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# *Sugar and Tension: Diabetes and Gender in Modern India*

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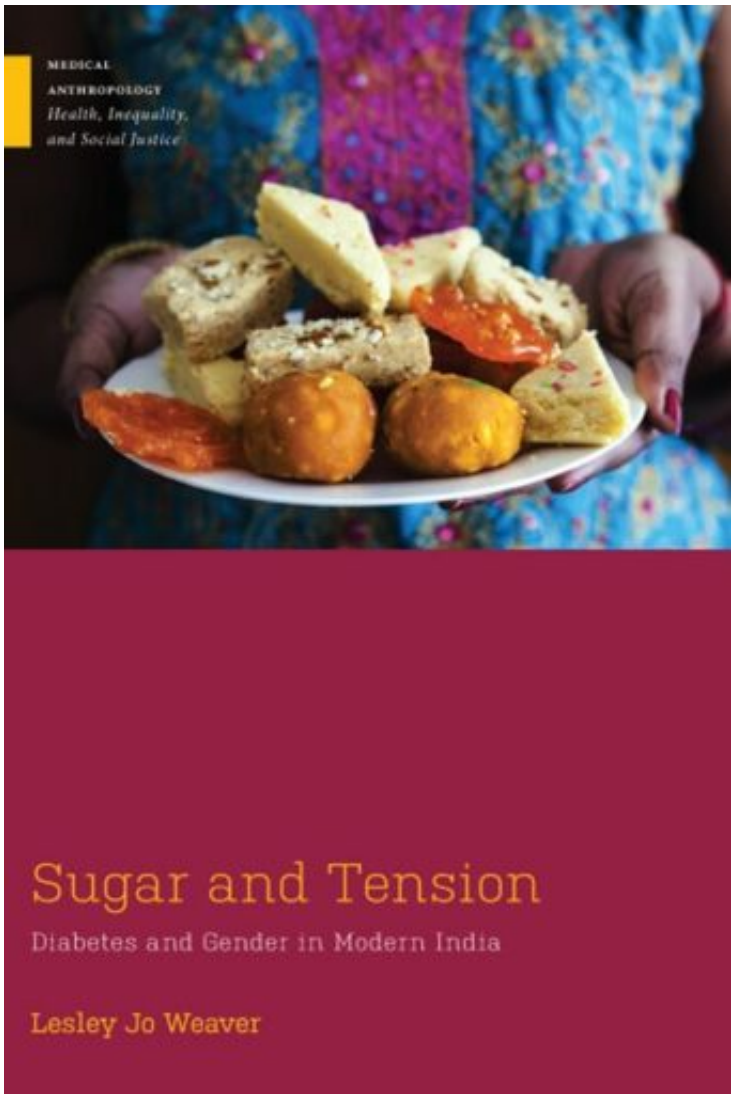


Sugar and Tension: Diabetes in Modern India

Lesley Jo Weaver

Rutgers University Press, 2019. 202 pages.

*Sugar and Tension* is a must-read for anyone interested in how social constructions of gender influence the physical and mental health of

individuals living with diabetes. Lesley Jo Weaver, a biocultural medical anthropologist with degrees in global health and in medical anthropology, presents case studies from a group of Indian women from different social classes and castes who live with diabetes in modern-day Delhi, India's capital city. The book asks what Indian women do when diagnosed with diabetes, and what —and who— become a priority in their care.

After briefly introducing a few of the 180 women who contributed to her research, Weaver details their struggle with the paradoxical position of women in contemporary India, who must blend Western 'modern' and Indian 'traditional' ways of living to produce what she calls "domestic modernity." In other words, women in today's Delhi are expected to choose a career and participate in the local economy, while also assuming the role of guardians of "Indian culture" and "propriety" (Weaver, 2019, p. 37), elements threatened by the increasing Westernization of Indian lifestyle. This adds a twist to the prevalent conceptualization of diabetes as a "quintessential disease of modernity" (Weaver, 2019, p. x). Domestic modernity highlights the intimate and often normative ways that women must care for others —spouses, children, in-laws— and for themselves as they navigate the challenges of living with metabolic disease.

