SIGNIFICANCE OF PREGNANCY AND CHILDCARE PRACTICES FOR CHILD SURVIVAL AMONG SCHEDULED CASTE WOMEN: AN EXPLORATORY STUDY OF THURAMBADY PANCHAYAT IN ERODE DISTRICT

Dissertation submitted to the Jawaharlal Nehru University
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MASTER OF PHILOSOPHY

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CERTIFICATE

This is to certify that the Dissertation entitled **"Significance of Pregnancy and Childcare Practices for Child Survival Among Scheduled Caste Women: An Exploratory Study of Thurambady Panchayat in Erode District"**, submitted by Ms. **S.KAVITHA**, in partial fulfillment of the requirement for the award of the degree of **MASTER OF PHILOSOPHY** of this University, has not been submitted for any other degree of this university or any other university and is my own work.

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We recommend that this dissertation be placed before the examiners for evaluation.

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For my Roots – My Grandparents and Parents

வேருக்கு விழுதின் கைம்மாறு

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Needless to say, I am solely responsible for any errors that remain in this study.

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Introduction

The health of an individual is characterized by biomedical as well as socio-economic factors. Health and welfare policies, however, tend to overemphasize the biomedical aspect and related solutions while not giving adequate attention to the socio-economic factors underlying these biomedical aspects. The adoption of a scientific and vertical approach has led to an isolated viewing of health-related problems.

Moreover, existing policies aim at achieving welfare of the woman only during the period of pregnancy. While during childhood the woman has been exposed to the risk of morbidity due to neglect and nutritional deprivation, after she bears a child, the focus shifts to the care of the infant. Thus, it is only for a limited duration of her life (i.e. during pregnancy) that health-related programmes and schemes focus on women. Policies aimed at infant care overlook the fact that the health of the infant is closely linked to that of the mother.

In India, 60% to 70% of the population belongs to lower socio-economic groups and is found mostly in rural areas. A majority of them have a hand-to-mouth existence. Amongst them, the worst sufferers are the women of the household. Exposed to deplorable and discriminatory conditions, a girl child grows up to face even heavier burden during her reproductive age. The neglect faced within the household, the burden of responsibility placed on her to manage the house, in the absence of her mother, does her immense damage at a tender age. This, along with the increased burden of productive and reproductive roles at an early age for girls of this section of the population, only makes her more vulnerable to a high risk of morbidity and mortality.

Early marriage and the pressure to beget children (especially a male child) are an accepted norm in all communities in India. The compulsion to have a male child leads to repeated pregnancies at short intervals. This further impacts a woman's health negatively. Pregnancy is considered to be a normal affair and does not entail special treatment. It does not translate into either increased nutritional intake or decreased physical activities.

The nutritional status of a woman before and during pregnancy, the age of marriage, the pressure to bear children early and the nature of ante natal care greatly impact the well-being of the foetus.

For the deprived sections of the population, the disadvantage begins at birth. A nutritionally deprived mother gives birth to a low weight child, which is an easy victim of morbidity and mortality. Though the caste-class combine determines the resource base of family and the mother's and child's access to food and other basic amenities, cultural factors may also influence child survival and morbidity. These practices differ among groups and for various regions and need to be studied for their impact.

The practices regarding infant and child care in terms of pre-lactation feeding, breast feeding, weaning, dietary practices, clothing, sanitation facilities have been established to determine the health of the child and its chances of survival. On the one hand, the order and sex of the infant, sex of the siblings, the family size, parents' desire to have the infant determine the care given to the infant since conception. On the other, it is the socio-economic and cultural factors, which determine the practices followed after delivery. Feeding practices like the duration of feeding, the administering of supplementary food, the dietary practices followed, care rendered during ailments, utilisation of health service system etc. are determined partially by the economic condition of the family and partially by the sex and order of the infant.

This study attempts to explore the socio-cultural practices of the schedule castes who largely belong to the poor socio-economic groups. In the process it will attempt to research the association that may exist between infant survival on the one hand and pregnancy and childcare practices and food availability on the other hand. It also attempts to see the influence of the broader socio-economic factors that act upon the family.

The study is divided into chapters as follows:

The first chapter on problems and methodology begins with an attempt to review available literature on various factors influencing infant survival and the childcare practices. This helps in the identification of factors that affect survival. These are used to

evolve the framework for the study and articulate the problem as we conceptualize it. The chapter then describes the methodology, including the objective of the study and the research design.

The second chapter is an overview of the *panchayat* and the study hamlets. The findings on the profile of the hamlets, economic and social life of people and availability of basic amenities along with the differences and similarities between hamlets are described here.

The third chapter deals with the married women of the hamlets. The pressure and burden on women during childhood and during their reproductive age is assessed using the available information. This chapter also attempts to see the linkages between a woman's productive roles and various practices followed since conception.

The fourth chapter attempts to study the childcare practices followed in the households with children under five years of age. Variables such as place of delivery, help sought during delivery, pre-lactation feeding, practices regarding breast-feeding, utilization of health services etc. were study. The findings on post delivery practices were also studied. An attempt was made to study the extent of influence of the sex of the infant and the order of birth on these variables.

The fifth chapter is a compilation of the case reports of ten families with children under five years of age. The study was done in Nathapalayam hamlet. The questions were asked regarding the childcare practices that are followed and other factors that would have either direct or indirect impact on the well-being of the child. We abstract from the case reports the factors that reinforce the quantitative study and other factors that bring new insight to the understanding of the people.

Finally, in the sixth chapter, a discussion is taken up linking pregnancy and childcare practices to socio-economic conditions and cultural practices on the one hand and to the infant mortality trends in the area on the other hand.

Chapter 1 - The Problem and the Methodology

I. Review of Literature

A person's life, since conception, is moulded by various factors. His/her place in society and in the family is determined by the social, economic and cultural factors acting at the broader level and the position accrued to him/her at the family level. Under this structural positioning, the chances of survival of a baby depend upon the social strata he/she is born in. The survival and development of children to their full potential has a direct bearing on the quality of the life of the population. Improvement in the quality of child life is clearly a function of socio economic development.

Various health studies establish that of the total mortality in India, death among children below five years of age is about 40-45%[1]. A recent study observes that "Mortality in India is very high at two extremes of life span. A significant proportions of deaths occur at the infant/child stage and old age." The study further observes that "32.7% of deaths is said to be occurring between 0 to 4 years and a majority of deaths between 0 to 4 years occur before one year of age."[2] The results of studies by Banerjee (1982)[3], Datta, (1960)[4]and, Saxena, (1967)[5] show that the mortality of children is highest in the poor landless class. These studies also show the proportion of death to be related to the income of the family, which in turn relates to poverty, hunger, ill health and finally to the mortality of the children.

Almost all the landless poor[6] in India depend on daily wages for their existence. This implies going without food on days when there is no work. Sheila Zurbrigg (1984)[7]

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1 Zurbrigg, Shiela, *Rakku's Story: Structures of Ill Health and the Sources of Change*, pp. 60, 1984.

2 Gopalan, Sarala and Shiva, Mira (ed.), *National Profile on Women Health and Development*.. Voluntary Health Association of India, April 2000

3 Banerji D., *Poverty, Class and Health Care in India,* 1982.

4 Datta, B.N.D., "A Longitudinal Study of Morbidity and Mortality Patterns of Children under Age of Five Years in Urban Community", *India Journal of Medical Research,* No. 57, pp 948-57, 1960.

5 Saxena D.N., *Social Context of Fertility and Family Planning,* Chapter III, 1967. as quoted in Sheila Zubrigg's *Rakku's story.*

6 According to Sheila Zurbrigg, a family is considered poor or below poverty line if after spending over 80% of the total family income on the most inexpensive of food they are still unable to meet the minimum calorie requirement.
According to Bannerji, measurement of poverty involves grouping the population according to whether the family gets enough food to have two full meals through the year. Those who did not get enough to eat for more than six months in a year were abjectly poor.

7 Op cit.1.

observes that for a majority of rural families, the struggle for daily wage employment is continuous and the balance between subsistence, indebtedness and hunger is extremely precarious. She adds that the implications of such economic insecurity of nutrition and health care are enormous. Qadeer (1985)[8], in her article, has cited various studies that show the impact of landlessness and the 'levels of living' on Infant Mortality Rate.

The main victims of such economic insecurity are the women and children. The women of the poor landless labouring class are denied basic rights due to their dependant position in the family and are usually made to carry the additional burden. This state of women, in turn, has a direct bearing on their life, health and well being. A study from Bangladesh[9] has shown that children of moderate to severe state of malnutrition are 20 times at a greater risk of dying within a month than a nourished child. Amongst the children at risk, female children outnumber the male children.

High male mortality is a biological norm, but in India there is a persistent excess of female mortality. This is indicative of the value assigned to girls in the Indian society. Sunita Kishore (1993)[10] argues that "scarce life-sustaining resources will be disproportionately allocated to male children as long as the returns to this investment are perceived to be greater than returns to a comparable investment in females." This, along with certain cultural factors, determines the worth of a female child in the family.

This section attempts to review the available literature on various factors that have an impact on childcare and infant mortality. The studies are grouped as follows: (1) Nutrition and Dietary Practices of the Family (2) Maternal Health (3) Sex-based Differences in Childcare (4) Maternal Employment and Education and (5) Utilization of Health Service System.

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8 Qadeer, Imrana., "Health Service System in India: An Expression of Socio Economic Inequality", *Social Action,* Vol. 35, July 1985.

9 Sommer.A. And Loeucistein, M., "Nutritional Status and Mortality", *American Journal of Clinical Nutrition,* pp. 287-92, 28 March, 1975.

10 Kishore, Sunita, "May God give Sons to All", *American Sociological Review*, vol. 58, Pg. 247-205, 1993.

Nutrition

Unfortunately, in India, a majority of the children are subjected to conditions of poverty that in turn leads to malnutrition and a set of constraints that affect survival of the young ones and their health. Malnutrition has important visible and non-visible health and social consequences for young children. It is often manifested in women and young children especially among children below five years of age and pregnant and lactating mothers. NNMB (88-90) Survey of Rural Children shows that only about 10% children are normal with weights about 90% of the standard. Another NNMB survey conducted from 1977 to 1996 shows very little improvement in the status of children within these years. A recent study by VHAI (2000)[11] finds no improvement in nutritional status among children.

According to Aneeta Minocha (1984) [12], "malnutrition in infants is closely related to mal-nourishment of the mother in a two-way relationship. Malnourished women are more likely to produce problem babies with poor health, low birth weights and high morbidity and mortality risks. The mother's mal-nourishment may further aggravate the infant's nutritional impoverishment by the decreased ability to breast feed her infant satisfactorily and pass on immunity to it." In other words, the state of maternal health or nutrition is a major determinant of lactation performance and therefore inevitably of the state of infant and child nutrition. Right from infancy, through the stages of development, a child, especially a girl, is nutritionally insulted which in turn results in deprived maternal health or nutritional status; the harm is thus passed on to succeeding generations.

Shiela Zurbbrigs (1984) [13] observes that the frequency of under-weight new born is closely related to the under nourished state of labouring women. Inadequate diet and the demands of their daily labour result in birth of infants smaller and weaker than infants of

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11 Op.cit.2, pp.2

12 Minocha, Aneeta, "Mother's Position in Child Feeding and Nutrition: Some Sociological Considerations", *Economic and Political Weekly*, Vol. XIX, No. 48, pp. 2045-2048, December 1984.

13 Op.Cit.1

non-poor mothers. She observes that a vast majority of deaths due to diseases or infections is contributed by underlying malnutrition among young ones. There are also studies that have shown the direct relationship between malnutrition of the mother and infant deaths. Khanna study (1971)[14] observes that inadequately breast fed babies develop malnourishment and are prone to infection. C.Gopalan (1978)[15] distinguishes between three grades of malnutrition and argues that the root cause of all forms is economic poverty.

Malnutrition in infants is a result of the vicious circle of poverty from which a family belonging to a low, socio-economic status is unable to come out. The inability of a male adult to maximize economic productivity due to malnutrition influences the socio-economic status and in turn the purchasing power of the family and consequently its intake and nutrition. The introductory statement in National Nutrition Programme (GOI 1993)[16] "...under nutrition is a condition resulting from inadequate intake of food or more essential nutrients resulting in deterioration of physical growth and health... This condition of under nutrition, therefore, reduces work capacity and productivity amongst adults and enhances mortality and morbidity amongst children."

After the green revolution, India reached a level of self-sufficiency in food production. But more than 50% of its population suffers from different degrees of Chronic Energy Deficiency.[17] According to Gopalan (1984)[18], the increased production of food grains *per se* does not improve the nutritional status; rather the per capita availability of food grains depends upon the purchasing power of the families. This argument is corroborated by the Human Development Report for 1990s. In the survey, it is stated "the per capita

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14 Wyon B.John and Gorden E. John., *Khanna Study,* Harvard press. Massechussets. 1971

15 Gopalan, C., "Classification of Under nutrition their Limitation and Fallacies", *Economic and Political Weekly,* Vol. 13, No. 22, pp. 924-927, 1978.

16 Op.Cit.2. pp.179

17 Reddy, Vinodini et al., *Nutritional Trends in India*, National Institute of Nutrition, Hydrebad. 1993

18 Gopalan. C., *Combating Malnutrition*, Nutrition Foundation of India.1984

consumption of food grains varies only marginally according to population group. The consumption levels are lower for landless labourers, those living in the lower segment - Below Poverty Level and those living in larger households. The lower levels of consumption among all these groups appear to be due to lack of purchasing capacity or lack of resources."[19]

Dietary Practices

Nutritional status of an infant, which has a direct bearing on the growth of the infant and its survival chance is influenced by various factors, such as social patterns and customs, educational level of parents, local availability of food stuffs, utilization of health services etc. Thus, it is important to understand the dietary patterns of the family in the study of childcare and infant mortality. The food consumption patterns reflect a family class position in the society. It also reflects its well being. The amount of food available to a family and the share given to the women and children has a great impact on the future of the family. Various studies establish that women eat less and get the minimum amount of food in the household. This has a direct impact on the well being of the child. The availability of food to an adult member reflects the productivity of that person and in turn the family's economic position, especially in the landless labour class.

Schofield (1974)[20] observes that rural households are able to produce adequate food due to increased productivity. It is the poor intra-household distribution of food among family members that is the contributing factors for the persistent state of malnutrition.

A study by Sen and Sengupta (1983)[21] suggests the change in seasonal availability of food to have an impact in nutrient intake and its distribution among family members.

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19 India - Human Development Report- A Profile of Indian States in 1990s. NCAER.

20 Schofield, S., "Seasonal Factor Affecting Nutrition in Different Age Groups and Especially Pre-School Children", *Journal of Developmental Studies,* No 2, pp. 22-40, 1974.

21 Sen, A., Sengupta, S., "Malnutrition of Male Children and the Sex Bias", *Economic and Political weekly,* pp. 855-864, May 1983.

Another study by Suresh Chandra Babu et al (1993)[22] shows that the intake of nutrients varies according to agricultural productivity. He further states that agricultural labour households consume the lowest amount of nutrition and protein irrespective of the agricultural production and the adequacy of the food at the household level does not guarantee adequate nutrition for all members of the household. It is thus important to understand the differences that exist within the family.

Women of these families consume the lowest amount of energy and protein. A study by Parischa (1958)[23] finds that the dietary intake patterns in a group of poor, pregnant and lactating mothers in South India show that protein calorie intake during pregnancy and lactation drops appreciably as compared to pre-pregnancy stage. There are other studies that show the direct relationship between land ownership and food consumption. Scholars like Behram (1988)[24], Sen and Sengupta (1983)[25] and Miller (1987)[26], while studying intra-household food allocation, have seen the sex-based discrimination existing within the household. However, a study done in Uttar Pradesh and Tamil Nadu by Basu finds no difference between sex of the members in terms of allocation of food.

It is a well-known fact that childcare practices differ according to community, region, social customs and practices though some practices may be universal. An attempt is made to see the relationship between these practices and infant mortality. Breast-feeding enhances child survival by transmitting to the infant, along with nutrients for growth, certain immunity-raising elements that help fight infections.[27]

The findings of the study in the Urban Pediatrics Centre and the Well Baby Clinic in the

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22 Babu, S.C. et al, "Agricultural Productivity, Seasonality, and Gender Bias in Rural Nutrition: Empirical Evidence from South India", *Social Science and Medicine,* Vol. 37, No. 11, pp. 1313-19, 1993.

23 Parischa, S., "Survey of Dietary Intake in a group of Poor Pregnant and Lactating Women", *Indian Journal of Medical Research*, vol. 46, pp. 605-609, 1958.

24 Behram, J.R., "Inter Household Allocation of Nutrient on Rural India: Are Boys Favoured? Do Parent Exhibits Inequality, Aversion?" Oxford Eco Papers, March1988

25 Op.Cit.21

26 Miller, Barbara, *The Endangered Sex: Neglect of Female Child in Rural India,* Ithaca, New York Cornell University Press 1981.

27 Op. Cit.10

Paediatric OPD, Jawaharlal Nehru Institute of PG Medical Education and Research, Pondicherry (1976) [28]are that the feeding patterns adopted by the mother reflect the social customs, beliefs, tradition, cultural practices, superstition and intellectual levels. In the study of a sample of 788 infants, it was found to be 100% in infants between the ages of one month and 20 months. 87.5% of them were intensively on breast milk at one month of age. This showed a gradual decrease at 42.6% at six months, 32.5% at nine months and 10% at 24 months.100% were completely or partially breast fed up to the age of four months and 95.8% up to the age of five months followed by a gradual fall subsequently. Someswar Rao et al from Hyderabad (1959)[29], Thaman and Manchanda from Amritsar (1968)[30], Mukerjee from Calcutta (1969)[31] and Datta Banik from Delhi (1975)[32] find similar trends in their studies.

In another study by Indira Narayanan et al (1974)[33] from the rural areas of Pondicherry, breast feeding was found to have been continued in 100% of children for two years and beyond in the *Harijan* community due to extreme poverty and illiteracy. Khanna Study (1971)[34] reports mothers to have breast fed their children for an average duration of 26 months. A study by Lalita Behl (1979)[35] from Himachal Pradesh finds 58% of children in a sample of 500 tribal households to have been breast fed up to 36 months of age and 13% beyond 36 months. The children were exclusively breast fed for about nine months.

Though breast-feeding is prevalent in India, it is delayed in most communities; very few

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28 Puri R.K. et al, "Infant Feeding and Child Rearing Methods in Pondicherry, South India", *Indian Journal of Paediatrics*, Vol. 43, No. 346 November 1976.

29 Rao, K.S, et al, "Protein Malnutrition in South India", WHO Bulletin, No. 603.

30 Thaman, O.P. and Manchanda, S.S., "Child Rearing Practices in Punjab", *World Journal of Paediatrics,* Vol. 35, No. 334, 1968.

31 Mukerjee, P.S., "Feeding of Children in Urban West Bengal – Calcutta", *Indian Journal of Paediatrics,* Vol. 24, No. 467, 1969.

32 Datta Banik, N.D., "Breast Feeding and Weaning Practices in Pre-School Children in an Urban Community in Delhi", *Indian Paediatrics,* Vol. 12, No. 509, 1975.

33 Narayanan, Indira, et al, "Some Infant Feeding and Rearing Practices in a Rural Community in Pondicherry", *Indian Paediatrics*, Vol 11, No. 10, 1974.

34 Op Cit.14

35 Behl, Lalita, "Some Aspects of Child Rearing Practices and Beliefs in Tribal Inhabitants of Himachal Pradesh", *Indian Paediatrics*, Vol. 16, No. 4, 1979.

children are put to breast immediately after birth.[36] Rao et al (1959), Sharma et al (1972), R.K.Puri et al (1974), Behl et al (1979) and Gopalan (1984) report a delay in initiation of breast feeding varying from few hours to one to three days, the delay in rural communities being the longest. This trend does not seem to have changed over time.

The practice of pre-lactation feeding is reported in various communities in these studies. Pre-lactation feed for infants includes *'Janam Ghutti'*, sugar water and honey mixed either with *ghee*, castor oil or water. Some studies, such as the one by Lalita Behl (1978) find no incidence of administration of pre-lactation feed.

Studies mostly show the practice of discarding colostrum before the first feed to the baby. Squeezing of the first milk from breast is found in 50% of mothers, which is more common in rural areas and for SCs and STs.[37]. Narayanan et al (1974) in a study of *Reddiar* and *Harijan* community in rural Pondicherry found that all mothers felt that colostrum is not good for their babies, though they could not give specific reasons for their beliefs. Rao et al (1972) and Aggarwal et al (1980)[38] found similar results in their studies. There are other studies like Solanki (1979)[39] among tribals of Madhya Pradesh, which negate the earlier findings. More than 90% of the mothers do not discard colostrum.

In almost all-rural communities in India, feeding is done on demand and no time schedule is adopted. It is only after the child cries of hunger that the mothers feed their babies. Thaman and Manchanda (1968), Sharma, (1972), Bhandari et al (1973)[40] corroborate this argument in their studies. Gopalan[41] argues that "inspite of nutritional deprivation and poor diets of mothers they are able to breast feed their infants successfully over

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36 National Family and Health Survey-2, 1998-99 (Andhra Pradesh)

37 Op Cit.36 pp.157

38 Agarwal K. and Agarwal K.N., "Infant Feeding Practice in India: A Review", *Indian Journal of Preventive and social Medicine*, Vol . 11, No 1, March 1980

39 Solanki, S., "Tribals of Madhya Pradesh – A KAP Survey", *Indian Paediatrics* Vol. 16, 1979

40 Bhandari N. R. and Patel G.P., "Dietary and Feeding Habits of Infants in Various Socio Economic Groups", *Indian Paediatrics,* Vol. 10, No. 283, 1973.

41 Gopalan, C., *Nutrition and Health Care, Problems and Policies: A Compilation of Recent Addresses,* Special Publication series 1. NFI

prolonged periods". He finds that the protein and lactose contained in an Indian mother's breast milk to be higher than that of British and American mothers. He observes that "regarding the nutritional point of view a child is happy in the first six months of its life, when the child is at the mother's breast."

The administration of supplementary food is critical to a child's health and survival. Khanna Study (1971) observes that children who start receiving supplementary food when they are a few months old seem to be at a greatly reduced risk of death, despite exposure to contaminants. No difference was found between the age at which boys and girls were given supplementary food. A study by R.K.Puri et al (1976) in Pondicherry finds that weaning with semisolid food was done in 4.2% of babies as early as the fifth month. After this, the incidence of weaning with semisolid showed a gradual increase to 50% of babies by the ninth month. 74.8% by the twelfth month and 90% by two years of age. This finding is in agreement with Bhandari et al (1975).

There are other findings Datta Banik (1974), Sharma et al (1972), Thaman and Manchanda (1958), Lala and Desai (1970) that show the introduction of food at the age of one year and after. Narayanan (1974) finds that supplementary food was started by the age of two years, in the Harijan community in rural areas of Pondicherry. The study by Katherine L. Bourne et al (1991)[42] shows a difference between male and female children in receiving supplementary food. Male children receive more or higher quality supplementary food while female children of the same age are dependent on breast milk for a larger proportion of their nutrients. National Health and Family Survey-2 on Andhra Pradesh (1998-99) shows a delay in the introduction of supplementary foods.

Once the children are put on supplementary feeding, the food given to them is the same as that cooked for the entire family. No special preparation is given to the children. A number of studies conducted amongst various communities in different parts of India corroborate this. The food administered to the babies is rice gruel in West Bengal and Kashmir, rice in South India, *chappati* in Punjab, and *suji kheer* and *khichdi* in Delhi.

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42 Katherine L, Bourne et al., "The Differentials Effect on Mothers Education on Mortality of Boys and Girls", *Population Studies*, No.45, pp.203-219, 1991.

These studies of the 1960s and 1970s again show that the patterns have not changed when compared with more recent work by Gopalan (1984), who finds delay in introduction of supplementary food.

Maternal Health

Maternal health has a direct bearing on child mortality. Various studies show the impact on factors such as nutritional status of mother, mother's age and parity. Preston Samuel (1978)[43] finds a U-shaped relationship between mortality, mother's age and parity. He argues that "failure to provide nutritional supplementary food may not be due to poverty; rather it may be due to the neglect of a particular child or children in general". Sandhya (1991)[44] finds age of the mother to have a negative relation with infant mortality. Khanna Study (1971)[45], ICMR (1994)[46] also finds infant mortality to be higher in mothers who are either too young or above 35 years of age. Gopalan (1993)[47] observes that "growth is complete only between 18 and 20 years. It is obvious that good parts of pregnancy in our country today are teenage pregnancies. Indeed, teenage pregnancy appears to be the rule rather than an exception."

Freizer Paul (1982)[48] ICMR (1994) finds high parity births and births following shortly after previous births likely to result in infant deaths. Pathak (1979)[49] and Knodes (1968)[50] find the order of birth to have a role in infant mortality. A different twist to the

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43 Preston, Samuel, *The Effect of Infant and Child Mortality on Fertility*, 1978.

44 Sandhya S., *Socio-Economic and Cultural Correlation of Poverty: A Demographic Approach.* 1991.

45 Op Cit.14

46 A Multi Centre Collaborative Study on the Care of Mothers and Infant with a Comprehensive MCH Care Package, Utilising High Risk at Primary Health Centre, Indian Council of Medical Research.

47 Gopalan, C., Child Care in India-Emerging Challenges, Towards Better Nutrition-Problems and Policies, NFI. 1993 as quoted in op. Cit. 2

48 Freizer Paul., Hogen, Denis., "The Impact of Class Education and Health Care, Infant Mortality in Developing Society: The Case of Rural Thailand", *Demography,* Vol. 19, No 13, pp 391-409, August 1982.

49 Pathak K.B., "Infant Mortality, Order and Contraception in India", *The Journal of Family Welfare*, 24(2), pp. 12-21, 1979.

50 Knodes, John, "Infant Mortality and Fertility in Three Bavarian Villages", *Population Studies,* 22(3), pp. 291-318, 1968.

determinants of child mortality was given by George Simmons et al (1982)[51] who conclude that infant mortality is not caused exclusively by external factors or broader factors; rather it is determined by the choices parents make.

After analysing the data available at the community, state and national level, the annual report for 92-93 of National Nutrition Institute concludes that there is a positive correlation between mothers and children's health. Gopalan[52] states that the nutritional status of the mother during pregnancy has an important influence in the conditions of her offspring. In his analysis of ICMR study 1956-57 and NNMB report for the year 1979, he observes that in the earlier study nearly a third of infants in the country are of low birth weight largely attributable to poor maternal status and under nutrition. In the latter study, there is no significant decline in the proportion of low birth weight infants. The World Health Report (1998) states that the health of the newborn and the child is strongly related to the social, economic and health status of the mother.

World Health Organisation (1989)[53], in its report, states that adolescent pregnancies are associated with higher risks of obstructed labour, hypersensitive disease of pregnancy, iron deficiency anemia and low birth rate. The risks are greater below the age of 17 because the young woman is still growing at that stage. A high number of anemic pregnant women are found in rural India. It is found that "low birth rate including premature birth is one of the major causes for infant mortality as this increases the susceptibility to infection."[54]

The studies on Andhra Pradesh[55] showed that pregnant women were more likely to have moderate to severe anemia than non-pregnant women. Subadra (1997)[56] finds anemia to have detrimental effects on the health of mother and children which may become an underlying cause of maternal mortality and perinatal mortality which results in an increased risk of premature delivery and low birth weight.

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51 George Simmons et al, "Post Neonatal Mortality in Rural India: Implications of Economic Model", *Demography, Vol.* 19, No. 3, pp. 371-391, August 1981.

52 Op. Cit.42

53 The risks of women of pregnancy and child bearing in adolescence: a selected annotated organization, Geneva WHO, 1994.

54 Op.Cit.2 pp.158

55 Op.Cit.36 p.155

56 Seshadri, Subadra., "Nutritional Aneamia in South Asia" in Stuart Gillespie (ed.)

Sex-based Difference in Childcare

Studies show excess female mortality in India despite the fact that female children are biologically stronger than male ones. Nathson(1984).[57], Sunita Kishore (1993)[58] and Waldron Ingrid (1983)[59] have shown a high female infant mortality in India. Excess female infant and child mortality is related to the low value attached to girl children. Bardhan (1979)[60] finds that the potential worth of a child in a household has both an economic and a cultural dimension. The under investment of resources in females can be explained in part by the low expected economic return to such investment. The preference for male children (Caldwell J, 1979[61] and Bourne et al 1991[62]) and the under valuation of female children (Miller Barbara, 1981[63]) places female children in a precarious position.

The recent study by VHAI (2000), while discussing the sex differences in childcare refers to the National Family Health Survey (92-93). The data had assessed son preference in 19 populous states based on factors such as immunisation rates, period of breast feeding, prevalence of chronic under-nutrition among children under age 4 and infant and child mortality rates. On nearly all these measures and in most states, male children have a decided advantage over female children. Female children are less likely to participate in income-generating activities or contribute to the family's material income (Rosenweig et

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Mal Nutrition in South Asia: A Regional Profile, 1997

57 Waldron, Ingrid, "The Role of Genetic and Biological Factor in Sex Difference in Mortality", pp. 141-64 in Hopez. A.O. and Ruziicha LT. (ed), *On Differences in India-Trends Determinates and Consequences.*

58 Op Cit.10

59 Op.Cit.58

60 Bardhan, Pranab, "On Life and Death Questions", *Economic and Political Weekly,* No. 9, pp 1203 – 1334, 1973.

61 Caldwell.J, "Education as a Factor in Mortality Decline: An Examination of Nigerian Data", *Population Studies*, No. 33 pp 395-413, 1979.

62 Op.Cit.43

63 Op.Cit.26

al, 1982[64] Sen and Sengupta 1983[65]).

Gender is seen as the most significant determinant of nutritional status. Studies by Chen et al (1981),[66] Sen and Sengupta(1983), Gopalan(1985),[67] Dasgupta (1987)[68] and Chatterjee (1990)[69] show the relationship between the gender and nutritional status. Gopalan observes that these differences set in during infancy and they persist through early childhood. Malobika (1993)[70] observes a different trend in the NNMB data (1991), that does not tally with generally observed social and nutritional status of the girls in various micro level studies. She, however, finds methodological flaws in the method of research. Gopalan (1984) in his study makes contrary findings, as there is no difference in the pattern of breast-feeding of boys and girls in the first three months after birth.

Maternal Employment and Education

Parthasarthy and Rama Rao (1973)[71] who have studied the wage aspect of women's employment, find average female wages to be only 84% of average male wages. Another study of six villages[72] from north and south India finds average female wages to be 56% lower than that of males.

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64 Rosenweig and Schultz, "Marketed Opportunities, Genetic Endowments, Family Distributions of Resources and Child Survival in Rural India", *American Economic Review,* No. 72, pp. 803-815, 1982.

65 Op.Cit.21

66 Chen et al, "Sex Bias in the Family Allocation of Food and Health Care in Rural Bangladesh", *Population and Development Review* 7, no. 1, pp 55-70, 1981.

67 Gopalan, C., "Mother and Child in India", *Economic and Political Weekly,* vol. 20, 1985.

68 Dasgupta, Monika, "Selective Discrimination against Female Children in Rural Punjab", *Population and Development Review*, Vol. 13, 1987.

69 Chatterjee, Meera, *A Report on Indian Women from Birth to Twenty,* NIPCCD, New Delhi 1990

70 Malobika., *The Study on Childhood in Rural Uttar Pradesh and its Implication: A Study of Two Villages in Allahabad District,* M.Phil Dissertation, Centre for Social Medicine and Community Health, JNU, New Delhi. 1993.

