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Research Paper

Rethinking Healthcare: Assessing Attitudes and Perception Across Sectors on Women's Health in the United States

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Abstract
Women's healthcare has been globally ignored on a number of metrics: the inadequacy of research, improper awareness, a lack of political will, and others. Often the grounds given for these are flimsy and rooted in traditionalist biases. As a result, the well-being of women is often in jeopardy. The paper similarly examines a health issue that plagues women worldwide: female genital cutting. By examining the condition of women in various countries and the challenges in their healthcare, it tries to isolate the various factors that might contribute to poor well-being. In order to do so, it concentrates on the issue of female genital mutilation and how that has been sustained through political, cultural, and material determinants. The paper also notes the relative position of women in developed countries so as to establish an alternative condition that policymakers can move towards. Further, in order to assess public perception, the paper includes a survey conducted amongst various participants coming from varied walks of life. It notes stark similarities in their perception of female genital cutting and the inadequate response around it. Lastly, the paper concludes by suggesting possible policy solutions to the problem of female genital cutting.

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I. Introduction

Women's health refers to the branch of medicine focused on the treatment and diagnosis of diseases and conditions that affect the physical and emotional well-being of women. Health is an important factor that contributes to human well-being and economic growth.

Indian women are currently facing a number of health challenges that will ultimately impact their overall economic performance. Addressing gender, class or ethnic inequalities that exist in health and improving health results in economic returns by creating quality human capital and generating higher levels of savings and investment.

Women in India face many challenges such as malnutrition, poor maternal health, diseases such as AIDS, breast cancer and domestic violence. India has one of the highest rates of malnourished women among developing countries. Maternal malnutrition is associated with an increased risk of maternal mortality and birth defects in children. Addressing malnutrition will have a positive impact on women and children. Poor maternal health contributes to economic inequality for mothers and their children. Poor maternal health not only adversely affects the health of children, but also reduces women's ability to participate in economic activity. India accounted for nearly 20% of the world's maternal deaths from 1992 to 2006. The main reasons for high maternal mortality are directly related to different economic conditions and cultural constraints that limit access to health care (National Health Portal, 2015).

Thus, safeguarding women's health is of extreme importance owing, not in the least, to its interconnected role with the economy. Similarly, the study of women's health is also important as it is only when we study the factors that contribute to the health of a specific section of the demographic that we can hope to improve it. In that regard, what is important to examine are the cultural attitudes that work towards determining women's health. These are some of the tasks the paper seeks to fulfil.

The paper seeks to review how attitudes and cultural determinants seek to impact women's health with an aim to highlight the importance of intersectional approaches. Furthermore, it considers the material factor of cultural attitudes as manifest in the violence perpetrated against women. Within that paradigm, it considers the case of female genital cuttings (FGC) as an atypical case of the same. Lastly, it concludes by suggesting how

one can change the cultural attitudes surrounding women's health in a way that includes effecting changes in the policy arena.

II. Background

Several studies have found that one of the reasons for the poor health of women in India is the discriminatory treatment of girls and women compared to boys and men. This forms the bedrock of discriminatory cultural attitudes that pertain towards the health and well-being of women. The most striking evidence of this is the large number of "missing women" (i.e., girls and women who have apparently died as a result of past and present discrimination). Recent estimates put that number at about 35 million (Velkoff & Adlakha, 1998).

The report goes on to unequivocally state that:

Differential treatment of girls and boys in terms of feeding practices and access to health care is among the factors responsible for higher female mortality. As a consequence of their lower status overall, women experience discrimination in the allocation of household resources including food and access to health services. Boys are breast-fed longer than girls; 25.3 months versus 23.6 months on average (IIPS, 1995). Boys who are ill are more likely to be taken for medical treatment than are girls (p. 7).

And then a little later:

One of the most extreme manifestations of son preference is sex-selective abortion. The use of medical technology to determine the sex of a foetus is on the rise in India, and over 90 percent of foetuses that are aborted are female (The World Bank, 1996).

The abundance of similar empirical abundance serves only to show that negative cultural attitudes towards women's health have a prejudicial, corrosive, and possibly fatal impact on the lives of women. It is this cultural bias that makes the crime of female foeticide palatable in societies. Such attitudes also seep into the working of formal health machinery and impact the delivery of health mechanisms and solutions to women. Furthermore, it is important to note how disparities prevail even within the broader class that is women, according to race, sex, caste, class, etc. Talking about the strengths of intersectional approaches in examining healthcare delivery systems, Caiola et al. (2015) arguesthat the "strengths of intersectionality as an approach for investigating health disparities are clear; namely, it provides insights into the nature of social inequality, social determinants of health, and power structure."

Recognition of power relations in intersectionality has three important consequences. First, the intentional privileged view of traditionally inferior groups means that the dominant group is no longer considered the benchmark for all group comparisons. Second, a comprehensive examination of power structures leaves room to explore privilege and the ways in which the process of becoming white is central to the emergence of health inequalities. Finally, by emphasising simultaneity, "intersectionality goes beyond uniaxial analyses that focus on dichotomies such as male/female, African-American/white, rich/poor, to the extent that heterogeneity is implied. It provides a means of multiaxial analysis that is shown in the context of social groups, rather than all social groups being considered homogeneous.

