Behind the Smokescreen of the Lush Green Tea Gardens of Assam: A Sociological Study of the Gendered Experiences of Health-Seeking Behaviour

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Abstract
This paper attempts to explore the gendered experiences of health-seeking behaviour within a tea garden community in the district of Cachar,in Assam by analysing the underpinning socioeconomic and cultural factors which impactthe health-seeking behaviour as well as the resulting health status. The study utilised a constructivist paradigm to analyse the influence of these factors and experiences of maladies which leads to the construction of meanings of health and illness through the participants' subjective experiences with the help of a multiple qualitative research approach. The findings highlight a significant influence of socioeconomic and cultural factors on health practices and beliefs within the community.
Keywords:Health-seeking behaviour, Gendered experiences, Health beliefs and practices, Socioeconomic factors, Cultural norms.

Introduction

Health cannot be only studied in terms of anatomy and is inclusive of the social phenomenon and factors that may impact the health of an individual and an entire community or population. The standard biomedical approach to health understands that health is measured through mortality, morbidity and the presence or absence of illness or diseases and that illness or disease is a possible invasion of a pathogen that disrupts the body's normal functioning. However, limiting the understanding of health to only its biological construct becomes problematic as it disregards the sociocultural and economic processes that contribute to producing health or causing a disease (Syme, 1996). Thus the conception of what is health may be understood in a multifaceted way. For some, health may be a general sense of well-being, while for some health may be confined within moral or sacred connotations, and for some meaning of health and being healthy may simply mean to have the ability to participate and indulge in daily essential activities within the family, community and the larger occupational workspace (Winkelman, 2009). The understanding and analysis of health and health-seeking behaviour that incorporates the importance of access to material and non-material resources and social, cultural and political factors that influence the health disparity and healthcare distribution is primary to Critical Medical Anthropology. To understand how health and health-seeking behaviour is constructed on the basis of the availability and affordability of the types of resources at the disposal of an individual (Schneider, 2020), it becomes important to analyse the social and cultural factors that facilitate or restricts the availability and accessibility of resources.Helmen (2007) considers the unequal distribution of resources and social inequality as one of the major factors that facilitate poor health along with other factors like individual factors, educational and environmental factors which further impact health and health-seeking behaviour and beliefs. Thus,

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individual behaviour is structured in accordance with their larger cultural and socioeconomic positioning within their respective community or population.

Culture also acts as a metatheory to conceptualize and study human behaviour which serves as one of the principle determinants that impact health, as it shapes the way of life starting from the most basic life requirement such as food, to patterns of procreation, family ties and lifestyle behaviours which may act as protective factors or risk factors to health (Winkelman, 2009). However, it also becomes imperative to understand how the impacts that cultural factorshave on health and health-seeking behaviour may overlapwith the impacts that solely socioeconomic factors may have. Among the tea garden communities, though certain behaviours and practices like indulging in the consumption of local alcohol and tobacco or practising less usage of resources like water and proper sanitation processes are considered to be a cultural aspect, it requires us to question and analyse the causal factor of such behaviour which may be a result of their lower social and economic status within the larger society.

Every society, especially smaller communities, constitutes a unique understanding of pain, illness, its symptoms, causation and remedy shaped by their sociocultural values and beliefs. These norms, beliefs and values then shape the gendered health disparities and how certain illnesses are perceived and experienced.The cultural values, and beliefs paired up with the economic, social and political conditions contribute to the construction of meanings as well as the causation of the diseases and its remedial measures (Winkelman, 2009). The economic and sociocultural factors of a society thus provide an intricate conceptualisation of human behaviour andhealth-seekingbehaviour. Therefore, the etiology of any disease or sickness can depend largely on the socio-cultural setting in which an individual resides.

'*Healthcare-seeking behaviour*' specifically comprises various medical facilities, including biomedicine and traditional healing systems,which an individual or a community approaches. In contrast '*health-seeking behaviour*' includes factors that enable or prevent an individual or community to indulge in making health choices and decisions (Das, 2017). Health-seeking behaviour thus looks at the complex process of sequential remedial action and the factors influencing the decision of opting for or rejecting certain healthcare practices to rectify or cure perceived ill health (Ahmed, 2001. cf. MacKian, 2003). This facilitates the need to understand and analyse the complexities that follow decision-making and the consequent action which needs to be understood in the light of their social positioning within the larger context of society (McKian, 2003). To understand the underlying factors and processes that fuel the cause of any disease or illness, understanding the subjective experiences of the sufferer becomes a crucial junction for mediation. To include and have a sensitized understanding of the patient's perspective, several evaluative models have been introduced which contribute to analysing the sufferer's experience and beliefs for the causation of a malady and the treatment that may be followed. The Health Belief Model (Becker, 1974; Sheeran and Abraham 1996) is one such model that had been introduced to understand how an individual reaches the decision of seeking health care depending on the perceived idea of disease and susceptibility to it, the severity of the disease, and the possible barriers to access the healthcare (Winkelman, 2009). However, this model has been criticised for considering individuals as rational decision-makers without the influence of emotions or social relationships. Thus, to understand how an individual is seeking health care requires a holistic and sensitised analysis and understanding of their economic, cultural and social settings along with their social relationships that significantly influence the accessibility and affordability of resources and the decision to avail or deny certain services which then impacts their health and health-seeking behaviour. Patients' interpretation of their malady or illnesses and their causation is required to be included in not only treating the symptoms but also avail holistic healing of the body and mind from the impacts of the malady. Thus, Arthur Kleinman's (1980) Explanatory Model considers the patients' interpretation and experience of a malady within their economic, sociocultural as well as religious dynamics which influences how and what kind of health behaviour is being followed. These interpretations may serve as a 'recipe for action' (Pool and Geissler, 2005) that may also include the cultural interpretation of a malady which can be useful to bothpractitionerand patient to curate the desired remedial measure.These models provide a conceptual framework for understanding how