In Chapter 1 – *Opening a Window on Diabetes Experience* – readers get a glimpse of the public health situation that women in Delhi are currently experiencing. Weaver presents diabetes as a disease associated with "modernity" and the adoption of urban lifestyles, encompassing a "lack of physical work, consumption of processed foods, and stress" (Weaver, 2019, p. 6). She focuses on the experience of tension that people living with diabetes in New Delhi experience when approaching health services, the concept of "tension" representing both a cause and an effect of diabetes (Weaver, 2019, p. 20). Free or low-cost public healthcare cannot keep up with the high demands from diabetic patients, resulting in overcrowding of hospitals and interminable waiting times. Resorting to private institutions does not necessarily translate in a better quality of care, given that the best doctors tend to work in public institutions and having access to resources does not mean that they will be employed adequately. She depicts how seeking care, and the care itself together add to the stress the women experience as they live under the diagnosis of diabetes.

In Chapter 2 – *Seeking Modern India*, Weaver presents us with a paradoxical India, embodied in the capital city. New Delhi, or simply "Delhi," as the locals refer to it, is both a "New" and an "Old" city, where some of the wealthiest people on Earth coexist with people still dying from tuberculosis and hunger in the streets (Weaver, 2019, p. 27). Women in particular are subject to the paradoxes of "domestic modernity." Though expected to carry on with Indian values and with the traditional role of housewife ascribed to them, women are also encouraged by

Westernization to get an education and financially provide for themselves and their family. Weaver highlights how these competing ideals affect elderly women as well as young women, both of whom have been expected to provide nourishment to families by Indian traditions and whose domestic roles are challenged by the rise in diabetes. Weaver tells the story of a seventy-year old woman living with diabetes who must care for her grandchildren because her sons and their young wives work, a situation that leaves her with little time or energy for self-care (Weaver, 2019, p. 39). Weaver unpacks the question: could holding onto Indian values to reject Western lifestyles be considered modern?

Chapter 3 – *Balance: The Moral and Practical Work of Diabetes Management* – examines the structural constraints (poverty, abusive family relationships) that may prevent women from caring for their diabetes. She illustrates how the stress of having people depending on them weighs down their physical and mental health. Weaver criticizes guidelines for diabetes care used in India, which are based on a neo-liberal focus on individualistic behaviors. In the paradigm of 'healthism' that she describes, self-care becomes a biopolitical technology in which the blame is deflected from structural flaws and redirected towards the individual. For the women Weaver works with, biomedical diabetes management involves the broader gender and power relations between doctor and patient (Weaver, 2019, p. 48). The moral code thus considers women whose diabetes is not under control as irresponsible, self-indulgent, and not committed to their wellbeing. In this paradigm, *they* – and not the health care system – have failed.

In Chapter 4*, Tension: Diabetes, Distress, and Mental Health,* Weaver disaggregates tension from stress. For women in her research *tension* was the pull between competing roles and expectations, whereas *stress* referred to the feeling of being weighted down (Weaver, 2019, p. 68). She describes tension as a phenomenon of domestic modernity that goes beyond stress, depression, and anxiety. Rather, this tension is a function and a consequence of changing gender dynamics and Western lifestyles that compete with traditional ideals (e.g. education, marriage, income). She asks the provocative question: which came first: tension or diabetes? She shows that the relationship between tension and diabetes is a vicious and ongoing cycle.

Weaver notes that women diagnosed with diabetes in India who have low socioeconomic status are less likely to show symptoms of depression than those of a higher status. Diabetes among low-status, impoverished groups tends to go hand-in-hand with a sudden increase in wealth and abundance, whereas among previously wealthy individuals, diabetes is not related to any added benefits to their already comfortable lifestyle. Furthermore, Weaver explains how a diabetes diagnosis feels less

disruptive in the life of someone who endures hardships daily. “Those from lower socioeconomic groups have more to gain, whereas those from higher socioeconomic groups have more to lose, from diabetes (Weaver, 2019, p. 90).” In that sense, diabetes might be seen as an unjust punishment for wealthy women, while in impoverished women it represents a ‘natural’ consequence of India’s globalizing economies.

