also. Meanwhile in the same time improving other social determinants of health is equally important issues to attain equity in health care system. And within social determinants of health , gender is important phenomena. Therefore concering on overall women health is very significant for attaing inclusive health care system.

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