SOCIO-ECONOMIC CONTEXT OF MATERNAL AND CHILD HEALTH PRACTICES— A CASE STUDY OF AN ANDHRA VILLAGE

Dissertation submitted to the Jawaharlal Nehru University
in partial fulfilment of the requirements for the
award of the Degree of
MASTER OF PHILOSOPHY

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CERTIFICATE

This is to certify that this dissertation entitled "SOCIO-ECONOMIC CONTEXT OF MATERNAL AND CHILD HEALTH PRACTICES - A CASE STUDY OF AN ANDHRA VILLAGE" submitted by Ms.GOPARAJU LAKSHMI in partial fulfilment of the requirements for the award of the degree of Master of Philosophy, has not been previously submitted for any degree of this or any other University. This is her own work.

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

Dr.IMRANA QADEER
Chairperson & Supervisor

ACKNOWLEDGEMENT

That a dissertation has at all emerged out of my divorse meanderings owes more to one person than anyone else - my supervisor Imrana Qadeer. In handling the dilemma between freedom and responsibility she was caringly sensitive to my particular temperament. While I worked in conditions of great independence, virtually every crucial turn in this dissertation, especially in the final stages, had much to do with Imrana's interventions, which were always in the nature of suggestions, pertinent and sharp. She coped uncomplainingly with the rigours of supervising a lethargic student like me.

My companion, Ashok Tankasala, had been pushed into loneliness for months and to take full charge of our home and little daughter. He has been a great support and encouragement in completing the dissertation.

The two little kids Ishan and Nehanda bothered us little, though unknowingly.

Prof.D.Banerji and Dr.Prabha Ramalingaswamy of the Centre gave valuable comments and suggestions on my work.

Sudha helped in codification and preperation of the master table, Bijaya Kumar Behera in collection of literature. B. Ashok helped in proof reading and many other friends helped in many other ways.

During my field work, my mother Vardhani and brother Ravi shared the responsibility of looking after my child. In the study village, Mrs & Mr.Ch.Parankusam and Mrs & Mr. Prasadh Rao bestowed their affection and hospitality. The PHC staff, particularly the MPW(F) Mrs. Jayamma, were quite helpful and cooperative.

I must not forget to mention the women, particularly the labourers of SJM, who taught me the naked realities of a woman's life in the rural context, more than anybody or anything else.

I express my heartfelt gratitude to all of them.

G. Lakshmi

(GOPARAJU LAKSHMI)

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EVOLVING AN APPROACH TO THE PROBLEM

1. INTRODUCTION

The evolution of Maternal and Child Health(MCH) services in India has a long history. It was inspired by the welfare movement in England and planned parenthood movement of the West. In the post-independence period, the health planners gave it a lot of emphasis. The Health Survey and Development Committee's(1949)(popularly known as Bhore Committee) recommendations for MCH were fully accepted. Despite the policy statements however, the status of MCH services has been pretty low. While in the fifties it was left in the hands of the scanty number of female doctors and nurse midwives as an independent programme, in the sixties it was merged with family planning on the pretext of integration. This, instead of invigorating MCH services in fact undermined the evolution of adequate MCH services as they were perceived as tools for achieving family planning targets rather than objectives in themselves. Apart from this operational problem, the content of services(of whatever existed) was also not derived from the basic needs of Indian population but from the prescriptions of the British Medical Council[1]. The entire approach to MCH was technocentric,

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1. Jeffery,R., 'Recognizing India's Doctors: The Institutionalization of Medical Dependency 1918-39', Modern Asian Studies, Vol.13,No.2,pp.301-326

emphasizing upon immunizations, institutional deliveries and treatment of complications. To this later on were added Iron and Vitamin supplements and nutritional programmes.

Even though in the seventies an attempt was made to develop a comprehensive approach towards health through the concept of primary health care, MCH for all practical purposes remained as technocentric as ever. This was because, though on paper the need to develop services necessary for survival and subsistence was conceded, in practice very little was done. And MCH services which formed an essential component of primary health care, continued to be based on technological interventions like immunization, oral rehydration etc. The social dimensions of the problem were never considered. Even if it is granted that some of the technological interventions are relevant, a technocentric approach fails to tackle the social problems which impinge on MCH, often due to its own constraints it misses the real problems among mothers and children. It is so because it begins from what techniques exist(like immunization) rather than what is required. It also fails to take into account social, economic and political factors which not only affect accessibility of services but also the nature of health problems in mothers and children.

It seems to us that unless and until these aspects of the problem are taken into account, MCH services will continue to

be based on inapproapriate technology and will remain inaccessible to the majority. It is for this purpose that we are interested in exploring the social and economic determinants of MCH problems.

2. DEVELOPING A PERSPECTIVE

If we believe that mothers and children are an integral part of the family, the social groups and the society at large, then MCH problems too have to be considered in a wider context of poverty and other sociological dimensions like the woman's status, her role in the economy and within the household. To locate India's MCH problems in their social and economic context, a brief review of literature on poverty, income and food distribution in classes, environmental degradation(including sanitation), morbidity and mortality patterns in women and children are presented here. An attempt is also made to look for class differentials and the degree of suffering of women as compared to men within the same classes.

2.1 PROBLEM OF POVERTY AND ITS IMPLICATION FOR MCH.

About half of the population lives below the poverty line i.e they spend 80 percent of their income on basic food items, but are still unable to get the minimum calories required. Even government estimates[2] admit that 48.8 percent of the

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2. Government of India, Sixth Five Year Plan, 1980-85, (New Delhi; Planning Commission, 1981), p.18.

population is below the poverty line. Many recent studies[3] suggest that the proportion of the population living below the poverty line is actually increasing.

The Union Ministry of Labour has also documented the increasing economic plight of the labouring poor. In 1974-75 the average daily money wages had decreased in real value by 12 percent from the previous decade. And further, that in the same period the total number of landless agricultural labourers had increased by 70 percent(from 28 million to 47.5 million) while the number of "cultivators" decreased- a reflection of increasing numbers of small peasant families being forced to leave their lands due to indebtedness and poverty.[4]

Inspite of deteriorating conditions for the poor, the per capita national product increased during the same period i.e.from Rs 306 to Rs 366 from 1960-61 to 1975-76(at 1960 prices[5]) This indicates a further widening of the disparties in income between the rich and the poor.

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3. Dandekar, V.M.and Rath,N.,'Poverty in India', Economic and Political Weekly, 1971,pp.25-48 & 106-46,see pp.28-29; Barreto,D., The Indian Situation,(Centre for Social Action, Banglore, 1977),pp.11-17.
4. Union Ministry of Labour, 'Getting Poorer,' Economic and Political Weekly, 1978,pp.1976-7
5. as quoted by Mitra, Ashok; India's Population(A Family Planning Foundation/ICSSR Book, 1978), p.711

The trend of percentage distribution of per capita private consumption by expenditure class of population is also disturbing; the share of the bottom 30 percent is becoming smaller and smaller over the years. The table below demonstrates it more clearly.