71 Parthasarthy G. and Rama Rao G.P., "Employment and Unemployment among Rural Households: A Study of West Godavari", *Economic and Political Weekly*, Review of Agriculture, 52 A. pp 118-32, December 1973.

72 Biaswagier and Rosenzwerg, *Contractual Arrangement, Employment and Wages in Rural Market in Asia,* New Haven, Yale University 1984

Thus, not only are women not expected to participate in economic activities but also when they do, they get paid less thus undermining their worth. Kalpana Bardhan (1985)[73] argues that the economic status of women cannot be viewed independently of the cultural one. She says, "the culturally prescribed power and prestige associated with having male children forms the basis of the relative cultural worth of the sexes". Sunita Kishore (1995)[74] and Barbara Miller (1981)[75] analyse the cultural value of dowry payment and relate it to the mortality of female children.

One can agree with Sunita Kishore (1995) who, when analysing the extent of cultural control over women and sexual divisions, finds this to vary according to two important socio-economic dimensions - caste and land ownership. She says that economic and cultural worth of females is likely to be greater in landless and lower castes. Liddia Joarne et al (1986)[76] find that landlessness reduces the pressure to have sons to inherit property.

Krishnaji (1995)[77] observes that in rural India, working mothers experience a greater degree of child loss than non-working mothers. Working mothers in rural India generally belong to poor labour or peasant families. He adds that extreme poverty in such families may explain the higher death rate of infants.

Mortality depends on various factors but at the household level, a factor that determines the survival chance of a child is the employment status of the mother. Women have to adjust and balance their roles in reproduction and production. Sundari Ravindran (1995)[78] observes that in poverty groups, participation in the labour force increases the risk of morbidity and is not an indicator of better status but of greater deprivation. Alaka

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73 Bardhan Kalpana, "Women's Work, Welfare and Status", *Economic and Political Weekly*, Nos 51 and 52, December 1989.

74 Kishore, Sunita, "Gender Differentials in Child Mortality: A Review of Evidence" in Monica Das Gupta et al (ed.) *Women's Health in India: Risk and Vulnerability,* OUP 1995.

75 Op Cit.26

76 Liddia, Joarne and Joshi, Rama, *Daughters of Independence: Gender, Caste and Class in India,* London Zed books quoted in op cit 9

77 Krishna Ji, N., " Working Mothers and Child Survival in rural India: Insights from spatial Patterns", *Economic and Political Weekly*, Nov.1995.

78 Ravindran, Sundari, T.K., "Women's Health in Rural Poor Population in Tamil Nadu" in Monica Das Gupta (ed) *Women's Health in India: Risk and Vulnerability* OUP 1995.

Malwade Basu (1991)[79] suggests that the conflict between work and childcare is expected to be more acute in the case of women who work for wages.

Helen Ware (1984)[80] observes that women's economic activity has a negative impact on childcare only where such activity is incompatible with simultaneous child rearing or where the mother lacks access to substitute care for the child. She further states that in existing demographic literature, "the discussion of the relationship between women's work and child mortality has always focussed on paid employment outside the home, which is believed to be a possible cause of child neglect and malnutrition due to abandonment of breast feeding". Another study finds child mortality to be higher among working women everywhere in India. It adds that there is an obvious cultural phenomenon and the women who work outside the house are mostly identified with poverty and low class status.

Jean Dreze et al (1996)[81] observe that greater involvement in remunerative employment of women gives them greater control over household resources and this has a positive influence on child health. Greater participation also reduces the gender bias in child survival, but on the other hand, it imposes a 'double burden' on women. This is corroborated by the findings of Sunita Kishore (1998)[82]. Leela Visaria (1985)[83] finds a clear disadvantage faced by the children of working mothers in the form of higher infant mortality rate.

Regarding the relationship between women of the family and infant mortality, a review of literature done by Shiv Kumar (1995)[84] does not point towards decreasing infant mortality with high income. He concludes that high income need not be a pre-requisite

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79 Basu, Alaka Malwade, "Nutritional Discrimination and Child Mortality", *Population Studies* 43, pp. 193-219, 1989

80 Ware, Helen, "Effects of Maternal Education, Women's Roles and Child Care on Child Mortality", *Population and Development Review*, Vol. 10, 1984.

81 Jean, Dreze et al, "Demographic Outcomes Economic Development and Women's Agency", *Economic and Political Weekly*, pp. 1789-1742, July 1996.

82 Op.Cit.10

83 Visaria , Leela., "Infant Mortality in India: Levels Trend and Determinants", *Economic and Political Weekly,* Vol. 20, No. 32, August 1985.

84 Shiv Kumar, A.K., "Women's Capabilities in Infant Mortality" in Dasgupta et al (ed.) *Women's Health in India: Risk and Vulnerability,* OUP 1995.

for low infant mortality rate. Sen (1990)[85] links the economic factor and excess female mortality, on the other hand, he sees female participation in income-generating activities as a means by which women can gain more bargaining power within the household. He views positively the 'gainful' employment of women.

Caldwell (1979)[86] observes that education of women acts as a catalyst, allowing a wide range of socio-economic factors to become effective. This has a positive relationship with infant mortality in developing countries. Katherine Bourne (1991)[87] also finds education to have well documented effects in reducing infant mortality through a combination of factors. Education, according to her, improves the ability of a mother to take decisions regarding the upbringing of the child. She argues that mother's education has a greater effect on the survival of her daughter than of her sons and it is greater in rural than in urban areas. She concludes that the "overall effect of mother's education, even in the short run is unequivocally beneficial, it saves children's lives". Jean Dreze (1996)[88] also finds that higher female literacy reduces child mortality and anti-female bias in child independently of male children.

Gopalan (1978)[89] has argued that higher literacy rates alone do not help and that an overall economic development should take place. A study NFHS (92-93)[90] indicates that infant mortality declines sharply with increasing education of mothers. After reviewing the literature on educational effects of women on infant mortality, Shiv Kumar (1995),[91] concludes that, "while literacy may increase people's propensity to seek out appropriate health care services, it may not translate into improved usage of services, if social norms prevent her from freely moving out to use it.

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85 Sen, A. K., "More Than Hundred Million Women are Missing", New York Review of Books, Dec 1990.

86 Op.Cit.62

87 Op. Cit.43

88 Op.Cit.82

89 Gopalan, C., "Classification of Undernutrition: Their limitation and Fallacies", *Economic and Political weekly*, vol.13, No.22, pp.924-927, 1978.

90 Op.Cit.36

91 Op.Cit.85

Again, one may expect as more educated woman to have greater abilities to alter the intra household balance of power, but socio cultural practices governing behaviour of women in society may greatly influence the extent to which she can do so or make independent decisions". Thus education *per se* does not seem to have an influence on infant mortality, if the existing socio-cultural norms remain the same. Das Gupta (1987)[92] finds that girls born to women with some education are at a greater risk of dying (relative to boys) than those born to women with no education. This negates the arguments in favour of women's education for reduction of infant mortality.

Utilisation of Health Care Services

Various studies have linked utilization of health service system and child mortality. In a study by ICMR (1994), an unsuccessful attempt was made to correlate the place of delivery with infant mortality. Another study by NFHS-2 (98-99)[93] shows that the number of births that were delivered with the help of institutional facilities decreases as the births of rises from one to four or five and over.

Alaka Malwada Basu (1989), in her study on nutritional discrimination and child mortality, concludes that an important determinant of sex differences in child mortality is the use of health care system. In her sample on Uttar Pradesh and Tamil Nadu, there exist differences between the two states in terms of nutritional status among children. In Tamil Nadu, the mortality of infant girls, in spite of their lower nutritional level, was no higher than that of their male siblings. The findings showed the girls to be doing better than the boys in terms of treatment received.

She concludes that, "There seems to be a much greater readiness to take action when the sufferer from fever happens to be a girl. However, this does not necessarily represent an emotional preference for daughters. It is rather an indication of a greater opportunity cost of an interactive illness like fever in girls. The girls from Tamil Nadu were much more involved in household work (especially if the mother works) as well as income-earning

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92 Das Gupta, Monica, "Selective Discrimination against Female Children in Rural Punjab", *Population and Development Review,* No. 13, pp. 77-100, 1987.

93 Op.Cit.36, pp.183

activities outside the house, even among those between five to Nine years old".[94]

NFHS (92-93) sees a sex difference in institutional care rendered during infections. 39% of females under four years were not taken to a health provider as against 29% of males under four years. Similarly, 22% of females were not given any treatment as against 17% of male children. In another study, Basu (1988)[95] concludes that "the sex differentials in the amount and kind of food given to the children is probably not so relevant because it is not as common as it is made out to be; rather it is the differential use of health care.

Katherine Bourne (1991)[96] finds the differential effects of mothers' education on mortality and concludes that 'with the exception of accident and malnutrition, exposure to different causes seems unlikely to vary by sex. The difference lies in the ability to recover, which is determined by child's overall health and medical treatment received. Kielman et al (1983)[97] in their Narangwal studies find the infant mortality and morbidity among children between the age of one to three years was less in the case of the villages that received health care services. The findings in the Khanna study (1971) show the differential treatment attributed to boys and girls with regard to the health care system.

There are other studies by Nag (1983)[98], Caldwell (1983)[99] etc. that find the reason for decline in child mortality to be related to the political tradition of the people. Nag's study shows infant mortality to be lower in Kerala than in West Bengal.

This brief review of literature brings out certain trends relating to various determinants of infant mortality and childcare. The studies reveal a consensus for determinants like maternal health, dietary practices of mother and child, utilization of health care services.

94 Op.Cit.79

95 Op.Cit.80

96 Op.Cit.79

97 Kielman et al., *Child and Maternal Health Services in Rural India: The Narangwal Experiment,* Baltimore 1983.

98 Nag, "Impact of Social Economic Development on Mortality: A Comparative Study of Kerala and West Bengal", *Economic and Political Weekly*, 18, 1983.

99 Caldwell, "Routes to Lower Mortality in Poor Countries", *Population and Development Review*, 12, 1986.

The literature however brings out a divergence of views for factors such as sex based discrimination of childcare, maternal employment and education. Our review brings out the fact that the determinants of child health are inter- related. Study of single factors often fails to grasp the complexity. There is a need for a comprehensive framework for understanding issues of child survival.

Conceptualisation of the Problem

Based on our understanding of the review of literature, we conceptualise the problem as below. What we would like to emphasis is that the inter linkages in these factors and their collective implications need to be further explored. It is obvious that a lot of these are dependent factors, the independent factor being their socio-economic status. The latter determines levels of education, work, access to services, time invested in childcare maternal health etc. The practices of pregnancy, delivery and childcare would depend upon the above. In addition certain cultural traditions may also be rooted in the socio-economic conditions.

With this basic understanding, for the present exploration we would like to take a given socio-economic group-the Scheduled Caste who own 0 to 2 acres of land (landless, very poor or poor farmers) and study the dependant variables focussing on pregnancy and child care practices.

Based on the review our assumption is that there is a direct relationship between land ownership and food intake in rural families. In the poor families, where the food intake is relatively less, women and girl children fall prey to nutritional 'insult'. Nutritional inadequacy manifests itself at every stage in women's lives. This, along with the demand for labour within and outside the house in poor households during and after pregnancy, places a woman at a risk. The deprivation of an adequate diet and health care along with the exploitation of women in work force leads to malnourishment. This, in turn, leads her to produce infants with low birth weight and less immunity to fight infections. Malnourished children, in turn, are also deprived of a normal healthy growth after birth. This is due to the inability of the mother to feed the baby satisfactorily and pass on the immunity.

In most households in India that are below poverty line, the vicious circle of poverty, malnutrition, infection, ill health, child mortality are a regular feature. Only health care

service without changing these is one important factor for low child survival. Within this framework we would like to further explore patterns of:

1. Diet and Feeding
2. Birth order and Sex of the baby
3. Work of women, wages
4. Time for child care
5. Maternal and reproductive health
6. Family support
7. Sanitation
8. Child care practices

These would then be assessed in relation to each other and for the impact they may have on child survival. No qualification of the linkages is attempted, as it is only an exploratory effort.

II. Study Design

Based on the conceptualisation of the problem, the design was set up to achieve the following objectives.

1. Objectives

1. To study the pregnancy experiences of SC women in Thurambady Panchayat, Mulanur Block.

2. To study the childcare practices among the SC population.

3. To study associations between pregnancy and childcare practices and infant mortality.

2. Data Required

This is a study of four hamlets. Given its objectives, the data obtained was as follows:

Data on an overview of the hamlets i.e. its caste, class and demographic structure was collected. The infrastructure and basic amenities available in the hamlets were studied. Information was collected from married women relating to their day to day life, work, relaxation, household chores, illness and reproductive health, care during pregnancy, dietary practices etc. In addition, details of children under five years such as feeding practices, weaning, substitute care, illness, mortality, use of health care services etc. were acquired. Also acquired were sub centre and Primarty Health Centre level mortality records over time.

The above data was collected through quantitative and qualitative means as described below.

Quantitative Data

A detailed survey was conducted of all the households of the four hamlets to draw out the

basic socio-economic information, reproductive history of women, child mortality, and delivery and childcare practices. An open-ended interview schedule was used for this purpose. Before the interview phase, two weeks were spent in the village for familiarisation with the people of the hamlets and to understand the socio-economic dynamics of the village.

Qualitative Data

Through individual interviews, group discussions and observation, data on various aspects relating to the productive and reproductive roles of women was collected. The practices relating to infant care and the mother's attitude towards her child with respect to sex and order of the child were studied. Their perceptions regarding infant mortality and its causes were also collected. Detailed reports regarding childcare practices of ten households with children under five years of age from Nathapalayam were prepared based on repeated visits and discussions with the women and other family members.

3. Selection of Study Area and Study Population

The study area Thurambady *panchayat* was purposively selected after taking certain aspects into consideration, such as familiarity of the place, accessibility of the study population and language of the people. The SC population of the area was then identified. They were located in the four SC hamlets of Thurambady *panchayat*, which were selected. These hamlets covered 38 households of Mettur, 25 of Nathapalayam, 22 of Parakadai and 32 of Thurambady.

4. The Household Survey

For the study, married women of all age groups (with children) were studied. This excludes five women who had never conceived. Since all households were covered, no sampling was required. A detailed survey was done with the help of an open-ended interview schedule for all households of the four hamlets (the interview schedule is attached in the appendix).

5. Research Tools

For the survey, we used the following tools:

(a) *Interview:* Individual households were approached and women of the household were interviewed on various aspects of childcare and child mortality, where applicable. In addition, old women were also interviewed.

(b) *Group Discussion:* The general practices during pregnancy and childcare were discussed during the discussions with the women of all four hamlets.

(c) *Observation:* Households with children under five years of age were observed to get first-hand information on childcare practices. The method was also used to validate the information given by the interviewees to the researcher.

(d) Analysis of Primary Health Centre and sub centre records on Infant Mortality Rates.

6. Time Schedule

The months of August to November were spent on reviewing the available literature to develop the framework within which the study was under taken. A research design was also formulated to carry out the study. The next three months (December to February) were spent on preliminary analysis of the study area. The month of March was used to fill the gaps in the preliminary data collected. The following four months (April to July) were used in analysis and writing.

7. Analysis

After coding, the schedule data was analysed according to class stratification. There was not much difference between hamlets or across economic classes except in some aspects. For analytical purposes, therefore, we treat the study population as belonging to a homogeneous socio-economic group.

8. Limitations

(a) Time was a major constraint. One needs more time to create a rapport that would help

to overcome the expectations people had from the researcher. Their misconception about the research, at times restrained people from giving the right picture regarding certain aspects of their lives.

(b) A rapport could not be created with Primary Health Centre Staff, Sub-centre Staff and *aanganwadi* workers. Since the plan to implement Integrated Child Development Scheme in place of Tamil Nadu Infant Nutritious Programme is on, they refused to either give any information or to entertain any queries from the researcher. They suspected the researcher to be a government official from Delhi, sent to review the working of the child development programmes.

(c) The inability to stay in the SC hamlets during the study also deprived the researcher from making in-depth observation.

Chapter 2 - Overview of Hamlets

Thurambady Panchayat is one of the 20 revenue villages of Mulanur block in Erode District situated in west Tamil Nadu. Except for some areas touched by river Amaravathy, a tributary of river Kaveri, the Panchayat is dry. It comprises about twelve hamlets, of which eight belong to backward caste '*Kongu vellala Gounders'* and four to the scheduled caste '*sakkaliyars'* or *'madharis'*. As per the 1991 census, the total population of the Panchayat is 2876, of which 1426 are males and 1450 are females. The Scheduled Caste (SC) population constitutes 20% of the total population, i.e 581 – 290 males and 291 females.

The four *madhari* hamlets covered by the study are Mettur (38 households), Nathapalayam (25 households), Parakadai (22 households) and Thurambady (32 households). Earlier, the SCs lived in a separate cluster within the backward caste (BC) villages. But since the 1980s, under *Anna Marumalarchi Thittam* (a TN government scheme), new houses have been built for '*madharis'* in separate areas. *'Madharis'* thus now live in separate hamlets and are totally cut off from the BC villages, their only interaction being during work in the fields.

The people mostly speak Telugu amongst themselves but also use Tamil to communicate with others. They might have come from Andhra *Desam* during Vijayanagar rule as immigrants from which time they have been employed as agricultural labourers.

Mettur (meaning a hamlet in a highly infertile area) has SCs from nearly three BC hamlets. It is 2.5 kms from Nathapalayam main road (the road that connects two union headquarters - Mulanur and Vellakoil - and also the district headquarters). It is 10 kms away from Mulanur, 17 kms away from Vellakoil and 25 kms away from the taluk headquarters at Dharapuram. It is connected to Dharapuram and Mulanur by a state transport bus that runs thrice a day. Earlier, the villagers had to walk 2 kms to reach Nathapalayam, to avail the transport facility.

Nathapalayam and Parakadai are situated on the Mulanur-Vellakoil main road. Nathapalayam is about 8 kms from Mulanur whereas Parakadai is 11 kms from Mulamur. Bus routes connect both villages to the important towns nearby.

Thurambady is the only SC hamlet that is not on the bus route. Though there are metal roads right up to the hamlet, a two kms walk is required for access to a bus. This is the only hamlet that is situated on the banks of river Amaravathy. All around the hamlet, the BC *Gounders* stay in their farms. The people of Thurambady either own vehicles to commute or they walk till the bus stop.

There are 222 males and 219 females members in four hamlets. Mettur, Nathapalayam, and Thurambady have more males than females (37 males and 44 females). The maximum of 232 members (117 females and 115 males) are found in the age group 15 to 45, followed by 95 members in the 6 to 15 age group.There is however, no marked variation between villages either in the composition of sexes or in the differences in age, except 6 to 15 years old in Parakadai and 45 and above in Nathapalayam, (table 2.1).

Table–2.1 Age Structure of the Population

Age in Years	Villages				Row total
	Mettur	Nathapalayam	Parakadai	Thurambady	
0-5	21	22	23	12	78
1	14.3	22.0	28.3	10.5	17.6
6-15	31	24	11	29	95
1	21.2	24.0	13.5	25.4	21.5
15-45	78	50	39	65	232
1	53.4	50.0	48.1	57.0	52.6
45 and above	16	4	8	8	36
1	10.9	4.0	9.8	7.0	15.5
Column Total	146	100	81	114	441
2	33.1	22.6	18.3	25.8	100.0

Note: *1*=column percentage, *2*=Row percentage

Economic Condition

The block receives about 665.1 mm of rainfall from the North east Monsoon every year (Oct – Dec). It also gets rainfall during the month of August. The Panchayat has about 3200 acres of land of which 65% is unutilised and the remaining 35% are utilised for agricultural purposes. The river Amaravathy, and the ring wells irrigate 25% of utilised lands and 20% by bore wells. 25% of the land is to be irrigated under a new scheme – *Nallathangal Stream Anai Thittam*. Earlier, the river provided water for irrigation of areas on its banks. After 1962, a government order was issued permitting the use of water beyond the banks through canals. Pursuant to the order, water has become accessible to areas beyond Nathapalayam (4-5 kms away). Even the very dry hamlets now have access to water for irrigation.

This access to water has resulted in a shift in agricultural practices. Earlier, the farmers sowed coarse grains like *ragi*, *sorghum* and *bajra* along with certain kinds of pulses during the agricultural season. This provided employment and food to the people and fodder for cattle. The wages were paid in kind and the foodgrains lasted for the entire year. Now, the farmers have turned to cash crop cultivation (cotton, groundnut, tobacco, and even sugarcane). The hamlets near Thurambady and Parakadai are under rice cultivation for eight months and sunflower or maize cultivation for the remaining months. The people (SCs and BCs) complain that coarse grains are not available for consumption at all and even if they are available, they are exorbitantly priced.

The areas surrounding Mettur and Nathapalayam remain fallow throughout the year except in the agricultural season. In these areas, drumsticks, onion and groundnut are cultivated. Recently, cultivation of *kanvili* plant (a poisonous shrub that grows on fences) has also started. The plant needs minimum care and little water. It is used for medicinal purpose and it gives a good yield. The product is exported to Italy. About 200-300 acres of the Panchayat is under this cultivation.

In some areas, tomato, brinjal, *bhindi*, coconut, mango etc are also grown. Most of the lands are owned by BC *Gounders*. About 96.6%of the *madharis* belonging to these four hamlets are landless. Thurambady has a family owning upto one acre of fertile land and

another owning two acres of fertile land whereas in Mettur two families own upto one acre of fallow land. The agricultural labourers are mainly *madharis* and landless BCs. About 15.1% of total *madhari* population of these four hamlets are agricultural labourers. 39% of them are associated with agriculture as well as other economic activities like powerloom and poultry. In Thurambady and Parakadai, more than 90% of the people are dependant exclusively on agricultural labour whereas in Mettur and Nathapalayam the nature of occupation is diverse, as the agricultural work is available for only 4-6 months. But the people of Parakadai and Thurambady find work throughout the year. The daily wages are approximately Rs. 45 for males and Rs. 35 for females during peak season and Rs. 30-35 for males and Rs. 25 for females in the other seasons. The timings are different for different villages - mostly they go by 7 a.m. and come back by 3 p.m. This shift in labour timing has also come about only recently. Earlier, the pay was in kind but due to the discontinuation of coarse grain cultivation that the farmers find it convenient to pay in cash. This shift has caused difficulties for the *madhari* population, in getting employment, thus forcing them to look for other sources of income in powerloom industry, poultry farms etc. They also go in search of employment to nearby villages or to far-off places.

It is clear from Table 2.2 that 90-95% people of Parakadai and Thurambady are dependent on agriculture. Out of this, a large proportion is exclusively agriculture-oriented. The situation is different in Mettur and Nathapalayam. The people of these hamlets work both in agricultural lands as well as power loom and poultry units. Thus it could be concluded that a majority of the people (95.6%) belonging to these four hamlets are agricultural labourers. It is also significant that in Nathapalayam and Parakadai, there are no households depending exclusively on power loom or poultry units.

Table– 2.2 Nature of Occupation

Occupation	Villages				Row Total
	Mettur	Nathapalayam	Parakadai	Thurambadi	
Agriculture only	18	10	18	27	73
1	47.3	40.0	81.8	84.4	62.4
Power loom only	3	—	—	1	4
1	7.9			3.2	0.8
Poultry only	1	—	—	—	1
1	2.6				0.2
Agriculture and Power loom	12	7	2	4	25
1	31.5	28.0	9.1	12.5	21.3
Agriculture and Poultry	2	7	—	—	9
1	5.2	28.0			7.6
Agriculture and others	2	1	2	—	5
1	5.2	4.0	9.1		4.2
Column total	38	25	22	32	117
2	32.4	21.3	18.8	27.3	100.0

Note: *1*= column percentage, *2*=Row percentage

Thus the occupations amongst the households vary marginally. It however does not make much difference to the economic condition, as 96.6% are labourers. Of the remaining 3.4% who own land, land holding is either marginal or small. There are no households in Nathapalayam and Parakadai owning land, whereas there are two each in Mettur and Thurambady,(table 2.3).

Table –2.3 Nature of Land Ownership

Nature	Village				Row total
	Mettur	Nathapalayam	Parakadai	Thurambady	
No land	36	25	22	30	113
1	94.7	100.0	100.0	93.8	96.6
> 1 acre	2	—	—	1	3
1	5.3			3.1	2.6
1 to 2 acres	—	—	—	1	1
1				3.1	1.9
Column Total	38	25	22	32	117
2	32.5	21.4	100.0	27.4	100.0

Note: *1*=column percentage, *2*=Row percentage

There are about 100 poultry farms in the Panchayat – this business started gaining popularity in the '80s. The ex-president of the Panchayat has a 'poultry unit' that delivers chicken and feed to the owners of the farms who are willing to look after the chickens for commission. Once the chickens are mature, the unit takes the responsibility to take the chickens from the farm to sell it in the markets. The SC populations of both Mettur and Nathapalayam are mainly employed in the unit. Their job is to either to deliver the chickens and the feed to the farmers or transport the chickens to other areas. A person employed here gets about Rs. 100 a day. Some of them are employed accroding to a permanent basis for daily wages while others are employed on the demand for people on a particular day or week. The people feel this job better in terms of work and wages than work in the fields. However, it is concentrated only in Mettur hamlet with only a few being involved in this sector.

There are about 70 powerloom units in various pockets of the panchayat. The units are mostly started in the uncultivable lands by small farmers .The bigger powerloom units of Karur and Pallipalayam (Erode District) distribute cotton yarn to these smaller units. 22.1% of the *madhari* population from these four hamlets work in this sector. Mettur has the highest number of people working in the powerloom sector followed by Nathapalayam. There are two shifts- morning and night and adjustments made for women

members to work only during day times. The wage per day depends on the amount of work a person has done that day. The looms are in operation throughout the year with the exception of on rainy days. Each worker has a fixed loom but could be out of employment if he remains absent for more than a week. The male members get about Rs. 45 per day and female members Rs. 35 per day. In case of emergency, the workers can take money from the employer on an interest basis or on a signed agreement to work in the same unit till the money is paid back.

Apart from these employment opportunities, the *madharis* practice cattle rearing. 42.5% of the total *madhari* population has cattle. Out of this, 46% have two goats and 11 % a goat. 18% have one or two buffaloes for a season and 10% have one or two buffaloes permanently. 4% own other cattle. Mettur has the maximum (42%) households having cattle and Nathapalayam has the minimum (16%) households. In these four hamlets, only a small number of households have regular incomes.

Assets

Table –2.4 Assets of the Households

Nature	Villages				Row Total
	Mettur	Nathapalayam	Parakadai	Thurambadi	
Nil	19	10	9	2	40
1	50.0	40.0	40.9	6.3	34.2
Electronic goods	3	1	—	1	5
1	7.8	4.0		3.1	4.3
Vehicles only	15	13	13	13	54
1	39.5	52.0	59.0	40.6	46.2
Electronic goods,Vehicles	1	1	—	16	18
2	2.6	4.0		50.0	15.4
Column Total	38	25	22	32	117
2	32.5	21.4	18.8	27.4	100.0

Note: *1*=Column percentage, *2*=Row percentage

As shown in table 2.4, there are 40 households (34.4%) without any assets. Nearly 50% of the population in all the hamlets claimed to have no assets except in Thurambady, (6.3%).

Out of the remaining 77 households, 54 (i.e. 46.2%) own only vehicles and 18 (i.e.15.4%) own both vehicles and electronic goods. Thurambady has the highest number of households 29 (i.e. 90.6%) owning vehicles. The need for a vehicle is more in the hamlet because of the difficulty faced in accessing transport facility. Mettur also faces the problem, but only 42% of households possess vehicles. Land ownership is found not to have an impact on possession of assets.

Saving

Out of 117 households under the study, 57 (i.e. 48.7%) households have savings. 71.9% out of 57 households had savings in post office and 28.1% had other means of savings. The hamlet that had the maximum number of households with saving is Thurambady (71.8%) and the reverse is observed in Nathapalayam,(table2.5). The Child Nutrition Worker of Thurambady *balwadi* acts as an agent by collecting the recurring deposits monthly in Thurambady and Parakadai. This would partially answer the high saving rates in these two hamlets. (71.8% and 54.5% respectively)

Table –2.5 Sources of Savings

Source	Village				Row Total
	Mettur	Nathapalayam	Parakadai	Thurambady	
Post Office	10	---	12	19	41
1	55.6		100.0	82.6	71.9
Other Means	8	4	---	4	16
1	44.4	100.0		17.4	28.1
Column Total	18	4	12	23	57
2	31.6	7.0	21.1	40.4	100.0
Percentage to the total household *2*	47.4	16.0	54.5	71.8	48.7

Note: *1*=column percentage, *2*=Row percentage

Debt

There are about 64.9% of households suffering from indebtedness. No one in these

hamlets has debts above Rs.10, 000. The maximum number of indebtedness is due to the need to buy buffaloes during the rainy season (42.1%), followed by expenses incurred for medical purposes (35.5%).

Table– 2.6 Nature of Debt

Nature	Villages				RowTotal
	Mettur	Nathapalayam	Parakadai	Thurambady	
Hospital					
	11	4	9	3	27
1	55.0	25.0	52.9	13.0	35.5
Ceremonies					
	2	1	—	4	7
1	10.0	6.3		17.4	9.2
To buy Buffaloes					
	7	7	5	13	32
1	35.0	43.8	29.4	56.5	42.1
Ignorant about the debt					
	—	4	3	3	10
1		25.0	17.6	13.0	13.2
Column Total					
	20	16	17	23	76
2	26.3	21.1	22.4	30.3	100
Percentage to the total household *2*	52.6	64.0	77.3	71.9	64.9

Note: *1*=Column percentage, *2*=Row percentage

9.2 % of the households took debt for conducting ceremonies in the house. 13.2% of the women who were interviewed pleaded ignorance about the families indebtedness. The maximum number of debtors are from Thurambady, (table2.6). Since the hamlet also has the maximum number of households indebted due to buying buffaloes for a season, a relation can be drawn. Most of the households take loans from the pawn brokers or from the farmers willing to lend money on interest, which ranges two to five percent, depending on the need, urgency and the time period.

It is interesting to note that in Thurambady, both the savings and indebtedness rates are

high i.e. 71.8% and 71.9% respectively. As said earlier, in Thurambaby and Parakadai, women do the savings. It is this small amount which the women of the households struggle to save every month which is referred to. High indebtedness in Thurambady is related to seasonal necessity and the saving is not enough to meet the expenses.

Social Condition

The Panchayat has about 20% of SC population in four hamlets.(The SC population considered in this study are '*madharis'* as they constitue more than 99% of the total SCs. The rest are p*ariyars* and *thottis*, who constitute 1% of the SCs and live scattered in the BC hamlets.) Earlier, the *madhari* population stayed in a corner of each hamlet but now they have been placed in a separate hamlet. The rest of the population are BC g*ounders* (75%) and the other subordinate castes (5%) carpenters, washermen, barbers etc., The caste practices are not followed strictly as in the earlier days but the stigma against *madharis* has not been done away with. The relationship between the other castes especially land owning g*ounders* and *madharis* are smooth. In some places the madharis have started to be at par with the other castes. For eg. In Thurambady, the entire population of *madharis* lead the life as agricultural labourers and are employed throughout the year. This gives them the chance to interact with BCs especially the dominant caste *gounders* all the time. (Olapalayam is a BC hamlet one km from Turambady. 50% of the people from Olapalayam do not own any land and 25% owns only one to two acres. Therefore, 75% of the *gounder* population also lives the life of agricultural laboures, thus economically not in a better position than the *madharis*.) Nowadays, the *madharis* have started imitating the BCs by conducting puberty and other ceremonies and also invite the *gounders* to attend their functions. In earlier times this was not the case. The *Aanganwadi* in the village is used as the place for the guests as the *gounders* do not go to the madhari houses. They exchange presents too. One among the *madharis* of Thurambady said "when we go for their ceremonies, why can't we invite them to come for ours? Nowadays, in no way are we below them and we can also do things as grandly as they do."