Such an intersectional analysis can be useful for examining the health issues related to women and transmen. As an example, the widespread practice of female genital mutilation (FGM)/ female genital cuttings (FGC) comes into sharp focus. In tracing the origins of FGC, Chatterjee (2018) defers to the opinions of ancient historians and archaeologists. According to Frank P. Hosken, it is believed to have originated in Egypt, where circumcised and fertilised mummies were found. Gradually, it spread among the tribes through Arab traders in the adjoining areas of the Red Sea coast.The practice is thought to have spread first in the form of penile closure, but Hanny Lightfoot-Klein claims that clitorectomy is becoming a more acceptable form of FGC.

III. Results

A survey of professionals was conducted on the topic of FGC. The total participants were five but owing to their cross-societal and temporal range, their responses on female genital cutting remain well-informed and generalisable. A total of four questions were asked pertaining to when they first encountered FGC, its perceived prevalence, its frequency as a function of culture or location or ethnicity, and research on the same. The settings in which people learnt about FGC were mostly formal such as conferences or volunteering sessions. This points to the need of pushing awareness about FGC in the mainstream discourse. When asked about the frequency of FGC, most tended to cite statistics from reputed organisations and remained sceptical about FGC's local frequency. All of them, without exception, saw FGC as entailing severe mental and physical harm on the victims of FGC and thought it best to have the practice eradicated. Towards that end, there was a striking consensus on the deficiency of research on FGC.

In a nutshell, people from varied cultures, ages, and professions agreed on the two most important things: a.) that FGC involves irreparable mental and physical harm on the victim and b.) the insufficiency of research and activist work in addressing the same. Ideally, the former should help propel the latter but this has not been the case. There is thus an overwhelming need to identify the gaps and obstacles that prevent research and awareness work on FGC from being carried out.

IV. Discussion

Gender, ethnicity, and culture have important implications for how disease is portrayed and individual beliefs about disease and health habits. In every society, women have different expectations and traditions that affect their access to health care and their well-being. Gender, ethnicity, and culture have important implications for how disease is portrayed and individual beliefs about disease and health habits. In every society, women have different expectations and traditions that affect their access to health care and their well-being (Benson et al. 2010). A report on American women's health by Ganjan et al. (2018) highlights the many problems faced by women due to material and cultural factors. A woman in the United States reported having the least positive experience of her 11 countries surveyed. They carry the greatest burden of chronic disease, are most likely to forgo medical care due to cost, have difficulty obtaining medical care, and are least satisfied with their care. More than a third of women in the United States say they do not seek medical care because of cost, a much higher percentage than in any other country surveyed. American women are also less likely to rate the quality of their care as "excellent" or "excellent" compared to women in all other countries surveyed. Women in the United States have one of the highest rates of maternal mortality from complications of pregnancy or childbirth and one of the highest rates of caesarean sections. In fact, this facet represents the most skewered cultural attitudes towards women in the United States. The report goes on to state that:

Caesarean sections are generally not recommended for younger mothers with uncomplicated births and are often more costly than vaginal births because of the costs of the operating room and medical personnel, longer recovery, and hospital stays ... The reasons behind the wide variation observed in caesarean section rates across developed countries warrants further investigation; however, some researchers suggest it is a combination of a country's specific health system, physician and patient preferences, cultural factors, population characteristics, and payment incentives.

These differences accumulate over time and tend to skew health mechanisms to disfavour the health of marginalised entities. In order to make outcomes more equitable and services more impactful and accessible, it is important that the influence of cultural perspectives on healthcare systems be incorporated and offset by policies. These can also provide a more valuable outlet for deliberating on how best to deliver solutions in cases where a question of intersectionality is involved. The government can, as it has in other economic structures, set up an incentive structure to motivate hospitals and healthcare providers in going the extra mile when it comes to women's health.

V. Conclusion

Female genital mutilation includes any procedure involving the partial or complete removal of the external female genitalia or other damage to the female genitalia for non-medical reasons. Practice is mostly done by traditional practitioners. In some settings, there is evidence that health care providers are more involved in performing FGC. This is because they believe that FGC procedure is safer if it is medically supervised. According to available data from 30 countries where FGC is practised in the Western, Eastern, and North-Eastern regions of Africa, and some countries in the Middle East and Asia, more than 200 million girls and women alive today have been subjected to the practice with more than 3 million girls estimated to be at risk of FGC annually (World Health Organisation, 2022).

In order to end FGC, there has to be a three-pronged approach: a.) infusing FGC awareness in mainstream discourse, b.) increasing the accountability of healthcare practitioners who enable FGC, and c.) increasing the funding of researchers so as to enable important research of the cultural factors that give rise to FGC. A combination of these three factors makes FGC possible in various locations and at various levels. Furthermore, pursuing these three approaches is no mutually exclusive, i.e., each objective can be pursued without harming the other. It can even be said that they are complementary. It is only when we tackle FGC as an issue seriously and promote informed solutions that we can get rid of such a global problem.

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