Table: 1. Percentage Distribution of Per Capita Private Consumption by Expenditure Class of Population.

Class of Population	1970-71	1977-78	1970-71	1977-78	1979-80	1982-83	1979-80	1982-83
Top 30%	49.5	51.9	54.5	54.0	49.5	51.9	54.5	54.0
Middle 40%	35.1	33.1	31.8	32.4	35.1	33.1	31.8	32.4
Bottom 30%	15.4	15.0	13.7	13.6	15.4	15.0	13.7	13.6
	Rural		Urban		Rural		Urban	

Source: Based on Periodic Surveys of Household Expenditure by National Sample Survey Organization(NSS).

The inequality of distribution of consumption expenditure remains extremely skewed. The poorest 30 percent of the people had a share of only about 15 percent while the top 30 percent claimed more than half the national cake. The contrast between the top and bottom 10 percent is even sharper.

As in other underdeveloped countries, outlay on food accounts for the major share of the family budget. However,

the decline in its share over the years is significant. An average household spent as much as 64 percent on food in 1970-71. The proportion went down to about 56 percent in 1982-83.

This data, seen in the light of consumption differentials, focuses on the plight of the poor. According to a recent estimate by the food and Agriculture Organization(FAO)[6], around 200 million Indians are malnourished, forming almost half of the world's total and about one third of the Indian population.

Banerji's(1981)[7] rural study showed that over 36 percent of families(in the villages studied) did not get "two square meals a day" to satisfy their hunger for at least three to six months a year. As of 1981, 59% of the population were without drinking water supply; only six percent had access to sanitation. 94 percent were without a proper facility for excreta disposal.[8] Needless to say that majority of these facilities are provided in urban areas but even there not all get it.

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6. As quoted by UNICEF, An Anlysis of Situation of Children in India,(New Delhi, UNICEF, 1984)
7. Banerji, D. Poverty, Class and Health Culture in India, Vol.I(New Delhi, Prachi Prakeshan, 1981)
8. Government of India, National Master Plan for Water Supply and Sanitation(April 1981-March 1991), (New Delhi, Ministry of Works and Housing, July 1983)

The policies of "development" which are responsible for existing disparities have also led to serious environmental changes which are in turn leading to a degradation in the life of the common man. Soil erosion, deforestation, water pollution, air pollution are a few examples.

The land area prone to floods has doubled from 20 million hectares to about 40 million hectares over the past 10 years. About 70 percent of all the available water in India is polluted. Some 73 million work-days are lost due to water related diseases. Soil salinity and water logging affect over a quarter of irrigated land[9]. The scarcity of firewood(which, together with cowdung and crop wastes, provides about 90 percent of the country's cooking energy needs), has become acute in rural as well as urban areas. Firewood prices have doubled in the past six years in many cities. Poor women of rural areas are the most affected by environmental destruction. Every dawn brings with it a long march in search of fuel, fodder and water . The culturally accepted division of labour within the family leaves the collection of household needs like fuel, fooder and water to women. As these become increasingly difficult to obtain, women have to spend an inordinate time foraging for them. It does not matter if the women are old, young

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9. The State of India's Enviornment-1982, (CSE, New Delhi-1982)

or pregnant; crucial household needs have to be met day after day. As ecological conditions worsen, the long march becomes even longer and more tiresome.

Before we look further into the problems of MCH an attempt is made to survey data on class differentials in health of women and children. Our National Sample Surveys and registration schemes show rural urban disparities in death and morbidity, but they do not focus upon class differentials. Some of the smaller studies however, do show that such a differential exists. A study on under five children in the villages of Punjab(Kielman and Oberoi 1972) shows that compared to the Jats(landowning peasants) the Ramdasia(Harijan)children not only have higher morbidity but also higher prevalence of malnutrition.[10]

A study by Sen and Sengupta(1983)[11] in two villages of Bengal, shows that level of malnutrition decreases as landownership increases. This was observed at two levels- between the villages(one with 18 percent landless population and the other with 60 percent landless population) and in the children of landed verses landless households in both villages.

According to the Registrar General's Report(1979) 'levels of living' have a direct impact on IMR. One economic index

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10. as quoted by Qadeer,I., Health Services System in India: An expression of Socio-Economic Inequalities, Social Action, Vol.35, July-September 1985, pp.199-221
11. Sen, Amartya and Sengupta, Sunil., 'Malnutrition of Rural Children and the Sex Bias', Economic and Political Weekly, vol.XVIII, 19-21(Annual number), 1983

used in their survey was the use of electric lighting and oil lamps in rural households. The IMR was 87 in the former and 1963 in the latter. According to K.N.Pillai's study[12] while the Harijans had an IMR of 266 it was 159 for Goundor (cultivators).

Thus, it is evident that in a stratified and hierarchical society where resources are limited, those at the bottom of the hierarchy will have the least access to MCH services. It is important that not only class differentials exist in health status but that within a class too, differences between men and women are quite visible for health and access to services. We present some data to support this contention in the following section, and also survey the scene of MCH.

2.2 INDICATORS OF WOMEN'S HEALTH STATUS:

Sex Ratio: The declining sex ratio(proportion of females to males) in India is exceptional to the general pattern in other parts of the world, namely an excess of female population. Over the years it declined from 972 females per 1000 males in 1901 to 935 females per 1000 males in 1981.[13]

Life expectancy of Indian women is about 10 years less than that of women of developed countries and is constantly lower than that of Indian men. According to 1981 census it is

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12. as quoted by Zurbrigg, Sheila, Rakku's Story(Madras, George Joseph, 1984)

13. Census of India 1981, General population Tables series I, (New Delhi, Resitrar General, 1981)

51.6 years whereas it is 52.6 years for men.

Infant Mortality: The IMR still remains higher at 126 per thousand births.[14]

Again within this, there are glaring differences between rural and urban areas and between sexes.

Table:2. Infant Mortality(expressed as number of deaths per 1000 live births)

AREA	SEX		
	Males	Females	Persons
Rural	130	142	136
Urban	69	77	70
Total	120	131	125

Source: Central Bureau of Health Intelligence(1983), Health Statistics of India, 1982, Ministry of Health and Family Welfare, New Delhi.