the sociocultural and economic background of individuals intertwines with how they respond to certain illnesses, influencingtheir health and care-seeking behaviour. It may also help formulate conscious consideration of the patient's background and a more sensitised biomedical approach by the practitioners in treating certain symptoms rooted in their sociocultural, psychological and economic conditions rather than simply medicalizing the problem. Thus, to bring forth a holistic understanding of health-seeking behaviour and formulate better public health approaches, it becomes imperative to consider the larger social and cultural setting of an individual within their community within which the decision and action take place.

Since health thus becomes a socio-cultural phenomenon, health and illness experiences are also shaped by the social construction of gender within a particular society. Health, as a gendered experience, encompasses how societal norms, expectations and gender roles influence one's physical, mental and social well-being. Gender influences an individual's experience and access to healthcare. Women from a marginalised section of society would experience more significant health inequalities than women from a privileged class. Quadeer (2002), argues that at each level of the societal hierarchy, patriarchy has inculcated and harboured gender inequalities around every aspect of life choices and decisions, rendering women inferior, and tilting the power scale towards men. These power hierarchies extensively impact the health practices and health-seeking behaviour among women from lower socio-economic strata, caste or classes. Therefore, it can be said that women are constantly subjected to social inequality and,suffer from a significant deprivation of resources as well as choices, and experiencea lack of control over their own life decisions which further impacts their physiological as well as psychological health, creating a '*social gradient of health*' (Helmen 2007).Thus, an illness or a disease is experienced differently by a woman than a man due to her social positioning within society. Health inequalities can be seen as a manifestation of disparities in the access to and utilization of these different economic, social, and cultural resources. The unequal distribution of economic, social and cultural resources shapes the health and health-seeking behaviour of the tea garden community and impacts the decision-making regarding the access and utilisation of healthcare services. This study humbly attempts to analyse how women of a tea garden community of Assamexperience and utilise health services and healing processes, their health beliefs and approach to seeking health care which may be based on their larger sociocultural and economic position within their families and the community at large.

The research was conducted in one of the tea estates of Cachar established in 1860. Tea plantations in Cachar started in and around 1855-1856 and the foundation of the tea industry was laid between 1839 to 1860 (Biswas, 2005-2006). The labourers were brought in from mostly Chotanagpur and Jharkhand in an indentured bond followed by the labor class's historical exploitation, first by the British Raj which now continues in the hands of the tea garden management. The demographic composition of the tea estate reflects a rich ethnic culture and consists of various community groups, the dominant being the Oraon tribe. The majority of the community population belongs to the marginalised Adivasi tribal community who had been brought in by the British as indentured labourers and their successorscontinue to work here through generations now.

The main objectives of this study were:

1. To study the tea garden community's socio-economic, demographic and cultural factors in relation to health outcomes.
2. To study the tea garden community's health beliefs and health-seeking behaviour.
3. To explore the gendered experience of healthcare in relation to the socio-economic and cultural dynamic of the tea garden community.

Assam, the largest tea-producing state, contributes to over fifty percent of the total production of tea in India. The Assam tea industry is a highly labour-induced industry, depending upon about two million labourers. The garden labourers' community remain one of the most backward, marginalised and exploited section of Indian society. The tea garden labourers endure poor socio-economic conditions, low wages, limited job security, poor housing conditions and inadequate access to basic life resources. They

often live in overcrowded and dilapidated housing provisions within the estate premises, which lack proper sanitation facilities as well as clean drinking water. Being subjected to long working hours, tasks demanding consistent physical endurance and a hazardous working environment results in their depleting health, perpetuated through a cycle of poverty and vulnerability. The women labourers form a significant portion of the labour force in the garden. Despite constituting nearly fifty per cent of the workforce, they are disproportionately impacted by various health challenges. According to NFHS-4 (2015-2016), Assam reports, only 10% of rural households have knowledge and access to government health schemes or insurance. Nearly 66% of women have certain levels of anaemia most of whom belong to the marginalised section of the society with lower socioeconomic status (NFHS-5). The women of the tea garden community sit in as a perfect depiction of the labour burden wherein the domestic, as well as the emotional labour that these women perform, goes completely unacknowledged and unrewarded, leading to both physical and mental exhaustion. Swaminathan (2009), talks about the double or at times triple overlap of labour burden that adversely impacts the health status and health-seeking behaviour of working-class women. Several previous studies have been conducted that establish the intertwining relationship between socioeconomic, cultural and environmental factors that propagate health inequalities largely impacting marginalised communities such as the tea garden communities (Baru et al. 2010; Acharya, 2002, Nambiar, 2020). The tea garden communities of the Southern part of Assam, here, the Barak Valley in the Cachar district, represent a unique socio-cultural scape that shapes the individual lives and experiences of the labourers. Within such sociocultural settings, gender dynamics play a significant role in shaping such individual experiences. It becomes imperative to understand and analyse the gendered dimensions of health-seeking behaviour and healthcare practices within this community to address the health disparities and promote equitable healthcare services that are both accessible and affordable.