This change has come about in the past two decades. Though the elders of the BC hamlets object to these new practices, they do not openly come out with statements of

condemnation as the younger generation has got accoustomed to these social changes. But in Mettur and Nathapalayam, the *madharis* do not move around with the other castes and they remain secluded. The younger generations of these hamlets are however getting alienated from the other castes and are being forced to remain aloof.

There is no social hierarchy amongst the SC population. However, an influential person in the village performs the religious ceremonies. He does not have any religiously sanctioned authority. He helps in performing rituals during the festival days. There is also a section of *pariyars* and *thottis* who are considered below the *madharis* in the social hierarchies. The *thottis* assist in the funeral practices of the BC *gounders* and the *pariyars* are employed as menial labourers for inauspicious functions. The *madharis* do not interact with the *pariyars* and *thotties*,who remain a separate group within the BC hamlets. The two groups also follow the practice of social hierarchy amonst themselves but it is not rigid. Due to better oppertunities, most of the younger generation of the above mentioned two castes have moved away from the villages. (many of the *pariyars* and *thotties* have converted to christianity and have benifitted from the facilities available).

The *madharis* speak Telugu and Tamil. These four hamlets are divided into two sections due to their economic status and some cultural practices. Though they stay within 5 km range, they do not interact with each other. The two groups comprise Mettur, Nathapalayam on one side and Thurambady, Parakadai on the other. The people of Thurambady, Parakadai think that the Nathapalayam, Mettur *madharis* are not civilised as yet. They also do not have marriage alliances with each other. The Mettur, Nathapalayam *madharis* have cross cousin marriages and the entire village is related to each other. They do not encourage the concept of dowry. It depends on the parents' ability to gift the girl a earring, nose ring and a pair of anklets. Mostly the bride price is paid (a *saree* for the mother in law). In Thurumbady and Parakadai hamlets, elaborate puberty ceremony is conducted before marriage. The marriage takes place with fanfare. They seek alliance from families other than their own, preferably families from the hamlets with agricultural lands. They give and take dowry. The entire village takes part in all the rituals . In one case, the villagers of Thurambady did not work for three days in a week due to the death of an old lady and immediately after that, for two days due to a puberty ceremony. This

happened during peak season and the landowners had to call labourers from the nearby villages for a week. After the ceremony, especially the 'polluting' ones like death, the entire village goes to the river for purification. This does not happen in Mettur or Nathapalayam as their ceremonies are simple and don't demand strict adherence to rituals. Though they are all relatives, only selected few stay for the entire ceremony.

Food Habits

Rice is the staple diet and is eaten with *dal* and vegetable in the form of *sambhar*. All the *madharis* have beef at least once a week. No milk product is taken. Earlier the *madharis* considered rice as a delicacy, as it was not grown in these villages. They had only coarse grains like *ragi, sorghum* and *bajra* for consumption.

Drinking is a social habit and many of them consume country-made alcohol. They have it during ceremonies and after a day's work; most of them spent half their daily wages on alcohol. Their source of entertainment is going for movies and watching television that is kept at the entrance of the villages.

Condition of Women and Children

Women in *madhari* hamlets are mostly agricultural coolies. In Mettur and Nathapalayam, they get work for 4-6 months whereas the women of Parakadai and Thurambady get work throughout the year. Regarding their position in the family, women of Thurambady and Parakadai also do not have any restrictions to voice their opinion in the family and they take part in decision making. Since the villagers of Mettur and Nathapalayam are interrelated women feel free to put forward her views.

There are about 78 children below the age of five in all the hamlets. In Thurambady, these children attend the *balwadi* whereas in other hamlets, they stay at home till the age of five. After the age of five, the children are sent to primary schools. Most children are looked after by their mothers, except in the peak seasons. Once the child is two years old, it is left on its own and is taught to do all its work. If it is a girl child, then she is taught to do the household work. She helps her mother in cleaning utensils, sweeping the floor, looking after the sibling etc. In all the villages, a boy child is preferred in the families. Though

they do not kill or abort a girl child, she is treated as unwanted if she is without a male sibling. They want a boy in order to feel secure about their old age.

Working of the Panchayat

Thurambady Panchayat has one president and six ward members. There are two *madhari* representatives (one male and one female). The woman representative does not take any part in the council meeting due to her family problems. The Panchayat also has one sweeper and a waterman (both *madharis*). There is a clerk from Nathapalayam to look after the records of the Panchayats. The Panchayat office is in Nathapalayam. Earlier the Panchayat president (a *gounder* caste) was from the village near Mettur. He has brought many changes in the lives of *madhari* population in terms of providing basic facilities.

Due to some problem faced by the *madharis* from Nathapalayam regarding the sanctioning of government built houses to some families, they turned against him and voted for the acting president (*gounder* caste). The Mettur *madhari* population showed their allegiance to the ex-president as most of the men working in his poultry unit are from Mettur. Due to this political turnabout, the Nathapalayam *madhari* men are taken only on daily basis in the poultry unit. On the other hand, the acting president has denied access to drinking water to the Mettur people. He expects the people of Mettur to apologise for supporting the ex-president, whereas the madharis are not willing to compromise their dignity and are hoping that the ex-president would come up with a solution.

Facilities

Housing

The housing of the four-madhari hamlets are of different nature. 41.9% of the houses are built and owned by the people. In this category Mettur has the maximum (47.4%) number of people having built houses whereas Thurambady has the minimum (28.1%). 51.3% are government houses built under *Anna Marumalarchi Thittam* for the SCs. In this category, Thurambady has the maximum of 65.6% of households owning government-built houses. The rest 8% are rented,(table 2.7).

Table –2.7 **Nature of Housing**

Nature	Villages				Row Total
	Mettur	Nathapalayam	Parakadai	Thurambady	
Own	18	12	10	9	49
1	47.4	48.0	45.5	28.1	41.9
Government Built	16	11	12	21	60
1	42.1	44.0	54.5	65.6	51.3
Rented	4	2	—	2	8
1	10.5	8.0		6.3	6.8
Column Total	38	25	22	32	117
2	32.5	21.4	18.8	27.4	100.0

Note: *1*=column percentage, *2*=Row percentage

Roofing

About 36% of the total houses have thatched roofing, 31.6% are tiled, 14.5% are terraced and 17.1% are mixed. In the earlier scheme (pre 1995), the government-built houses had tiled roofing but the post 1995 scheme houses have terraced roofings.

Rooms

The houses in the hamlets have either single room or single room with a veranda. About 58.1% of the houses have a single room and 37.6% have a single room with a veranda. Only 4.3% have two rooms or two rooms with a veranda. All houses in Parakadai have single rooms.

Electricity

Out of the entire sample, 47.9% houses are electrified. Thurambady has the maximum (78.1%) electrified houses and Parakadai has the minimum (13.6%) houses. If one looks at the houses that are not electrified, Parakadai has the maximum of 36.4% and Thurambady the minimum of 78.1%. Parakadai has newly constructed government houses, which are yet to get the electricity connection. Thus the figures for Parakadai do not give the actual picture. The *madharis* do not have to pay user charges for electricity consumption (table2.8).

Table –2. 8 Electricity in the Houses

Electricity	Villages				Row Total
	Mettur	Nathapalayam	Parakadai	Thurambady	
Electrified					
1	11	17	3	25	56
	28.9	68.0	13.6	78.1	47.9
Not electrified					
1	27	8	19	7	61
	71.1	32.0	86.4	21.9	52.1
Column Total					
2	38	25	22	32	117
	32.5	21.4	18.8	27.4	100.0

Note: *1*=column percentage, *2*=Row percentage

Water sources

The people of Thurambady Panchayat get water for drinking and other purposes separately, through different schemes. 60% of the population gets its water from the river Amaravathy, 20% through the open wells dug with the help of European Economic Aid and 10% by the E.K. Pudur scheme of TN Water Board. There are also 25 hand-pumps throughout the Panchayat. Each hamlet has a water tank at the entrance and a helper to operate it daily and clean it once a month. According to the official estimate, each person gets about 40 litres/day. 51.3% of the sample use water from handpump alone and the rest use water from hand pumps and taps, (table2.9).

Mettur has two hand-pumps (one within the village and another few metres away). Due to party politics, in the Panchayat election, the entire village has been denied access to drinking water. They used hand-pumps till Lok Sabha elections. They got a separate well dug nearby through the Member of Parliament fund. (The project is not yet operationalised). As the water from the hand-pump is hard and not fit for cooking, the villagers had to go two kms to fetch drinking water.In Nathapalayam, the tank is at the entrance and they have three taps - one inside the colony and two at the entrance. They also have two hand-pumps within the hamlet, of which one is non-functional. The water comes from 4-6 pm daily after the women folk come back from daily chores. The taps are

also used by other castes of the village, after the people of the hamlet. Parakadai has a hand-pump a few metres away from the colony and a tap for drinking water within the colony. Since the hand-pump water is drinkable, they prefer to use water from the hand-pump rather than to wait for the tap water. Thurumbady has a tap and a hand-pump. Since the location is near the river, people directly use their source for other household activities. For drinking, they use water from the tap, hand-pump or river.

Table –2.9 Sources of Water

Source	Villages				Row Total
	Mettur	Nathapalayam	Parakadai	Thurambady	
Hand pump	38	—	22	—	60
1	32.5		18.8		51.3
Handpump and tap	—	25	—	32	57
1		21.4		27.4	48.7
Column Total	38	25	22	32	117
2	32.5	21.4	18.8	27.4	100.0

Note: *1*=Column percentage, *2*=Row percentage

Sanitation

The people of the Panchayat do not have latrines. They use the open space meant for defecation. The SC houses built in the recent phase under the *Anna Marumalarchi Thittam*, have latrines built (houses in Mettur and Parakadai), but people do not use them as they feel that (i) not hygienic to use latrines, near the house (ii) not enough water to keep it clean. Some said that it is only for the rich and not for them. They also said that they do not feel comfortable using this, as they have never used it before. The pit of the latrine is not very deep, so the people cover the pit and use it as a bathroom. The central government, under its rural sanitation programme, gives Rs. 2000/- as subsidy for a family to build a latrine; this scheme is however misused to build a room as an extension to their houses.

Education

Out of 363 members above five years of age, 193 (53.1%) never had any formal education –106 males and 87 females. 170 (46.8%) members responded positively when asked about formal education. Of this, 95 members (55.8%) are males and 75(44.1%) females. Mettur, Nathapalayam, Thurambady hamlets have 38-43% of the population having had some formal education.Parakadai has the lowest of 28.6% of the population having received formal education.It is significant that people from Thurambady and Mettur, inspite of not having easy access to the basic facilities in terms of education and transportation, have the same percentage of people with formal education as that of Nathapalayam people. Out of 170 members who responded positively 70% have education upto fifth standard, 22.9% till eighth standard, 7% between ninth and twelfth standard (table 2.10).

Table –2.10 **Education**
(Level passed and studying in school)

Education level	Villages								Total
	Mettur		Nathapalayam		Parakadai		Thurambady		
	M	F	M	F	M	F	M	F	
1-5 standard	25	17	13	13	10	10	18	13	119
1	71.4	62.9	61.9	65.0	83.3	90.9	66.6	76.4	70.0
6-8 standard	8	8	5	7	2	1	6	2	39
1	22.8	29.6	23.8	35.0	16.6	9.0	22.2	11.7	22.9
9-12 standard	2	2	3	—	—	—	3	2	12
1	5.7	7.4	14.2				11.1	11.7	7.0
Column Total	35	27	21	20	12	11	27	17	170
2	20.5	15.8	12.3	11.7	7.0	6.4	15.8	10.0	100.0
Percentage of population *2* educated	42.4		41.0		28.4		38.6		100.0

Note: 0-5 years of age group (78 members) are not included. *1*=column percentage, *2*=row percentage

Basic Facilities

Each hamlet has street lamps at important junctions. When the bulb fuses, repair work is instant. Mettur does not have any facility except a grocery shop. They have to come to Nathapalayam to shop for rations. The people complained about the neglect they face at the hands of the politicians. There is just one government bus that plies thrice between Mulanur and Dharapuram (Taluk Head Quarter) via Mettur. The people of Mettur however walk down to Nathapalayam (two kms away from the hamlet) to get a bus if they miss the government bus. The children have to walk one and a half to two kms to go to primary schools that is in a BC hamlet or to Nathapalayam. They do not have *anganwadi* or the child nutrition worker. The people (especially women of Mettur) want at least a *Balwadi* to be built so that they could leave their children while they are out to work. They said that somebody has to forego their wage every day to look after the children of the village everyday.

Every Sunday, the merchants come to sell goods on instalments. People in the hamlets feel comfortable to buy things (sarees, clothes, clocks, utensils, groceries, etc.) on instalment. They could pay their debts in small amounts every week. The people also go to the weekly market held at Mulanur every Wednesday to buy their requirments. On Sundays, someone takes the responsibility of buying a pig and selling the pork.

The village has a black and white television at the entrance. A person from the village is responsible to operate it. The people watch TV from 6:30 to 8:30 daily. Nathapalayam colony is within the Nathapalayam hamlet, which is occupied by different castes. The *madhari* colony is on the left side of the road. Since the hamlet is the biggest in Thurambady Panchayat, all the important offices are here. The Panchayat office, The Tamil Nadu Cooperative textile Society, the milk society, a small outlet of Canara bank, a post office, panchayat run middle school, ration shop, a hospital sub centre, Tamil Nadu Infant Nutrition Programme (TINP) centre are located here. Since the hamlet is situated at the side of the main road that connects Mulanur and Vellakoil (two Union HQ) the availability of bus facility and the frequencies are good.

There are many powerloom units that have recently sprung up. The workers for these are either from the village itself or from Madurai and Virudhunagar, who are on contract basis. There are shops all along the main road. The grocery shops provide the villages with all the ingredients prescribed by the traditional practioners for the children during ailments. There is a homeopathic lady doctor who treats the patients with allopathic medicines too.

Ration Shop

There is one common ration shop for the entire Thurambady Panchayat. It remains open from 9:30 am to 4pm. Earlier, the people had uniform cards but now the SC people have red cards to distinguish them from other classes. The people possessing this card get 20 kg of rice at subsidised price. The people across the class lines however complained about the poor quality of rice that is distributed. None of them prefer to buy this rice and they opt to pay little extra to buy a better quality. They said that their health would suffer if they eat the rice served in ration shops.

Community Hall

A community marriage hall has been built for the benefit of the SC population. But it has not been used for the purpose. The hall is used for medical camps or for other government activities. The hall was used for AIDS camp during December for ten days and for the leprosy camp for a day in January. When asked, the officials said that (i) SC people do not know how to use it as it comes for free and (ii) the people prefer sacred place for marriages to this hall.

Panchayat Union Middle School

The school has primary and middle section and is managed by the Mulanur Panchayat Union. There are about five lady teachers and four male teachers including a Head Master. After completing their primary education in their village schools, the students come here for their middle schooling. Some continue and go to Mulanur for higher education, but most of them stop after eighth standard. There is only one *madhari* girl from Nathapalayam who has completed her tenth standard and is planning to pursue her

secondary education. In Thurambady too, a girl has completed her eleventh standard and is in now twelfth standard.

The school functions from 9 A.M. to 4:30 P.M. with an hour break in the afternoon. The period of curriculum is June to April. There are about 170 students with girl strength exceeding that of boys. This may be due to the fact that the BC *gounders* prefer to send their sons to English medium schools. In the *madhari* population too the number of girls exceed the strength of boys.

The students who are registered under midday meals programme (mostly all the *madhari* children are registered) get their foods on working days along with an egg every Wednesday. They also get a uniform set for the year along with the books. The teachers however complained about the irregularities of the *madhari* students, their disinterest in studies and their parents consisently asking the teachers for the government sanctioned finance aid to the SC students. (Rs. 500 – Rs. 1000/- per student per year depending upon the class in which he/she is studying). Most of the *madhari* students quit schooling after fifth standards and almost all of them after eighth standard. The teachers opined that the *madhari* students are least interested in studies and do not work hard. Some of the students who are willing to work hard and want to pursue further schooling are constrained by their economic position.

The school has one latrine for the female teachers, which is kept under lock and key. After the constant persuasion by the headmaster, the *panchayat* union has recently built a latrine for girls. Otherwise, the students urinate behind the school or in any other open space.

Banks and Post Office

The *Canara* bank has a branch at Nathapalayam. The *madhari* population does not however transact in the bank. There is a post office in which some *madhari* have their savings. Parakadai has no facility of its own. The only advantage of the hamlet is being on the main road that connects Mulanur and Vellakoil (two unions HQ). The availability and the frequency of buses are good. There is a grocery shop at the bus stop where the people buy the needful. They have to come to Nathapalayam or go to Mulanur for any work.

Since the colony consists only of 20 households, the officials do not feel the need to set up any facility there. They have a black and white television. The cooperative milk society is in the farm near by (for want of a place) and the few other caste houses are scattered as they are all living in the farms. The *madhari* people of Parakadai said that they wouldn't mind any facility being installed even within the BC cluster as long as they benefit from it.

Thurambady is in the midst of the fields. The area has BC populations living in the fields around it. The people of Thurambady have been denied the basic facilities. The people have to walk two kms to Parakadai to avail the bus facility to go to the town. They neither have any shops within the hamlet. They have a merchant coming with commodities to sell on instalment. The *madhari population* of Thurambady has only an *anganwadi* and a *Tamil Nadu Infant Nutrition Programme* (TINP) Centre in their village. This too, has been threatened removal, due to less attendance by the children.. Once the existing Child Nutrition Worker retires, they are planning to shut it down. They have to walk about two kms to go to Parakadai. The children have to walk one km to go to the primary school in nearby Olapalayam or five kms to go to Nathapalayam school two kms walking and three kms by bus). The Olapalayam School has strength of approximately 30 students from near by Olapalayam BC hamlet and Thurambady, Parakadai *madhari* hamlets. There are two teachers for one to five classes with the worker and a helper for mid day meal programme. The attendance of the students is irregular with the *madhari* students topping the list of absentees. Tamil Nadu Government Education Department manages the school. Once the students complete their primary education here, they go to Nathapalayam Union School.

Anganwadi and Tamil Nadu Infant Nutrition Programme

The Tamil Nadu government scheme of providing nutritious care for the infants has been in operation since 1990s in Erode District. The hamlets of the panchayat have been divided into two groups, each under a Child Nutrition Worker (CNW). The *madhari* colonies of Mettur and Nathapalayam come under a Child Nutrition worker (CNW) of Nathapalayam Centre. The villages of Parakadai and Thurambady fall under the Child Nutrition worker (CNW) of Thurambady Centre. The Child Nutrition worker (CNW) neither visits all the villages daily to give the nutritious food to the under-nourished nor do

the parents of these children come to collect it. She gives the nutritious food only to those children of the village where the centre is located. The rule of giving to only the undernourished does not apply as the other children also come to collect it.

In the Thurambady *Aanganwadi* Centre, the Child Nutrition worker (CNW) does both the works as the supervisor for midday meals programme and as the *TINP* worker. Since both demand a lot of paper work and attending meetings, she simply instructs the to look after the children and goes for meetings everyday. This *Aanganwadi* was established due to the initiative of the ex-president of the panchayat. On popular demand, it was set up in Thurambady *madhari* colony. Earlier there were about 20-25 children coming to the *balwadi* but now the number has come down to five children. The other caste children however do not come to the *balwadi* as the BC people observed that their children might go into the *madhari* houses with the *madhari* children. They said that they wouldn't have had any problem sending their children to the *balwadi* if it was somewhere outside the colony.

Now the government is planning to close the *balwadi* due to small number of children attending it (the government has a stipulated number for each *balwadi*). The villagers are strongly opposed to this and they said that it is not their fault if there are fewer children than earlier. "On the one hand, by their family planning programme, government asks us to have one to two children and on the other they want so many children in the *balwadi*." The villagers, especially women, feel that the *balwadi* is a must as it helps them to leave their children there safely while working in the farms. They feel scared to leave children even with the elderly people due to the fear of the river nearby. They said that the children do not like the food that is served (each child is allotted five paise per day for the vegetables and lesser than this for the masala) as the rice is of a poor quality. The financial inability of the *balwadi* teacher to buy the requirements to prepare a better meal results in preparation of the same kind of food everyday.

However, the people of Thurambady hamlet have said that they would strongly oppose the move to close down the *balwadi*. They however feel indebted to the Child Nutrition Worker (CNW) who helps them in many ways. For instance, she helps them to get the

financial aid given by the government during the time of delivery (Rs. 500/- per delivery). She also helps them to get the financial assistance given to the mother of two girl children after her family planning operation. She collects the money among the women to be deposited in the post office.

Nathapalayam has an *anganwadi* with two supervisors and an *ayah.* There are about 10-12 children of different castes from the Nathapalyam village. The composition of *madhari* children is less because the *madhari* mothers feel that the food served is not good. The Child Nutrition Worker (CNW) doesn't visit the villages to give the nutritious food to the malnourished children. She said that (i) the villagers do not want to eat the food given (ii) the villages are too far to go early in the morning (iii) she has so much of writing work to complete everyday that she is unable to go to the villages. She said that she needs to satisfy her higher officials by producing finished records rather than to go to the villages where her work is never appreciated.

Health Service System

Primary Health Centre (PHC)

The PHC is in Mulamur eight kms from Nathapalayam. The madhari population prefer to go to the PHC than to the sub centre even for minor ailments. The SC villagers also go to the private doctors in Mulanur and Dharapuram. For the vaccinations, the Village Health Nurse (VHN) are deployed to go to the villages. There is a weekly meeting for health workers including the Tamil Nadu Infant Nutrition Programme (TINP) workers with the doctors to study the progress of the week. The PHC remains open from 8:30 a.m. to 11 a.m. The doctors have their private clinics and sometimes ask the patients to come to the clinic for treatment. The ambulance service is efficient as it goes to the hamlet like Thurambady (where no bus service) to treat the patients if they are suffering from acute diarrhea or any other illness that needs immediate medical help. There are two doctors and subordinate staffs with indoor facilities. The indoor facility however is rarely used. More than 80 percent of patients visiting the hospital are from the *madhari* population.

Sub Centre and Village Health Nurse (VHN)

There is a sub-centre at Nathapalayam for the people of Thurambady and nearby panchayat. The sub-centre has a newly deputed VHN. She provides the villagers with the tablets and sometimes assists the women during delivery. The CNWs get the tablets from her to give the villagers when needed. Apart from this the sub centre maintains records and helps to organise camps and distributes the polio drops.

In the description, it is clear that there are certain differences that exist between the hamlets, especially between Mettur, Nathapalayam and Parakadai, Thurambady hamlets But the differences are not substantial. Therefore in the study the hamlets are treated as one unit.

Chapter 3 – Women: Social Production and Reproduction

Overview of SC Women in Thurambady Panchayat

In India, despite changes in social, economic and cultural spheres, the position of women has not changed much. In the patriarchal society, she is denied the right to be an individual. Gender bias plays an important part in influencing her position in society and in the family. Women of the socially and economically deprived sections of the population face more discrimination than their counterparts from a better off class. Studies show differences among various societies regarding the value placed on women.

In a society that has a higher female employment rate, the value attached to the women is higher than in other societies. The SC women of Thurambady Panchayat engage themselves in income-generating activities and so have greater freedom in deciding family matters. But the productive, reproductive and domestic roles rolled into one, places a heavy burden on her. This, along with poverty and malnutrition, deprives women of their well being. This, in turn, has an impact on her health, which directly and indirectly affects the health and the survival chance of the infant.

Age Structure

There are 219 SC women in the four hamlets under study. The distribution of women in the Panchayat can be assessed from table 3.1. Mettur has the maximum (32.4 %) females and Parakadai has the minimum (20.1%) females. The highest number of members (53.4%) is in the 15-45 age group that is followed by 21.4% in the 6 to 15 age groups. The age group of 45 and above has the minimum number (17 members), with Nathapalayam having just one woman in this age group.

Table –3. 1 Age Structure of SC Women

Age in Years	Villages				Row total
	Mettur	Nathapalayam	Parakadai	Thurambady	
0 – 5	8	10	15	5	38
1	11.3	20.8	34.1	8.9	17.4
6-15	15	13	5	14	47
1	21.1	27.1	11.4	25.0	21.5
16-45	41	24	19	33	117
1	57.7	50.0	43.2	58.9	53.4
45 & above	7	1	5	4	17
1	9.9	2.1	11.4	7.1	7.8
Column Total	71	48	44	56	219
2	32.4	21.9	20.1	25.6	100.0

Note: 1= Column percentage, 2. = Row percentage
All the female members in the hamlets are included

Education

Education for girls is seen as a means to development of society in general and women in particular. There is a remarkable shift in the attitude towards education amongst the SC population. Nearly 100% of the children are sent to school till fifth standard. There is an increase in the number of children attending middle school. Angathal, a teacher Nathapalayam School, said that there is an increase in the number of girls from the SC community attending middle school over the past few years. Many girls from the hamlet wish to study further so that they can at least get a job with a regular income and a better lifestyle.

A middle-aged woman from Nathapalayam said that in their time they were denied the

right to education. They want their daughters to be educated so that they can at least read the bus numbers and the signboards. Another woman from Thurambady complained about the difficulty in getting a white-collar job. She opined that the amount of spent on girls in higher education is a waste. Another old woman was annoyed with the "attitude" of the educated girls. She said that educated girls want to lead an easy life without indulging in any physical work.

Chitra from Nathapalayam has completed her eighth standard last year, She has lost her mother and has four siblings to take care of. Her father encourages her to continue further studies, but due to the family situation, she is unable to do so. Kavitha from Thurambady is in twelfth standard. Her mother wanted her to study so that she does not have to go through the misery she experienced. She wants Kavitha to be financially independent and confident. Selvi, mother of two daughters, said that in spite of financial constrains they struggle to send their daughters to School, till eighth standard, which would help them avail the financial aid given by the Tamil Nadu Government.

Out of 181 women over the age of five years, are only 41.4% have had formal education. The remaining 58.5% is illiterate. Almost all the girls who fall in the age group 6 – 15 years have formal education.Table 3.2 indicates that out of 75 women who have had formal education, 53 fall in the first to fifth standard level followed by 18 falling in sixth to eighth standard level. Only 4 have ninth to twelfth standard level educations. Mettur has the maximum number (36%) of women with some formal education, followed by Nathapalayam with 26.6%. Parakadai has the lowest of 14.6% having had formal education. In the category of women who have not had formal education the maximum number (33.9%) come from Mettur village, followed by Thurambady (32%), Nathapalayam and Parakadai (16.9% each).

Table –3.2 Education Levels of SC Women

Levels (Standard)	Villages				Row Total
	Mettur	Nathapalayam	Parakadai	Thurambady	
1to 5					
	17	18	16	13	53
1	62.9	65.0	90.9	76.0	70.6
6 to 8					
	8	7	1	2	18
1	29.6	35.0	9.0	11.7	24.0
9 to 12					
	2	—	—	2	4
1	7.4			11.7	5.3
Column Total					
	27	20	11	17	75
2	36	26.6	14.6	22.6	100.0
3	14.9	11.0	6.0	9.3	181

Note: All female members in the hamlets are included except 0 – 5 age group.
1 = Column percentage, 2 = Row percentage,
3 = percentage of literate women to the total women (181), excluding 0 – 5 age group

Employment Opportunities

The Madhari women of Thurambady Panchayat have to perform both the household duties and the work outside the house. Since childhood, the women imbibe a sense of duty and responsibility towards the family. They hold the family together, especially in a crisis situation. Outside the home, there are only two occupations for women as agricultural labourers and in the powerloom sector. Most of the female members in these four hamlets are agricultural labourers. The largest number from Parakadai and Thurambady are agricultural workers (100% and 96% respectively). Even in Mettur and Nathapalayam hamlets, only 11.6% of the total females interviewed work in the powerloom sector, (table-3. 3).

Table – 3.3 Occupational Pattern of SC Women

Occupation	Villages				Row total
	Mettur	Nathapalayam	Parakadai	Thurambady	
Agricultural Labourers	29	20	22	31	102
1	76.3	80.0	100.0	96.8	87.1
Power loom	9	5		1	15
1	23.6	20.0	—	3.1	12.8
Column Total	38	25	22	32	117
2	32.4	21.3	18.8	27.3	100.0

Note: *1* = Column percentage, 2 = Row percentage

The wages for female workers in the agricultural sector range from Rs. 35 (in the peak season) to Rs. 25 (in the lean season). During the lean season, as there are more workers than required in the fields, the fixed amounts of wages are shared amongst themselves by mutual consent. The working time is from morning 7 O'clock to afternoon 3 O'clock with an hour's break in between. The women of Thurambady and Parakadai come home (as the fields are nearby) for their breakfast and to feed their children if necessary. In hamlets such as Mettur and Nathapalayam, the women come back only at 4 O'clock in the evening. The womenfolk are engaged in agricultural activities such as transplanting, weeding, harvesting, transporting grains from the fields to the house etc. During the lean period, women also engage in other income generating operations such as collecting and selling neem seeds, construction work etc.

In the power loom sector, the working hours are between 9 a.m. and to 4.30 p.m. with an hour's break in the afternoon. All the 15 women workers in the power loom sector belong to the 20 – 30 year's age group. These women feel the work in the power loom sector is lighter than in agricultural sector. Their wage per day depends on the amount of work they put in. On an average, a female worker gets about Rs. 25 – 30 per day. Each worker has a fixed loom, but the employment is not permanent. The only 'benefit' is that a worker can ask her employer for money on credit or on interest in case of emergency.

This is not possible in case of agricultural workers. It came across in the study that the women of the younger generation prefer work in the power loom when compared to the older generation, all of whom are agricultural labourers. The reason for preferring power loom work is the regularity of to work throughout the year and comfort of working in the shade.

Social Status

The female population of the *Madhari* caste in Thurambady Panchayat enjoys a relatively good status. They enjoy the right to voice on opinions within the family and demand their acceptance. The women of Parakadai and Thurambady are economically better off than women of Mettur and Nathapalayam as they get work throughout the year. The decision making pattern suggests that as women earn more, they have a greater say in the household, they are more capable of influencing decision-making. In the Mettur and Nathapalayam hamlets, marriages are mostly within the family. This practice also gives the women more confidence to speak out in her in-laws place, as she is not a stranger to the place.

In the other two hamlets too, the women exercise their right to voice their opinion in all matters. Both the husband and wife always decide the family matters. Though a majority of the marriages are not consanguineous, the women take sometime to adjust. But because most of the families are nuclear in nature, the women get the opportunity to take individual decisions.

In the family, a girl child is not un-welcomed. Infact, a girl child is desired as she can help the mother in household activities till the time she is married off. Some women opine that there is no difference between a boy and a girl child, since everybody has to work, even in their old age, to earn their living. They said that their children will be busy with their own family affairs and that one cannot expect them to look after the parents or provide them financial support. They further added that under these circumstances, at least a girl child would care for and provide emotional support to the parents. Some women in the hamlet said that they wanted to limit their families even if they had only

girl children and it is their husband's desire for sons that made them conceive till they delivered a boy.

Palanal, mother of three children, said that her husband refused to talk to her when she wanted to have a family planning operation after having borne two female children. He was adamant about having a male child and even threatened to marry again if she carried on with her plans. She adds that the expenses incurred on bringing up a boy or a girl is the same. Veerai, from Nathapalayam said that she does not mind having four girl children, but the social pressure to beget a male child are difficult to face.