Children under the age of 15 years constitute about 40 percent of the country's population, a proportion which has remained almost constant for the past 70 years. 17 percent of the population is under the age of 5 years. 40 percent of all doaths occur under the age of five years. About half of them take place in the first month of life and more than half of them in the first week of life. 30 percent of total deaths occur in the first year of life.[15]

14. Ibid

15. Government of India, Sample Registration System 1970-75 and 1976-78(Vital statistics Division, New Delhi)

Maternal mortality in India is one of the highest in the world; though exact figures are not available, estimates range from 500 to 800 per 100,000 live births.[16]

Table: 3. Distribution of maternal deaths due to causes related to child birth and pregnancy- 1980.

Causes	Total Deaths		Age groups in years 15-24		25-34		35-44		45-54	
	Number	%	Number	%	Number	%	Number	%	Number	%
Abortion	26	12.5	12	13.7	7	8.1	7	21.2	-	-
Toxaemia	26	12.4	11	12.5	10	11.6	5	15.2	-	-
Anaemia	33	15.8	12	13.6	15	17.5	14	12.1	2	100
Bleeding of Pregnancy and puerperium	33	15.8	12	13.6	20	23.3	1	3.0	-	-
Malposition of child leading to death of Mother	28	13.4	11	12.5	10	11.6	7	21.2	-	-
Puerperal sepsis	26	12.4	14	15.9	7	8.1	5	15.2	-	-
Not classifiable	37	17.7	16	18.2	17	19.8	4	12.1	-	-
All causes	209	100.0	88	100.0	86	100.0	33	100.0	2	100.0

Source: Survey of causes of death (Rural) 1980, office of the Registrar General.

16. Government of India, Health For All by 2000 A.D., (Report of the Working Group, Ministry of Health and Family Welfare, New Delhi, 1981), p.61.

The table clearly states that a large percentage of maternal deaths are still being caused by such easily preventable diseases like anaemia, sepsis and bleeding. Malposition of child leading to death of mother also deserves attention. 13.4 percent of maternal deaths which occured due to this reason could have been simply averted with provision of trained birth attendants.

Abortion: About 50 percent of all pregnancies end up in abortion- spontaneous or induced. The incidence of this phenomenon has remained constant over the period 1957-68, a period which witnessed intensification of family planning activity. In fact there was even an increase in actual number.[17] As late as in 1972, pregnancy wastage of malnourished mothers was 30 per cent.[18] Still births were reported as constituting 11 per 1000 live births.[19] Much of this pregnancy loss and perinatal mortality is caused by premature births and malnutrition.[20]

Differentials in Mortality: In developed countries, still birth rate and death rate of male children is higher. However, in India, this seems true only upto the first week of life

17. World Health Organisation, Vital and Health Statistics, (South East Asian Region, 1966) Table 9
18. Gopalan, C.J. and Naidu, A.N. 'Nutrition and Fertility', The Lancet, Nov. 18, 1972, p. 1073
19. World Health Organisation, World Health Statistics Annual, 1967, 1970.
20. Gopalan, C.J., Collected papers: 1943-1973, (Hyderabad, 1973).

after which the female death rates take over. Female death rates in the peak reproductive age 15-29 years were reported to be consistently higher than male death rates in this age group in both rural and urban areas. The causal factors for this difference lie in the hazards of pregnancy and child birth. For the years 1979 and 1980, female deaths were relatively more in the age groups 1-4, 5-14, 15-24 and 25-34 years as compared to males in both the years.

Table: 4. Age-Sex distribution of reported deaths-number and percent- all India, 1979-80.

Age Group	1979			1980		
	Persons	Males	Females	Persons	Males	Females
Below 1 year	3,296 (19.6)	1,767 (19.6)	1,529 (19.4)	3,296 (18.7)	1,818 (18.8)	1,478 (18.5)
1-4	1,675 (9.9)	720 (8.0)	955 (12.2)	1,624 (9.2)	753 (7.8)	871 (10.9)
5-14	910 (5.4)	456 (5.1)	454 (5.8)	963 (5.4)	474 (4.9)	489 (6.1)
15-24	1,570 (9.3)	727 (8.1)	843 (10.7)	800 (4.5)	349 (3.6)	451 (5.6)
25-34				947 (5.4)	463 (4.8)	484 (6.1)
35-44	2,192 (13.0)	1,392 (14.8)	863 (11.0)	1,008 (5.7)	570 (5.9)	438 (5.5)
45-54				1,235 (7.0)	762 (7.8)	473 (5.9)
55 and over	7,205 (42.8)	3,992 (44.4)	3,213 (40.9)	7,799 (44.1)	4,488 (46.4)	3,311 (41.4)
Total	16,848 (100.0)	8,991 (100.0)	4,857 (100.0)	17,672 (100.0)	9,677 (100.0)	7,995 (100.0)
Per cent by Sex	100.0	53.4	46.6	100.0	54.8	45.2

Source: Survey of causes of death(Rural) 1980, Office of the Registrar General.

2.3 Women's access to Health Services

A study[21], conducted in 1957, in six rural communities covering six districts in Maharashtra with a total population of 37,000 has shown that at a given point of time, there were 730 sick females as compared to 513 sick males under 15 years of age. Yet the percentage of males getting treatment was higher. A difference in the quality of treatment was also noticed. More adult females had to be content with free or traditional treatment or no treatment whereas males sought modern treatment.

A comparision of the nutrition status of children observed in 1955 and 1978 " shows very little improvement. If anything, the figures for 1978 appear to be somewhat worse"[22] However, cultural norms and attitudes to girls in societies like ours result in a preference for boys even in infant nutrition. A nutritional study of 17 villages in Morinda, Punjab,[23] showed that nutrition is determined mainly by sex. By being breast fed longer and by being given more food after they were weaned, boys aged 6-24 months in all castes were better nourished than girls of the same age. The nutritional

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21. Dandekar, Kumudini, A Demographic Survey of Six Rural Communities, (Bombay, Asia, 1959)

22. Health For All: An Alternative Strategy(New Delhi, ICSSR/ICMR, 1981), p.51.

23. As quoted by Safilios - Rothschild, Constantina, The Role of the Family in Development, Education Kit on Women, Health and Development, (Geneva, W.H.O., 1986).

discrepancy was much larger in the lower agricultural caste. Girls in the same caste were not only breast-fed for a shorter time period but also consumed less supplementary milk and less solid food, began consuming solid food later and received less of each of the nutrients.