Methodology

The research study used a constructivist paradigm to analyse the influence of sociocultural factors, individual experiences and how meaning is constructed through these subjective experiences. This study relied on interpretative analysis to understand how the participants' social dynamics and health status and practices intertwine through the narratives of the participant labourers of the tea garden. A combination of qualitative research methods has been employed to gain an in-depth insight and analyse how healthcare and health-seeking behaviour becomes a gendered experience within the concerned tea garden community in Cachar, Assam. Through an ethnographic lens, the study attempted to explore the nuances of the participants' experiences in their sociocultural context by observing their living and working conditions, how they interact with the health facilities available to them and the practices and beliefs they indulge in when it comes to health and health-seeking behaviour. Cameron (1990) argues that ethnography is learning from the people.s Therefore, the study attempted to learn the patterns of health-seeking behaviour and health beliefs and practices of the tea garden community, from the community itself, especially from the women labourers. The methodology of the study has been sensitive to'cultural competence' (Helmen, 2007; Winkelman, 2009) from the end of the researcher in order to provide a more sensitised and bias-free analysis of the community's cultural practices and beliefs, as well as the structural and organisational barriers like the quality of health services, its affordability and availability.While indulging in this process, it has been observed how the social positioning of the female labourers as 'women' automatically puts them in a secondary position as compared to their counterparts and how such social conditionings result in health becoming a gendered experience. In addition to taking an ethnographic approach to study the health behaviour of the community, the study included in-depth interviews with open-ended questions with the participants followed by a few focus group discussions that facilitated first-hand understanding of the experiences of the participants and analysed the intermingling of the socio-cultural and economic framing and the construction of their health beliefs and how healthcare services are sought and in what form (professional allopathy, herbal, traditional or ritualistic healing processes).

During the initial field visits, the study attempted to carry out a survey by conducting unstructured interviews in various households in the labour lines. Since tea estates are heavily under surveillance, it was mandatory to go through an official procedure to gain access to the labour lines. The officials who accompanied them during the fieldwork actively interrupted the participants. Thishindered understanding the reality of their experiences in the tea garden. However, with time, through four to five visits, the researcher was able to build a rapport with one of the subordinates who happened to be an influential candidate in the labour community which eventually paved the way to gain access to the labour lines and the garden sections unofficially. Thus, the study opted for an ethnographic approach to observe the field area, the labour lines and gardens, the laborers' living and working environment, and the hospital facilities and care services available in and around the tea estate.

The Field

The demographic composition of the tea estate reflects a rich ethnic culture and consists of various community groups, the dominant being the Oraon tribe.The tea estate is located in Cachar district in Assam. The majority of the community population belongs to the marginalised Adivasi tribal community who had been brought in by the British as indentured labourers and have continued working here for generations now. Though these tea garden labourers belong to ethnic tribal origins, they are considered within the reserved category of Other Backward Classes and do not enjoy the government benefits that are being provided to the reserved Scheduled Tribe.

A total of 17 interviews were conducted during the fieldwork, including ten female labourers, three male labourers, the pharmacist, the Welfare officer and two Anganwadi workers. The selection of the participants was made keeping in mind the critical interplay of the social constructs, gender and healthcare within the tea garden community.Prior to each interview and conversation, due consent of the participants has been sought. The orginalnames of the participants have not been used to maintain the respondents' anonymity and confidentiality.

The route into the labour lines is extremely narrow and uneven with houses huddled up closely along the two sides of the lane. A few children played around the places, and there were some labourers who were on their way to the garden sections. The houses are mostly half-built, semi-pucca houses. Some houses are entirely made of bamboo and tarpaulin. The roads are covered with loose sand which makes it difficult to walk. A respondent mentioned that these roads get washed away during the monsoons, making it worse.

The tea estate has one tea garden hospital, five schools, and three Anganwadicenters. The hospital is a small building, which is usually crowded with patients, especially women and children. The pharmacist of the garden hospital was more popular and preferred among the patients as they said that, most of the time, the pharmacist attends to them. The hospital staff of the PHC was observed to be extremely understaffed. The pharmacist informed that the garden hospital only provided primary healthcare services and conducted normal deliveries, while all other cases are referred to Silchar Medical College which is located nearly at a distance of 30 km from the estate.

