

# ***The Interrelationship Between Gender and Malaria Among the Rural Poor in Jharkhand***

## **Sama- Resource Group for Women**

### **EXECUTIVE SUMMARY**

This is a qualitative study conducted by Sama in collaboration with Mahila Jagriti Sanstha, a community-based organisation in Gomia, Jharkhand. The aim of the study was understand the interrelationship between gender and malaria among the rural poor of Jharkhand. The study area was Gomia, one of eight blocks of Bokaro district in Jharkhand.

The specific objectives of the study were: a) To examine how gender, poverty, and reproductive biology influence vulnerability to and the experience of malaria; b) To examine how these factors influence health-seeking behaviour, the social, economic and physical consequences of malaria; c) To examine the responses of health care providers to malaria.

The study was based on in-depth narratives of 39 respondents and 11 key informants. The 39 respondents comprised 14 men, 14 women, and 11 pregnant women. This number was arrived at through random sampling from a list collated through house-listing. The criteria for selecting the sample were: (a) The respondents had malaria in the last two years (backwards from August 2003), and (b) They belonged to a population living below the poverty line. The second criterion was dropped for pregnant women due to limitations in number.

Other data collection methods include mapping of villages and health services, and observation. Apart from the tools used to collect primary data, secondary data was collected from official records, and newspaper cuttings were maintained to gather an overall epidemiological profile of the area.

The vulnerability and experience of malaria was examined at two levels — the community and the individual— that placed respondents at risk to frequent episodes of malaria. The geophysical characteristics of Gomia, seasonal employment, hazardous occupations, and dependence on natural resources for livelihood, contributed to making malaria endemic. These factors also resulted in economic and food insecurity. Poverty emerged as an overarching factor across all categories of respondents. This was reflected in their dietary intake, mainly of starch (maar) rice, lack of warm clothing, and poor living conditions. These constituted the larger risk factors experienced by the communities.

Individual vulnerabilities included age, family size, and household income. Gender and the reproductive biology of women placed them in a far more vulnerable position. This study reveals that even in comparable economic situations (poor households) men were better positioned as compared to women in terms of vulnerability to and impact of malaria because they got more rest and care.

The impact of malaria on women was made more severe because of their social, economic, and psychological burdens. Women, especially in the age group of 35-40 years, faced harassment from their husbands and in-laws for expenses incurred on their illness and their inability to continue with the household work. Daughters and girls were forced to become the main caregivers. The economic burden caused due to prior health conditions and the marriage expenses of daughters added a great deal of psychological and emotional stress. Pregnant women reported loss of appetite during malaria, which resulted in low birth weight babies. They reported miscarriages and stillbirths due to malaria medication. Early marriage and frequent pregnancies further increased their vulnerability.

The distant locations of public health services and inadequate delivery of health care compelled respondents to rely on the ad-hoc treatment given by the “compounders” who visited the village, and on traditional healers. Men sought some form of immediate treatment (such as medicines from chemists). Better access to cash, credit, and the power to make decisions about pawning household assets gave them an edge with regard to treatment-seeking. Vulnerability was pronounced among men in the age group of 48-60 years because of their role as bread-earners or because they were dependent on their children for support. It was worse for women in a similar age group because of a decline in their “productive capacity” to earn and make ends meet.

Women depended on the “compounders” for treatment because they provided flexible payment arrangements. They took recourse in traditional healers for treatment and advice. This was true among pregnant women too, who had experienced miscarriages or stillbirths. Five pregnant women sought treatment from recognised medical doctors for fear of losing the child. Expenses on treatment and the level of care received were directly linked to support from the natal family. The burden on the maternal family was pronounced not only among pregnant women; men too were dependent on their wives’ natal family for support.

A lack of power to make decisions within the household, economic and household work burden, and prior health conditions placed women in a position more vulnerable to frequent episodes of malaria. Gender and reproductive biology played a significant factor in influencing the experience of malaria among women. These factors cut across overarching factors of poverty, and living and working conditions, placing women at greater risk.