In 1978, about 75 percent of the deliveries in rural areas were conducted by untrained practitioners.[24] The Committee on the Status of Women reported that during their tours they were repeatedly informed of the inadequacy in the number of, and services rendered by ANM.[25]

In rural areas, 93 percent of the deliveries are conducted at home. But only 18 percent of them are attended by any kind of a trained person,[26] ranging from a trained dai to a private doctor. Who the 18 percent are(privileged enough to have the services of a trained professional during child-birth) becomes clear when we look into the studies conducted on the accessibility of rural health services. Banerji(1981) has shown that the PHC network is inacessible to the poor. According to his Harijan respondents, the nurse is 'memsab'. "How can she visit us? we are poor. We cannot pay her fees. She visits rich people and spends considerable time in their houses!"[27]

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24. Office of the Registrar General, Survey on Infant and Child Mortality, 1979,(New Delhi, 1981).
25. Towards Equality,Report of the Committee on Status of Women in India(New Delhi, Government of India, Ministry of Education and Social Welfare, 1974).
26. Government of India, Fifth Five Year Plan 1974-79(New Delhi Ministry of Health and Family Planning, Department of Family Planning 1974).
27. Banerji,D(1981)op.cit.

According to NSS data(1973-74), in Maharashtra as many as 90 percent of rural pregnant women did not register with any health centre.[28] 30.4 percent thought that it was not necessary that their health was good. 12 percent complained that there was no health centre nearby, and as much as 10.6 percent did not know that a health centre existed. However, only one percent preferred private treatment. 89.8 percent delivered at home, 7.8 and 2.4 percent at hospitals and PHC respectively. Those who delivered at home were largely attended by Dai(61.7 percent) and others (29.4 percent)ANMs attended just three percent and doctors attended one percent of the deliveries.

2.4 Linkages between Women's health and their Socio-economic status.

Though majority of Indian women work for longer hours than men their total earnings remains low. This is because (1) household work and child care which eats away a larger part of a woman's day is considered as devoid of economic value; (2) they are paid lower wages as compared to men; (3) their employment opportunities are low within what is available; and (4) due to their reproductive function, which

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28. Khandekar, Mandakini, Maternal and Child care in Maharastra (Secondary Analysis of NSS 28th Round Data for Maharastra on Maternal and Child care), (Bombay, Tata Institute of Social Sciences, 1980) (Memo)

makes them abstain from work at least for few days, they are treated as unrealiable. The estimate of the total female labour force was 78.6 million in 1973, 88.9 million in 1978 and 99.4 million in 1983- an average annual addition of 2.1 million. The total labour force in 1983 was 306 million. According to 1981 census,[29] female work participation rate is 21 percent. More than 80 percent of them are engaged in agriculture as labourers.

It is estimated that 16 hours or nearly two thirds of a woman's day is spent in working.[30] According to the estimates of Srilatha Batliwala(1982)[31], the respective energy contribution of many women and children per day are 31 percent, 53 percent and 16 percent respectively. Hence women are working for longer hours and harder than men. However, according to the same study food distribution within the family is very disproportionate- 2 units for a man 1.5 units for a woman and 1.0 unit for a child(of cooked cereal regi). Hence here is a deficit of nearly 100 calories per day, and this is felt more acutely during pregnancy and lactation when an additional

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29. 1981 Census op.cit.

30. Jain, Devaki, Women's quest for Power: Five Indian Cases, (Vikas Publishing House, New Delhi, 1979)

31. Batliwala, Srilatha, 'Rural Energy Scarcity and Nutrition- A New Perspective',- Economic and Political Weekly, Vol.XVII, No. 9 Feb 27, 1982, p.329.

500-600 calories are required. The same study found that women expend about 700 calories, or one third of their energy expenditure, on the domestic tasks of cooking and firewood and water fetching.

Apart from economic reasons many social factors also effect the health of women. Caste system, social status derived from caste and class background, educational levels- all these have a definite impact on the health status of people, particularly women.

Ironically, the unique reproductive function of a woman which should be regarded as a social contribution since it creates labour force[32], has never been considered as a cause for receiving better medical care or better social treatment. It has in fact derogated her to a lower status. In the present day society it makes her more subservient to man.

Women's health is also influenced by certain cultural factors. For example, it is customery for Indian women to first serve food to the family and then eat whatever is left In the survey conducted by the Committee on the Status of Women, 48.53 percent of persons stated that in their families males eat first.[33]

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32. Banaji, Rohini; Wage Labour: The production and sale of the commodity Labour power, n.d.

33. Towards Equality, op.cit.

This custom is common for all the classes, but in poor families this results in more malnutrition for women and girls. Many surveys have revealed that men eat first, then boys, then girls and women eat last. Despite the fact that all family members must work had, scare resources and immediate needs often result in unequal distribution between men and women, between adults and children and between boys and girls.

The cultural norms that particularly affect women's health are the attitudes to marriage, age of marriage, value attached to fertility and sex of the child, the pattern of family organisation and the ideal role demanded of the women by social conventions. They determine her place within the family, the degree of her access to medical care, education, nutrition and other acessories of health. While these cultural factors are important they have been overemphasised by researchers working on MCH. We shall explore it further in a later section.

Even this brief review of literature does indicate that the existing socio-economic structure and cultural patterns not only lead to extensive poverty of the majority but also excessive deprivation and hardships for women in particular. The socio-economic and cultural processes involved not only determine her social status but also her health. A comprehensive understanding of women's health therefore demands that we make an effort to understand these processes.

3. APPROACHES TO WOMEN'S HEALTH

A review of the available studies on women's health, particularly on MCH reveals four main trends.

3.1. Technological Approach:

The major trend is to look at MCH as a purely medical problem and suggest technological interventions as solutions. Anaemia, abortions, infant deaths, maternal deaths, infections etc. are all primarily treated as medical problems of a vulnerable group. The emphasis is on diagnosis, early detection or prevention through medical intervention. The social roots or the genesis of these problems is not considered.

Efforts of World Health Organisation(WHO) to identify and tackle MCH problems over the fifties and sixties are the best examples of this approach. In the following years the WHO experts have realised the significance of enviornment and subsistence levels for MCH. However this has only led to an expansion of the technocentric approach in which apart from the medical technology, they only add interventive technology to improve water supply, sanitation, disposal of waste, nutrition and so on. Their technical report series[34] are example

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34. World Health Organisation, Public Health Aspects of Low Birth Weight(Technical Report Series No.217(Geneva, 1961); The Midwife in Maternity Care(Technical Report series No.331),(Geneva, 1966); The Organisation and and Administration of Maternal and Child Health Services (Technical Report Series, No,428)Geneva 1969); The prevention of Perinatal Mortality and Morbidity, (Technical Report Series No.457); Human Development and Public Health ,(Technical Report Series, No.485)Geneva 1972); New Trends and Approaches in the Delivery of Maternal and Child Care in Health Services(Technical Report Series No.600)Geneva 1976).

of the earlier trend while the later broadening of tho approach is reflected in series of documents produced during late: seventies and eighties.[35]

A latest example to this approach is the suggestions made by Grant(1983)[36] for child survival. He again beats the same old bush advocating oral rehydration, promotion of breast feeding, immunization and spacing of births without giving any consideration to the environment—both social and biological—in the Third World countries where his target children are.