Findings and Analysis

The data analysis foussed on the narratives and experiences shared by the participants and identifying patterns or themes underlying the health-seeking behaviour of the tea garden community. The information gathered shows commonality in the response of the participants regarding healthcare provisions and disparities and how their sociocultural and economic construct impact their health-seeking behaviour.

The tea plantation labourers in the Tea estate in Cachar comprise of multi-ethnic and cultural communities belonging to different tribal communities, mostly, Oraon, Pasi, Kalihandi and Munda. Though the labourers ethnically belong to different tribal groups and communities, they generally identify themselves as '*Bagaaniya'*, or *'Adivasis'* (people of the tea garden). Over the years, the cultural differences among these tribal communities have merged and dissolved into a singular identity that is of the tea garden community, as one of the respondents mentioned while talking about her origin and ethnicity, *"AmratohChaaBagaaner*

Manus." (We are the people of the tea garden.) It appears that the tea garden has become their only source of identity and they unhesitantly accept it as their home. According to the National Commission of Backward Classes (2012), no single community is described as a 'tea tribe', but the various groups of the tea garden communities have been listed under the OBC (Other Backward Classes) category. Thus, the tea garden labourers have been systematically deprived of the political benefits of their indigenous ethnic identity within the category of Scheduled Tribe (ST) in Assam, while their counterparts enjoy the same in the other states. Almost all the women within the garden are completely unaware of the political caste deprivation that they are subjected to. They are even unaware of the specific benefits that they are entitled to. Most of the women did not know about any maternity policies or schemes being offered by the State Government or the Central government and are entirely dependent on the Accreddited Social Health Activist (ASHA) Workers for any kind of information regarding any health beneficiary schemes, maternity benefits, information regarding any illnesses, sexual health problems, and other healthcare assistance when it comes to accessing health care benefits and services.

The ratio of male and female labourers is roughly 55:45, with 756 labourerswithin the estate. Though the Welfare Manager of the estate mentioned that most of the labourers were permanent workers and the estate strictly followed the clauses of the Plantation Act of 1951, the claims of the respondents were observed to be contradictory. Out of the thirteen labourers interviewed, nine laborers worked as casual labourers and were not covered under the benefits provided by the garden management according to the Plantation Act, 1951. According to the Act and the Welfare Officer, each worker is allowed fourteen leaves in a year. Female workers are given maternity leave eightweeks before the delivery and twenty weeks post-delivery. The labourers are paid a daily wage (haziri) of Rs-210 for plucking 24 kilograms of tea leaves each day with an incentive of Rs-6-8 per extra kilo. The Accreddited Social Health Activist (ASHA) and the Anganwadi workers look into the health as well as other female and child hygiene requirements of the labourers and the garden hospital provides all the necessary primary health care services and medications that the labourers may require. He also mentioned that an informed paid sick leave is also provided to the workers where the worker is paid a full haziri for 3 days in lieu of illness and then paid 2/3 of the payment if the leave extends. However, during the interviews, a few labourers mentioned that the garden strictly ran on a 'no work, no pay' policy and that they sometimes did not receive the full amount even after meeting the daily limit of 24kg. Most of the time, the wage is reduced to rupees 160-180/- by the person who disburses the money to them. A structural hierarchy within the garden system systematically renders the labour community subjugated and exploited in the hands of the people in higher positions within that hierarchy.

In the case of the women of the tea garden community, there is an intersectionality of social identities and roles that plays in, as their social positioning as a woman intersects with social identities as a mother, a wife or a daughter or daughter-in-law which further intermingles with their socio-economic status, cultural embeddedness, financial constraints and lack of awareness influencing their health practices and health-seeking behaviour which results in poor health outcomes.

Socio-cultural conditions impacting health-seeking practices and behaviour

Being a woman has become more of a cultural phenomenon than a biological phenomenon. During the fieldwork, it was found that nearly all women have symptoms of anaemia and malnutrition. The hospital pharmacist mentioned that the women of this area mostly suffered from anaemia and malnutrition, mostly due to frequent pregnancies and lack of basic nutrition intake among the women.

> *"I am a mother of four. I need to take care of my family and also complete my daily task to get the haziri. Going for follow-up treatments every time consumes a lot of time I can use to get other work done. Also, it becomes financially difficult sometimes. I have to first attend to the requirements of my children and husband as a mother and wife instead of my ailing health."*

(Moni Ree, a casual worker.)

Women are considered primary caregivers within the family which naturalizes their emotional labour and invisibilizes the deprivation of care on the receiving end. Acute nutritional deficiencies mark the women of the tea garden labourer community due to their social and cultural responsibility and economic constraints. The above quotation from one of the respondents depicts how the cultural positioning of a woman as the primary caregiver poses certain restrictions when it comes to seeking proper healthcare. Her position as the woman of the house, the wife, and the mother renders her constrained and oppressed by the burden of caring for others, which results in the suppression of her capacity and desire to access better health care services, engage in better health practices and health-seeking behaviour (DeVault, 1991).

