



Seclusion, decision-making power, and gender disparities in adult health: Examining hypertension in India



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ARTICLE INFO

Article history:

Received 24 January 2014

Revised 25 April 2015

Accepted 26 May 2015

Available online 17 June 2015

Keywords:

Gender

Empowerment

Autonomy

Veil

Health inequalities

Chronic disease

Hypertension

Blood pressure

Sociocultural factors

Developing country

Asia

India

Low- and middle-income countries (LMIC)

ABSTRACT

Research on the social determinants of health in developing countries is increasingly focusing on the importance of gender. Cardiovascular conditions such as hypertension are a growing concern in developing countries, where they are now the leading cause of death. Researchers have documented differences in hypertension between men and women, but the importance of gendered practices in shaping these differences has been left unexamined. Using national data from the India Human Development Survey 2005 ($N = 101,593$), this study assesses the moderating role of two salient and widespread gendered practices—women's seclusion and decision-making power—on hypertension disparities between women and men. Both seclusion and low decision-making power are associated with increased odds of hypertension for women, but in the case of seclusion reduced hypertension for men. Results also show the gender gap in hypertension is exacerbated with women's seclusion and low decision-making power.

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1. Introduction

Chronic diseases such as cardiovascular disease are the leading cause of death not only in wealthy countries but also in lower-income countries.¹ In fact, eight in ten cardiovascular disease deaths occur in lower-income countries. However, to date, research in lower-income countries has focused more attention on reproductive and child health, with relatively little research devoted to chronic conditions such as cardiovascular diseases (Bloom et al., 2001). Hypertension² not only increases the risk of cardiovascular diseases (e.g., stroke, heart disease, heart failure, atherosclerosis), but also kidney disease, dementia, and cognitive decline. Hypertension is the main preventable risk factor for premature death throughout the world (Beavers et al., 2014). With roughly one in four adults in the world experiencing hypertension, it has become a major global health concern. The majority of the world's population lives in lower-income countries, and as life expectancies within these countries increased, chronic conditions such as hypertension have become central. Indeed, the prevalence of hypertension is now higher in lower-income countries than in wealthy countries and the prevalence of hypertension in lower-income countries is increasing more rapidly than in wealthy countries (Kearney et al., 2005; World Health Organization, 2013).

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¹ For simplicity, low- and middle-income countries are referred to as lower-income countries.

² Hypertension is also referred to as high blood pressure.

Though biological factors play an important role in the occurrence of hypertension, so also do social determinants such as socioeconomic status, lifestyle behaviors, ethnicity, social support, and socioecologic stress (James and Kleinbaum, 1976; Krieger and Sidney, 1996; Morenoff et al., 2007; Pickering, 1999). Gender is also a key social determinant of health to which global forums have increasingly drawn attention.³ Gender encompasses a variety of practices, beliefs, roles, opportunities, and constraints which may differently shape men's and women's health. Recently, gender scholars have highlighted the importance of gendered practices as key carriers of gender (e.g., Elson, 1999) and as inputs to demographic outcomes (Jejeebhoy, 2000). Female health disadvantages in many lower-income countries have been repeatedly shown (Caldwell, 1986; Santow, 1995), although less attention has been paid to chronic conditions such as hypertension and little research has examined whether gendered practices play a role.

India is an important case for studying gender and health among lower-income countries. India has the second largest population in the world, one of the largest gender gaps in health (Hausmann et al., 2010) and one of the smallest female–male longevity advantages (Arber and Thomas, 2006). Few population-based studies in India have examined chronic health conditions among adult men and women. Significant work has examined how patrilineal family systems and norms shape young female mortality in countries such as India (Dyson and Moore, 1983) and China (Lavelly et al., 2001). Although often not explicitly elaborated, these studies implicate gendered practices in the relationship between gender and health. Demographic research on gender in India has drawn attention to the importance of gendered practices (Desai and Andrist, 2010; Mason, 1986). Considerable research has examined the social determinants of hypertension and considerable scholarship exists on gender in lower-income countries such as India. However, the extent to which gendered practices relate to men and women's chronic conditions such as hypertension remain relatively unknown in India (Stroope, 2015) and elsewhere (Vögele et al., 1997). This is an important gap in knowledge considering the importance of hypertension as a key risk factor for death and disease, the greater prevalence of hypertension in lower-income countries (Kearney et al., 2005), the established significance of gendered practices in previous demographic studies (Jejeebhoy, 2000; Mason and Smith, 2000), women's low health status in many lower-income countries, and the rigorous nature of gendered practices in India (Dyson and Moore, 1983; Kapadia, 1998).

Motivated by this background, this study tests whether two gendered practices—women's seclusion and decision-making power—have differential effects on hypertension for women and men. Seclusion and decision-making restrictions are prevalent not only in India, but also across the Indian subcontinent, Asia, Africa, and in other parts of the world (González, 2013; Mandelbaum, 1988; Mason and Smith, 2003). In India, approximately 53% of Indian households practice seclusion and 35% of households restrict adult female household members' decision-making power.⁴ With the broad reach of these practices in people's lives, assessing their differential relationship with an important chronic health condition in the world's second largest country is an important and useful contribution to social science and health research. Examining the role of these gendered practices in hypertension carries important implications for gender disparities in a variety of health conditions, especially in lower-income countries. Additionally, studying the effects of these gendered practices has implications for growing research on symbolic aspects of social status and health. This study uses national data from the India Human Development Survey-2005 on 101,593 women and men and builds on prior gender and health research that typically (a) overlooks the role of gendered practices in gender disparities in chronic conditions, (b) focuses on wealthy countries rather than lower-income countries, (c) does not include both men and women, (d) mainly studies child and reproductive health, and (e) does not use large nationally representative samples.

2. Background

2.1. Hypertension and gender in India

Chronic diseases are the leading cause of death globally (Alwan et al., 2010) and cardiovascular disease deaths make up the largest part of these deaths for people under the age of 70. In contrast to popular perceptions, cardiovascular diseases are less prevalent in wealthy countries than in lower-income countries where their impact on vulnerable populations is more devastating and occurs at earlier ages. In fact, eighty percent of cardiovascular disease deaths take place in lower-income countries. Additionally, the rate of increase in such deaths has been rising more rapidly in lower-income countries compared to high-income countries (Alwan, 2011). Going from high-income to increasingly lower-income countries, there is a marked stepwise increase in rates of cardiovascular disease deaths. While men have higher rates than women across all these country income categories, the increase in rates grow more sharply for women going from high to low income countries such that women more closely resemble the poor health profile of men in the lowest-income countries (Mendis et al., 2011).

One in four adults is hypertensive. Hypertension is the main preventable risk factor for premature death internationally and increases the risk of cardiovascular diseases, kidney disease, dementia, cognitive decline, and disability. Rates of hypertension are notably lower in wealthy countries compared to lower-income countries where hypertension is a mounting public health concern (World Health Organization, 2013). Due to prohibitive costs, hypertension frequently goes untreated in lower-income countries, resulting in devastating healthcare costs for long-term treatment of complications (Saksena

³ Recent examples include the United Nations (2005) and the World Health Organization (2008, 2007).

⁴ Author's calculations based on India Human Development Survey data.

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