None of these documents explore tho social and oconomic roots of the MCH problems. Many Indian researchers also use this approach. For example, Ghosh[37] suggests that effective child health programme, improved environmental sanitation, nutrition and health education and effective fertility control can break the cycle of malnutrition of children. Sho further says that rampant malnutrition is not all due to poverty but also due to widespread ignorance of mothers

35. World Health Organisation, Aspects of Public Health Nursing, (1961), Deprivation of Maternal Care: A Reassessment of its effects, (1962); Trends in the study of Morbidity and Mortality (1965).

36. Grant, James P., 'A Child survival and development Revolution', Assignment Children, 61/62, 1/1983; UNICEF.

37. Ghosh, Shanti, The Feeding and care of Infants and Young Children, (New Delhi, UNICEF, 1976).

about nutritional requirements for children. However, she neither explores which one is epidemiologically the major cause nor probes the reasons of absence of these basic amonities.

To ensure health and nutrition of infants, subsidised foods for nursing women, provision of facilities for breast feeding for urban working mothers and education of would be mothers are suggested by Gopujkar and others.[38] C.Gopalan,[39] who has done many laudable studies in nutrition also find similar solutions to solve the problem of breast-feeding. Provision of creches at work-sites, increasing maternity leave, stopping of commercial baby food advertisemonts through the media are his recommendations. However, increasing maternity leave is recommended only for two children, that too in the case of mothers of the weaker sections only.

Mishra and others(1982)[40] who used systems analysis to assess the implementation of family planning programmes, despite their extensive coverage failed to look into the sociological dimensions of the problem. They concentrated on organizational improvement and concluded that family planning goals could only be attained if measures were undertaken

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38. Gopujkar, P.V. et.al, Infant Feeding practices with special reference to the use of commercial infant foods, (Nutrition Foundation of India), n.d.
39. Gopalan, C. 'Why breast milk is better than formula baby foods', included in Gopujkar, P.V. et.al. Infant Feeding Practices with special reference to the use of commercial infant foods, (Nutrition Foundation of India), n.d.
40. Mishra, B.D., et.al, Organization for change: A systems Analysis of Family Planning in Rural India, (New Delhi Radient Publishers, 1982).

to drastically improve the existing organizational capacity of medical and health organisations. Their recommendations however were devoid of a sociological understanding of the family planning needs as well as sociological insights into the organisations and remained valid perhaps only in the administrative domain.

Muttayya(1972)[41] who carried out a study in Andhra Pradesh on Child Welfare had collected data on health, nutrition, hygiene, practices of mothers and children in clusters of villages and did a comparative analysis without making any reference to the class differences on which he infact had collected data.

3.2. Culturological Approach:

Those who adopt this approach basically link mainutrition and ill health problems, particularly of women and children, to cultural beliefs. Less intake of food by women in general and pregnant women in particular is attributed to cultural beliefs. Food is referred as a cultural concept in which beliefs are rigid and difficult to change in the interest of better nutritional status. Thus, Foster and Anderson[42] say that "what tribal and peasant people have not learned is the relationship between food and health and between diet and pregnancy and the special food needs of children

41. Muttayya: Child Welfare- Existing conditions and parental attitudes: A purposive study in Andhra Pradesh(National Institute of Development, Hydrabad, 1972).
42. Foster, G.M. and Anderson, B.G., Medical Anthropology (New York John Wiley and sons, 1978) p.264-272.

after weaning". The National Institute of Nutrition(1977) in one of its studies concluded that most rural mothers do not give supplementary foods to their children because of fear and wrong belief.[43] J.P.Naik commented that even in situations where food is not particularly short, women often resort to remain without food due to religous beliefs.

Some eminent physicians who participated in the fifteenth Internationl Congress of Paediatrics(1977)[45], are of the opinion that during pregnanacy the mothers were surrounded by time honoured taboos and a good deal of toddler malnutrition is due to ignorance of the mothers.

It is true that cultural beiefs influence the food intake of women. But these scholars attempt to study culture in isolation from sociological and economic dimensions. They therefore, fail to see the link between culture and socio-economic processes and hence treat the former as constant, rigid and unchangeable.

3.3 Feminist Approach:

Women's Health was central focus of Feminist movement in the West. Despite all its controversies it did contribute to demystification of medicine, a change in the doctor patient relationship and the generation of self- help movement[46].

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43. Government of India, National Institute of Nutrition; 'Supplementary Food', Centre Calling, vol.XII,No.11.Nov.77
44. Naik,J.P. and Barden, Kalpana, Nutritional Problem of women in India: Some Socio-Economic aspects(New Delhi, Ministry of Education, Government of India),n.d.
45. Government of India 'Breast feeding with love', Centre Calling, vol.XII/No.11/Nov.77,pp.3-5.
46. The Boston Women's Health collective, Our Bodies Ourselves (New York, Simon and Schuster,1971); Chesler, Phyllis,Women and Madness, (New York, Double Day, 1972); Frankfort,Ellen, Vaginal Politics,(New York, Quadrangle Books, 1972).

Inspired by this, some middle class women in India also attempted to develop a similar approach to the problems of health among the Indian women. The efforts to mobilise women on issues such as freedom to decide and know about their bodies, freedom for abortions and contraceptives remained limited to a very small section and did not inspire the majority, since for demystrification of medicine is a relatively insignificent issue in a situation where the majority of women have little contact with modern medicine. The generation of a self-help movement is not relevant here as majority of the women spend all their time and energy just to survive and do not have the access to even basic minimum facilities and services. Moreover, in a situation of scarcity and deprivation perhaps the focus on health alone itself is misplaced.

The Indian feminists failed to relate themselves to the real problems of the majority. Secondly, they failed to grasp the essential nature of social processes and focussed their attention on the man-woman conflict. Their targets thus became men and their 'male chauvinism' rather than the social structure and its ruling class.[47]

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47. ~~Shah, Kalpana: Women's Liberation and voluntary action;~~ Kishwar, Madhu and Vanita, Ruth: In search of Answers Indian womens voices from Manushi, (London, Zed Books) 1985; Mehta Susila, Revolution and the Status of Women in India, (New Delhi, Metropolitan Book Company), 1982; Subbamma, Malladi, Women : Tradition and Culture, (New Delhi, Sterling Publishers), 1985.

Within this approach then, for understanding health problems of women, the essential determinent was oppression by men and the socio economicfactors got neglected.