The study found that most women showed a sense of hesitancy in communicating about sexual health and indulging in sexual health practices and there was a complete ignoring of any symptoms of intimate health problems, other than for reproduction.

> *"I take 'jungleeasudh' (local herbal medicine) when I experience cramps during my month's cycle. I cannot tell in the dispensary as the attendant is a male and the ASHA Didis are not always around."*
>
> (Sujata, a casual worker)
>
> *"I have a baby. I wouldn't be able to conceive if I had problems like menstruation cramps. You have it only when you have impurity in your body."*
>
> (Malti, a 34-year-old casual worker talked about her idea of conceiving.)

The above conversation took place simultaneously with two women workers. It depicts how health-seeking cultural norms are framing behaviour regarding access to sexual health and awareness. It also depicts how certain health problems like menstruation cramps are seen as a diversion from ideal female sexual health and are associated with impurity. Social conditioning of women heavily influences and hampers healthcare utilisation and health-seeking behaviour when it comes to sexual health complexities as well as mental stress which generally has a social stigma attached to it. Thus, the 'perception of an illness is strongly influenced by sociocultural ideologies and practices (Das, 2017). This also leads to the dismissal of symptoms, the use of folk or popular remedies, or the hesitance to seek biomedical care (Winkelman, 2009). Thus, it can be inferred that women may follow different approaches to different illnesses, depending on their social networks, cultural customs, perceptions and ideologies regarding an ailment that may carry a social stigma attached to it (Sujata, 2017).

Health beliefs and healing systems

This tribe is believed to have a treasure of ethnomedicine and has unique magico-religious beliefs towards health and illnesses. However, in the present study, it has been observed that there has been a sharp inclination towards professional allopathy medications, especially among the newer generations. The community displays a varied array of medical pluralism that is being practised among them. Most of the labourers said they preferred allopathy over herbal medication as they feel it provides them faster relief from bodily discomfort or illness. RumilaPasi, one of the respondents who fell down while working and has had severe back pain since then, said that the faster she felt better with the medications, the faster she couldresume her work. Since the community is completely dependent on their work in the estate for their livelihood which entirely follows a 'no work no pay policy', opting for allopathic medication becomes a source of means to an end.

The study also brought to the fore that the community not only has specific ideas of impurity connected to menstruation, but the women who suffered from symptoms like abdominal pain during their cycle are also considered to be a possible cause of infertility and are said to symbolize misery and misfortune (*olokhhi/ kopaljola*). Thus, the community displays a lay explanation of misfortune as a result of individual behaviour, biological causes or other supernatural causes (Helmen, 2007). This idea is also embedded in their cultural understanding of an ideal functioning of a female body, which is shaped by gender and power relationships, the deviation from which may be considered unnatural.

There is a huge influence of this community's religious and cultural conditioning on how they perceive health and approach the health care systems. The culture of a certain community patterns group behaviour

that is passed on and continued through generations and thus provides a crucial conceptualisation of human behaviour which further impacts health behaviours.

The community associates certain illnesses with the act of an evil spirit or the consequence of an evil eye by someone who hopes for an ill fate for them. The locality has two ritualistic or shamanic healers, a *pandit* of the local *Kali Bari (Kali Temple)* which is believed to be extremely woke and have the miraculous power of granting wishes and *Naga Baba,* a mysterious shaman who is in possession of a *Djin* (a spirit) who has the power to heal people even from acute illnesses. RukimiKalihandi extensively shared her experience about the ritualistic healing of her child who was initially disabled. She saidafter going through a lot of formal treatment and exhaustion of financial backup, they prayed in the temple for their daughter who was born disabled in an attempt to heal her.It is believed that the Goddess possesses the Pandit and grants the wishes of her devotees through him. The little girl was given a small religious totem to be tied around her waist called a *kabaj*or *tabeez*. The respondent believes that her daughter can now walk by the grace of the Goddess. Another respondent Amira shared her experience in ritualistic healing and confiding in the shaman Naga Baba, after being unable to manage the medical expenses of her husband, who has been suffering from jaundice and acute back pain for the past one and a half months. Being unable to bear the expense, the couple sought ritualistic healing in the hope of getting relief. Though the community extensively emphasises the miracle of God, evil spirits and evil eyes as the remedy and cause of certain maladies, there is a pattern to when and why ritualistic healings are being sought. It has been inferred that such beliefs are not only constructed on the basis of religious and cultural beliefs but are heavily influenced by the lack of economic capital and the inability to afford professional health. Thus, the choices of medical systems of the people not only depend on their social and cultural conditioning but also on the knowledge, accessibility, affordability and availability of treatments (Minocha, 1980).

The community also possesses ethnomedicine knowledge, including popular healing practices for treating illnesses and ailments based on their cultural understanding of the cause of the disease. Herbal medications are used for various illnesses, especially among children.

Damyanti, one of the respondents, shared her knowledge about the various herbal remedies they generally use, mostly for younger children. Popular medical practices indicate common knowledge passed down by generations (Kleimen, 1980, cf. Quinlan, 2011). Thus, the community indulges in popular healing practices not only in cases of children but also in cases where professional treatment seems inaccessible, unaffordable or unacceptable (Quinlan, 2011).