During her childhood, a girl is taught about their responsibilities towards the household. By the age of six, she helps her mother in all household activities like cleaning utensils, sweeping the floor, fetching water, buying the daily requirements from the local shop, looking after her siblings etc. By the age of 12, she cooks especially the evening meal, for the entire family apart from doing the other household work.

After marriage, she is expected to perform all the functions of a dutiful wife. Though most families are nuclear, the daughter-in-law of a family is expected to provide additional help needed for the in-laws family.As a mother, a woman's responsibility increases many fold. The pressure to bear children immediately after marriage is strong, in these hamlets. The women then have to simultaneously meet the demands of both domestic and activities outside home.

Practices regarding Marriage, Pregnancy and Child Birth

In the landless families, the girls are married early and are under tremendous pressure to bear children immediately after marriage. About 52.1% of women in the hamlets are married before the age of 18, with Parakadai and Thurambady having about 54.6% and 75% respectively. A total of 85.4% of the women are married by the age of 20, Thurambady and Nathapalayam having the maximum number of women in this group. Parakadai is the only hamlet showing 16.2% women who have been married at 20 to 25 age group, (table–4).

Table –3. 4 Age at Marriage

Age in Years	Villages				Row total
	Mettur	Nathapalayam	Parakadai	Thurambady	
13–15 years	8	1	2	8	19
1	21.1	4.0	9.1	25.0	16.2
16- 18 years	13	3	10	16	42
1	34.2	12.0	45.5	50.0	35.9
18 – 20 years	8	18	8	5	39
1	21.1	72.0	36.4	15.6	33.3
21-25 years	3	—	4	—	7
1	7.9		16.2		6.0
25 & above		1		1	2
1	—	4.0	—	0.9	1.7
Doesn't remember	6	2	3	3	14
1	15.8	8.4	13.6	9.4	12.0
Column Total	38	2.5	22	32	117
2	32.5	21.4	18.8	27.4	100.0

Note: 1 = Column percentage, 2 = Row percentage

Though Mettur and Nathapalayam hamlets do not differ very much from Parakadai and Thurambady hamlets in terms of age at marriage, the practices regarding marriage are different for these two groups of hamlets. The former hamlets follow mostly intra-kinship marriage alliances whereas the latter mostly seek alliances from outside the family, (table– 3.5).

Table – 5 Alliance Sought During Marriages

Alliance	Villages				Row total
	Mettur	Nathapalayam	Parakadai	Thurambady	
Cross cousin					
24	13	2	4	43
1	43.1	53.0	9.0	12.5	36.7
Maternal uncle					
4	1	—	3	8
1	10.5	4.0		9.3	6.8
Not blood relation					
10	11	20	25	46
1	26.3	44.0	90.9	78.1	39.3
Column Total					
38	25	22	32	117
2	32.4	21.3	18.8	27.3	100.0

Note: 1 = Column percentage, 2 = Row percentage

From childhood, the potential future relationship between cross cousin in inculcated in the minds of the children. Since birth, the parents calculate the alliance to be sought for their children. In Parakadai and Thurambady, the practice was widely prevalent but now it seems to have reduced, which is not the case in the other two hamlets. For marriage with maternal uncles, the age of the groom and the bride is an important consideration. The groom is usually the mother's youngest brother and the bride the eldest daughter in the family.

The women of Mettur and Nathapalayam said that they prefer marriages within the family, as they do not have to face any dowry problem. They added that if the son-in-law is a blood relation, the family become close-knit after the marriage and the chances of misunderstandings is reduced. On the other hand, they feel that if the son-in-law is from another family, it is difficult to point out or rectify his shortcomings. To illustrate this, they sighted examples from the households in the hamlets. Selvi from Mettur had

problems related to her married life. Now she stays with her parents. She feels that the problem could have been easily solved if she had consanguineous marriage. She said that she will not allow her parents to look for an alliance outside the family for her sister. The forceful give and take of dowry does not exist in Mettur and Nathapalayam hamlets as the families are mostly related, whereas in the Parakadai and Thurambady hamlets the practice persists. They also have elaborate marriage ceremonies and seek alliances only from the agriculturally rich hamlets.

After marriage, the woman has to prove her worthiness in society by conceiving at the earliest. There is constant pressure on her from the family and society to produce children. One woman of Nathapalayam said, 'As girls of the community, we do not have any life of our own. Immediately after puberty, our parents wait to get us married. After marriage, there is pressure to have children. We give birth to children, one after the other, as if we are machines. Once the children are born, we look after the children and worry about their welfare all the time. Our life ends there'. This sentiment was expressed by many across different groups, landless and landed. This sums up the plight of women in the Thurambady Panchayat once they reach the age of marriage.

Time of First Conception

Table 3.6 shows the difference between the hamlets regarding the time of first conception. The highest percentage of women in Parakadai and Thurambady hamlets conceives within a year after marriage. Nathapalayam shows one to two years after marriage as the time of first conception for 48% of women. It is distributed evenly amongst Mettur women. It is interesting to note that 50% of women conceive within two years of married life and the remaining 50% are distributed in the following with 35% conceiving within five years of marriage.

Table –3. 6 **Time of First Conception**

Time (after marriage)	Villages				Row total
	Mettur	Nathapalayam	Parakadai	Thurambady	
Under one year	6	1	8	12	27
1	18.2	4.0	36.4	37.5	24.1
1 to 2 years	7	12	4	6	29
1	21.2	48.0	18.2	18.7	25.9
2 to 3 years	6	4	1	5	16
1	18.2	16.0	4.5	15.6	14.3
3 to 4 years	4	8	6	5	23
1	12.1	32.0	27.3	15.6	20.5
4 years	5		2	2	9
1	15.2	—	9.1	6.3	8.0
Doesn't remember	5	—	1	2	8
1	15.2		4.5	6.3	7.1
ColumnTotal	33	25	22	32	112
2	29.4	22.3	19.6	28.5	100.0

Note: out of 117 women interviewed, 5 did not conceive at all
1 = Column percentage, 2 = Row percentage

Discussions with the women of the hamlets showed that they seem to be in control over reproduction choices but only after a certain age. The indirect indicator to assess the extent of control on reproduction choices is to see the proportion of women not married in the age group fifteen to nineteen. Women who get married at a young age are often less capable of asserting an influence on their families and husbands.

The five women, who said that they had not conceived ever, belong to Mettur hamlet. Out of this, four have been married to cross cousins and sought alliances from blood relations. Their years of marriage range from two to seventeen years. Palaniammal, one amongst the four, said that they had visited various hospitals to get treated for impotency. The repeated failure of the treatment and the loss of financial support made them go to

temples and traditional practitioners. She added that the problem was with her husband and not her. But he refuses to accept this and wants to prove the doctors wrong. Sellathal who has not conceived in her seventeen years of married life, says that society does not recognize a women if she doesn't produce children.

A barren woman is considered to be inauspicious in the society. Therefore, she said that she stopped attending all ceremonies except for the near ones, as it is humiliating. More than the desire for a child, it is society's attitude towards them, which brings misery to a barren woman.

There are about 49 women who had two pregnancies, 20 women had three pregnancies, 19 women had four pregnancies and 17 women have experienced one pregnancy. Only about five women have experienced five to eight pregnancies, (table-3.7).

Table – 3.7 Pregnancy Experience of SC Women

Number of pregnancies	Villages				Row total
	Mettur	Nathampalayam	Parakadai	Thurambady	
1 pregnancy	4	3	4	6	17
1	33.3	12.0	18.1	18.7	15.1
2 pregnancies	11	7	14	15	47
1	33.3	28.0	63.6	46.8	41.9
3 pregnancies	9	8	3	5	25
1	29.2	32.0	13.6	13.6	22.3
4 pregnancies	8	5	1	8	19
1	24.2	20.0	4.5	15.6	16.9
5 to 8 preg nancies	1	2		1	9
1	3.0	8.0	—	3.1	3.5
Column total	33	25	22	32	112
2	29.4	22.3	19.6	28.5	100.0

Note: 1= Column percentage, 2 = Row percentage

Our data shows (table-3.7) that in this group of women, only 3.5% could be said to have

too many children and if those with 4 pregnancies are included, this proportion goes up to 20% only. As many as 57% women have only one to two pregnancies and the proportion becomes 79% if we include women with three pregnancies. This is a critical observation regarding family size.

The total number of pregnancies experienced by women under study is 288. Out of this, there were 25 cases of miscarriages, with a woman from Nathapalayam having seven consecutive miscarriages. Two out of 11 women, who have had miscarriages, are in the power loom sector and the rest work as agricultural labourers. Pushpa from Mettur, is one of the two mentioned above. She had three consecutive miscarriages. She had been married to her own cousin five years back. The doctor advised her to take complete rest. She said that this would be impossible, as she has to work daily in order to survive. Rasathi, 24 years old from Nathapalayam, had seven consecutive miscarriages. Her mother-in-law wants her husband to opt for a second marriage because of this.

It is interesting to note that out of the total figure of 25 miscarriages, 12 comprised repeated miscarriages in three women. Of these three, two had consanguineous marriage. This shows that the incidence of miscarriages is not very high (25 out of 288 pregnancies, i.e. 8.7%) and out of these 48% happened to be women with consanguineous marriages.

Intervals between Pregnancies

Pregnancy intervals is an important factor in the study of maternal and child health. It has been suggested that a close succession of pregnancies and periods of lactation leads to deterioration in the mother's nutritional status. This in turn has serious consequences on overall health of mother. Women from low socio-economic status are under tremendous social and economic pressure to have children early and in quick succession.

Chellathaal, a mother of four girls from Nathapalayam, said that she conceived her first child at the age of 15 and had the rest of her children before she turned 20. Since all her children are girls, she faced tremendous pressure to stop breast feeding the girls and to conceive fast. Theivathal, mother of two boys, from Mettur, had both her sons within two years of married life. Due to low economic status, she had both her sons in a short span so that she could go back to work.

Table-3.8 Interval between Pregnancies

Interval	Villages				Row total
	Mettur	Nathapalayam	Parakadai	Thurambady	
Under1year	15	19	3	17	54
1	24.9	38.5	4.3	38.6	30.6
1 - 2 years	18	21	16	17	72
1	30.0	42.8	69.5	38.6	40.9
2 to 4 years	22	7	3	8	40
1	36.6	14.2	13.0	18.1	22.7
> than 4 years	5	2	1	2	10
1	8.3	4.0	4.3	4.5	5.6
Column total	60	49	23	44	176
2	34.0	27.8	13.0	25.0	100.0

Note: - Out of 288 pregnancies, 112 are first. So we are concerned with 176 subsequent pregnancies.
1 = Column percentage, 2 = Row percentage.

The table deals with 176 subsequent pregnancies. The interval between each child is asked separately and analysed. One finds women of Nathapalayam, Parakadai and Thurambady had the maximum number of births (75-81%) with less than two years interval between children. Mettur has 55% of birth with less than one to two years interval and 36.6% of birth with two to four years interval between children. There is only 5.6% birth that has more than four years between the children. It is critical to note that 30.6% pregnancies occur within the first year The maximum number of pregnancies (40.9%) are with an interval of one to two years, (table – 3.8). This no doubt is the reflection of the social pressures on women.

Employment of Women during Pregnancy

During pregnancy, women go about their usual routine. Begetting the first offspring is of a high significance in the families. So newly married girls stop working outside the house

when they conceive. The resumption of work outside the house depends on availability of childcare. Table –3.9 shows that a maximum number of women (46) work for about first six months. It is also significant that 33 women continued to work in their third trimester. Thurambady has the maximum number of women (15) in this category. 23 women did only household work till delivery, with the maximum number of 114 Mettur and nine in Nathapalayam . Thus only 19.6% do not work outside the house, 28.2% work till the end and 52.1% till at least the first six months of pregnancy. This implies that hard labour is frequent with 79% of women working out in the field up to second or third trimester end. It is important to point out that a majority of these families have irregular work opportunities for men. Hence women's work outside the house is critical for families income.

Table – 3.9 Employment of SC Women during Pregnancy

Did'nt work (period)	Villages				Row total
	Mettur	Nathapalayam	Parakadai	Thurambady	
Since conception	11	7	3	2	23
1	28.5	28.0	13.6	6.2	19.2
After 6 months	21	10	15	15	61
1	55.3	40.1	68.1	46.9	52.1
After delivery	6	8	4	15	33
1	15.8	32.0	18.2	46.9	28.2
Column total	38	25	22	32	117
2	32.7	21.3	18.8	27.2	100.0

1 = Column percentage, 2 = Row percentage

Veerammal, 35 years old and mother of four children, from Thurambady said that for her first two pregnancies, she worked only for three months each and took complete rest for the rest of the pregnancy period. She was taken to the hospital for her delivery due to pregnancy complications. Unfortunately, neither of her children survives. For her next two pregnancies, she worked till the time of delivery, and had home deliveries. She

delivered both the babies after the day's work. She further added that the girls of the new generation do not want to work after conception, as they perceive it to be very 'modern'. This, she says, will lead to complications in pregnancy due to inactivity.

Women have to do the household activities irrespective of their health status. Most women said that they do get help from their husbands, daughters and female relatives. Since most of the homes from Mettur and Nathapalayam have consanguineous marriage,they said that they get helping hands from their relatives in the village.Whereas in Parakadai and Thurambady hamlets, the women have to manage on their own or wait for her husband or other relatives to come back, for aid. But during emergency women from all four hamlets said that they could approach anybody in the hamlets for help.In the seventh month of the first pregnancy the woman is taken to her parents home after a brief ceremony. She returns only when the child is five months old. But for the subsequent pregnancies, she mostly remains in her husband's house.

Employment of Women with Children under Five Years

The maximum number of women (68.6%) hasn't worked since conception. Mettur, Parakadai and Thurambady have about 60 to 66% of women having abstained from work since conception while Nathapalayam has 82%. There is also a high percentage of women who work till the time of delivery. Parakadai has the maximum number of women being forced to work till delivery, (table –3.10).

Table –3. 10 Employment of Women during Pregnancy

(With children under five years of age)

Didn't work (period)	Villages				Row Total
	Mettur	Nathapalayam	Parakadai	Thurambady	
Since conception *1*	10 66.6	9 81.8	10 66.6	6 60.0	35 68.6
After 6 months *1*	4 26.6	2 18.2	3 20.0	4 40.0	13 25.5
After delivery *1*	1 6.6	—	2 13.3	—	3 5.8
Column total 2	15 29.4	11 21.6	15 29.4	10 19.6	51 100.0

Note: 1 = Column percentage, 2 = Row percentage

When the work patterns of the total number of women surveyed and the mother with children under five are compared, one sees a marked shift. Only 19.6% of women didn't work since conception in the earlier category that has increased to 68.6% in the latter. The number of women working up to six months of pregnancy has decreased from 52.1% in the former to 25.5% in the latter. A remarkable decline in the number of women working till delivery can also be noticed (i.e. 28.2% to 5.8%).

There seems to be a strong relationship between the order of birth and the employment of women after conception. For about 65.4% of children under five years, the mothers reported to have abstained from work since conception. For 14.1% of children, the mother reported to have worked till delivery. One can see the marked difference in percentages while comparing the order of the children. The first pregnancy being considered important has 72.7% mothers reported to have abstained from work since conception. This can be seen decreasing with subsequent order of birth. During the first pregnancy too, 18% worked for 0 to 6 months, which increases with subsequent pregnancy. It is also important to note that for the third and fourth order birth, highest

percentage of mothers reported to have worked till delivery, (table-3.11). This shows that if they have their desired children by the first two pregnancies, then they continue to work even after conception.

Table –3. 11 Women's Employment and Order of Pregnancy (With children under five years of age)

Didn't work (period)	Order of pregnancy				Row total
	1st	2nd	3rd	4th	
since coneption	24	20	4	3	51
1	72.7	68.9	44.4	42.8	65.4
6 months of pregnancy	6	5	3	2	16
1	18.2	22.7	33.3	28.6	20.5
Afterdelivery	3	4	2	2	11
1	9.1	13.8	22.2	28.6	14.1
Column total	33	29	9	7	78
2	42.3	37.1	11.5	8.9	100.0

Note: 1 = Column percentage, 2 = Row percentage
The table shows the order of pregnancy with respect to the number of live children.

Dietary Habits during Pregnancy

Women know that during pregnancy, it is important for them to have better food intake, but in the low socio-economic group, the dietary intake doesn't improve during pregnancy. There is a belief that if a pregnant woman is either denied or not given the food items she wants it would affect the hearing sense of the child. Though they are aware of this belief, they said that it is not feasible for a poor family like theirs to buy the food items. They also belief that if a pregnant woman consumes more food than on normal days, then it will result in difficulty in delivering the baby.

Arukani from Mettur said that during second and subsequent pregnancies, the woman gets even less to eat as she has to feed the child. She added that a woman, whether she is

pregnant or not, can go hungry but cannot let the child cry of hunger. As put by a woman of Nathapalayam hamlet " during pregnancy, we eat only half stomach, as our income reduces by half". Palanal from Nathapalayam said that the reason for reduced consumption of food during pregnancy by the women of the hamlets is partially due to the disinclination to have the available food due to the change in taste during pregnancy.

Almost all of them said that they take all the food items that they consume on other days, during pregnancy. They added that they are however careful about "hot" food items like papaya and seasame during the first four month of pregnancy for the fear of miscarriage. The pregnant woman eats what is cooked for others in the family and does not eat anything "special".

Practices during Delivery

The practices during and after delivery differ from culture to culture. The order of the child, sex of the sibling, experience during early pregnancies and the confidence of a woman to meet the next pregnancy have a direct impact on the practices. But the broader socio economic factors play a major role in determining the direct factors.

Place of Delivery

Out of 263 Madhari children born to the women under study in Thurambady Panchayat, in their life time 83 births (31.5%) in the government hospital, 31 births (11.7%) in the private hospital and 149 births (56.6%) at home. Thurambady has the maximum percentage of 62.3 home deliveries (43), Mettur with 60.4% deliveries at home (55), Parakadai has the maximum percentage of 60.4 deliveries (23) in the hospitals. Nathapalayam has 55.3% delivery (36) at home and the remaining 44.6% delivery (29) at the hospital, (table – 3.12).

Table – 3.12 **Place of Delivery**

Place	Villages				Row total
	Mettur	Nathapalayam	Parakadai	Thurambady	
Public hospital	26	19	20	18	83
1	28.5	29.2	52.6	26.1	31.5
Private hospital	10	10	3	8	31
1	10.9	15.4	7.9	11.6	11.8
Home	55	36	15	43	149
1	60.4	55.4	39.5	62.3	56.6
Column total	91	65	38	69	263
2	34.5	24.6	14.3	26.1	100.0

1 = Column percentage, 2 = Row percentage

The place of delivery is, however, related to the order of the child born. For the first delivery, the hospital deliveries (24.7%) exceed the home delivery (17.4%). Irrespective of the sex of the child, the reason for hospital delivery is the value placed on the birth of the first child which is seen as a *raison d'etre* of marriage and in respect of which the family does not want to take undue risk. In the second delivery, the numbers of home deliveries (19.9% of the total) exceed the hospital deliveries (11.7%) by 8.1%. This trend is followed in the subsequent deliveries too. From the fifth delivery onwards, all the deliveries are conducted at home irrespective of the sex of the child.

When asked about the reason for the conscious choice made by the women regarding place of delivery, they said that home deliveries are more cost effective and less cumbersome than hospital deliveries. Kuppathal, 45 years old and mother of four children of Thurambady had two hospital deliveries and two home deliveries. She said, "in the public hospitals, the attitude of the doctors and nurses is deplorable. When we go to the hospitals with pain, the staff does not pay attention until you pay them some amount of money. They behave as if they are doing you a favour. If we had to pay them so much money, then we might as well go to the private hospital and get personalized care". Some other women said that since they got a male child during their first delivery, they stayed back at home for their second and subsequent ones. An old woman of 60 years, however, argued that during her time, women never went to the hospitals for any delivery. The reason she gave is the practice of consuming coarse grains and the labour they put in

throughout the gestation period. She further adds that "it is only in the modernized age, the girls go to the hospital at the slightest problem. They face problems because of increasing practice of rice consumption and their inability to put in hard work."

Help during Delivery

In the home deliveries, elderly woman conducts 77.1%, 10.8% by the mother of the pregnant woman. There are two cases where deliveries that have been conducted by the husband. In the category of hospital deliveries, the doctor and the rest conduct 85.1% by the nurse and village health nurse, (table –3.13).

Table - 13 **Help during Deliveries**

Nature of Help	Villages				Row total
	Mettur	Nathapalayam	Parakadai	Thurambady	
Doctor	28	28.8	20	21	97
1	31.8	43.1	46.5	31.3	36.9
Hospital Nurse	6	1	3	5	15
1	6.8	1.5	7.0	7.5	5.7
Village health nurse	3	1	2	—	6
1	3.4	1.5	4.7		2.3
Elderly woman	30	30	14	33	115
1	43.2	46.2	32.6	49.3	43.7
Mother	12	4	4	8	28
1	13.6	6.2	9.3	11.9	10.4
Husband	1	1	—	—	2
1	1.1	1.5			0.8
Column total	88	45	4.3	69	263
2	33.5	24.7	16.3	25.5	100.0

1 = Column percentage, 2 = Row percentage

A common instrument used for delivery at home is the sickle. The sickle, according to

the women of the hamlets, has religious importance. Though the health workers ask them to use new blades, due to the religious importance of the sickle, they continue to use it to cut the umbilical cord. The kit that was provided by the government for delivery purposes has been withdrawn from distribution, as there were complaints about rusted blades in it.

Practices after Delivery

After delivery, the mother takes rest for few days. After the first delivery, the period of rest extends up to two to three months and reduces to 5 – 10 days in the subsequent deliveries. The 'purity – pollution' concept related to pregnancy and delivery is not followed strictly in these hamlets. A small ceremony is conducted by bathing the mother and the child, thus symbolically purifying them. In Mettur and Nathapalayam, the women said that they are helped by their relatives who stay within the hamlets for 10 – 15 days after the delivery, whereas the women from Parakadai and Thurambady said that they sought help from the neighbours if necessary, or did their work themselves.

Utilization of Health Service System

The Madhari women of Thurambady Panchayat practice home remedies for many of their common ailments. They to ignore it at first but when it starts interfering in their daily chores, they take a day or two off from their activities (work outside the house). If they feel that they are not better even after the rest, they they go to the public hospital. Most women complain about the perpetual pain in their hips, and inability to do work due to tiredness. Most of them are anemic (This is known to most of them as not having "good blood" - a term used for anemia in Tamil).

As for the utilization of health service system during pregnancy, a maximum number of 42.9% said that they had been to the hospital only for tetanus injections. (It is important to note that the pregnant women get an amount of Rs.500/- per pregnancy to meet their delivery expenses. This is given to them only if they are vaccinated). 34.5% said that they had never been to the hospitals during pregnancy. 11.6% went to the private hospital for consultations and 8% to the public hospital. Out of the 22 women who went to the hospital, 90% went due to complications in their pregnancies. 10% went for regular check-up during pregnancy, (table –3. 14).

Table –3. 14 Utilization of Health Service System (HSS) during Pregnancy

Nature of HSS	Villages				Row total
	Mettur	Nathapalayam	Parakadai	Thurambady	
Private hospital	2	3	2	6	13
1	6.0	12.0	9.1	18.8	11.6
Public hospital	7			2	9
1	21.2	—	—	6.3	8.0
Vaccination only	11	10	12	15	48
1	33.3	40.0	54.5	46.8	42.9
Didn't go to the hospital	10	12	8	9	39
1	30.3	48.0	36.3	28.1	34.8
Column Total	33	25	22	32	112
2	59.4	22.3	19.6	28.6	100.0

Note: Out of 117 women interviewed, 5 from Mettur did not conceive at all.
1 = Column percentage, 2 = Row percentage

The women who went to the private hospital said that the treatment rendered to them is faster and more effective when compared to public hospital. Most of them felt comforted due to the personalised care given to them by the private doctors who are also available round the clock. An important reason for them to seek private hospital assistance is the provision of loan facilities. They say that for delivery, a high amount is to be spent which becomes difficult for these families to arrange immediately. Thus, they feel confident in going to the doctors who allow the people to pay their debt slowly.

When asked about the reasons for not going to the hospital during pregnancy, they said that they do not go to the hospital unnecessarily. They added that they do not seek any medical assistance unless the ailment is perceived as serious. In case of ailment they try to cure it through home treatment and only if they are un-satisfied, they go to the hospital. Many of them said they stopped taking treatment once they feel comfortable.

SC Women's Experience of Child Mortality

Out of 288 pregnancies reported, only 199 pregnancies ended in live births. There were about 25 early terminations of pregnancies and four still births. There are 31 infant deaths, leaving 168 live children. The maximum number of 14 infant deaths out of the total of 31 is reported from Thurambady, eight from Mettur. Parakadai had the minimum of two infant deaths All four still births are of males, (table-3.15).

It is significant to note that there are 17 deaths in the first birth order (14 infant deaths and 3 still births), 13 with the second birth order (12 infant deaths and one still birth) and five with the third birth order (all five are infant deaths).

Regarding the causes for mortality, 10 infants have died due to illness, three due to prematurity (includes two still birth) and for 22 infants the causes for death are not known (includes two still births)

Table –3.15 SC Women's Experience of Infant Mortality

Mortality	Villages								Row total
	Mettur		Nathapalayam		Parakadai		Thurambady		
	M	F	M	F	M	F	M	F	
Infant deaths	4	4	5	2	—	2	6	8	31
Still birth	2	—	1	—	—	—	1		4
Column total	6	4	6	2	—	2	7	8	35
1	10 28.6		8 22.8		2 5.7		15 42.8		

1 = percentage of women experienced child mortality to the total number of women in the hamlets

The delivery place for six infants who died was government hospital, and for two infants, it was private hospital. The maximum number of infants that died was delivered at home. However, as we do not have data on total hospital deliveries, this difference has no comparative value.

As is clear from table 3.16, there were about 25 miscarriages in four hamlets with the maximum number in Nathapalayam. Parakadai women did not report any miscarriage.

Table –3. 16 Abortion Experience of Women

Number of times	Villages			Row total
	Mettur	Nathapalayam	Thurambady	
Once	2	2	—	4
Twice	—	2	2	8
Thrice	1	—	1	6
Seven	—	1		7
Total abortions	5	13	7	25

Conclusion

The practices regarding production and re-production amongst Madhari women of Thurambady Panchayat is not an exception to the status of poor women in India. The pressure on them to perform both the functions of production and re-production is tremendous. Apart from the above-mentioned practices a woman also has to perform the role of a mother. The next chapter deals with this aspect in women's life – the childcare.

Chapter 4 - Child Care Practices

Overview of Children under Five Years of Age

This chapter attempts to provide an overview of child-rearing practices amongst the Madhari population in Thurambady Panchayat. It deals with children below the age of five years. An attempt is also made to study the differences if any, between the child care practices for older children and those under five years of age.

Age of the Children

There are about 78 children between the 0 – 5 years age group. Table 4.1 gives the sex distribution of these children.

Table – 4.1 Sex Distribution of Children Under Five Years of Age

Sex	Villages				Row total
	Mettur	Nathapalayam	Parakadai	Thurambady	
Male					
1	13 61.9	12 54.5	8 34.7	7 58.3	40 51.2
Female					
1	8 38.0	10 45.9	15 65.2	5 41.6	38 48.7
Column Total					
2	21 26.9	22. 28.2	23 29.5	12 15.4	78 100

Note: *1* = Column percentage, *2* = Row percentage

From the table, it is clear that there are more male than female children in the habit except Parakadai, which has a reversed ratio (1.8 female to one male) as compared to the other hamlets. It has the highest percentage (39.5%) of all female children below five years in the hamlets. Parakadai also has the highest proportion of female under five years (28.3%) in the total population of the hamlet. Thurambady has the lowest proportion of children below five (10.5%) with respect to total population but the population of under five years-old girls is lowest in Mettur hamlet (38%)

Out of the 78 children, there are 20 children below one year old. Of these, Mettur has

three, Nathapalayam has six, Parakadai eight and Thurambady three. Thus, Thurambady and Mettur have the lowest and Parakadai the highest number of infants.

The children under five year's age are distributed in 51 houses in all the four hamlets. There are 14 households with one child under five years, 21houses with two children under five years and nine houses with three children and seven houses with four children under five years, (Table 4.2). Here again, one finds that hamlet 90% of the families in Parakadai and Thurambady that have two children. In Nathapalayam the number of households increased with the increase in the number of children in the house hold. In Mettur it shows an equal distribution.

Table –4. 2 Households with Children Under Five Years of Age

Number of household	Villages				Row total
	Mettur	Nathapalayam	Parakadai	Thurambady	
1 Child	4	1	7	2	14
1	26.6	9.1	46.6	20.0	27.5
2 Children	5	2	7	7	21
1	33.3	18.2	46.6	70.0	41.2
3 Children	3	5	1	—	9
1	20.0	45.5	6.8		17.6
4 Children	3	3	—	1	7
2	20.2	27.8		10.0	13.7
Column Total	15	11	15	10	51
2	29.4	21.6	29.4	19.6	100.0

Note: *1* = Column percentage, *2* = Row percentage

Regarding the sex distribution of the children under five and the order of birth it is interesting to note that in the second and subsequent deliveries there are more male than female children in all hamlets except in Parakadai, which has more females in the second delivery. Also it is only in the first order birth that female infants seem to have a better

chance of survival. Nathapalayam has more third and fourth order deliveries followed by Mettur, whereas Parakadai and Thurambady have fewer deliveries after second delivery, (table –4.3).

Table –4. 3 Sex Distribution and Order of Birth in Under Five years of Age

Order	Villages								Row total
	Mettur		Nathapalayam		Parakadai		Thurambady		
	M	F	M	F	M	F	M	F	
1st child *1*	2	5	3	3	8	6	4	1	33 42.4
2nd child *1*	5	2	5	3	—	6	2	4	29 37.1
3rd child *1*	2	1	3	2	—	1	—	—	9 11.5
4th child *1*	3	—	1	2	—	—	1	—	7 8.9
Column total	13	8	12	10	8	15	7	5	78 100
2	21 26.9		22 28.2		23 29.5		12 15.4		

Note:' M' and 'F' refers males and females respectively
1 = Column percentage, *2* = Row percentage

Place of delivery

Table 4.3 shows 42 children (53.8%) were delivered at the government hospital, 17 children (21.7%) at the private hospitals, and 19 children (24.7%) at home. In Nathapalayam, 18 out of 22 children (81.8%) were born in hospitals, followed by Thurambady with 9 out of 12 (75%) born in hospitals, Mettur has 16 out of (21 (76.1%) and Parakadai 16 out of 28 (9.5%) born in the hospitals.

Table – 4.4 Place of Delivery for Under Five Years of Age

Place	Villages				Row total
	Mettur	Nathapalayam	Parakadai	Thurambady	
Government hospital	11	12	13	6	42
1	52.4	15.4	56.5	50.0	53.8
Private hospital	5	6	3	3	17
1	23.8	27.3	13.0	25.0	21.8
Home	5	4	7	3	19
1	23.8	18.2	30.4	25.0	24.4
Column total	21	22	23	12	78
2	26.9	28.2	29.5	15.4	100.0

Note: *1* = Column percentage, 2 = Row percentage

Table 4.4 shows Nathapalayam having a maximum of 81.8% of children born in the hospital. Mettur and Thurambady have 75% to 76% children born in the hospital. Parakadai has the least number of 57.5% children reported to have been born in hospital. It is interesting to note the decrease in home delivery in the case of children less than five years. Out of 263 children born in the SC hamlets, there were 149 (56.6%) deliveries at home. This has reduced to 24.3% instances of deliveries at home. The number of deliveries in the private hospital also shows an increase when compared to the total deliveries in the hamlets. This reflects the change in the attitude of the people regarding hospital delivery. Out of the total deliveries, Parakadai has the least number of deliveries (39.5%) conducted at home while the other hamlets had 55% to 63% deliveries at home. The figure for children under five years shows Parakadai having the highest number (30.4%) of deliveries at home while the other hamlets showing only 18 to 25%.