3.4. Socio-Political Approach:

An analytical approach to health which takes into account its economic, social and political determinants can be traced back to the works of Engels[48] and Virchow[49]. This approach however, was oversh adowed by those who looked at health as an isolated biological phenomenon and supported the germ theory.[50] Later the ecological approach came into fashion because the pure technological interventions did not succeed and the ecological approach offered a way to check the growing social conflicts. While this approach still continues to be the more popular, some scholars have attempted to reasess its relevance. They have emphasized the need for a morecomprehensive analysis of health and have used the socio-political framework for analysing health problems. Among these, the significant contributors has been Rene Dubos[51] who has attempted through a historical

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48. Engels, Frederic, Conditions of the Wroking Class in England in 1844, (London, George Allen & Unwin, 1926).
49. As quoted by Waitzking, Howard; 'A Marxist view of Medical Care' in Socialist Health Review, Vol.I,No.1, June 1984
50. Rosen, G., History of Public Health (New York, M.D. Publications, 1958)
51. Dubos, Rene; Mirage of Health, (Anchor Books, Doubleday, 1961)

analysis to focus on social, environmental and political factors which influence health in the West. Yet another person who has attempted to look at health and population issues with a socio-political perspective is Mckeown who has not only questioned the role of health services in the improvement of health of the people[52] but has also shown how social processes effected health and health services.[53]

A crusader in the seventies was Ivan Illich[54]. His analysis, however, is confined to the American society. He deals with the negative impact of industrialization, professionalization, bureaucratization and use of high technology. But he did not take into account the social processes inherent in a capitalist system. His analysis therefore is limited specially for those who are interested in the third world situation. All the same he does very forcefully bring into focus implications of some social processes for health as well as health services system.

Various papers presented at a seminar in 1976, organized by Health Marxist Organization, looked into the socio-economic causes of health and analysed the links between

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52. Mckeown, Thomas; 'A Sociological Approach to the history of medicine' and 'A historical appraisal of the medical task' in Medical History & Medical Care- A Symposium of Perspectives, Mclachlan, Gordon, and Mckeown Thomas(eds),(London 1971)
53. Mckeown, Thomas, The Modern Rise of Population,(London 1976)
54. Illich,Ivan, Limits to Medicine(Bombay,Rupa and Co.1977)

social processes and health patterns.[55] In a paper on political ecology of disease, Turshene[56] takes the position that the mode of production in which medicine develops, determines the nature of medicine. Medicine or any other scientific knowledge is not neutral in itself but its nature and scope are determined by the economic system in which it is practiced. She recognised the link between the general philosophy behind capitalism and medicine, as practised within capitalist system, and states that unless the philosophy of the system changes, the paradigm of medicine cannot change since the later is guided by the earlier.

Though all these authors do not analyse the health problems in similar terms nor in similar situations and periods, they all try to see the roots of the problems in the social, economic and political context. A similar trend can also be picked up in the literature available on the Third World. Though the context of analysis is quite different, all these researchers do share the general approach.

In India the population problem was the first area where the use of this approach helped to question the official perspective of "over population".

55. Guynor David, et.al, Materialist Epidemiology, (New York, 1976); Kelman, Sander, Definitions of Health, (New York 1976).

56. Turshene, Meredene, The Political Ecology of Diseases (Health and Society Group, October 1981)

Banerji[57], Mamdani[58], and Rao[59] used this approach to study the population question in the Indian context. Banerji later used the same approach to study health problems of rural populations.[60]

Shiela Zurbrigg[61] while analysing the available material on structures of ill health, has taken into consideration the socio-economic factors that decide the health behaviour of people, particularly women and children. The case report that she poses as an introduction is a vivid illustration of socio-economic influence on the health of children.

Djurfeldt and Lindberg[62] attempted to understand the health problems of a South Indian village in its socio-political context. Though their approach is challenging as it considers the class structure of the society as determinent of health status and accessibility of services for different classes, when they analyse their data they sometime overlook its limitations and stretch it too much to fit in their conceptualisation.

Banerji's study[63] covered 19 villages and probed into

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57. Banerji,D.,'Political Economy of Population Control in India' in Bondestam,L and S.Bergstrom(eds), Poverty and Population Control,(London, Academic Press)pp83-101
58. Mamdani,M.,The Myth of Population Control-Family Caste and Class in an Indian village,(Monthly Review Press New York, 1972)
59. Rao,S.K., 'Population Growth and Development:A counter Arguement', Economic and Political Weekly,vol.11, No.31-33,Special No.August pp.1149-58
60. Banerji,D.,(1981)op.cit.
61. Zurbrigg,Shiela,(1984)op.cit.
62. Djurfeldt,G,and Lindberg,S, Pills Against poverty; A study (New Delhi, Oxford and IBH Publishers, 1975)
63. Banerji,D.(1981)op.cit.

various dimensions of health culture and its determinents. The definition of health culture that he proposed significantly takes into account cultural perceptions of health problems, their cultural meanings and the cultural response to these problems, both in terms of formation of various institutions to deal with various health problems and actual (health)behaviour of individuals or groups. Because of its cultural connotation, health culture is subjected to change as a result of cultural diffusions and purposive interventions from outside to bring about a desired change in health culture Such a connotation also links it closely with the overall way of life of the community its overall culture, which in turn is influenced by the ecological background, cultrual, economic and social setting and the political structure of the people. This broad definition has served as a basic premise to Sahu's (1981)[64] study of health behaviour of tribals.

It is within a similiar but a much limited framework that we attempt here to study MCH problems among different classes in a village. While we are not looking at the regional, political and cultural entirity in a time framework, the

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64. Sahu,S.K., Health Culture of Oroans and its hinterland, (Unpublished Ph.D Thesis, submitted to Jawaharlal Nehru University, 1980).

essential elements of our approach would be-

a it locates MCH within a socio-economic context;

b it attempts to identify processes through which the context impinges upon health;

c it takes into account stratification within the village;

d it considers perceptions of MCH, an outcome of social interactions within people and between people and services; and

e it does not take for granted that medical services are 'scientific' but, explores its scientific content.

By using this approach we hope to fill in the gaps which have been left by the studies conducted in the area of MCH.

We would like to review briefly studies which claimed to take into consideration the socio-economic conditions to analyse the child bearing and postpartum practices. One was carried out in rural Java and the second one in rural Bangladesh. We picked up these because the conditions and practices in Bangladesh are not very different from ours and even Java shares the features of backward stratified societies in south-east Asia. The other two were carried out in India itself.