The cultural practices of a community include how a disease or a malady is perceived and produce various practices and behaviours that may contribute to producing risk factors that may enhance the susceptibility to a disease or malady (Winkelman, 2009). Among the tea garden community, the food and nutrition intake structure is significantly inadequate. Women's dietary intake is primarily characterised and marked by nutritional deficiencies due to their socioeconomicconstraints (Dey et al., 2020, Sahoo, 2011). The persistent problem of malnutrition and anaemia is also aided by the social positioning as the woman of the household which demands her to put the nutritional requirements of her family before hers. Thus, culture intertwines with malnutrition as the ascribed rules of food consumption restrict women from attaining the required nutritional value (Helmen, 2007).In addition to such social conditioning, certain food habits and hygiene practices in this communityadd to the poor health-seeking behaviour and health status. A major chunk of the community also suffers from hypertension symptoms as per the pharmacist's information. There is an inclination towards the consumption of tobacco (*khaini)* and *'surapaan'* among both men and women, while the consumption of local alcohol (*Haria/ Laaupaani*) is more prevalent among men.The labourers believe the consumption of such items helps to keep themselves active during their time in the sections and increases their work capacity. The alcohol is made indoors, and specific households sell the same and generate an extra income for the household. Though such food practices within the cultural framework of the community significantly contribute as risk factors to health and health-seeking behaviour, it becomes crucial for us to ask why such practices have been introduced in the first place. The

social and economic framework within which certain food intakes are practised and encouraged contributes to their poor health-seeking behaviour, increasing risk factors for certain diseases.

Gendered division of labour and Familial dynamics

The study identified an intrinsic role of power dynamics within families that interplay with the socio-cultural norms and gender roles limiting the ability of the women to make decisions and access resources for seeking health care services, resulting in poor health outcomes. The tea gardens are characterised by a patriarchal socio-cultural set-up wherein gender becomes a form of structural marginalisation for women labourers (Dhanaraju, 2019). Family is considered to be the primary social unit that influences the basic health-seeking behaviour, the decision to access or utilise a certain type of healthcare service or healing processes and mediates health-seeking behaviour through the transmission of gender roles and values (Winkelman, 2009). The family as an institution is strictly based on patriarchal structure and norms, forcing women to occupy a marginal status within the family dynamics. Such marginalised status plays a significant role in aiding the poor health care practices and health-seeking behaviour among women labourers. The study also finds a general acceptance of the low social position of women labourers, coupled with the dual pressure of paid and unpaid labour. The community also displayed a cultural division of labour that has assigned women more responsibilities in care and domestic labour than men (DeVault, 1991). The position of the women labourers within their family dynamic as a mother, wife, daughter or daughter-in-law and social requirement of adhering to these ascribed gender roles leaves her under multiple layers of labour burden which goes wholly unacknowledged and unrecognized. The gendered nature of unpaid domestic labour along with the other responsibilities thus leaves the women with little or no time and energy to seek any medical health care in case of any illnesses (Bora, 2022).

> *"Marad log bagaan e kaamkoriyaghorokemnekaamkorboe? Amraghorahilekhananaibanailehumderbachha-kachhakhabeki?" (How would the men work at home after a long day of working in the garden? If we don't come back home and prepare food, what would our children eat?)*

These structures of accepted gender roles and sexual division of labour within the household are thus seen to be innately embedded within the family structure's cultural dynamic, which invisibilizes the women's domestic and emotional labour (Hochschild, 1940).

Within the patriarchal family settings of the gardens, the husbands exercise autonomy over their wife's sexuality and choices. The study found that most of the women are completely unaware or are not in a position to protect themselves from the risks of frequent pregnancies.

> *"There is a lack of family planning within this community. Or it can also be said that in case of frequent pregnancies despite providing the knowledge and procedures that can be used to healthily plan pregnancies, there is no follow-up among the patients. It's mostly the husbands who disapprove of such procedures. So even when we suggest any contraceptive methods or simply ask them to use condoms, the husbands usually pressurize their wives not to use or get it removed."*(Pharmacist of the garden hospital.)

The above quotation depicts how the sexuality and autonomy of choice of the women over their bodies are controlled by their male counterparts. Women have the least control over their bodies and reproductive health. Thus, in the case of the women labourers of this community, it is not only the lack of health services that impact women's health and health behaviours, but also the power relation between men and women becomes an essential barrier to proper health-seeking behaviour, where women are systematically deprived of decision making power. The women are also subjected to frequent domestic and physical violence within their families. Respondents have mentioned that they are under constant stress of meeting their responsibilities towards their family and work. The study thus infers that these social responsibilities, the lack of decision-making powers and violence, not only impact their physiology but also create a mental agony that usually goes unrecognised and thus unhealed.