Table –4.5 Place of Deliveries and Order of Birth

Order	Village						Rowtotal
	Government hospital		Private hospital		Home		
	M	F	M	F	M	F	
1st	9	9	9	4	—	2	33.
1	21.4	21.4	52.9	23.6		10.5	42.3
2nd	7	6	3	1	2	10	29
1	16.6	14.3	17.6	5.8	10.5	52.6	37.1
3rd	5	1	—	—	—	3	9
1	11.9	2.4				15.8	11.5
4th	5	—	—	—	—	2	7
1	11.9					10.5	8.9
Column Total	42		17		19		78
	53.8		21.8		24.3		100.0

Note: 'M' and 'F' refer to male and female respectively
1 = Column percentage, *2* = Row percentage

As shown in table 4.5, parents prefer hospitals for their first child. 31 out of 33 children (93.9%) of first birth order were delivered in the hospitals. The number decreased in the second order. 17 out of 29 children (58.6%) belonging to the second order were delivered in the hospital. In the subsequent deliveries, the children born in the hospital decreases, even though more male babies are born in third and fourth order births. Though there were no cases reported regarding female feoticide, one is left to find answers for the higher births of male children in the third and the fourth deliveries. Due to time constraint and the seriousness of the problem, the topic was not discussed in detail with the people.

Childcare practices

It has been established that the period from birth to about two years is the important phase, as it forms the basis of later development. In order to understanding the dynamic relations and the complex interaction between the mother and the offspring, with each affecting the other, is important in the study of child care. The practices that are followed

after delivery differ from one culture to another and help in enhancing the bonding between mother and child. The most important interaction between the mother and the child in the initial stages is breast-feeding followed by other caring activities, all of which are culturally determined.

The practice of pregnant woman going to her parents home in the seventh month, after a brief ceremony (*Simaandham or valakappu* in Tamil) is mostly, prevalant among the *Madharis*. Depending on the customs followed in the girl's village, the mother and the newborn return to the village either after the first weaning or after the mundan ceremony. Most mothers said that due to their inexperience in childcare, the maternal grandmother or elderly women in the family look after the first baby. At the same time, the mother is given advice and instructions regarding handling of the baby. Only few go to their parent's house for subsequent deliveries as mother starts handling the baby on her own.

Breast feeding practices

In Thurambady Panchayat, amongst the *Madhari* population, the initiation of breast-feeding is delayed by few hours to three days. The newborn is given either castor oil or sweetened water as prelactational feed. The women of the hamlets said that the prelactational feed acts as a mild laxative to remove the wastes from the stomach ('*Kadipi*" in colloquial terms) of the newborn. The nature of prelactational feed depends upon the place of delivery. In the hospitals, administering castor oil is prohibited, therefore sweetened water is given. Recently, due to the government policy, emphasis is laid on the importance of colostrum for the newborn. Thus, the hospitals born babies are being advised to be given colostrum. The babies born at home are mostly given castor oil. More than 80% use dropper ('*Sangu'* in Tamil) to give prelactational feed and the rest use pieces of cloth or fingers.

Table –4. 6 Place of Delivery and Prelactational Feed

Nature	Place of Delivery			Row order
	Government hospital	Private hospital	Home	
Castor oil				
1	5 11.9	—	15 78.9	20 25.1
Sweetened water *1*	25 28.5	10 58.8	4 21.0	39 50.0
Colostrum				
1	12 28.5	7 41.1	—	19 24.3
Column total				
2	42 53.8	17 21.9	19 24.3	78 100.0

Note: *1* = Column percentage, *2* = Row percentage

As reflected in table 4.6, 20 children (25.1%) were given castor oil, the maximum number being for those born at home. Sweetened water was given to 39 children (50.0%). Colostrum was given to only 19 children (24.3%) with the highest number being those born in private hospitals (i.e. 41.1% of the total children born in private hospital).

When asked about their perception on colostrum, the women said that though colostrum is not considered something 'bad they discard it because it hinders regular bowel movement of the newborn. They also said that in the hospital when they are instructed to give colostrum to the baby, they pretend to give it but, they try and discard it.

Our data shows that despite hospitals emphasizing early breast feeding and the larger proportion of hospital deliveries, colostrum is still denied to the babies in about 75% of the cases. Sweetened water is popular and puts infants at the risk of infection. Theiivanai, from Mettur, mother of two children, both born at the hospital, said "after seeing the difficulties faced by the first child, due to feeding of colostrum after birth, I refused to give it to the second child when instructed by the doctor".

Breast-feeding was done in 100% of the infants. It was done only on demand, irrespective

of age and sex. The women said that the child would know better that about the time it wants to feed. The baby is fed with the mother either in a sitting or lying down position. For a child who is below six months, the feeding is done seven to eight times for three to four minutes. Once the weaning starts, the duration of breast-feeding reduces and the interval between two feeds increases. Women who come from poor families' breast-feed their children for longer period. This undermines maternal health, which has a direct impact on the child.

The *Madhari* women of Thurambady Panchayat partially breast-feed their babies for about a year or more. About 38 children (48.7%) are partially breast fed for one to two years, while 24 children (30.8%) for about a year. It is also clear that more number of male children (22 males) are partially breast fed for one to two years compared to their female counterparts (16 female). This trend is reversed in the 6 – 12 months grouping, where more female children (15) are partially breast fed than their male (9) counterparts. Nathapalayam has the maximum number of children (22.7%) breast fed for more than two years. Parakadai and Thurambady have 47.8% and 41.6% of children breast fed for 6-12 months (table 4.7). Since these two hamlets belong to the agriculturally rich area that demands labourers around the year, there could be compulsion to stop breast-feeding at the earliest. No case was reported in the hamlet regarding the children depending on total breast feeding after nine months.

Table –4.7 **Years of Breast Feeding**

Years	Villages								Row total
	Mettur		Nathapalaym		Parakadai		Thurambady		
	M	F	M	F	M	F	M	F	
0-6 months *1*	2	—	—	—	—	1	1	—	4 5.1
6-12 months *1*	2	2	2	2	3	2	2	3	24 30.8
1-2 years *1*	7	6	8	5	4	3	3	2	38 48.7
More than 2 years *1*	2	—	2	3	1	3	1	—	12 15.4
Column total *2*	13	8	12	10	8	15	7	5	78 100.0
	21 26.9		22 28.2		23 19.5		12 15.4		

Note: 'M' and 'F' refer to male and female children
Table includes 28 children under 5, who are breast-feeding at present
1 = Column percentage, *2* = Row percentage

Almost all the *Madhari* women of Thurambady Panchayat said that their diet did not change during lactation. Some of them said that they avoided certain food items contained coconut, and excess tamarind, during lactation, for fear that the child would not be able to digest milk that contained these items. Otherwise, they did not avoid any food items in particular, except when they experienced the unsuitability of a particular food item for the baby.

Most of them added that they consumed beef regularly in order to increase the secretion of breast milk. The women of the *Madhari* community are given a mixture of palm sugar and jaggery after delivery for about a week or two to increase the secretion and flow of breast milk.

Causes of stoppage of breast feeding

There are various methods adopted to stop breast-feeding. The commonly prevalent method is the physical separation of the child from the mother. Most mothers said that the child gets depressed due to the sudden stoppage of breast milk and separation from the mother for the first time. The child usually and sometimes, also falls sick. They said that this is a normal process. The other methods adopted are applying bitter substance like juice of *Kathalai* (a plant) or *neem oil* over the breast. Some mothers also said that the children stop breast feeding on their own once the mother's got pregnant.

Sellathal, mother of four children, is still breast feeding her two-year-old daughter. The method of applying the juice of *Kathalai* had failed to stop breast feeding the child. She does not want to send the child to her parent's house as she had already suffered. Her second child was separated forcefully in order to stop breast-feeding. This made the child lose weight and the family had to suffer to save the child.

Table – 4.8 Causes for Discontinuation of Breast Feeding

Causes	Villages				Row tota
	Mettur	Nathapalayam	Parakadai	Thurambady	
Next pregnancy	8	11	6	2	27
1	53.3	68.7	60.0	22.2	54.0
Less secretion	3	1	2		6
1	20.0	6.3	20.0	—	12.0
Child had grown	4	4	2	7	17
1	26.6	25.0	20.0	77.7	34.0
Column total	15	16	10	9	50
2	30.0	32.0	20.0	18.0	100

Note: 28 children breast feeding at present are included
1 = Column percentage, *2* = Row percentage

Table 4.8 shows 54% of children had stopped breast-feeding due to the mother's next pregnancy. 53 to 58% gave the cause as the next pregnancy for discontinuation of breast

milk in all the hamlets. Thurambady had the reason of child being old enough to stop breast-feeding. It also did not have any case of inadequate secretion. Nathapalayam had 6.3%, which is three times lower than Mettur and Parakadai. Since Thurambady belongs to an agriculturally fertile area, the pressure on the mothers to stop breast feeding the child would be tremendous and they perceive the child being grown up as the reason.Valli, mother of two children from Nathapalayam said that there is a pressure from her husband to stop breast feeding the recently born girl child because this will help her in early conception.

Cleanliness and clothing

The new borns are kept under the rising sun for five to ten minutes daily. Most of the mothers didn't know the reason for that practice. They all however said that it is good for the baby. The baby is given bath once a week for a month, followed by once a day or once in two days in the subsequent months. The water is warmed and either besan or a mixture of special ingredients is used to clean the baby. The baby is massaged while bathing. The head bath is given after a month of birth with 15 days interval. The baby is exposed to the smoke of a *sambrani* (a type of Lac) after the head bath, to be protected from catching common cold. After the bath, the baby is powdered and given black *bindhis* (dots) on the forehead, cheeks and feet to ward off the evil eye. The baby is also made to wear black bangles and a black sacred thread around the neck. It is customary for the maternal grandparents to give a waistband and a pair of anklets made of silver.

The child is clothed in a cotton fabric. Most of the time, the baby's body is not covered. The head of the child is also not covered except when the baby is taken out in the evening during winters.

In all the houses in the hamlets, the child sleeps in a cradle made of cotton fabric during the daytime and on the floor in the night with the mother. The rest of the day the child is laid down on the floor over a cotton cloth. The soiled pieces of cloth are washed in hot water once or twice a day. *Gingelly oil* or *coconut oil* is applied on the baby's head, in order to reduce the heat from the body. Earlier castor oil was given regularly to the babies to clean the system, but now this practice has stopped. The mothers of the hamlet said

that the hospital staff abhors the practice of giving castor oil. When they take their children to the hospitals during ailments, they are shouted at and refused treatments if the hospital staff knows their practice of giving castor oil to their babies. This made them stop the practice.

Weaning

The children of Thurambady Panchayat are weaned by the fifth month. By this time, the mothers said that they feel more confident in handling the child, especially the first one, on their own. According to them, this phase of child growth needs more attention as they start to crawl and are prone to accidents.The mothers' do their household works only after the child is asleep or somebody comes to relieve the mother. The father or the siblings help the mother to look after the child, while she is engaged in her household work. But some mothers like Vellathai, Aral and Nachi find other ways to look after the child while working.

Vellathai, mother of two children from Nathapalayam said that she goes to the entrance of the village to find somebody to look after the child till she finishes her household work in the evenings. Aral, from Thurambady, said that she finishes her household work when the child is asleep. Nachi, of Mettur leaves the child in the courtyard with puffed rice scattered while the child is busy picking up and eating she finishes the household work. Mangathal said that when her child started to crawl, it needed her full time and attention and had to be looked after. This, according to her, was very tiring.

The regular administration of additional food along with the breast milk to a child is an important phase in its life. Amongst the *Madhari* population of Thurambady Panchayat, the initiation of weaning is early.

95% of the children under five in these hamlets were weaned at the age of five months. The rest were weaned before their ninth month. The mothers feel that breast milk is not enough for a child of five months. They start with mashed *idlis* and biscuits. Once the child starts to eat food on its own (by the sixth month), the mother then feeds the baby with rice mixed with coconut oil or curry. By the time the child is one and a half years

old, the child is taught to eat on its own. Most of the mothers said that the family members while eating also fed the children. The mother usually serves the food and nothing special is prepared for the children. The children are fed with the food cooked for the elders. The children, on an average, eat four to five times. Almost all the mothers said that they do not avoid any food items for the children, unless the child is specifically allergic to it. There are about 30 children from Mettur, seven from Nathapalayam, five from Parakadai and ten from Thurambady who were given supplementary milk during weaning. The maximum numbers in that category are male (about 20 of them). On an average, these families were buying quarter to half litre per day for the babies. The mothers of these children said that the babies are given diluted milk because the babies would not be able to digest the undiluted form. The milk is given only at the interval between meals and not as a subsititute for a meal.

Apart from food, the mothers said that the children need 'snacks'. In Nathapalayam, where there is a grocery shop, Rs. 5 to Rs. 10 is spend on an average in a household with two children. This also depends upon the amount of money a mother had. In the rest of the hamlets, they buy 'snacks' from the town. Some mothers said that they do not buy any 'snacks' for the children, as it becomes a bad habit.

Socialization

Children of this age group are not directly under the mothers' care all the time. The family members 'take over to look after the child though the mother looks after the feeding and other activities that need her attention. The child is fed without the mothers knowledge, when it is taken to the near relatives house with the village. By the age of three, in Thurambady and Nathapalayam, the child is sent to the *Balwadi*. In the other hamlets, the mother or an elderly woman of the village (who is invalid to work in the fields) either looks after the child. The child is slowly taught to do work and manage to look after itself. If it is a girl child, she is taught to help the mother in household work. By the age of five, she is equipped to keep the house in order and to help her mother in the kitchen.

Palanal from Nathapalayam has three female children and a newborn male child. She is

assisted by her eldest daughter (six years old) in doing household work. She sits with the baby in the cooking place and gives instructions to her daughter for cooking. While the eldest daughter assists her in cooking and fetching water, the younger daughter, four years old, goes to the shop for purchasing commodities that are needed.

Mari, 40 years from Parakadai, said that it is important for the girls to learn household work. The practice according to her should start from a young age, which will help her to master it, else it will bring bad name to the girls' family. She also said that a girl seen sitting idle brings ill luck to the family. A boy, according to her, can get away with anything in society. He can do things as he wishes but a girl should learn from childhood the way to carry the family through.

Impact of resumption of employment on childcare

The economic condition of the family pushes the mothers to resume their work outside the house shortly after delivery. This has a direct impact on childcare, as this affects the dietary habits and the personalised care needed for a child. Table 4.9shows the resumption of employment is prevalent mostly between three to twelve months. Keeping in mind the need for agricultural labourers throughout the year in Parakadai and Thurambady, one can see the highest percentage in these two villages in resumption of work by women between three to twelve months. Nathapalayam has the highest percentage of cases where the mothers had reported to have not resumed work before three months.

Table –4.9 Resumption of Employment

Years	Villages				Row total
	Mettur	Nathapalaym	Parakadai	Thurambady	
3 months after delivery	1	—	1	1	3
1	4.8		4.3	8.3	3.8
Between 3-12 months	4	7	15	8	34
1	19.0	31.8	65.2	66.6	43.6
After 2 years	7	3	2	3	15
1	33.3	13.6	8.7	25.0	19.2
Not yet	9	12	5	—	26
1	42.8	54.5	21.7		32.0
Column total	21	22	23	12	78
2	26.9	28.2	29.5	15.4	100.0

Note: *1* = Column percentage, *2* = Row percentage

Palanathal, from Thurambady said that she resumed her employment when her child was three months old. She used to take the child to the field. The child was born during the peak season of agricultural activities. She said that if she didn't work, then she would not be able to save any money for the dry season, she added that once the child is six or seven months, it would become impossible for her to take the child to the field. Pushpa, mother of a two-month baby, from Thurambady works in the powerloom unit. She is not living with her husband. She started working as she finds it difficult to depend on her brother for the expenses. She took the child along with her but finds it difficult to cope with both the works in the unit and caring for the child. She also feels tired. After two days, the baby fell ill as it was unable to take the sound of the loom and the heat in the unit.

There are *Balwadis* in Thurambady and Nathapalayam where the mother's of these hamlets leave their children while going to work outside the house. The mother looks after the child for two to three years. The mother of children under five, work

temporarily, when they are pressurized for money to meet expenses.elammal, mother of two children under five, from Mettur said that she goes to work outside the house when her husband does not give her money to meet the household expenses. She added that it becomes difficult to run the house, with two young children, and just one earning member in the family. She leaves the children with a elderly woman when she goes to work.

In Mettur, and Parakadai, there are no *Balwadis*. The women face problem, regarding the care of the children, when they are out to work. They say that they do not want any facility but a *Balwadi* in their hamlet. There are cases in Mettur and Nathapalayam where the sibling takes care of the child.

Table 4.10 Substitute for Child Care in Under Five Years of Age

Substitute	Villages				Row total
	Mettur	Nathapalayam	Parakadai	Thurambady	
Old women	2	2	14	1	19
1	9.5	9.1	60.9	8.3	24.3
No substitute	16	10	8	—	34
1	76.1	45.5	34.8		43.6
Sibling	3	—	1	—	4
1	14.3		4.3		5.1
Balwadi	—	10	—	11	21
1		45.5		19.6	26.9
Column total	21	22	23	12	78
2	26.9	28.2	29.5	15.4	100.0

Note: *1* = Column percentage, *2* = Row percentage

In Nathapalayam and Thurambady one can see *Balwadi* to be an alternative for childcare. 43.6%of the children are reported to have been looked after by the mother herself. A

large number of children (24.3%) are looked after by the old women of the village. It is important to note that these old women are at home only because they are unfit to work outside the house. Most of them stay indoors with the child, till the mother comes back. The mother of the child gives the food to these old women to feed the child when it cries.5% percentage of children are taken care of by their siblings. Mettur has the highest percentage in this category (Table 4.10).

Utilization of health service system

Mettur and Nathapalayam are in the dry part of the Panchayat whereas Parakadai and Thurambady are in the wet area. Therefore, the mothers of Parakadai and Thurambady complained about seasonal ailments during rainy season. Water logging in the hamlet acts as a breeding ground for mosquitoes. In Mettur and Nathapalayam, the mothers complained about chronic ailments like common cold, scabies, boils etc. In all the four hamlets, the mothers said that if the ailment is mild, first they try to cure through home remedies and only if it does not get cured they take the children to hospital. They also added that for specific ailments, for which there is no cure in the allopathic medicine (like *yettu kunam*[1], *punupu*[2], etc.) they approach the traditional practitioner. It is only for fever, diarrhea, and other ailment for which they find the cure inadequate among traditional practitioner that they approach the doctors.

There are only three households in the hamlets, which said that they go exclusively to private doctors. The family from Thurambady utilizing the service of private hospitals said that they had a child after four years of married life, which was possible only due to the medication given by the doctor they approached. Therefore, they feel confident going

1 The symptoms are the child becomes inactive, shows disinterest in eating, playing etc.
2 When the breast-fed child vomits smells of sour milk.

to the doctor for the child's treatment. The other two families from Mettur said that the young children need more care during ailments and this is provided only by the private hospital. Therefore they prefer this.

The rest of the families in the hamlet do utilize the service of public, private and the traditional health service systems depending on the ailment, time and the money they have at that time. A 50-year old woman, mother of eight home delivered children from Mettur said that the newborn face problems because of regular visits to hospital. She complained that it has become fashionable among the newly married couples to go to the hospital since the time of conception. Once the habit of going to the hospital is cultivated, then it becomes a routine affair. Even small ailments cannot be cured through home remedies or traditional practitioners. She believes that the medicines given in the hospitals reduce the immunity among children and increases the dependence on them.

99% of the mothers had got vaccinations done for their babies. Though they could not recall the exact time of vaccinations for their children, they seemed to be aware of the importance of vaccinations and a broad time period within which they should get the vaccinations done. The role of workers from Tamil Nadu Infant Nutritions Programme and the staff of Primary Health Centre is noteworthy in giving information to the mothers regarding the time and importance of vaccinations.

Chapter 5 - Case Reports

Case Report No. 1

Selvi (23 years) and Palanisamy (25 years), cross cousins, have been married for five years. Palanisamy works in the poultry farm and earns about Rs.100-150 in two days. His work is irregular in nature. Selvi works at home. She stopped working in the fields after she conceived her first child and she has not resumed work ever since as there is nobody to take care of her children. The family owns a tiled house, which has one room and a verandah. A thatched kitchen is built separately on the right side of the house. They own a television set (black & white), a two-wheeler and a cycle.

The couple had a son after a year of marriage. The child was delivered in a private hospital. Selvi went to the hospital only after eight months of pregnancy when she faced severe back problems during the ninth month. The doctor advised her to opt for an operation to avoid further complications. As the amount for the operation (Rs.20, 000) was too much for them to pay, they told the doctor that they would return with the money and came back home. After fifteen days, when the pain became unbearable Selvi was taken to another private doctor where the baby was delivered with the help of forceps. The amount spent was only Rs. 1,000/-.

The baby boy was given sweetened water immediately after birth and was breast-fed after a day. Though the doctor told Selvi to feed the baby with colostrum, the elders advised her to discard the colostrum before feeding the baby. The child was breast-fed only on demand. For five months, the child was given only breast milk. After that, biscuits (1-2 pieces) dipped in 100 ml of milk were given. In the seventh month, when he started eating rice from other's plates, the mother started giving him a handful of rice mixed with coconut oil in the mornings and afternoons. In the tenth month, the boy was fed with meat and rice mixed with curry. By the age of one and a half years, the boy started to eat separately and was given food in the morning, afternoon and evening. Food is cooked in the morning and in the evening. While cooking in the evening, Selvi drains the starch water and feeds it to him. During this time, the boy was breast-fed three-five times, whenever he asked for breast milk. Each breast-fed lasts for about 3-4 minutes.

The baby was given the rice and curry that was cooked for the other members of the family. There was no special preparation for him. A week's supply of rice is bought at a time while *dal* and vegetables are bought daily from the local shop, depending upon the

availability of money. The baby does not have a separate plate or glass for its exclusive use. Warm water is given to him only when he catches a cold. He stopped breast-feeding after two years, when Selvi was two months pregnant with her second child. She said that during pregnancy, she ate rice cooked for the entire family. There was no special preparation. She didn't reject any food items.

The second child was born in the house. As the couple faced problems during the delivery of their first child and since they had a son during the first delivery, they did not feel the need to go to the hospital for the second delivery. Two elderly women who cut the umbilical cord with a sickle conducted the delivery. The elders did not welcome the birth of a girl child. The father did not come home to see the daughter for three days and the paternal grandfather has not seen the child till today. Selvi felt hurt by the attitude of the family members and she said that it is the girl child who would care for the parents in their old days. Though the near relatives pay more attention to the male child, Selvi does not discriminate her girl child. The baby was given castor oil immediately after birth and after two days, she was breast-fed. The child was not given colostrum. Selvi had to resume her household work after five days of her delivery. The baby is breast-fed only on demand. During the daytime, the breast-feeding is done in a sitting posture and during the night, the baby sleeps beside the mother and feeds on her own and sleep. The baby was given rice with coconut oil when she was five months old. She was given rice in the morning (8:30 a.m.), afternoon (12:30 p.m.) and night (8:00 p.m.). The mother gives starch water to both the children. Whenever the children cry, she gives them bananas or biscuits or puffed rice from the local shop. The baby girl is still breast fed and has not been given non-vegetarian food yet. The mother feels that she should stop breast feeding the child as she is growing up. She says that she had not avoided any food during her pregnancy or lactation period.

The family has meat twice a week. Selvi says that she has enough breast milk due to the beef they consume. The cooked food is shared amongst the family members as per requirements. The mother eats after serving the children, leaving a considerable amount for her husband. Her husband gives her Rs.50/- in two days to meet the household expenditure. Once this sum is over, she has to ask him again. If it is his working day, he gives her the money, otherwise he asks her to show the bills of expenditure. Selvi feels scared to ask her husband for money while he regularly spends money on alcohol. She

says that his spending is justified because he is the one who earns for the entire family. In case of an emergency, he goes to the owner of the poultry farm and gets some advance, which is paid back in installments from his earnings.

Selvi tries to keep the house clean by sweeping it when it gathers dust. The boy goes out to play with other children in the street. The girl remains naked and is made to play inside the house with old bottles and cans. She crawls all over the house and puts whatever comes in her way into her mouth. Her mother does not object to this. Selvi mops the house with cow dung during festival times.

The boy and the girl are given a bath in the afternoon everyday in cold water. For about 10 days after birth, the elderly person who accompanied the mother bathed the child with warm water and a mixture prepared with turmeric powder and *besan*. After a month, the baby was given a head bath and was shown incensed powder (a lac from a tree) to protect it from cold. The baby is massaged everyday before being given a bath. After two months, the baby was bathed with baby soap. Then the children's faces and bodies are powdered. A black *kajal bindi* is put on the forehead, cheeks and below the feet of the younger child and on the forehead of the elder child. Coconut oil is applied for both in the morning and evening. The daughter's hair is tied in a band. At the eleventh month or at three years of age, the girl's hair will be removed and her ears will be pierced. The children are made to wear clean clothes. The daughter sleeps in a cradle after this (a baby is made to sleep in a cradle till 5-6 months). The mother finishes her household work while the baby sleeps. She fetches water from the tap, washes clothes, bathes (once in 2-3 days) and cooks for the night. By 5:30 p.m., she finishes her work and sits outside her house or watches television till 7:30 - 8:00 p.m.

The water source is the public tap. There are separate taps for hard water and drinking water. Water and drinking water is stored in plastic pots for other purpose and in a stainless steel vessel for drinking. The family has very few utensils for their daily cooking. They wash the utensils in front of the house, using ash and mud to remove the soot.

For defecation, the mother and father go outside in the open field. The daughter is held between the mother's legs and is made to defecate on a piece of paper. Later, the paper is thrown outside the house. The son is made to sit just outside the house and the faeces are

left in the open. The mother cleans the boy and girl after defecation but she doesn't wash her hands with soap. She does household work immediately after this. Sometimes, she does this in the middle of cooking activities like cutting vegetables or cleaning rice.

The son has been given vaccination four times (3 months, 5 months, 1½ years, 3 years) and polio drops are given whenever the scheme comes. The daughter has been vaccinated twice (3 months and one for small pox). She was also given polio drops twice. Selvi does not know the reason for giving these injections but she said she promptly gets these done because the nurses have told them about the consequences of not giving vaccinations.

The children are taken to the hospital for fever and cold only if it is not cured with the tablets bought from the local shop. When the child cries without any reason or if the child suffers from stomach upset, they go to the traditional healer and get the required materials, put it in the fire and make the baby inhale it. They also get an amulet and tie it around the baby's waist. The elders in the village usually advise the parents to go to the healer because they believe in the competence of the traditional healers. Selvi says that in her experience, she has seen that these problems do not have any cure in the 'English' treatment.

If she has to take the child to the hospital, she waits for her husband to come. They usually go to the government hospital and only on recommendation, they go to the private hospital. She says that there are contradictions between what the elders say and what the nurses and TINP workers say. For vaccination and for other diseases that need hospital treatment, they follow the nurses' advice and for the rest they follow the elders' advice. Selvi is waiting for her children to grow up before she gets family planing operation. She is satisfied with one boy and one girl.

Case report No. 2

Poongodi (30 years) and Chenni (35 years) have been married for more than ten years. Both are uneducated. Chenni works in the powerloom sector situated within the village. He gets work throughout the year except in the rainy season, when the yarn takes time to dry after dyeing. His wage depends on the number of pieces he weaves per day. On an average, he weaves for around Rs. 60-75 per day. The system works in shifts and he works day shifts and night shifts in alternate weeks. Sometimes, he tries to do extra shifts if a person absents himself. Sunday is a weekly holiday for the entire powerloom sector. Poongodi feels that there should be no Sunday at all because her husband, like the other men of the village, drinks and gambles. The womenfolk of the village cannot raise objections openly. She does household work and looks after the children.

The couple owns a house, which is tiled and electrified. It has one room and a verandah. The room has a platform with a *chulah* that does not have any opening for the smoke. There is a small space in front of their house and a boundary wall encloses the house. The drainage facility is in front and the drain water flows into the street. This is also used as the bathroom. They fetch water from the separate taps for drinking water and water for other purposes. The water comes from 4 p.m. to 6 p.m. For defecation, the adults go to the open space and the elder son is made to sit on the other side of the street that opens into a field. The infant daughter is made to sit on the mother's legs; the faeces are cleaned later by the mother. The mother helps the boy clean himself.

The couple did not conceive for five years after their marriage. So they went to a private doctor in the *taluk* headquarters, Dharapuram. After conception, Poongodi went for monthly checkups. She was given injections and tablets regularly for the entire period of pregnancy. She does not know the reason for her failure to conceive for so long. Nor does she know the name or purpose of the tablets she was given; she did, however, consume them regularly without fail. Each visit to the doctor cost them about Rs. 100-150. She stopped going for her *coolie* work. During pregnancy, she did not avoid any food. She argues that, "We do not buy anything nutritious to eat as do the rich families, even during pregnancies. What will happen to us and the babies if we avoid this and that?" She

however avoided any hard labour for the fear that it would be dangerous for the baby. In the seventh month of pregnancy, a ritual was conducted to take Poongodi to her mother's place. Since her mother's village is not well connected by bus, she stayed in the same village (This village is on the main road that connects the union headquarters, from where there is a round-the-clock bus facility to go to *taluk* headquarters, Dharapuram). In her tenth month, when her pain started, she was taken to the hospital she regularly visited, in a taxi and had a normal delivery. She said that the total expenses since conception came up to Rs.10, 000.

The child was given colostrum immediately after birth. After three days in the hospital, the mother and child returned to the house. Poongodi's mother stayed with her for ten days, after which Poongodi started doing the household work herself. Though her in-laws stayed in the same village, they helped her only after her mother left that too only in fetching water and bathing the baby. By the time the baby was a month old, Poongodi started managing all her work herself.

The baby was bathed everyday in hot water and *besan* for 12 months. After that, it was bathed with cold water and detergent soap. Head bath was given once a week in hot water and *besan*. He was powdered and *bindis* were put on his cheeks and forehead. Incensed powder (*sambirani* – a lac from a tree) was shown to him after a head bath. The baby slept in the cradle in the mornings and afternoons and with the mother during the nights. Breast milk was given in a sitting posture in the afternoon and lying down in the night. He was breast fed for four years. Though there was pressure from elders to stop the feeding at the age of two, Poongodi didn't pay any heed. But later, they had difficulty in putting the baby off breast-feeding.

The child was fed with biscuits at three months and by seven months, he started having rice on his own. Between 1-2 years, he had food about 7-8 times in a day. Nothing special was made for him; the food that was cooked for everybody at home was served to him – rice from the local shop and *dal* with a few vegetables and sometimes pepper water. Whenever he felt hungry, he was given food. By the time he was three years old, his diet got regularised into morning, midday, afternoon, evening and night. By now, the breast-

feeding had reduced to four times a day; it was on demand as it had been since infancy. Nowadays, he has his afternoon meals at school (midday meals programme). She complains of 'evil eye' having set on his eating habits because he asks for snacks all the time and eats little food, that too irregularly. She spends about Rs.10-15 everyday buying biscuits and snacks from the local shop for both the children.