In Chapter 5 – *Sacrifice: Domesticity and Care among Women with Diabetes*, Weaver unpacks the Indian ideal of women as self-sacrificing saints. She describes how self-sacrifice has been a desirable quality in Indian women even before India’s non-violent campaign for independence from Great Britain, led by Mahatma Gandhi. Diabetes, however, adds a new burden to Indian women’s lives. Traditional women live in a double bind, in which they are expected to eat what others in their family are eating, while also caring for themselves to prevent the complications of diabetes. They are, in other words, caught in the tension of domestic modernity.

In the last chapter, *Resilience: Living Well with Diabetes,* Weaver presents the stories of women who found a way to live well with diabetes in Ayurvedic medicine, religious devotion, and other resilience-building mechanisms. The women she portrays had found a way to cope with the tension derived from chronic disease and gender norms. Weaver concludes that self-sacrifice and self-care among these women should not be mutually exclusive and advises against reductively reading gender norms as simply oppressive. Surely, traditional roles versus modern expectations produce a wide array of complexities in a woman’s life in Delhi, but she shows how the struggle for the Indianization of Western values can generate a vital form of consciousness, providing a path for women to become capable of caring for their families and themselves. In ‘domestic modernity,’ families become involved in the woman’s diabetes care, providing a support net that allows for resilience.

Weaver leaves us with an important question: what does “success” look like for people diagnosed with diabetes? After all, not everyone benefits from a biomedical regime. She suggests that newly diagnosed people should be offered the kind of approach that will best orient them towards living well with diabetes. Furthermore, diabetes education should be embedded in cultures of nonbiomedical systems in India, such as Ayurvedic medicine.

Though book maintains a focus on India, it has broad implications for diabetes and diabetes care. As a dietitian and diabetes educator who was trained and worked in Mexico City, I often heard people living with diabetes talk about how they developed the disease on account of *el susto*, which translates literally into “the scare.” Any unexpected

situations that generate distress cause an imbalance in the hormonal systems —particularly in regards cortisol and adrenaline— which have a direct effect on blood glucose. “When the stress is chronic, however, those hormones are constantly activated, and they can induce metabolic changes like chronically high blood sugar and insulin resistance that are implicated in diabetes (Weaver, 2019, p. 79).” Thus, the biological responses to tension feedback into diabetes, generating a cycle that augments the seriousness of both.

Additionally, in Mexico — as in Delhi— the best hospitals are public but overcrowded with patients from all over the country, who will most likely have to wait at least a week to have major surgery. At the same time, herbal medicines are still quite prevalent, particularly in rural, marginalized areas that have little-to-no access to allopathic services. Conventional medicine in Mexico dismisses and stigmatizes traditional medicine. Yet the latter is sometimes the only available or the most efficient source of healthcare. What if newly diagnosed patients could decide the focus of their treatment before it begins? From the experiences Weaver describes along her text, having a sense of control over diabetes according to their cultural preferences could potentially improve the mental health implications that generate a vicious cycle of tension and biochemical responses that worsen the patient’s health. Currently, three of the seven ‘self care’ behaviors that the American Association of Diabetes Educators promotes pertain to mental health, but none of these are supported by allopathic medicine. Weaver’s text serves as clarion call to reprioritize ‘experience’ as central to any strategy for diabetes treatment.

Weaver’s thorough descriptions and rich narratives of the situations in which the women she encountered live generate an imagery that allows the reader to develop empathy with her informants. Her in-depth and well-rounded analysis illuminates the array of challenges of diabetes care in modern-day India, from the power dynamics at play in patient-doctor relationships to the intersections of traditional and Western values that shape dietary change.

Nutrition is a science that constantly transforms, especially in the face of growing global challenges of obesity, diabetes, and other metabolic diseases. Addressing the structural inequalities of these illnesses will require an approach that treats physical and mental health as inextricably interconnected. *Sugar and Tension* illustrates the capacity for nonbiomedical systems to treat not only the body but the stigma from which diabetes develops. This text is a must read for health professionals, medical students, and public health policy makers.

**Works Cited**

Weaver, L. J. (2019). *Sugar and Tension: Diabetes and Gender in Modern India*. New Brunswick, New Jersey: Rutgers University Press.

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