Outside the realm of the family, there is also a clear gendered division of labour within the working of the tea garden as an industry. The women are generally employed in plucking the tea leaves during the lush season as it is said that their delicate fingers attribute to the quality of gentleness required for plucking the

tea leaves (Dutta &Samanta, 2022; Rasaily, 2014). However, when the study was conducted, it was not the flush season; hence, the work mostly comprised cutting and pruning the gigantic hill slopes.

> *"It is not the flush season right now, so the plucking is not happening now. We now go to the sections and do the cleaning, weeding and pruning works (khuchrakaam/ baajekaam) and the men usually do the work requiring more physical strength like carrying the irrigation pipes and machines. We are paid according to the weight of the stuff that we gather during the cleaning and weeding."*
>
> (Purnima, a casual worker)

'Baaje' or *'Faltukaam'* in the local language means bad, loose or unnecessary work. The very depiction of the labour work performed by women as bad or loose renders it inferior to that of the labour of the men. Though the labour of pruning, weeding and cleaning entire slopes of tea bushes requires extreme physical toil and severely causes breathing problems and chest infections, it is considered as bad, or loose work which indicates a significant implication of gendered division of labour. These terms perpetuate from a structural hierarchy that renders women's labour devalued and unrecognized, not only within the domestic realms but also within the working of the tea estate, despite both genders contributing equally to the overall functioning of the estate. Such gendered division of labour also manifests in unequal pay as women are frequently compensated at lower rates during the off-season due to their labor. This creates an economic constraint on women. Such gendered division of labour both within the homes and within the working of the garden reinforce structural hierarchy and gender-based economic inequalities resulting in a lack of resources and decision-making abilities due to lack of recognition of labour which further constrain them from seeking required health precautions and practices.

Structural Barriers to Accessing Healthcare

Poverty

Being from one of the most extremely backward and deprived socio-economic backgrounds, the tea garden community lacks the ability to afford and access any healthcare services or assistance that may go beyond the primary healthcare that the garden hospital and the ASHA workers provide. Poverty is one of the key determinants of health and acts as a structural determinant of any illness (Fissin, 2003). Poverty becomes one of the key aspects of poor health-seeking behaviour and health outcomes among the tea garden community, especially women.

> *"My husband does not work. And sometimes the wage that I get at the end of the week does not seem to be enough to sustain the family. The ration given hardly meets the end and I have incurred a loan in the process. I have to feed my family at any cost even if it requires me to work twice as hard and reduce my share of grains. If I go to medical college, it will consume an entire day for me. I have to ask for a leave and I don't know if they will pay me for that day. They usually do not pay. We survive on whatever we get from working every day, it will be difficult to manage if I take any leave. Moreover, till the time I can work and fend for my children, I feel I am doing okay, the little physical discomfort does not bother me much."*
>
> *(Malati, a casual worker)*

The above statement by the labourer reveals how poverty intertwines with gender roles and responsibilities to enhance health disparities and poor health-seeking behaviour among women, which usually results in total denial or ignorance of symptoms to meet the social responsibilities within the family. In several cases, female workers work during pregnancy to meet their economic requirements, sometimes resulting in severe consequences. Though according to the Plantation Labour Act of 1951, and the Welfare manager of the estate, maternity leave with full pay length is recognised as the right of the labourer and the management diligently looks into such requirements and adheres to the norms of the Act, eventual discussions with the labourers revealed that in many cases, the wage usually gets reduced to half. One respondent, Shabita, shared that she lost her grandchild a few days back as her daughter-in-law, Neela faced some complications post-delivery.

"The baby was stillborn and seemed bloated. She (Neela) was too engrossed in her work to even care about the baby." (Shabita)

Lack of education and awareness

A lack of education characterizes the tea garden communities. However, women and girls of this community are further deprived of any kind of education and awareness due to the gendered perception that girls do not require education and should be more inclined towards looking after the family's requirements (Nambiar, 2020; Kalita, 2016). A conversation with one of the Angarwadi associates mentioned that the plantation labourers are extremely reluctant towards education. There is a lack of awareness and maturity regarding sexual health and menstrual hygiene.

"I have stopped getting my monthly cycle. ASHA didi says that it is because of my age. However, for the past few months, I am having difficulty with my sight. I told ASHA didi about it, but she said it is only because I have stopped getting my menstruation cycles and it can impact my body in some ways with age."
(Surekha)

The narratives indicate that the risky behaviour of the women labourers is not an individual behavioural factor. These behaviours are facilitated by a lack of resources and information access regarding menstrual hygiene or sexual health which are further aided by the cultural stigma that follows.

Environmental constraints

The labourers are also susceptible to the environmental conditions, including the living, working and geographical location of the garden, making it difficult for them to lead a healthy life while opting for appropriate health-seeking behaviour. The lack of sanitation facilities, practice of defecating and urinating in open toilets which are kept in unhygienic conditions and drinking water from the wells and taps lead to intimate infections among women and other illnesses like jaundice and diarrhoea among the labourers making environmental conditions detrimental, both within and outside the home.

Lack of health infrastructure

The garden is characterised by a lack of health facilities, especially for women, as there are hardly any female attendants within the hospital, making it difficult for the women labourers to convey their problems and discomfort.