The boy (six years old now) has been injected thrice. She has forgotten the months when the injections were given and doesn't know the diseases for which they were given. During the second injection, the child had high fever, for which they went to the VHN for tablets. Otherwise, they always go to the private doctor in Dharapuram. She never buys medicines from the local shop. In case of an emergency, she calls her husband from the powerloom in order to go to the doctor.

The second child, Nandini is one year old and was also born in the private hospital, Dharapuram. During pregnancy, Poongodi didn't go to the hospital for checkups. The injections were given at the VHN itself. Only after the pain, she was taken to hospital in a taxi. As with her first pregnancy, Poongodi didn't avoid any food during pregnancy and lactation. She had a normal delivery and they spent about Rs. 5,000/- for a three-day stay at the hospital. This time, her mother stayed for two days only. Her mother-in-law helped her for about ten days. Asked about her feelings towards the girl child, Poongodi said that they didn't mind the child being a girl as they already had a boy. She has not undergone a family planning operation as she wants another child "...with God's blessing...". After the birth of the girl, the boy was sent to his maternal grandmother's house for a month.

Nandini was given colostrum immediately after birth. Weaning started at the third month, as the mother didn't have enough milk. She ate beef every week to increase breast milk but it didn't help. They bought buffalo milk from the cooperative milk society (400ml in the morning and 200ml in the evening). They also started to feed the baby with rice from time to time. Now (at age one), they have stopped buying milk from the cooperative society. The mother feeds the baby in the morning, midday, afternoon and night. In between, snacks are given. No special preparations are made for the child. Starch water is given in the evening sometimes, during cooking.

The child is made to play in the house. She remains naked most of the time as it is too hot for her to wear clothes. After a bath in the evening, she wears only her undergarments. Her hair is tied with a band after applying coconut oil. Talcum powder is applied on her face followed by *bindis* on the cheeks and forehead. Poongodi said that the child's hair has to be removed and the ears pierced at the age of three.

The second child has been vaccinated thrice (10 days, 15 days, 1 month) and given polio drops 5-6 times. The mother doesn't know the diseases for which the child is vaccinated. The VHN and TINP workers go home to give injections. Poongodi complained of the child being underweight and asked me to suggest some tablets. She got angry at the mention of TINP and said she doubted the efficiency of the programme.

When the children are sick, the couple goes to the hospital. Nandini was suffering from cold recently. For two days, they gave her rice with a little chilli powder. When this didn't help, they went to the child specialist. He asked them to come for 2-3 days, but they felt that the cold was better after a day of tablets. So, they didn't feel the need to go again. During cold infections, they do not give the baby anything liquid and feed it with rice and pepper water (a South Indian preparation made of tamarind, garlic, pepper, curry leaves etc.).

Poongodi also talked about various ailments that her children had suffered from. One is *Yettu Konum* (the eyebrows stand straight, the child keeps crying, refuses to eat and becomes dull). She went to the traditional practitioners to get an amulet and some ingredients to put in the fire for the baby to inhale. After every 3-4 months, they had to renew the amulet as its effective power diminishes with time. The other is *Punnuppu* (the faeces and the burp is smelly). For this too, she went to the traditional practitioners and got a mixture to feed the baby. Within an hour, the baby was all right. For constipation, they give a little bit of *perali* oil (oil produced by a specific group of people and sold in the shops).

Poongodi said that for the English ailments like fever and cold, we need to go to the doctors because the traditional practitioners do not have a cure for it. But for the ailments that are curable by the traditional practitioners, she approaches them. She says that

though the elders advise them to do certain things for the children, they always decide on their own what is to be done. (eg: when the first child was three and a half years old, he started losing weight and was not feeling well. The elders asked her to go to the priest of a particular temple but they decided to go to the hospital instead). For small burns or cuts, she grinds tablets and applies the paste on the wound. She also uses turmeric powder and coconut oil. Only for major problems, she goes to the hospital.

Since the entire village is interrelated, she can freely ask anyone for help. People do not hesitate to help her. School-going children also pick up the child in the evenings, so that Poongodi can finish her household work. She doesn't discriminate against the girl child.

The family faces a financial crunch, though the father works everyday. This is because of his lavish spending on drinking and gambling. Poongodi feels scared to ask him for money as he screams at her for asking for too much. She has not resumed work since first conception. She was at home to take care of the baby. When the child was old enough to be left in *balwadi*, she conceived again. She said that in families like theirs, it is a must for a woman to work and support the family. Since she has to take care of child she feels constraint to work outside the house. However, she is waiting for her child to grow up show that she could leave the child in *balwadi* while at work. She further states that a mother with one and a half-year-old child has more work then the others. When she went to the hospital for Family Planning operation the doctors advised her to go after few years, as she is anemic.

Case Report No. 3

Sellathal (32 years) has been married to Senthil (35 years) for about ten years. Senthil works in a poultry farm and earns about Rs.100 in two days. His work is irregular and strenuous in nature. He has to unload chicken baskets from the van and carry them to the shops. He goes at 3 p.m. and comes back after two days. He gets work depending on the need for such peoples (some months, he works daily; other months, he gets work for 4 or 5 days). Sellathal does household work and looks after the children. They stayed at Madurai for five years after their marriage but shifted here due to better opportunities and to be near their family members. Both are uneducated.

They live in a thatched unelectrified rented house. The rent per month is Rs. 30. The *chulah* is within the room. There is a dilapidated door made of palm leaves. Apart from this door, there is no means of ventilation. They have a cot outside for the father to sleep in on summer nights. In the house, there are 8-10 utensils, three plates, two plastic pots and a few tumblers. There is a space in front of the house where water is stored in a broken plastic pot to clean utensils with. Ash and mud are used to clean utensils. After washing, the utensils are kept outside to dry, and is picked up from here when needed.The drain water is allowed to flow into the field next to the house. They have a small enclosure made of palm leaves in which Sellathal bathes. The children and her husband bathe outside in the open. The water source is the public tap and to defecate, they use open spaces or the fields nearby.

Sellathal has four children, Durga (8 years), Ramesh (6 years), Rekha (4 years) and Deepika (1¼ years). The first three children were born in the government hospital at her mother's place and the last child was born at home. She says that the birth of her last two children was a result of her own fault. When asked by the hospital authorities to conduct family planning operations after her second child, she refused, as she was scared. When her fourth child was a month old, she got a family planning operation done.

For the birth of her first two children, she was at her mother's place, because they could not manage at Madurai. Though she did not go for her work as a *coolie*, she managed all the household work. She had a normal delivery for two children and her mother helped

her to look after the children till the boy was two years old. After this, her husband shifted to their native village, where they are staying now. When she was carrying her third child, her husband helped her in her household work. She said that she didn't face any difficulty during pregnancy and had a normal delivery at Mulanur PHC (Union Headquarters - five km away from the village). After two days, they returned from the hospital and her mother stayed with her for two days. Sellathal managed her household work with the help of her first child who was five years old then. The first child used to clean the utensils, sweep the floor, help her fetch water, etc.

While talking about the third chld, she said that the infant was given sweetened water and was breast-fed after a day. By the fifth month, she was given biscuits dipped in water. The child was breast fed 7-8 times in a day on demand. After weaning, the frequency reduced to 5-6 times. By the seventh month, they stopped feeding her biscuits as she got worms in her stomach. The elders advised them to stop feeding her biscuits. She was breast fed for eleven months and was then sent to her maternal grandparent's place to get off the habit. Meanwhile, she became weak and was admitted in hospital (she still looks weak).

Both the elder children eat their noon meals in school under the midday meal programme. Sellathal cooks only twice a day (mornings and evenings). The third child doesn't go to the *balwadi.* Sellathal tried to make the child go to the *balwadi* at least in the forenoon but she refuses to go. Sellathal complains that the child keeps asking for food all the time. The mother gives the child food only at the scheduled times. She feels that it is a bad habit to eat lots and anyway, "...once they eat food, they only shit it out". Once, at 4 p.m., the child got plain curry in a plate outside the house and was licking it. The mother said the child was a curse on the family as she keeps eating all the time. Wherever this child (third one) cries and misbehaves, she scolds her, saying that she will kill her, as she is dark-skinned.

The last child was born at home and Sellathal's mother cut the umbilical cord with a sickle. The child was given castor oil immediately after birth and breast fed after two days. At five months, she was fed with biscuits dipped in water. At the same time, her

siblings gave her food. Whenever they ate, she would eat from their plates or they would feed her. Now the mother feeds her at 9 a.m. - 1 p.m. - 8 p.m. Even now, breast-feeding is done on demand; within half an hour, the child breast-fed thrice for about half a minute to one-minute duration. Sellathal said that this was becoming a nuisance. But she was scared to leave the child at her mother's place for the fear that the child would face the same problem as her sibling. She tried applying *sothu kathalai* (grows in the wild, normally bitter in taste but grown at home as it keeps flies and snakes away) over her breast but the child washes the breast and feeds. She buys snacks from the local shop, when she has money. When she doesn't have money, she scolds the children when they ask for snacks. She also says that it is a bad habit to buy snacks from the local shop because the children keep demanding even when there is no money at home.

The youngest child has the habit of eating mud. So Sellathal has to be careful. She carries the child all the time and does not let her down. Sometimes, she leaves the child with her siblings or with the elders who sit at the entrance of the village, to do household work. The third and the fourth child remain unclothed. They are bathed once in 2-3 days. Sometimes, the children are clothed, but they wear torn clothes. Sellathal says that she managed bathing the children when they were infants, as she got help from her elder children.

All the children have been vaccinated four times each. She doesn't remember the age of the children or when they were injected except for the fourth child (10 days, 5 months, 10 months, and 1 year and two months). The third and the fourth child have been given polio drops thrice. She complained about the constant cold infection of the third child. When the children get fever, they buy tablets from the local shop. Only after that, they go to the hospital - that too for a day. She doesn't go alone because she usually has no money. She waits for her husband to come back. When asked about the help from the neighbours, she said that though all are relatives and they come when asked, they themselves wouldn't have money to look after their own children in an emergency. So, how can one expect them to be able to lend money?

She believes in home remedies for minor ailments. One day, her second child was hit with a small stone while playing. She applied coffee powder on the cut as a remedy. When asked after a day, she said that the boy was fine and the wound had healed. Like the others in the village, she goes to the traditional practitioners for *yettu konum* and *punnupu*. She also goes to the *tantric* and gets amulets to wade off evil spirits. She said that she tries all the practices before going to the hospital. When the first child got boils all over her body (*akki*) at the age of two, she went to the *tantric.* The amulet she got was such that within a week, the child was all right. Along with this they also applied mudpack.

For 'English' diseases, they go to the hospital and for traditional ones, they approach the healers. According to her, "The elders in the family and village know about child care by experience. They know why the child behaves in a certain way, which the doctors do not understand or know. If the doctors do not understand the causes for a particular behaviour of the child, they do not openly say that they do not; instead they give some medicine and extract money from us".Sellathal doesn't distinguish between a boy child and a girl child. She is more attached to the younger daughter as she says that she would not be able to live without her even for a day.

The husband drinks but does not gamble like the others. Sellathal justifies this because his work demands some drinking. According to her, the money that he brings in is not enough to bring up four children. Once the children start going to school, she plans to resume work as an agricultural labourer.

Case Report No. 4

Nallathal (30 years) and Ammasai (32 years) have a daughter Chandralekha (1½ years old) who was born after five years of their married life. Ammasai is an agricultural *coolie*. He gets Rs. 60 per day during the peak season (October - February) and Rs. 40 - 45 per day during the lean period. When there is less work in the agricultural fields, he goes for construction work or for any work that comes his way. Nallathal stopped going for *coolie* work since she conceived. She does household work and looks after the child. She is, however, planning to go for *coolie* work once the season starts. Both have been married for six years. Since he married against his parents' wish, the parents have severed ties with the couple.

Chandralekha's grandparents stay in a tiled, electrified, government-built house. In the space provided between their house and their neighbours, they have built a thatched hut, in which Chandralekha's parents live. The door opens into the street. At the right side, in front of the house, there is a big stone and a broken bucket. This is used as bathroom cum place to wash utensils. The drain water is allowed to flow into the street. The mother has a bath in the neighbour's bathroom. They defecate in the open and the child is also made to go to the side of the main road that is a few yards away from the house. Nallathal says that they are waiting for a house under a government scheme, the application for which had been given five years back.

After two miscarriages, she conceived after going to the temple. She says that the child is safe due to 'God's blessings'. After the pain started, she was taken to the public hospital. Due to some complication, the doctors advised her to go to the private clinic. The child was delivered in a private hospital at Dharapuram. They spent about Rs. 5,000. Due to complications, forceps were used in her delivery. Her mother stayed with her for ten days and looked after the household work. Though her in-laws stayed next to them, they did not come for help. After ten days, she managed her household work herself, including fetching water from the taps. Her elderly neighbour helped her to bathe the child. She said sarcastically that only after the child started to crawl, the husband's family showered

love on her. Though both the families shared the expenses incurred, her husband has repaid his debts whereas her parents are still struggling to pay back theirs. She says that she wants to work and help them pay back the debt.

The child was given sweetened water immediately after birth and was breast-fed after 12 hours. Colostrum was discarded before feeding (Nallathal's mother asked her to discard it). The baby was delivered late in the evening and the doctors went home after the delivery, without telling them what to do. So her mother instructed her about the post partiem activities. The child weighed two and a half kgs at birth. By five months, they started to feed the child with rice with coconut oil and salt. They neither gave it biscuits nor milk from the cooperative society.

By the seventh month, she started to eat non-vegetarian food. Nallathal said that whenever they ate, they gave the child a small piece of meat, which made her develop a taste for it. The child eats 4-5 times a day. Sometimes, the mother feeds her and sometimes she eats on her own. Once, the child had got a small cup full of curd rice to the street. An elder asked her to share it with the other small children playing around. All of them ate with the same spoon. When she dropped the spoon in the street by mistake, the spoon was washed with the water kept outside some other house. She also takes out some cooked pulse before adding *masala* for that day's curry. Though they do not prepare anything special for the child, they do not let the baby go hungry.

The child is bathed everyday in cold water at 4 p.m. She is neatly dressed, powdered and a black *bindi* is put on her cheeks, forehead, palms and feet. She wears buckled shoes. Her mother says she removes them only at night while sleeping. She goes into the house with the shoes on. When Chandralekha was an infant, she was bathed in hot water and *besan* - turmeric mix. She was given head bath once in a week or ten days. The child was massaged everyday during her bath. Nallathal calls somebody everyday to help her while she massages and cleans the baby.

The child was always breast-fed on demand. Now when the child demands, she does not feed the baby in public. She feeds the child lying down. The child always sleeps beside the mother except in the afternoons. When a friend of Nallathal teased her for breast feeding a 1½ years old child, she got angry and said that she had the child after a long time and she is not sure if she will conceive again. So she wants to let the child breast feed for as long as it wants to.

The child has been vaccinated twice (one month and five months) and given polio drops thrice. The injections had to be given at the subcentre or primary health centre but the polio drops were given at home. She has not got two injections one at tenth month and the other after a year (at 1¼ years). She says that she went to her mother's place with the child on the due dates and that she has not gone to enquire about when to give the injections next. She says that whenever she goes to the subcentre, the VHN is not available. The child has three threads around her neck from the *tantric*. There was one tied on her ankle too. Nallathal believes that till the threads are around her neck, nothing bad will happen to the child and no injection is needed to protect the child.

The child is taken to the local shop by her aunts, grandparents and uncle who buy her whatever she wants. One of her aunts and uncles are suffering from tuberculosis. While delivering a girl recently, the child's aunt was diagnosed as having tuberculosis. When Chandralekha's aunt was here, they were prepared for a home delivery as the first child was born that way. Due to complications (the pain had not started even after two days of the stipulated date of delivery), she was admitted in hospital. She is undergoing treatment now from her husband's place. Her child is underweight and looks pale.

Another aunt died a few years back, leaving four children behind. It was found that she had died of 'cold and cough'. The uncle who is unmarried has also been diagnosed for tuberculosis. He was working in the powerloom sector. For the past 1½ months, he stopped going to work, as he doesn't keep fit. During their visit to see her sister in hospital, the doctors looked at him and asked him to stay in the hospital for three days to do the mucus test. They however did not stay beyond a day. They approached a private

doctor after a month to get tablets for cough. The private doctor advised them to go to the government hospital. Meanwhile, he gave them tablets for three days. He told them that he has got tuberculosis and would recommend him for free tablet after conducting the required tests. After the tablets finished, they kept postponing the visit to the hospital, as the 'right time' had not arrived. When asked, they said, "if they go against time, they would return only with a dead body."

The people of the village have different versions of the disease and its remedial measures. One person said that this disease would be cured if the patient has crow's meat. Another advised him to go to Ernakulam in Kerala for the treatment of this disease. Instead of spending so much money going to different doctors, they just need to spend Rs. 500/- for the journey. Yet others advised him to go to Erode Government Hospital (District Hospital) or the Madurai Government Hospital (District Hospital). However, when asked on the fifth day, the patient's mother said that they spent Rs. 500/- and got amulets from the *tantric*. After tying the amulet, the patient had started to feel better and now eats properly.

According to her, the cause for this disease is evil spirits. She narrated a story of how the patient is possessed by spirits. "Once, after work, he was taking a nap under a tree. Suddenly, in his dream, a lady asked him to come along with her. When he followed her, she tried to bury him alive. He struggled to come out of her control but could not." She says that he still cannot come out of her control. She should have been warded off immediately but due to his negligence, they didn't come to know of this incident. Now, it is a little difficult, as the evil spirit has already shown its malevolent tendencies. She believes that the powerful amulet will drive her away.

Though they have two rooms, the kitchen is an extended enclosure in front of the house. In the small space, is the *chulah*, a big cemented drum for drinking water; the plates are kept in the extension made from the walls of the house. In the remaining space that leaves a little pathway to go into the rooms, the patient's cot is placed. He coughs all the time

without covering his mouth and blows his nose there itself. He uses his hand and the wall or the floor. There is no separate plate or tumbler for him.

He has got two sisters who are thin and have slight coughs. His sister's son stayed here when she was pregnant. He used to play in this space. Chandralekha keeps coming this side and while eating something, she often drops it on the floor, picks it up and eats it. Sometimes, she has her meals here. The cloth used to pick up hot vessel lies around everywhere. On instruction, they keep a plate filled with mud under the cot for him to spit in. Though Chandralekha's parents know that her uncle suffers from some disease, they are unaware of the seriousness of the disease and how vulnerable the child is to infections. When asked about her Family planning, Nallathal said that only after another pregnancy she would think of it.

Case Report No. 5

Palanimal (28 years) and Semmalai (35 years), cross cousins, have been married for eight years. They have three children – a son aged six years, a daughter aged four years and another one and a half year-old son. Since they already had a son and a daughter, Palaniammal tried unsuccessfully to abort the third child when she was two months pregnant. She says that the third child is unwanted. Both Palaniammall and Semmalai are uneducated. He works in the poultry farm. Though his work is irregular in nature, he manages to get some work regularly. He works within the factory itself and unlike others, he need not go outside the village. He earns about Rs.60-70 per day. Palaniammal stays at home to look after the children. She tried going for *coolie* work last month, leaving the child behind with her mother-in-law, but the child cried bitterly, so she stopped going.

They live in a tiled electrified government-built house. Thought they have a separate room on the right hand side as a kitchen, she doesn't cook there. Her mother-in-law stays in that room. So she cooks outside in the open. Earlier, they stayed in the site allotted to them by the *panchayat* president on which they would get a government-built house. Since the scheme has not come through as yet, they came to the village. There is an unused public well in front of their house. She cleans utensils on the cemented floor around the well. The drain water stagnates and is left to dry on its own. They have a separate bathroom at the back of the house. They bathe once in 2-3 days. They also have a fence in front of the house to cover the area where the *chulah* is kept.

Of her three children, only the first child was born in the government hospital. The second and the third child were delivered at home. After the third child, she got her family planning operation done. Only for the first pregnancy, a ceremony was conducted in the seventh month to take her to her mother's place. She has never been to the hospital except for her first delivery. The injections normally given during pregnancy were not given. While talking about the first pregnancy she said that she had a normal delivery and stayed at her mother's place for another three months. Weaning for the first childstarted by the third month, as she did not have enough breast milk to feed the baby. She bought

500 ml milk in the morning and 400ml in the evening. Only once a day, she fed the child with breast milk. By the fifth month, the child was fed rice and *idlis*. By the seventh month, the child was given beef.

The second and third children were born at home. Her mother-in-law helped her in her delivery and cut the umbilical cord with a sickle for both the babies. The second child was premature by two months. The second child was bottle-fed by the third month, as she didn't have enough breast milk. The third child was never breast-fed. During infancy, milk was given to the child in a small cup with a tapering mouth. Later, bottle feeding was adopted. For the second child, 300 ml of milk was bought in the morning and evening. For the third child, they bought about 200 ml in the morning and 200ml in the evening till about 3-4 months. As the child was grew up, they had to buy 400 ml in the morning and 300ml in the evening. She complains that everyday, they need to have ready cash to buy milk and the milk prices have also gone steeply (Rs.13/litre). On some day, when they don't have any money at home, the child has to go hungry. So she decided to buy a bottle of '*Horlicks*'. This could be bought on credit in the local shop. She feeds the toddler a spoonful of *horlicks* mixed with hot water in the midday and evening. In the morning, afternoon and night, he is fed with rice and coconut oil or curry.

She feeds the other children only at stipulated times. The second child is fed in the morning, afternoon and night. In case she asks for food at other times, she is given a little rice immediately after it is cooked in the evening. If she disturbs her midway, Palaniammal scolds her and sends her to play. Palaniammal says that only if she is at home, the child asks for food. So by 10 a.m., she locks the house and goes to sit at the entrance of the village with other women.

The children are made to play in the ground there. The elder son has his meal in the school under mid day meals programme. She says that she should force her daughter to go to the *balwadi* at least for afternoon lunch. When her husband is out of station, she does not eat in the afternoon. She cooks a little extra while cooking the previous meal,

feeds the children in the morning with the same food and cooks only in the evening when she feels hungry. She drinks 4-5 glasses of water in a day.

The second child has been vaccinated twice (three months and seven months). When she was asked to come for the first injection (when the child was 15 days old), she could not go as she had stomach pain. The child has constant cold infection. Her nose keeps running all the time and the child wipes it in her dress. The third child has not been given any injection except the polio drops. He is very inactive. He keeps sitting motionless all the time. He doesn't crawl or attempt to walk.

When he was four months old, he was unwell for a week. By the end of the week, they thought the child was dead but on elders' advice they took him to a *tantric*, got amulets and went to the traditional practitioners to get the required ingredients given for *yettu konum*. Within a day, the child seemed all right. They never took the child to the hospital.

When any child has fever, she goes to the local shop and gets medicine. She says that the traditional practitioners are more effective than the allopathic doctors. When anything goes wrong, she doesn't ask anybody, not even the village elders but goes straight to the practitioners. She also doesn't wait for her husband. She says that her husband drinks and gambles a lot. He comes home by 8 p.m., has dinner and goes out to gamble for the entire night. When she questions him, he screams at her saying that since he earns, he can spend the way he wants. He comes late in the night, sleeps outside on the cot and goes in the morning without telling her (this is if he has lost all the money in the gambling). Otherwise, he eats his breakfast and goes. According to her, he has never won a game in his life (She gets to know from others about the money he won or lost the previous night).

She says ruefully that only after they came to the village, he has developed this addiction resulting in suffering for the family. She is seriously thinking of going for *coolie* work, as she does not have any other option right now.

Case Report No. 6

Selvi (24 years) and Murugan (28 years) are cross cousins. They have been married for six years. They have four sons, aged 5, 3, 1½ years and two months. Murugan works in the poultry farm while Selvi stays at home to look after the children. Murugan earns about Rs. 100-150 in two days. He gets work for 15-20 days in a month. His work of unloading chicken baskets takes him outside the village. When he comes back from work, he takes rest for two days as he goes sleepless for two nights. Selvi hasn't gone for *coolie* work since marriage, as she conceived within two months of marriage. Both are uneducated.

They live in a tiled, electrified government-built house. In one corner of the enclosure in front of the house, they have a *chulah* and in the other, they have a cot on which the child sleeps. In between, they have an opening to the house. A stone near the entrance is used for cleaning utensils and bathing the children. The used water flows into a small pit dug outside the house in the street. When the people come to watch the *panchayat* television that is placed in front of their house, they all sit right next to the pit, which has stagnated, dirty water.

The government-built bathroom at the back of the house is not used because it does not have a proper drainage system. They use it as a storehouse for firewood. The adults defecate in the open fields and the children across the road a few metres away. The source of drinking water and water for other purposes is the public tap. The water comes from 4 p.m. to 6 p.m. Selvi complains that the amount of water they get (4 pots per house) is not enough for a family. Earlier they used to get more water but due to innumerable powerloom sectors that have sprung up in these two years, the population of the village has increased (to the north of this colony, there are settlements belonging to different castes). This has led to a reduced water supply.

Selvi has four children. After the first boy, she hoped for a daughter. Since she already had a boy to take care of her in her old age, she wanted a daughter to provide her emotional support throughout her life. She was very disappointed after delivering male twins recently. Now she has got her family planning operation done.

The first child was born in a private hospital and was a normal delivery. A ceremony was conducted at her seventh month to take her to her mother's house. Selvi's father paid for the entire delivery expenses. They were very happy that the first child was a boy. He was given sweetened water immediately after birth and colostrum after a day. They were in the hospital for three days. She stayed in her mother's house for another five months till the child started to eat rice. She avoided coconut, brinjal, mango, items as they presumably lead to gastric problem as well as preparations containing too much tamarind etc. since the fourth month of conception. After the birth of the child, she avoided curd and anything that is cold as she believes this would make the child susceptible to cold infections.

The child was weaned at five months and was not given curd for three years. The child is watched over constantly so that he doesn't drink too much water and only a little water is given to him for the fear of his catching cold. Now the child eats three to four times or more a day. Sometimes, he eats from the plates of the adults (when they eat, they also feed the children). The child was breast-fed for a year and he stopped by himself when Selvi conceived next. The mother serves all the children but they eat on their own as she is busy with the infant. Under the nurse's instructions, she fed the first baby with mashed boiled *dal* for about a year.. He was vaccinated thrice (10 months, 1½ years and 2 years) and given polio drops.

The second child is four years old. He was born in the government hospital. According to Selvi, he was a healthy baby though she does not know his weight. He was given sweetened water after birth and breast fed after two days. Colostrum was discarded before breast feeding the child. She says that they suffered by giving colostrum to the first child (the child had stomach upset because of it). He was weaned by four months with rice and coconut oil. She avoided the above mentioned food items when the second child was in her womb and during lactation too. He was given boiled *dal* and nothing was specially made for him. The child was breast fed for 1½ years till Selvi's next conception. He got the preparations from the Tamil Nadu Infant Nutrition Programme. But it was shared amongst all the children. He was vaccinated twice (10 months and 1½ years).

The child was again a disappointment for them. He was also born in the government hospital. Sweetened water was given and breasts milk after a day. Colostrum was discarded before breast-feeding. Weaning started by the fourth month and slowly the child began to eat on his own and from his siblings' plates. The child was breast fed for 1½ years and stopped by him. None of the children were given milk from the cooperative society. All three of them are given rice and *dal* that is cooked for the family and there are no restrictions on how much food a child should eat. She said that whenever they feel hungry, she serves them.

After Selvi's mother left, her mother-in-law (paternal aunt) who lives next door looked after all three children. According to her, the mother and child are polluted for three days after delivery and since these three days are spent in the hospital itself, for ritual sake she observes a day by not touching any utensils and staying out of the house. After having a bath and bathing the child, she enters the house and does her normal work. She says that this particular ritual is observed in her mother's place and not in this village. Since she observed this for her first child, she says she should do so for all.

The fourth child is one of a twin. Out of the twins, one died after a week of delivery. The children were delivered in the government hospital, She says that the babies were really underweight that they had to be kept in the incubator for five days.. For one week, she suffered, as she did not have enough breast milk to feed both the children. After the death of the first baby, the second one is showing some change. She feels that he is gaining weight. He was given colostrum immediately after birth as he was removed from the incubator after 12-14 hours. On the third night after they came from hospital, the first child died. She feels that it is good that he died else they would have lost both the children.

The child has not been bathed as yet. He is breast fed on demand in a lying posture and after feeding, his mouth is wiped with the mother's *saree* (mother had not bathed for two days and had been wearing the same *saree* for two days). While doing household work, she leaves the baby at her in-laws' or she makes the elder sibling sit next to the child. The child wears his siblings' clothes, is powdered and *bindi* is put everyday after wiping his

body with hot water. When the child urinates, the cloth is reused without washing (the cloth is Selvi's old cotton *saree*). The child has not been vaccinated as the doctors advised her to bring the baby once it is healthy. She is very careful about her eating habits. She asks her mother-in-law before eating anything new, as she is scared it might affect the child. The other siblings either play in front of the house or are picked up by the children of the village and taken to the ground in front of the entrance.

When they fall ill, she takes the children to the hospital. She says that she doesn't take the risk of postponing or going to the traditional healers except for *yettu konam* and *punnupu.* She either waits for her husband or calls her mother-in-law or anybody in the village to go to the hospital. She complains about the constant cold infection that all her children suffer from. She also avoids giving them anything sweet as it aggravates cold. She said that when they go to the hospital, the nurses instruct her about childcare. In the village, TINP workers tell her:

1. What to give to the child eg. eggs, green leafy vegetable, mashed half-boiled vegetables, *ragi* porridge etc.

2. How much to give: egg per day, mashed boiled vegetables in the midday etc.

She says that she follows only what she can (like boiled *dal* for the first child). If they ask her to give egg everyday to all three children, where will she get the money? She also complains about the exorbitant prices of vegetables, which make it difficult for them to buy even for everyday meals. She adds, "Since the nurses are earning a handsome amount and staying in the town, they can afford all this. With one man's meager salary how can we survive if we provide all this? Anyhow, we grew up without eating all this so let them say what they want. All we have to do is listen to them and lie when they ask us next."

Case Report No. 7

Pasuvathal (30 years) and Chellamuthu (32 years) refused to be interviewed the first time as they had lost a one-year old male child three months back. On the second trip, she had delivered a male child and was very happy to talk about him. The couple has three female children aged seven years, five years and four years and a male infant (two months). Chellamuthu is an agricultural *coolie*. He gets Rs. 40-50 per day depending upon the season and work. During the peak season (Oct-Feb), he goes to the nearby fields and gets about Rs. 50 per day. In the other seasons, he goes outside the village to seek jobs ranging from construction work to cutting trees. On an average, he gets work for 20-22 days in a month. Pasuvathal stays at home and looks after the children. She conceived immediately after marriage and had to be at home to look after the children, who were delivered, in quick succession.

The family lives in a tiled, electrified government-built house. There is an enclosure in front where they have a *chulah* in one corner and a cot for the baby in the other. A cradle was also hung near the cot. In the space between their house and the neighbours, they have their drainage system. The drain water is allowed to flow into a small flower garden. The government-built bathroom is used to store firewood and other things. The adults defecate in the open fields and the children in the field a few metres to the left of the house. The source of drinking water and water for other purposes is the public tap. Two of her daughters were born in the government hospital and one of the girls and the two boys were born at home. Her sister-in-law conducted her delivery and the umbilical cord was cut with a sickle. All of them were given sweetened water. Colostrum was discarded and the babies were breast fed after two days. She was taken to her mother's place for her first two deliveries. They expected male babies on both these occasions and since they were disappointed, they did not go to the hospital for the third baby. Pasuvathal got helped from her mother for ten days after the first two deliveries. For the last delivery, she started doing the household work in two days. Her eldest daughter helped her.