The rural Java study[65] basically concentrated on the birth

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65. Hull, Valerie J., The Ngaglik Study: An Enquiry into Birth Interval Dynamics and maternal and Child health in rural Java, World Health Statistical Quarterly 36(1983)

interval dynamics. It claims to study this dynamics in the background of socio-economic conditions. It studies educational status and work patterns of pregnant and post partum women in its universe(two villages in Java). It presents data on pregnancy practices, conditions of delivery, post partum behaviour, illness of mothers and children, etc. However, while analysing the data, even the educational levels of women and their working background(the only socio-economic factors for which data was collected) were not considered. Despite this the study claims,"to attempt to place aspects of child bearing and health in a socio cultural context and to assess the impact of social change in this stratified society". In actual analysis, this was not done. In fact, more emphasis was placed on medical problems during pregnancy and post partum periods.

The Bangladesh study[66] claims to have looked into the economic conditions of people but is basically a discriptive anthropological study. It presents data on child bearing and delivery practices. It deals more with the concept of pollution, bhut, purdha etc., but these are never linked

66. Theresa, Blanchet, Meanings and Rituals of Birth in Rural Bangladesh, (University Press Limited 1984)

with the economic conditions. Calling a dai to act as birth attendant is analysed in terms of religious(Muslim and Hindu) differences. Giving birth without any help, was described as an act to avoid others from becoming polluted. But the economic disability to pay a dai was not dealt within specific terms nor was the fact that the health services were simply not available in the area.

The Bijnor study[67] claims "to locate women's child bearing experiences within specific and differing social and economic context". It presents data on child bearing and delivery, particularly on changes in work patterns of women during these periods. But again while analysing, it limits itself to the study of kinship patterns, their role in providing support to pregnant women and how they affect the work patterns of women. The authors of the study seem to conclude that "microdemographic factors impinge differently on individual women, some having virtually no break in their duties after giving birth, while others have several weeks rest". This obviously shows that for them the variations in work load of women is an individual phenomenon and hence no effort is

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67. Jeffery, Patricia et.al. Child Birth and Collaboration among women in Bijnor district(1983).

made to correlate it with socio-economic backgrounds of women.

The Maharashtra study[68] analysed the 1973-74 National Sample Survey data on Maternal and Child-Care practices to study the social correlates of MCH care and to find out the differences between rural, urban areas. Registration of expectant mothers(EMS) following visits to health centres, visits by health staff, consultation with medical practitioners, additional food for expectant mothers, place of delivery, type of birth attendant, Auxilary Nurse Midwife's (ANM), visits after child birth, consultation with medical practitioners, family planning advice, immunization of children, weaning and child's diet, food given to small children etc., were studied. Influence of different variables on all these practices were analysed. In all, twelve variables were used, namely, town class (city, town, village), household group (caste groups), household industry and occupation, household size, economic status, age and education of head of household, education of expectant and nursing mothers, age, parity and activity status of the mother.

The study certainly establishes the differences between the rural and urban areas. It also shows the differences in

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68. Khandekar, Mandakini(1980) op.cit.

MCH care between casto groups and economic groups. Their data on household industry and occupations was not adequate to give them relevant clues. The study's major shortcoming is its failure to link up these variables with one another and see their inter-relationship. Its scope is limited since the study concentrates on status of service utilisation by the different categories and does not look into the reasons for it. Their basic thrust is on rural urban differences while the class differences have not been fully explored in the two settings. Though such an effort was made at times(eg.to analyse registration and visits of expectant mothers to health centres) it was not carried out throughout. Additional food for mothers and diet of children is perceived as a matter of belief and is treated independently without relating it to caste or class background.

It seems that all these studies while claiming broader framework, not only do not actually use it but are also limited in their exploration of MCH problems as they only study some specific aspects of it- cultural, social, medical or nutritional- but do not develop a comprehensive understanding of even MCH problems.

CHAPTER II

METHODOLOGY

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METHODOLOGY

1. OBJECTIVES OF THE STUDY

Our review of literature shows that there is a near concensus on the issue of relevence of MCH problems and the need to solve them. The need to look at MCH within its socio-economic context is also well noted. The research efforts, however, are fragmented and not fully integrated. To fill in a few gaps the present study attempts to understand the economic and social reality in the village and its influence on MCH problems. Secondly, to explore the gaps between perceptions and actual care of mothers and children in different classes. To do this we have studied the lives of women in their totality. We closely looked at their daily lives as agricultural workers(supervisors as well as labourers), housewives and as mothers. The implications of these and their families' economic position for their health status and their access to health care services are studied in detail.

The specific objectives of the study can be stated as follows:

(1) to study the differences in the patterns of maternal and child health care in different agrarian classes;

(ii) to identify social processes responsible for these differences; and

(iii) to identify gaps in perception and action and to explore their causes.

2. THE DESIGN

Since the focus of the study is on social processes that influence health of women and young children, the methodology has to be such that the qualitative aspects of women's lives are fully explored in all their dimensions. For this, one village was studied intensively to grasp the dynamics of socio-economic life of the village and its linkages with the health status of women and children. The processes at work that influenced health, were located at first through qualitative explorations and later quantified to give them appropriate weightages.

Our Universe is one village because a village alone gives us a composite social unit which, though small, reflects the major complexities of a dynamic social system. We could not go in for more villages given the time and resource constraints.

To achieve the purpose of the study, apart from the socio-economic data, information on a variety of sensitive issues was necessary frommarried women respondents. This required certain degree of familiarization with local culture, knowledge of social customs and proficiency in local language and dialect. Taking the above factors into consideration, the researcher has chosen a village in her home district of

Guntur, in Andhra Pradesh, where the degree of communication and interaction with the respondants was easy and feasible.

2.1 STUDY VILLAGE AND ITS POPULATION

A village called Sangam Jagarlamudi(SJM) in Tenali taluk of Guntur district in AP was selected to conduct the study. This village is well connected with nearby towns. Its caste distribution is not different from the usual pattern in the district. Agriculture is well developed in the village and so we felt that different classes of agriculturists will be easily available.

According to the local primary Health Centre(PHC) survey records, by January 1985 population of the village was 5,280. Number of households was 1,225. Decadal growth of population is not much between 1971 and 1981. The population was 4,619(M-2289 and F-2330) in 1971 and 4,893 (M-2,493 and F-2,400) in 1981. Number of households was 1009 in 1971 and 1200 in 1981. Literacy rate was about 40 percent in 1971 and 49 percent in 1981.

2.2 NATURE OF DATA REQUIRED

Since the objective was to understand women's health in its totality, we wanted to explore the influence of the socio-economic environment on women's health. For this, it was

necessary to study the nature of economy and the production pattern in the village. Also, its social structure in terms of castes and their relation to classes was to be explored. Within this complexity, the effort was to establish points of linkages within health of women and their social and physical environment. For this the following data were collected.