"We only carry out normal delivery here. While usually the women prefer delivering in their respective homes, if there are complications we refer the cases to Silchar Medical College. The hospital only deals with providing primary care and any cases of emergency is usually referred outside." (Pharmacist of the garden hospital)

"The doctor is usually not very responsive and talks in a hurry whenever we go for any issue. He simply writes down medicines and we are taken to the dispensary by the attendant who gives us the medicine. Sometimes there are women attendants of ASHA workers nearby to whom we can go and comfortably speak about our problems."
(A patient in the hospital, a casual worker)

There is a discriminatory gap in delivering and accessing healthcare services for this community from a point of view of class and caste perceptions with the care provider being from a dominant class (George, 2015). The lack of female attendants also contributes to the delay in seeking health care among women as they feel uncomfortable reaching out about their problems, especially regarding intimate health problems.

Conclusion

The women labourers of the tea estate under study represent extreme marginalization in terms of accessing healthcare resources, facilities and services which is dominantly characterised by their gender roles, economic constraints and socio-cultural positioning as a woman within the family and the community, which influences their health-seeking behaviour. Limited availability and inadequate medical facilities within the tea gardens, influenced by patriarchal structures and the dominant group hegemony in the

professional healthcare-providing institutions, further exacerbate healthcare disparities. Traditional gender roles and expectations relegate women to subordinate positions, limiting their decision-making capacity and control over their own bodies and health-related choices. The patriarchal family structure often results in an acceptance of the subordinate position of women, which further creates barriers for them to access certain types of health services. This generally exerts a dual division of labour, both physical and emotional, on the woman of the family as she is the primary care provider of the household and a regular labourer in the tea garden. This dual pressure always goes unrecognised and unpaid whilst she works for the economic sustenance of the family.

At the community level, strong networks are absent, which limits access to resources and information regarding healthcare services. The health disparities among women are further perpetuated by a lack of education which heavily hinders women's ability to make informed decisions about their health. There is a sense of negligence towards providing genuine health information even by the community healthcare provider like that of the ASHA workers along with the non-availability and discriminatory behaviour of the doctor in the garden hospital.

The management too,demonstrates a stark gendered division of labour. The very usage of the term *'baje'* and '*faltukaam'* which means bad and useless tasks put a gendered connotation to the work of the women as inferior to that of the men within the tea garden. This gendered division of labour renders women's work within the plantation undervalued as compared to men, despite them contributing equally to tea production.

The community also displays a pluralistic approach to healthcare and healing systems with a wide array of popular and folk healing systems. The marginalization experienced by tea garden women influences their health-seeking behaviour, often leading them to rely on alternative healthcare sources, especially in sexual health. However, in other cases, traditional, ritualistic or folk healing is only opted as an alternative after exhausting the economic resources.

The lack of economic resources, basic sanitation facilities, drinking water, education and awareness regarding health, and lack of health infrastructure within the garden remain as the structural barriers to accessing health care and poor health-seeking behaviour.

Suggestions

Addressing the gendered experience of healthcare requires comprehensive interventions. Recognizing the intersectional nature of the gendered experiences of the women labourers and their marginalisation, the provision of healthcare should include improving healthcare infrastructure within the tea gardens and ensuring that the healthcare system is more inclusive and sensitized towards the health requirements of the women. The management and community, health service providers, should take responsibility for enhancing access to quality healthcare services and raising awareness about women's healthcare rights through rigorous awareness programmes. These programmes should not only be subjected towards women but also demand compulsory participation of men to ensure a more sensitised understanding of women's health and health requirements which would contribute to dismantling the systematic social and cultural barriers along with the basic structural ones that perpetuate healthcare disparities. Within the realm of public health, the concerns of women's healthcare should also go beyond sexual and reproductive health and provide a more holistic approach to female healthcare which may include counselling therapies. The plantation management should take full responsibility for the breach of the clause under the Plantation Labour Act, take immediate remedial measures to facilitate a better work and living environment, and provide proper sanitation facilities and drinking water. The state government should investigate frequently and thoroughly the proper implementation of health and welfare schemes. The government may also reframe certain clauses within the Plantation Act that benefit the permanent workers and provide basic relief and assistance to the casual workers. Such initiatives should include providing health care facilities within the garden, sanitation facilities, and clean drinking water.

Limitations of the study

One of the most complex difficulties faced during the fieldwork was the potential interference and interruptions by the management staff. As the research involved studying a community within a hierarchal work structure, the presence of management created a power dynamic that impacted the respondents' responses. This led to the non-responsive nature of the respondents in several instances. Time constraintshave also been a driving limitation of the study. Due to having limited time in the field, the study was cross-sectional which also led to a limited sample size and thus the findings may not be universally applicable. Though the study has been attempted with an emic approach, the findings may have reflected certain levels of personal perceptions.

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Declaration of Interest Statement

The authors report there are no conflicts of interest to declare.

Data availability statement:

Given the sensitivity of the research topic and the implications for the research participants, the actual names or locations of the participants and associated details of the data cannot be shared.

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