She refused to talk about the infant who died. The neighbours said that the child kept crying for four days. The parents took the child to the traditional practitioners and got an amulet, which was of no help. When the child became tired of crying, it stopped feeding

too. Then on the way to the hospital, the child died. Pasuvathal says that it was the evil eye of the people that took him away from them.

All three children were breast fed for about a year and then to her mother's place to overcome the habit. The third child looks underweight and is inactive. It keeps crying all the time. The mother said that the child is suffering from 'milk sickness' (i.e. she longs while the baby is breast-fed). The first child is in third standard and she has her lunch under mid day meals scheme. The second and the third children are sent to the *balwadi* for lunch. She cooks in the morning and in the evening. The eldest daughter (seven years old) helps her in the household work. She heats water to bathe her brother. She can cook rice with a little help from her mother. She cuts vegetables, sweeps the floor and fills the pots for her mother to carry. She and her sister (five years) have small pots in which they fetch water. The second child helps her mother in bathing her infant brother. The mother said that they are all very attached to the brother and that they had refused to have food when the first brother died. Now they don't let the infant out of their sight. Somebody or the other always keeps an eye on the baby. They have a table fan that is used only for the infant.

The baby is bathed daily in hot water and Johnson baby soap. He is massaged during the bath. Once in a week, an oil bath is given. The mother doesn't eat preparations that have coconut and sesame items that are too sour and anything cold eg. Left over rice of the previous day. She feels that these will affect the child's health. She stopped eating these items since conception. The father has leftover rice. The children are given fresh food everyday.

On observation, it was found that the eldest daughter was grating beetroot, half of which kept falling on the cowdung plastered floor. She picked it up and put it back in the utensil. There were flies in and around the utensil with the grated beetroot. By the time she finished, it had turned black. The mother sat with the baby near the *chulah* instructing her to cook the beetroot for dinner. The second child had gone to buy 200 ml of milk for her brother. They buy milk in case the child cries if there is not enough breast milk. The feeding bottle is washed immediately by the siblings. Once a day, it is washed with hot water.

The three daughters have a problem with bright light. They are not able to face the light with their eyes fully open. The parents have not taken them to any doctor. All three of them have been vaccinated five times and given polio drops. She does not remember when they got vaccinated. The baby has been vaccinated twice (10 days and 1 month). She says that one was a 'skin injection' and the another was to stop any disease from attacking the child. The children wear black threads from the *tantric* around their neck and also in the wrist. The infant wears black bangles and bead chain to keep away the evil spirits. He has black *bindis* on his forehead, hands and soles.

Pasuvathal says that they go to the hospital after trying all home remedies and traditional ones. Her second daughter met with an accident and hurt her foot. For two days, they left it without taking any serious note of it. When the child started to cry in pain, they applied coconut oil as some elders instructed them. They mixed tamarind bark powder with coconut oil and applied it. Meanwhile, Pasuvathal had also applied the hospital medicine given for the baby (to keep on the navel). The child continued to do household work though in pain. Only on the fifth day, when it swelled up, and the pain become intolerable for the baby, the father took her to the government hospital. Pasuvathal said that she is busy with the baby and the father is busy with his work. When asked about the helping hand from the village people, she said she was planning to ask somebody that day, in case the child's father had work and was unable to take the child to hospital.

She says that for any illness, they try home remedies first. She asks the elders, according to her, are rich in experience. She says that she never listens to the nurses or TINP workers as they tell her things she is unable to follow (eg. food practices). She also says that their only concern is the family planning measures. "They scold me every time I meet them for having too many children. When I say that I wanted a boy, they don't seem to understand. They had pressurized me to get my family planning operation done after my fourth child. Thank God I didn't listen to them and was pregnant again. At least I have a boy child now. Would they have given me a boy child in place of the dead one, if I had got operated?"

Case Report No. 8

Gandhimati (32 years) and Shekhar (35 years) have three children. They are cross cousins and have been married for 15 years. They didn't have any children till five years after marriage. When she had two daughters, her husband was angry with her for not delivering a boy. She wanted to go in for a family planning operation after the second daughter, as they would get Rs.10, 000 as fixed deposit on the children's name under the Tamil Nadu government scheme. But her husband did not allow it and now they have a boy. The baby is four months old and weighs about 4 kgs.

All three children were born in the Dharapuram government hospital. All three times, she was taken in a taxi to the hospital. She was taken only after the pain started. She delivered immediately after reaching the hospital. They spent about Rs. 500 for each delivery. Her first child was a boy who died a few days after birth. He was delivered at home. He refused to drink milk; he was taken to the hospital but couldn't be saved. All three children were given sweetened water and colostrum after two days. She didn't discard colostrum because the doctors advised her not to. Only after the delivery of the first child, her mother helped her for a few days. For the rest of the babies, she started to work immediately after she came back from the hospital. Whenever she wants any help, she approaches her mother (who stays in the same village). She went for *coolie* work till the time of delivery.

Both the daughters go to school now. She leaves the baby with her mother when she gets *coolie* work. She started bottle feeding the baby in the third month, so that she could go for *coolie* work. She earns about Rs.35 per day (peak season) and Rs 25 per day in the lean period. Her husband is also an agricultural *coolie* and earns about Rs 45-50 per day. She says that he spends half the money drinking. She usually goes outside the village for work but now she is unable to because of the child. On an average, both get work for 20 days in a month. They live in a hut. The hut is located between two houses and has no space even to walk. In that little space, she has kept a cemented drum for water. Next to it, there is a stone to wash their utensils. The drain water stagnates in front of the house itself.

Her eldest daughter (8 years) helps her in cooking, carrying water and in other household work. The second daughter (4 years) sweeps the floor, helps her bathe the child etc. She bathes the child in cold water in the afternoons and in hot water at 4 p.m. She brings the child to the entrance of the village in the afternoon. She hangs the cradle (made of white cotton *saree*) in the shade of a tree so that the child sleeps peacefully without feeling uncomfortable in the heat. She also sleeps there and goes back home in the afternoon. The ladies who come there to sit usually pick up the child. She complains about a lady who kisses the child on the lips and also those ladies who touch the child after coming back from work. She says that since they are all relatives she can't tell them openly not to do so but they should understand by themselves

The second daughter who comes from the *balwadi* at 12:30 sits with the mother at the entrance and keeps asking for snacks that are sold there (cut pieces of mango, packed coloured ice, powdered bier, preparations of some sweets, biscuits etc.) Gandhimati spends about Re 1-2 everyday on snacks for the children. She says that it is very essential for a mother to keep some money with her so that she can feed the children or use it during an emergency.

She cooks in the morning and in the evening. They buy vegetables and rice from the local shop. She says that if they go late to the shop, they get rotten vegetables at a cheaper rate. The children eat at their schools and when they come home they want to have food again. She says that it will become a bad habit and that she serves them only at stipulated timings. The two daughters were breast fed for 1½ years each and the boy is still breast-feeding. They also buy milk from the cooperative society (200ml in the morning and 200ml in the evening). The washed feeding bottle was lying on top of the water drum outside. She said that she washes it with hot water everyday. She is very careful about feeding the baby and she doesn't give bananas, curd rice, certain *dal* preparations, biscuits etc. She also keeps away from these preparations, as he is still breast fed.

Once she screamed at the second daughter for feeding the baby with a particular variety of bananas. She complained about the child defecating too many times and with a bad smell. As the child had defecated as she was saying this, she made the child sit in

between her legs, in the same place. When the child finished, she washed the child with the help of her mother and gave the child to her mother. She called her second daughter to find a piece of paper, picked up the faeces with the paper and gave it to the child to throw. The daughter was instructed to hold the packet of biscuits she had in the right hand in the left hand. The child took it to throw it a few metres away from the house on the street, She didn't wash her hands after that. When the child cried, the mother asked for the child to be breast-fed.

The children were vaccinated thrice. She doesn't remember the months for her daughter but the son has been vaccinated on the tenth day, second month and fourth month. He had fever after his second injection for which she went to the VHN to get tablets. They go to the hospital only if the illness is serious. She tries to cure it by giving tablets bought from the local shop or from the VHN. They neither take the child to the VHN nor does the VHN come to the colony to check the child before giving tablets. They go and ask for either fever tablets, headache tablets or stomach upset tablets.

She complained about her second daughter having constant cold infection. Her running nose is left unwiped. She bathes the daughter once in 3-4 days. The second child is bathed in hot water due to the cold problems. When asked why she doesn't take them to the hospital, she replied that even if they go to the hospital, it doesn't get cured so it's a waste of money. After some days, it will automatically be cured. Anyway, it is not such a major illness requiring attention of the doctor immediately.

The second child also had *akki* (boils all over her body). The mother applied orange *chunna* (*kaavikal*). She said that both the daughters suffer from worms in the stomach. They came to know about it when the children kept asking for more food than they normally eat. For that, they get a red fruit (*manathakkali*) from the fences and give it to the children in the evenings.

A few days back, the baby kept crying because the second child dropped him by mistake. They patted the stomach on either side and when it was sounding differently on the right side (decided by the elderly woman) they took the baby to traditional healers and massaged it with castor oil (it seems the intestine shifts place when the baby is held in an

unusual manner). This could be cured only after massaging it with castor oil. None of the doctors can cure this.

After this incident, the baby had an eye infection. She said that these series of happenings are due to the evil eye of the villagers, so she took the child to their ancestral temple. She had also put a burning needle (not very hot) on the baby's forehead to scare the evil spirits. Every week, on Sundays, she burns camphor, takes *aarthi* and throws it in the street to wade the evil eye. Traditionally *aarthi* is done by taking red chilli,salt,tamarind and mud from the streets and burning it in the fire.

She also said that they cannot go to the hospital for every small thing and in case they decided to, they would need a lot of money. Anyway, every time they go to the public hospital, they are given the same tablet, which do not cure the illness. The private hospitals just fleece the hard-earned money. Therefore, they either stay at home or go to the traditional practitioners who are not so expensive and are easily accessible. She also complained about the inaccessibility of the government doctors (they go away by 10 in the morning) and the long queue in the private hospital.

She says that with the small amount she gets irregularly and the irresponsibility of the male members towards the family, she is very worried about the future. She says that the money is not sufficient to have even three square meals. Though she is happy about her son, she doesn't discriminate against her daughters. She says that all three are her children and she sees them with the same eyes. Asked about the family planning operation, she said that she has not got it done as an agricultural *coolie* like her needs to be very careful. For someone who earns her bread everyday, this would not be a right decision. She said that she will go when she knows she will not get work for a month or so.

Case Report No. 9

Murugathal (25 years) and Easwaran (27 years) have two male children aged two years and six months respectively. Both Murugathal and Easwaran are educated till fifth standard. They shifted to this village three years back, looking for better options. Murugathal's parents stay in the same village. Her family lives in a hut where her parents had stayed earlier. The hut is right at the entrance with a huge tree in front. The village ladies come here during their leisure time. Since their prospects are not too bright here, they are planning to go back to his village. He works in the poultry farm but as the demand for men is saturated there, they pay him less for the work. He gets about Rs.300/- in a week out of which he spends Rs.200/- on drinking and gets home only Rs.100/- this money too, he doesn't give to her.

The hut is made of palm leaves and the *chulah* is kept outside the house. Except in the rainy season, they usually cook outside. The drain is situated within the enclosure and the water is allowed to run on to the streets. They get water from the public taps and defecate in the open fields. Once the first child defecated in front of the house and Murugathal cleaned the faeces. She cleaned the child they're itself (in front of the entrance). After a while, the child played in the same place in bare feet. She also stepped on it many times before going inside her house.

Both the children were born in a private hospital. The maternal grandfather looked after the expenses incurred. Though it was a normal delivery, they had spent more than Rs.5000 for both children. She stayed in the hospital for five days for both the children and took rest for about a month for both. Her mother and her sister helped her to do the household work. She hasn't gone for *coolie* work ever. After the children grow up, she is planning to go to the powerloom sector. She said that for five years after marriage, she didn't have any children.

She said that once one conceives, it is like a duty to have children and finish it off. The experience she had when she was unable to conceive was bad. She said that whosoever saw her asked her only about her pregnancy and mourned when she said that she hasn't conceived yet. She questioned as to why a woman should get pregnant as soon as she is

married? She said that once a girl is married at the age of 16, she should have children by 18 or 20 years and wait for the children to grow up to get them married at 16 years. When asked about family planning, she said that she has not got the operation done as yet and is waiting for the second boy to grow up. In the meantime, if she gets pregnant, she plans to abort. She feels very happy about not having a girl child. She said that it becomes difficult to bring up a girl child. Where as the boy, once he is 13, looks after himself. They needn't worry about anything (job, marriage etc.)

She complained about her back problem and said that when she was seven months pregnant with the second child, she fell in the hospital bathroom. Since then she has a back problem and feels tired all the time. She has not been to the hospital as yet for the treatment.

The children were given sweetened water immediately after birth. She had discarded colostrum and breast-fed the babies after a day. Both were 2½ -3 kgs during birth. She has started weaning the second child. The first child was weaned at the fifth month. The second child is given rice once a day, biscuits, puffed rice etc. The family members also feed him while they are eating. He breast feeds 5-6 times a day. She sits and feeds him. When the child demands while she is sitting out, she feeds him in public. In the night, the baby is made to lie down next to her and he feeds whenever he wakes up in the night. The rest of the day he sleeps in the cradle (clean white cotton *saree*) outside the house, under a tree.

The elder child was also fed on demand. She said that he goes to her mother's place and eats sometimes, so she doesn't force him to eat here too. Whenever he feels hungry he asks by himself and she serves him. He was breast fed only for a year as she had conceived again. The child stopped breast feeding on its own. They used to buy milk from the milk cooperative society (400ml in the morning and 200-ml in the evening). They have stopped now, as they might have to buy for the second child. The grandparents buy snacks from the local shop for the first child whenever he demands (mango pieces, powder, jelly sweet, coloured ice cubes, etc.). Though she has requested her parents not to buy these, they do not listen to her.

She cooks in the morning and in the evening (when her husband is around). Otherwise, she sends the first child to her Parents house and eats leftovers of the previous day or goes hungry for a day. They cook *idlis* only on festival days. The rest of the days it is rice and *dal* bought from the local shop. They either buy it on a daily basis or on weekly basis. They eat beef once or twice weekly. The meat is bought only if her husband gets it. The children eat it at her parents' place. The second child has been fed meat recently.

The first child has been vaccinated four times and the second child only twice (when the child was 15 days and again at 4 months). They always go to the private hospital. It is her father who pays for all the expenses. When the children are ill, she tells her father or mother to accompany her to the hospital. Even when her husband comes along, her father accompanies them because the husband never has money. She said the root of the problem was that her husband is not related by blood. If he was her cousin, then her father could have asked him about his work and the money he is spending unnecessarily. Since he is from a different family, there is a strong ego clash. Therefore she strongly feels that her sister should get married to one of her cousins even if they are not well off.

They go to the hospital only for fever and cold (though according to her, going to the hospital has not helped them to cure cold infection). For the other illness such as *yettu konam*, they go only to the traditional practitioners. Once, the mother burnt the second child on the forehead with a needle to wade off the evil spirit. She said that he kept crying throughout the night in a peculiar manner ("the ghost is very fond of small children") and stopped after she tried this treatment. For cold, she doesn't take him to the hospital anymore. She is careful about the first child. She doesn't give him too much water to drink and stopped getting him coloured cold ice cubes. They don't give him tender coconut or palm fruit (grandfather sells these).

For the second child, she stopped eating the left over rice in water. He is not given water at all. She follows the traditional practitioner's advice. He has given them a mixture to put in fire, the smoke of which is to be inhaled by the child. She also said that when the ladies of the village come here to sit, they touch him, play with him and by night, he

becomes very tired, so she bathes him in the night, shows incensed powder and puts him in the cradle for some time. The location of the house at the village entrance is not good for the children.

The children have black threads from the *tantric* tied around their neck and wrist. She says that when the children fall ill, it is her parents who decide where to take the children and what to do.

She has a bath only once in 3-4 days and wears a dirty blouse and *saree*. She sometimes wipes her breast with the *saree palla* before feeding. When asked, she said that if the women folk of the village bathe everyday and comb their hair, their respective husbands get wrong idea about the woman. They do it once in four days and on occasions.

Case Report No. 10

Pappa (25 years) and Velluchamy (28 years) have two female children, aged three years and five months respectively. Velluchamy works in the poultry farm and gets about Rs. 100-150 in two days. He works for about twenty days in a month and for the rest of the days, he either looks for work outside or takes a break from work. Pappa hasn't gone for *coolie* work since marriage. They live in a government-built, electrified house. There is an enclosure in front of the house where a cot is put for the baby to sleep in during the daytime. There are two cradles too in the enclosure for two children, which can be removed (white cotton cloth). During rainy and cold season, they go inside the house. They also have a hen pen inside the enclosure. The hen moves freely and even eats from the child's plate sometimes. Even if the hen is chased out, it comes back soon. They get their water from the tap. They defecate in the open fields as the rest of the villagers do and the child goes across the road to defecate.

Both the babies were born in the private hospital. When she was 7½ months pregnant with the first baby, a ceremony was conducted and she was taken to her parent's house. From there, she went to the private hospital, as her Parents incurred the expenses. She had a slight complication in her first delivery. When her husband heard that the child is a baby girl, he didn't come to see the child. After everybody scolded him, he came after four days. Even after that, he was least interested in knowing about her well being. When he heard that the second child is also a girl, he didn't come to see her for three months. When the baby was three months, Pappa took the baby to the husband's place to show him. He was very unwelcoming and after a day, told her to bottle feed the baby so that she could resume her *coolie* work. He scolds her by saying that she has to suffer till the time of her death for having two daughters. She however got back to her mother's place and came back only when she could manage looking after the children without any help (the second child needed extra care as it was premature and underweight). When asked about family planning, she said that her husband wants a baby boy and she cannot get the operation done now. She is scared about having a baby girl next time.

The first child was about 2½ kgs when born. She was given colostrum, as the baby herself started to feed without initiation. It was breast fed for about two years after which

she stopped breast-feeding. She was given food when she was six months. They gave her biscuits dipped in milk and curry once a day. By the eighth month, she started to eat by herself and had food 4-5 times along with breast milk (4-5 times). When the child cries, the father refuses to give any money to buy snacks. The mother keeps money separately with which she buys food for the child.

The second child was only 1¼ kg at birth and was kept in the incubator for about 15 days. They spent more than 15,000/- during the second delivery. After six months, the baby is 3½ kgs. She said that the doctors really praised her as she tried hard to bring the baby to normal weight in six months. She said that she stayed back in her mother's place because she needed help to keep the baby warm all the time. She said that there should be a person separately to look after the baby, as she needs extra care. Though the child was fed on demand, she said that when the child doesn't cry, sometimes she feeds the baby by herself. When she is sitting in the street (talking to somebody - there is television at the end of the street, so people sit in the street) and if the baby cries, she feeds the child there itself and while feeding, she plays with the pebbles in the ground. With the same hand, she touches the baby, her breast and cleans the baby's mouth once fed.

When the child was born, she didn't feed the child for three days. She said that she never thought that the child would survive. She didn't bathe the child for three months as per the doctor's advice and even now, she bathes her with hot water and tries to keep her warm all the time. She keeps the child covered in a towel all the time. The baby is bathed at 10 o'clock, powdered and a *bindi* put on forehead and cheeks. The baby had not been weaned till now. She said that she has to go to the doctor to inquire about weaning.

She cooks in the morning and in the evening. She buys rice and *dal* from the local shop. Even if her husband does not give her money, she buys with her money. She has full meals daily in order to feed the baby. She has beef twice in a week so that there is enough breast milk for her child. Whenever she cannot manage here, she goes to her mother's place on some pretext or the other. She does not eat mango, jackfruit, egg and coconut, as these do not suit the baby. She says that she has to be very careful.

Whenever the children feel ill, she goes to her mother's place to go to the hospital (the mother's place is walking distance). When the second child suffered from ear problem a

few days back (pus from her ears), the father gave her Rs.20/- for treatment. He also told her not to ask for money in future relating to the children's ill health.

The first child has been vaccinated thrice. The second child has been vaccinated once. When asked about the illnesses of the children, she said that she doesn't know anything about the first child's illness because her mother and brother's family looked after the baby. So when the baby had any illness, they took the baby to places (traditional practitioners, healers and doctors) and she is not aware of these. Since the second child is premature, she looks after the baby. She said that she would give the baby to her brother, once she grows up, as he does not have any children.

Conclusions

The indepth study of the ten households with children under five years of age from Nathapalayam hamlet throws some light on the women's pregnancy outcomes and childcare practices. The pregnancy experience and childcare practices in Nathapalayam hamlet are found to be similar to that of other hamlets.

In the hamlet, the women are married early and face the social pressure to have children early. The status of a barren woman that is reflected in the study substantiates the amount of pressure faced by women. The women in the families have not had more than four pregnancies, thus showing the desired family size. In two cases, the desire for a male child has emerged as the cause for the third pregnancy. But in women with more than two pregnancies, the sex of the children from the previous pregnancies does not seem to have had any influence on the subsequent pregnancies. This finding substantiates the quantitative data obtained for all the hamlets.

The study showed that the girl child is not unwelcome, especially if she already has a male sibling. Once a girl child is born, the discrimination is not shown in the care given to the girl child. A girl child is looked after with as much care as given to a boy. In the report, it could be seen that the increasing number of pregnancy experiences of a woman is also due to her desire for a girl child.

The women of the hamlet bear the burden of productive and reproductive work. They work for wages throughout except during pregnancy. If a woman stops working after conception, she is forced to lead a pitiable life during the months of pregnancy, as she has to depend on the money earned by her husband. The food is cooked once or twice a day and the woman eats last irrespective of her condition. There is strong evidence of self-denial with regard to the amount and quality of food intake among women, especially in families with a large number of children. Even the children seem to be constantly hungry. The child's cry for food is misinterpreted as being unrelated to hunger. The child is either given inadequate amount of food or some pacifier. The child too is denied quality food. Food intake and the practice regarding quantity and quality of food consumed throws

A majority of the women complained about the indifferent attitude of the fathers regarding the financial condition of the family; a major portion of his wages is spent on himself. At the same time, they justify the spending of their husbands as they earn their wages through hard labour. That a woman struggles to meet the demands of the basic food requirements of the family and the extra demands of childcare is clearly reflected in the study. Due to the familiarity within the house, a woman is not treated inferior in the family. She enjoys the right to take her own decisions. With regard to childcare practices, the women take their own decisions on the choice of treatment to be given to the child. They also talked of the contradictory advice given by the hospital staff and by the village elders relating to treatment of ailments. They said, however, that they listen to the hospital staff as they do not want to take unnecessary risk, especially with an infant. But for specific ailments - indigestion problem or infection - they go to the traditional practitioners. For grown-up children, they exhaust home remedies before seeking help from the hospital. They sometimes approach the village health nurse for treatment.

They are cynical about the intent and effect of the various government programmes as they fail to see any direct and tangible impact. The bad quality of food served in the mid-day meal programme and the poor performance of Tamil Nadu Infant Nutrition Programme (TINP) has had a negative impact on the attitude of people towards them. The past records of the their role in motivating family planning programme is fresh in the minds of the people. In general, the people have shared a strained relationship with the health workers and programme implementors.

Thus one can see that indepth study of the hamlets has opened up certain insights into the life of the people. Many factors have substantiated the general findings. But some factors like the nutritional status, dietary patterns of the family especially mother and child, the husband's role in the family and his responsibility, have shown a deeper understanding of the family and their socio-economic condition.

Chapter 6 - Summary and Conclusions

The well being and chances of survival of an infant is influenced by a multiplicity of factors. The basic factor underlying infant mortality is the socio-economic condition of the family that not only has a direct impact on the infant's health but also has an indirect impact as it fundamentally effects the health of the mother. Shiv Kumar states that "An analysis of infant mortality indicates that child survival is influenced by the operation of several biological, social, economic, environmental and other factors." He further states that "issues of child survival are intimately connected with maternal capabilities and the level of entitlements of the individual or household upon whom the child is dependent."[1] Thus the two sets of factors one acting independent and the other being influenced by the above helps to understand variables that act upon the well being of an infant.

In our study area, out of four hamlets, Thurambady and Parakadai are in the agriculturally wet area and Mettur and Nathapalayam are in the dry area. Over the years there is a shift in the agricultural productivity. The study population belongs to a low socio-economic group with majority of the families depending on agricultural labour. In recent times, there are other income generating activities like poultry and powerloom that has drawn a sizable number (30%) of population away from agriculture. 4% of the people own land not more than two acres and all the households have irregular incomes except 4%.

A majority of the SC women in the *panchayat* are agricultural labourers. There is however a shift in work among the younger generation. Due to less availability and irregularity of agricultural work, the women from Mettur and Nathapalayam tend to seek work from other income generating activities available in the vicinity. Because of this, work is comparatively more regular in Thurambady and Parakadai and this makes the population of Mettur and Nathapalayam economically more vulnerable. However, they get work as groups and share the wages during dry seasons. Despite this difference, a clear categorization seemed improbable and we have looked at the total population of the four hamlets after dividing them into basic economic categories. The group was homogeneous in terms of social class. Our data shows that there are a number of practices

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1 Shiv Kumar, AK, "Women's Capabilities and Infant Mortality: Lessons from Manipur", pp. 55-96 in Dasgupta, Monica et al (ed.), *Women's Health in India: Risk and Vulnerability,* 1995.

with regard to marriage, pregnancy and childcare that may contribute to problems of child survival. Most of these are rooted in the poverty of people and few cultural practices such as the following.

Early marriage and social pressure to bear children immediately after marriage are found in all four hamlets. The feeling of social insecurity and the inability to face dowry problem are the cause for prevalence of consanguineous marriage in the two dry hamlets - Mettur and Nathapalayam. It is however, different in the agriculturally fertile areas. The marriage alliance is sought from outside the family and the practice of elaborate ceremonies along with dowry practice shows the pressure on people. A girl child is considered to be a burden for the family till she is married off. It is widely believed that a 'wise family would never keep a daughter at their house for long after puberty.'

This belief is practically manifested as 16.2% of women were married before the age of 16 years and 35.9% before 18 years of age, thus making a total of 52% marriages before the completion of a girl's physical and mental development. Thurambady has about 75% of marriages before 18 years and Parakadai and Mettur have 54-55%. It is well known that child survival is comparatively poor in early pregnancies.[2]

Only after a few pregnancies, women of the hamlets tend to have control over their reproductive choices. According to Shiv Kumar[3], "the indirect indicator to assess the extent of control over reproduction is to see the proportion of women not married in the age group 15-19. Women who get married at young age are often less capable of asserting an influence on their families and husbands." This is corroborated by our findings from the study. When one studies the age of marriage and the time of first conception, it is found that 50% of the women experience their first pregnancy by the age of 20 (i.e. within two years of marriage). The two agriculturally wet hamlets - Parakadai and Thurambady - have more than 35% of women having had experienced first pregnancy within one year of marriage.

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2 Gopalan, Sarala and Shiva, Mira (ed.) *National Profile on Women, Health and Development,* Voluntary Health Association of India, April 2000, pp.179.

3 Op.Cit. 1.

Spacing was yet another factor that had social determinants. 71% of children have an interval of less than two years and out of this, 30.6% children have just a one-year difference. This not only effects the health of the baby and the care the mother could give but also has an impact on the health of the mother. The early marriage and the time of first conception in these hamlets is linked to socio-economic factors that act on women.

Pregnancy of a woman is considered to be a part of normal routine. In the first pregnancy, her family members care for her but it is not the same in subsequent pregnancies, especially if she already has a male child. The fact that no special care is taken during pregnancy means that over time, women's health is effected and the possibility of low birth weight babies is high. This is known to be a key factor in infant mortality in India.[4]

The study shows a preference for small family size. A maximum proportion (79%) of women had only three pregnancies. There are just 3.5% women with multiparous pregnancies and 16.9% with four pregnancies. 68% of the household (with children under five years old) reported to have two children. Thurambady and Parakadai have 90 % of the households with two children. The apprehension in bringing up many children has come out as the cause for small family preference. This reflects a positive shift in desired family size.

The economic condition of the family puts pressure on the women to continue working even after conception. In Mettur and Nathapalayam, since the work availability is less than that of Thurambady and Parakadai, one finds fewer women said to have worked after conception (28.5% in Mettur and 28% in Nathapalayam). On the other hand, 28.2% women, maximum number from Thurambady (46.9%) said to have worked till the time of delivery. In these families, it is inevitable for a woman to continue working irrespective of her pregnancy. It is obvious that this adds to the pressure on women's health and an unborn baby. Hard work in the last trimester is known to affect birth weights.

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4 Visaria, Leela, "Infant Mortality in India: Levels, Trends and Determinants", *Economic and Political Weekly*, vol. 20, no.32, August 1985.

Sundari Ravindran (1995)[5] observes that in poverty groups, participation in the labour force increases the risk of morbidity and is not an indicator of better status but of greater deprivation. But Sen (1990)[6] on the one hand links the economic factor and excess female mortality, but on the other hand, he sees female participation in income-generating activities as a means by which women can gain more bargaining power within the household. He views positively the 'gainful' employment of women.

In recent times, as reflected in the experience of mothers with children less than five years, the trend is different, as an increasing number of women did not work outside the house since conception. But in Parakadai, there were 13.3% women forced to work till delivery. There is a strong relationship between the women working outside the house and the parity. Amongst the women with children under five, 72.7% reported to have not worked since conception for the first pregnancy which then shows a declining trend from 68.9% in the second to 44.4% in the third to 42.8% in the fourth pregnancy. The women reported to have worked for six months show an increasing trend from 18.2% in their first parity to 22.7% in the second parity to 33.3% in the third and 28.6% in the fourth. This trend is also seen in the category that reported to have worked till delivery (9.1% in the first to 28.6% in the fourth). This shows social desire to save initial pregnancies despite poverty. The fact that for third and fourth babies, mothers do not stop working is perhaps more a reflection of poverty than a cultural practice. In very few cases, the sex of the child from earlier pregnancy is found to have an impact on her working.

The importance of first pregnancy and the care taken to avoid undue risk provides a woman less productive burden. It is important to note that the girl's family shares the expenses incurred during pregnancy and at the time of delivery along with the couple. But in the following pregnancies, the family had to earn their living and cope with their expenses. This increase in financial burden in turn puts pressure on women to seek work outside the house.

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5 Ravindran, Sundari, T.K., "Women's Health in Rural Poor Population in Tamil Nadu" in Monica Das Gupta (ed.) *Women's Health in India: Risk and Vulnerability* OUP 1995.

6 Sen, A. K., "More Than Hundred Million Women are Missing", New York Review of Books, Dec 1990.

The care given to the mother and the child by the family members range from two to ten days. During a first delivery, a woman is at her mother's place and does not resume the household work for some time. But in her subsequent pregnancies, a woman starts to manage the house either on her own or with the help of elder children. This finding is clearly reflected in the case reports. In the hamlets of Mettur and Nathapalayam, The women get help from the near or distant family members because of consanguineous marriage, which is however not the case with the women of Parakadai and Thurambady. Our findings of shifting patterns of maternal care over subsequent pregnancies strongly reflect the influence of economic constraints. Only in the first pregnancy, the families practice socially desired norms.

In all the hamlets, families show their preference for a male child. This does not lead them to neglect a female child. Once a female baby is born, the family slowly accepts the girl child. By observation of all hamlets and by studying the case reports, it can be said that the families with a few exceptions do not show any discrimination towards girl children. This again is a positive shift for the observed family.

Another key factor that influences child survival is the place of delivery. There has been a shift towards institutional deliveries in recent years. 42% of the total children born were delivered in the hospitals. This trend has shown a further increase in recent years with 75% of children under five years having been delivered in hospitals. The parity of a woman is found to influence the choice of place of delivery. The importance given to the first delivery is reflected in the choice made towards hospital deliveries. Sundari Ravindran[7] observes that the reason for hospital delivery is the value placed on the birth of the first child which is seen as the *raison de'tre* of mother and in respect of which the family does not want to take unnecessary risks.

The women who said to have gone to the hospital for vaccination during pregnancy continued to go there for deliveries too. The sex of the earlier child has an insignificant impact on the choice. In 44% deliveries, institutional help was sought. In about 43.7% of

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7 Ravindran, Sundari, "Women's Health in Rural Poor Population in Tamil Nadu", *in* Dasgupta, Monica (ed.) *Women's Health in India: Risk and Vulnerability,* 1995.

deliveries, an experienced old woman from the hamlet has helped in the delivery. Compared to the Indian average, the study population shows a high level of institutional delivery (43% for total children of the hamlet and 75% for children under five years).

Breast feeding in all cases was delayed by few hours to three days. Castor oil or sweetened water was given as a 'laxative'. Colostrum was denied to a majority of the children. But the nature of the place of delivery has shown a positive impact regarding the pre-lactation feed to the baby. The administering of pre-lactation feed shows no discrimination based on sex and order of the baby. Yet, the very practice of feeding castor oil instead of colostrum was significant. It was noted that in institutional deliveries, this practice was curbed (only 11.9% of children less than five years were given castor oil). But in home deliveries of recent time, 78.9% were given castor oil.

This finding, when seen with our data on shifts of the sex of the surviving child in subsequent pregnancies throws up some disturbing questions. Our data show that while in the first pregnancy, the proportion of male and female children is as expected (almost equal). As the pregnancy numbers increase, the proportion of female children declines drastically. There is no evidence of infanticide. But given the evidence of female infanticide in some parts of Tamil Nadu (Madurai[8], North Arcot district[9], Salem) and the fact that indiscriminate use of castor oil as pre-lactation feed can cause serious consequences.Therefore a possibility of a negative attitude towards a girl child cannot be excluded.

Mothers breast-fed all the children irrespective of sex and order. Exclusive breast-feeding was done for five months in all case. The importance of breast milk is understood and they fed their babies for one or two years. The male children are found to have breast-fed for a longer period than the female counterparts. Nathapalaym has the maximum number of children (22.7% who were breast-fed for more than two years). The fact that the poor women despite their poor diets, poor body and poor nutritional status are able to breastfeed their infants for prolonged periods has tended to obscure the importance of

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8 Goldenberg, Suzanne, "Where Baby Girls Must Die", *Sunday Observer*, 22 October 1995.

9 Sahu, George et al, "Female Infanticide in Rural South India", *Economic and Political Weekly,* 30 May 1992.

maternal health and nutrition in ensuring and sustaining good lactation.[10] This in turn effects the birth weight of the subsequent babies due to nutritional depletion of mothers. However, in the agriculturally wet areas – Parakadai and Thurambady, majority of the children were breast fed for six to twelve months. This reflects the work pressure on women, which in turn has a direct impact on childcare.

The dietary practice of the mother does not change during the lactation period. They report (clearly evident from case reports) that they sometimes avoid certain food items due to their personal experience of unsuitability of that item for the breast-fed baby. Weaning is done mostly by the fifth month. The mothers try to feed supplementary food at regular intervals. Once the baby starts to feed on its own by picking up food items from other's plates, the mother said that they start giving full meals to the child. 95% of the children were weaned at the age of five months and the rest by ninth month. The mothers said that the breast milk is not enough for a child of five months. They start with mashed *idlis* or well-crushed rice. Milk is also given as supplementary food but mostly it is given to the male child. The children were given food cooked for the entire family. Beef is cooked in majority of the households about once in a month and the child is fed with beef by the age of one to one and a half years. The inability to buy nutritious food is mainly due to the economic condition of the family.

The cause for stoppage of breast-feeding is mostly due to the mother's next pregnancy or the feeling that the child has grown up. One and a half to two year of age are considered to be the right age for discontinuation. A low percentage of women reported to have discontinued breast-feeding due to less secretion of milk. Majority of women also said that beef is consumed to increase breast milk. This shows that women try their best to provide for their babies' nutritional needs. By looking at the dietary patterns, one finds no change in the dietary habits of pregnant women. Our findings corroborated the study by Parischa[11] regarding dietary intake in a group of poor, pregnant and lactating women in South India shows that protein calorie intake during pregnancy and lactation drops

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10 Gopalan, C., "The Mother and Child in India", *Economic and Political Weekly,* 26 January 1985.

11 Parischa, S., "Survey of Dietary Intake in a Group of Poor, Pregnant and Lactating Women", *Indian Journal of Medical Research*, vol.46, 1958.

appreciably as compared to pre-pregnancy stage. Families in our study area are dependent on the wage earned by a single member till the woman resumes her work.

From the case reports, it becomes clear that the children do not get adequate meals. In the houses, the food is cooked once or twice a day, A full meal is cooked in the evening which is kept for the night and the morning. Depending on the amount of leftovers, a small meal is cooked in the morning. The school-going children are sent to the *balwadis* for lunch and the mother eats the leftover rice. This routine does not change much even during the pregnancy. This practice is followed in all hamlets except Mettur and Parakadai where there is no *balwadi*. Lunch had to be cooked for the small ones.

When the child cries, sometimes out of hunger, it is fed with eatables like puffed rice or biscuits from the snacks shop. In the study, it came out that the child is fed with food cooked for the entire family. Sometimes the starch water or water drained from the cooked *dal* are also given to the babies. *Most under five are persistently demanding food and the mother is unable to offer adequate quantities of food.*

Regarding the cleanliness for the first few months, the baby is bathed daily and care is taken to ensure protection against infection. Due to various pressures on the mother, the intensity gets lost over the months. The child is left on its own to care for itself in the later months as the mother is busy with her work or with the other children. This makes younger children more prone to infections, particularly diarrhea.

One of the factors that have a direct and a serious impact on a child's well being is the early resumption of work by the mother. In the study, 29% of children had experienced the early resumption of work by the mother. The mothers of about 3.8% of children were forced to work even before three months of pregnancy. The percentage is higher in the agriculturally wet hamlets - Parakadai and Thurambady. Though the mothers have said that they did not continue their work for a long time, during the agricultural seasons, it becomes inevitable. This is because in the poor families, this extra earning is indispensable for their survival. Parischa[12] says that women's diet has been seen to

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12 Ibid.

actually deteriorate during pregnancy, as she cannot continue to work, thus contribute to the income of the household. If she continues to do hard physical labour which poor women would do, she undermines her own health as well as endangers the life of the baby. The early resumption further contributes to restriction of breast feeding which ultimately adds to the vulnerability of the child. This comes out clearly in the agriculturally active hamlets where maximum number of women breast-fed their babies for six to twelve months. In the other hamlets, this period extended to one to two years.

It can be seen from the study that burden and pressure on a woman increases since infancy. In the families belonging to low socio-economic group, a mother, in spite of early resumption has to bear the insecurity of leaving the child with a substitute. Helen Ware (1984)[13] observes that women's economic activity has a negative impact on childcare only where such activity is incompatible with simultaneous child rearing or where the mother lacks access to another person able to care for the child.

In the study it was found that 43.6% of the children did not have any substitute and were looked after by the mother. But high percentages (24.3%) were left under the care of old women. This needs to be understood as these women in the village are at home because they are unfit to work. 5.1% of children were under the care of their siblings. The hamlets of Nathapalayam and Thurambady enjoy the benefit of the *balwadis* in their hamlets. 26.9% of the children are left in the *balwadis* till the mother returns from work. Presence of *balwadis* has changed childcare practice in about 26.9% of the families.

The utilisation of health service system has not shown a positive outcome with regard to both women and children. Only during pregnancies, some women said to have visited hospitals to get tetanus injections. Otherwise, all of them try home remedies to cure the ailments. They attribute their inability to go to the hospitals to the clash of timings of hospitals and their working hours. For their children, first they try home remedies but in the case of infants, they approach the hospital for treatment. The traditional practitioners treat some problems of the infants. From the case reports, the difference with regard to

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13 Ware, Helen, "Effects of Maternal Education, Women's Roles and Child Care on Child Mortality", *Population and Development Review*, Vol. 10, 1984.

the ailment that could be cured by institutional care and that could be cured by traditional practitioners becomes clear.

In our study, there are some factors like smaller family size, work pattern during pregnancy; where women do not perform outside labour, institutional delivery, breast feeding for two years and weaning practices at five to six months, care of a girl child (keeping the fact of fewer girls in third and fourth pregnancy in mind), use of *balwadi* for substitute care etc. that have shown positive trends. These factors could be seen having a positive influence on child survival. In the two agriculturally wet areas – Thurambady and Parakadai there are however, differences as women work till delivery and they stop breast-feeding by about six months. The remaining variables that were taken up for study such as age at marriage, time of first conception, intervals between pregnancies, resumption of work after pregnancy, dietary practices are found to be negatively affecting survival as shown by the review of literature. These are variables, which have not changed given the socio-economic conditions of the study population. Therefore, for better understanding of child survival, it is imperative to study the influence of these factors as a complex rather than in isolation.

There are 31 infant deaths reported in the hamlets by women of various age groups. Women having children under five years old reported 35% of the infant deaths. This shows substantial mortality in recent years. There are 27 households in total that have experienced infant mortality. One house experienced three infant deaths and two houses with two infant deaths each. Out of these households, the maximum number of households was found in Mettur and Thurambady. The former belong to agriculturally dry area and latter to the wet area. All the households belong to the landless and low socio-economic groups with no regular income. Out of 27 women who experienced infant deaths, 89.3% depend on agricultural labour. 35.9% women reported to have stopped working for wages since conception and 14.8% worked till the time of delivery. 59.2% said to have worked for six months since conception. This trend has undergone a change. None of the mothers who experienced infant deaths worked till the time of delivery. 60% said to have stopped working since conception and 40 % worked upto six months.

This data, when compared with the pattern of work during pregnancy shows that women in 27 families where infant deaths were reported, in fact, worked a little less than the general study population. Work therefore, though very critical, cannot be the only factor in the death of their babies. The causes for the majority of the infant deaths were identified as refusal to feed, excessive crying, infections and low weight. The mothers were not aware of any specific diagnosis. In two cases, they said that the baby died while they were in the hospital for sterilization. This shows that perhaps maternal and infant malnutrition and infections were the key factors in the death of these babies.

Out of 27 women, 80 % reported to have been married by the age of 18 years and their first conception was within two years. In recent times too, majority was married before 18 years and they faced the social and family pressures to produce children early. A World Health Organisation (WHO) (1989) report shows that the age of marriage may have a direct influence on infant death. Out of 31 infant deaths, 64.5% were delivered at home and 33.5% in public hospital and 3.2% in private hospital. All the hamlets show a high percentage of home deliveries.

If one probes more into the socio-economic conditions of the families that experience infant mortality, there is no marked difference from the general findings. Therefore, it is clear that not only the general low socio-economic status is important but also the fact that within these the most vulnerable economically (landless and irregular work) are more affected.

If one looks into the data on Infant Mortality Rate (IMR), there are some interesting observations that can be made. For the district as a whole, the IMR is quite erratic between 1990 – 96 and shows a consistent decline between 1994-96. For the Mulanur block, however, we have data till 1998 and it shows that there has been a decline from 1992 onwards but in 1997, IMR jumps upto 41.3 as against 18.3 in 1996. The previous IMR over the nineties ranges from 32-39. The Mulanur Primary Health Centre (PHC) however has a relatively higher IMR between 1992 and 1997. It ranges between 27.3 to 61.3 and the 1995, 1996 and 1997 figures are 50.2, 27.3, 45.6. Given the fluctuations, the figure of 27 is perhaps more of an aberration than of a real decline. 45.8 therefore a still

high IMR compared to the district value of 29.7. When we look at Nathapalayam sub-centre which includes the study population as against Mulanur PHC we find again very high IMRs – 78.4 in 1995, 53 in 1996 and 41 in 1998 (table-6.1).

Table –6.1 **Infant Mortality Rate**

Year	Erode District	Mulanur Block	Mulanur PHC	Nathapalaym Sub-centre
1990	43.7	25.2	34.8	55.5
1991	50.8	31.5	32.1	36.3
1992	47.5	39.5	39.2	59.7
1993	36.4	39.3	61.3	28.6
1994	45.0	38.9	44.6	NA
1995	33.1	33.8	50.2	78.4
1996	29.7	18.3	27.3	53.4
1997	NA	41.3	45.8	NA
1998	NA	NA	NA	41.1

Source: Mulanur Primary Health Centre Records

Our study reveals two sets of factors, one that contributes to and the other that perhaps lowers mortality as discussed on page 146. Among the study population – the SC group – perhaps it is the former that is more dominant as the shifts in the later are not effective.. This may be true of the other SC population as well, which constitute the majority of the landless in the block. The block has 36.3% of SC population and this in itself may contribute to the high IMR of the block, PHC and the sub-centre.

The shift in agricultural production from coarse grain to cash crop cultivation due to the increase in powerloom sectors and other agriculturally related income-generating activities have influenced the employment opportunities available to the people of this section. This shift has also increased the prices of food grains over the years.

The government-sponsored programmes like Public Distribution System (PDS), mid-day meal scheme and infant nutrition programme too have not brought about a positive change. The poor quality of foodgrains served in PDS has made the people buy foodgrains from the rice mill or at the local shop at a high price. The insignificant amount of money spent on each child and the deplorable food served in the mid-day meals

programme has a negative impact on the attitude of the families towards these programmes. The infant nutrition programme is running more on paper rather than making any positive input towards childcare. All these factors put together contribute to inadequate child survival.

Apart from these economic conditions that have not only direct impact on the well being of the family in general and women and children in particular, there are other factors such as social and cultural that also act upon them. The social status of the SC families and the woman's position within the family, the attitude of the family members towards later pregnancy, women's work and childcare in her absence impinge on the survival chances of the child. The desire for a male child and the practice of giving castor oil to the children as a pre-lactation feed even in recent times tend to have a negative impact on chances of survival of the new born.

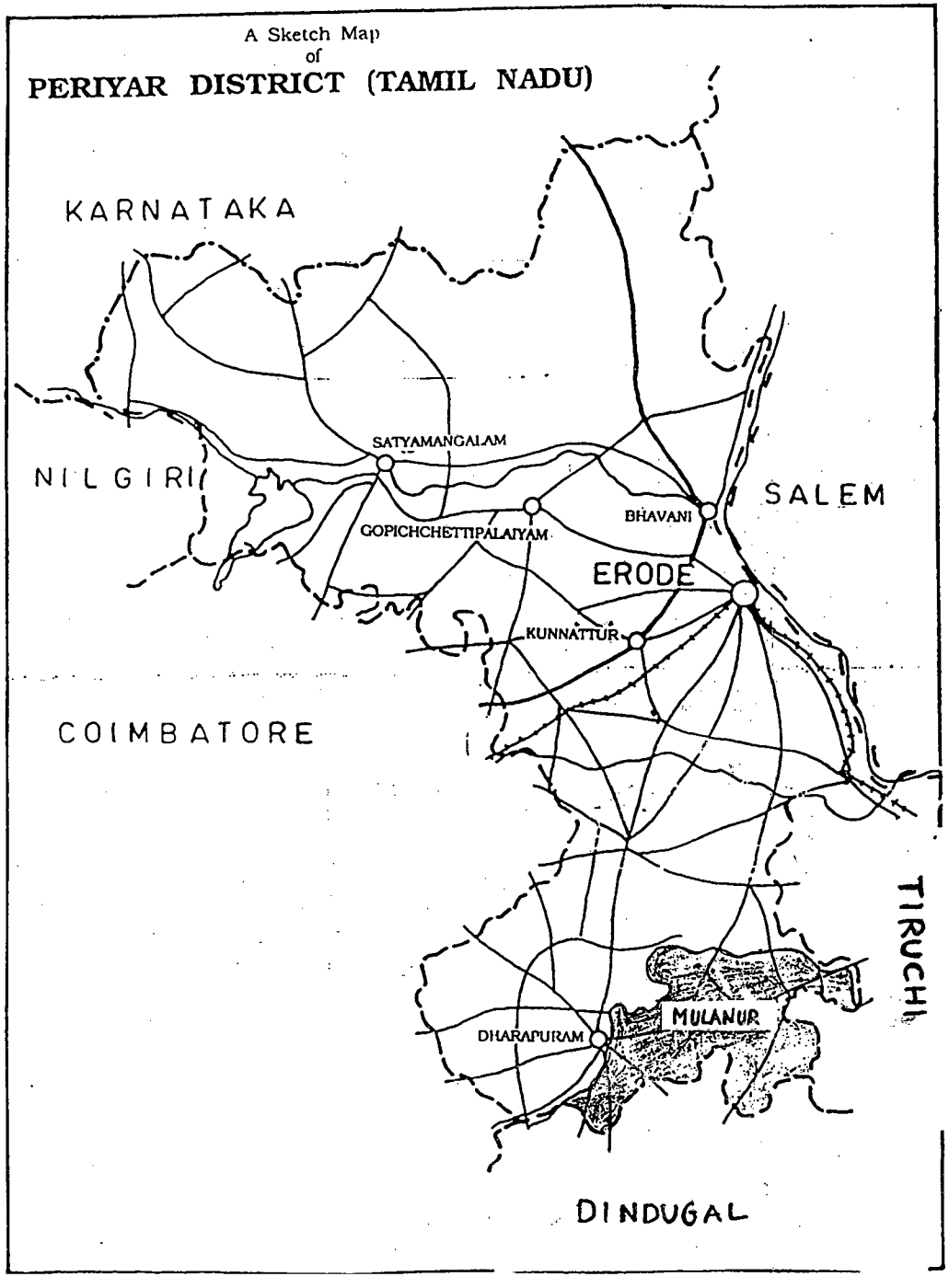
Apart from these factors, the poor image of PHC among people restrains them from seeking institutional care. The preference given to the traditional practitioners over the hospitals for treatment throws a poor light on these institutions.

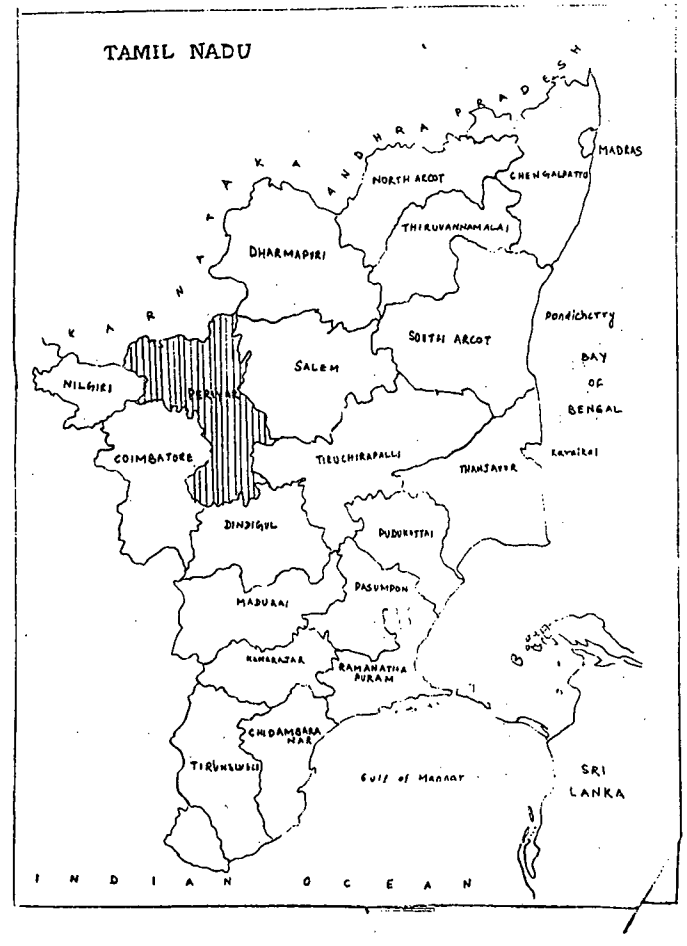
Thus one finds a negative impact of the broader socio-economic factors acting on the SC population. Despite the positive shifts in - the family size, work pattern during pregnancy, equal care given to the children of either sex at least in the first two pregnancies, increase in institutional delivery, breast feeding practices (in Mettur and Nathapalayam), use of *balwadis* for substitute care – which seem to reduce IMR, their degree and impact are not sufficient. The tension between the two sets of factors seems to be in favour of the set that has a negative impact. Therefore, it is important to understand that technological interventions at the level of services alone can at best have limited impact. We cannot turn a blind eye to broader and independent factors that influence the health of a woman and survival of the child because access to and quality of the services depends on the family's socio-economic status. It is well known that poverty itself, through maternal

malnutrition has an impact on child survival.[14] In addition it leads to other forms of deprivation of the child that endangers survival.

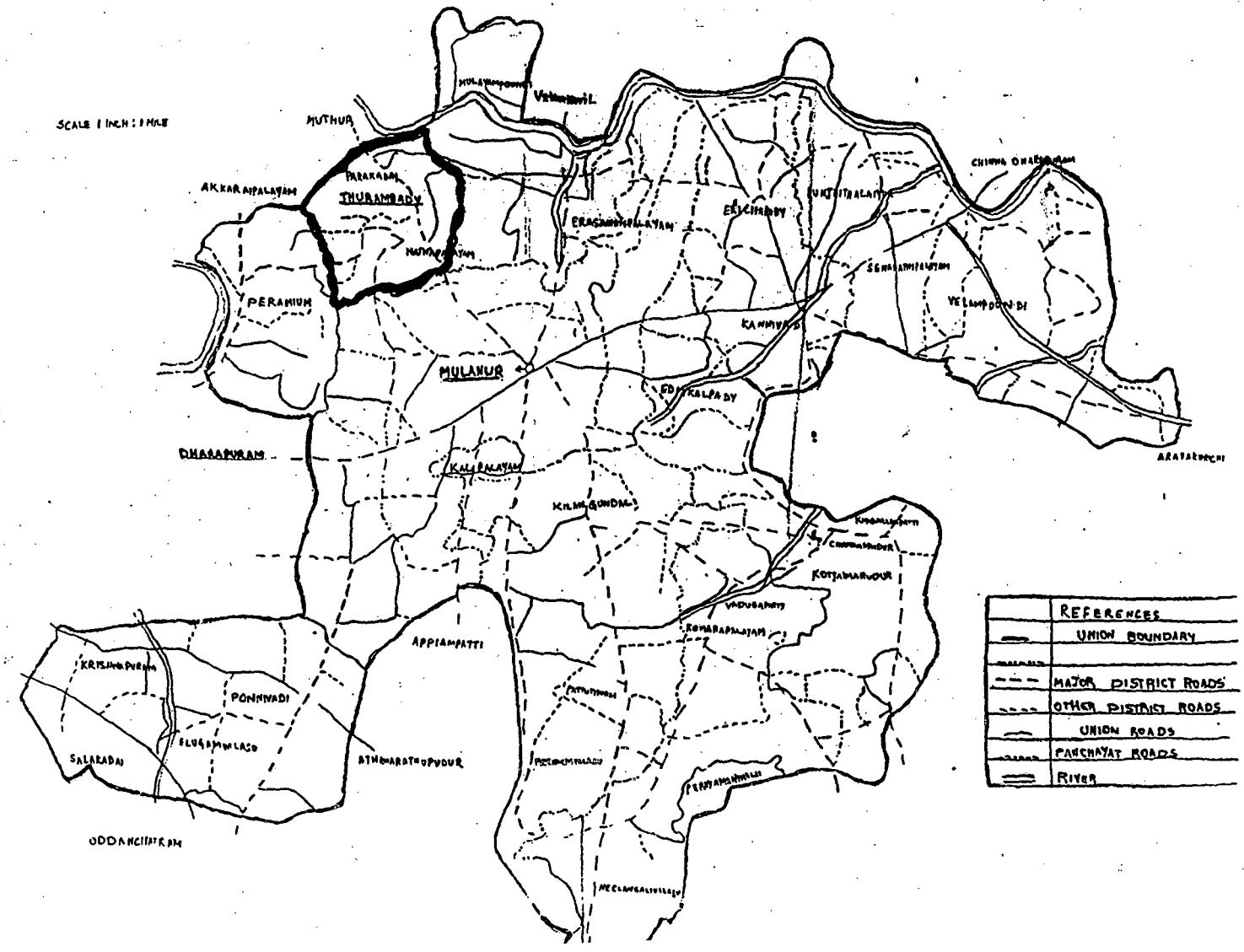
14 Wadsworth, Michael, "Early Life", p.44 in Marmot, Michael and Wilkinson, Richard (ed.), *Social Determinants of Health*, 1999.

Appendix

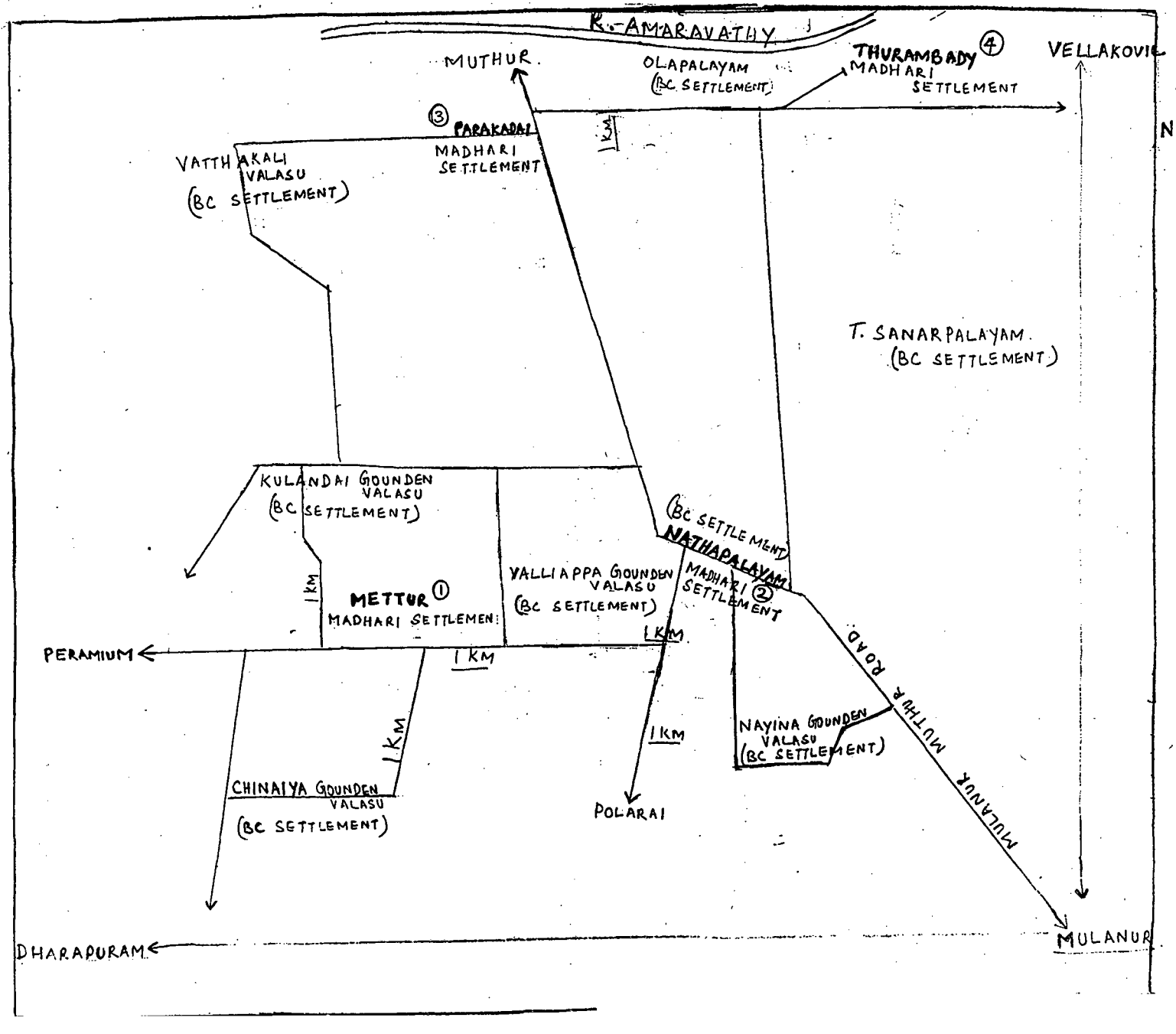

A Sketch Map
of
PERIYAR DISTRICT (TAMIL NADU)
KARNATAKA
NILGIRI
SATYAMANGALAM
GOPICHCHETTIPALAIYAM
BHAVANI
SALEM
ERODE
KUNNATTUR
COIMBATORE
TIRUCHI
MULANUR
DHARAPURAM
DINDUGAL


TAMIL NADU
KARNATAKA
ANDHRA PRADESH
MADRAS
NORTH ARCOT
CHENGALPATTU
THIRUVANNAMALAI
DHARMAPURI
Pondicherry
SOUTH ARCOT
SALEM
NILGIRI
PERIYAR
BAY
OF
BENGAL
COIMBATORE
TIRUCHIRAPALLI
THANJAVUR
Karaikal
DINDIGUL
PUDUKOTTAI
MADURAI
PASUMPON
RAMANATHA PURAM
CHIDAMBARA NAR
TIRUNELVELI
Gulf of Mannar
SRI LANKA
INDIAN OCEAN

MULANUR PANCHAYAT UNION



THURAMBADY PANCHAYAT



Interview Schedule

Village name:
Household number:
Respondent's name:
Total number of members:
Total number of children under five years:
Infant deaths: Y/N
If yes, how many

Members

Name:
Sex:
Age:
Relation:
Education:
Occupation:
Marital Status:

Socio-economic Details

Land ownership: Y/N?	If yes, how many acres?
Do you own Livestock: Y/N?	If yes, details
Possession of Assets: Y/N?	If yes, what are the items?
Do you have any savings: Y/N?	If yes, where do you save and how much?
Do you have any debt Y/N?	If yes, for what purpose are you indebted?

Nature of housing	Government-built/Own/Rented
Number of rooms	
Nature of roofing	
Is it electrified?	
Source of drinking water	
Sanitation facility	

Marriage and Pregnancy Practices

What was the age of Marriage?

Are you blood-related to you husband?	If yes, what is the relationship?
How many pregnancies have you had?	
What were the intervals between pregnancies?	
For how long did you work after conception?	
Did you avoid any food during pregnancy or lactation?	
Did you go to the hospital during pregnancy?	If, yes for what purpose
Did you get the injections regularly?	

Details of children

Order
Place of delivery
Pre-lactation feed
Initiation of breast feeding
Weaning
Age of stoppage of breast-feeding
Causes for stoppage
Food given to the baby

Practices after delivery

Details regarding care given to the child
Resumption of work
Substitute Care

Use of Health Services

Where do you go for treatment during illness?
What are the reasons for not seeking hospital help?
For what ailments do you approach the traditional practitioners?
Do you approach the elders for treatment?

Infant mortality experience of women including abortions

Order
Sex
Place of delivery
Cause of death
Duration of survival
Age of conception
Work before pregnancy
Resumption of work

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