(a) General data:

(i) An overview of the village: Location, communication, transport linkage, irrigation facilities, institutions—Government and non-government like the PHC, Schools, Post Office, Telephone Exchange, Bank etc. and mapping the village.

(ii) Economic aspects: Cropping patterns, land holdings, possession of milch cattle, terms and conditions of labour exchange, wages, hunger situation etc.

(iii) Social aspects: caste and religous groupings, educational levels, family structure, decision making powers, cultural beliefs, social customs, ceremonies etc.

(iv) Health Sorvices for the village: Availability, treatment meted out by health workers to different classes of people at the PHC and in their day to day work in the field and accessibility to private hospitals.

(b) Role of Women in the Village life

(i) Economic Activity:
In the village economy different kinds of economic activity done by women, female participation in agriculture as cultivators and labourers, different types of jobs allotte to them, their wages, ~~comparision with awages~~, comparision with wages of men, kinds of work done by women of different classes at home etc

(ii) Social Status:
Their roles as wives and mothers, status within the family and the society and its sociological and cultural dimensions, decision making power in family affaris in general and differences in various classes.

(c) MCH Practices:
Qualitative data- regarding food patterns and work patterns during pregnancy and after delivery, interaction with health services, practices at the time of delivery, care of pregnant women, postpartum mothers and small children, feeding and weaning practices, customs, ceremonies and superstitions regarding MCH etc.

These were collected from women of different socio-economic groups of the village as explained later through group discussions and conversations.

In addition to the above, to ensure that the data recorded on MCH practices is objective and the respondents' memory is fresh, an interview schedule was administered to a group of women who had given birth to a child/children in a time span of last two years- i.e from May 1983- April 1985.

2.3 NATURE AND SIZE OF THE SAMPLE

During the preliminary investigation we found that the population size is lower than expected. Birth rate in the village is almost half that of the state's (17.4), which means that there were about 90 births in a year. Rate of sterilisations is high— 56 percent of the target couples were covered by June 1984. In such conditions, to see that the sample should be of a considerable size, we included in the survey all those women who had given birth in the preceeding two years, i.e. from May 1983- April 1985. This was expected to give us roughly 150 women for the sample.

Only those who are settled and continue to live in SJM only were considered while choosing the sample . Daughters of this village who married men of other villages and unsettled in places other than SJM were not included in the sample , though they delivered in SJM. Because firstly, they are non-residents of the village for all practical purposes(they come to deliver at mother's place as per the

customs of the land). Secondly, they won't be available in SJM always, as they live with their husbands in other villages. Daughters-in-law of SJM were included in the sample irrespective of the village/town where they delivered. Because, even if they deliver at their parents' places, they come back to SJM along with their infants and continue to live in SJM. These births were also recorded in the PHC's births register under a special category called 'out births'.

2.4 IDENTIFYING THE SAMPLE

To acquire information on all women who could qualify for this sample, the following sources were explored:

(a) Births register: Lists of women who had given birth to a child/children during the period between May 1983 and April 1985 were prepared with the help of the births register maintained by the PHC. From them, those who belong to the agricultural classes were made seperate on the basis of their/their husbands' occupation(also recorded in the births register), and with the help of the ANM. There were 165 births during the choson period. Of them 120 took place among the agriculturists.

(b) MPWs Register: as a second stop, the population survey register of the MPWs of the PHC was used t

crosscheck. 13 more births were identified from that register.

(c) Dai: Dais' help was also sought but yielded no new results.

(d) As a fourth step, enquiries were made wherever the researcher went to meet women or interview them. 11 births could be identified in this manner also.

Thus altogether 140 women who gave birth to 144 children were identified. However, one of them had died. Two persons left the village to settle elsewhere. Nine women were not available during our field work, most of whom went to their parents' home to deliver. On the whole, we could interview 128 women who gave birth to 132 children.

2.5 TOOLS

(i) Secondary Sources: Certain important primary data like birth rate, death rate, population, sterilisation achievements, number of persons treated in the PHC, etc.could be collected from the PHC. Details of 1981 census-distribution of workers, literacy rate etc.were collected from the taluk office at Tenali.

Size of command area, kinds and intensity of crops grown in SJM, number of acres they each covered etc. were collected from Panchayat office.

(ii) Primary Sources: We have employed the methods of non-participant observation and discussions with groups as well as individuals, followed up with indepth interviews with some of the key persons like the Dai, ANM, PHC's lady Doctor and with those who volunteered to give information. Some case reports have also been used.

Interview Schedule(See Appendix 1)

An interview schedule was also administered. It was formulated basing on the qualitative data collected in the first phase of the field work, pre-tested and necessary changes were made before administering it finally.

Apart from socio-economic conditions and MCH practices, there were also questions to collect data on gynecological problems, other health problems, sterilisations, and on how frequently they sought medical help. Obstetric experiences of these women were also recorded together with number of children alive and dead, causes of death and ages at the time of death, and number of still births and abortions, if any.

Assessment of Caste and land distribution

Given the number of 1225 households and the time limitation, it was not possible to conduct a house to house survey to assess caste distribution and land ownership. We

therefore had to depend on less exact methods.

For assessing the number of households in different caste groups we primarily depended upon our discussions with each caste members and cross checked it with others. Assessing land holdings posed a bigger problem because this was going to be our main criteria for developing economic categories for the purpose of analysis. To arrive at dependable list we first approached the panchayat office.

According to the records of Panchayat office, 295 people had land in SJM. Of them 125 are holding less than 2.5 acres and 170 are holding more than 2.5 acres. The problem with this list is that, some people who own quite a small holding in SJM may own much more land in other places. For example, one rich farmer of the village has only one acre of land in SJM whereas his total landownership accounts to more than 40 acres. Even according to the Village Development Officeer(VDO) 327 farmers of SJM own land in other villages: Vadlamdi, Sekuru, and Augalakduru, adjacent to SJM. They pay land revenue outside the village upto about one lakh rupees whereas in SJM the total revnue collected is just Rs.25,000/-

It was therefore necessary to make independent assessments of land ownership. We contacted the PHC clerk who was

born and brought up in SJM and still lives there. Being a middle farmer himself, belonging to the dominant Kamma caste and an old resident, he was fully familiar with the ownership patterns of the village. With his help the Panchayat list was corrected. The fact that the distribution of our sample among different classes tallied with this list gives us some confidence that our list is dependable.

2.6 Scheduling of field work:

Field work was carried out from May to mid-August, 1985. It was done in two phases. In the first phase(initial 2 months), rapport was developed with villagers, MPW(F), Dai and the Doctors. Births among the agricultural classes during the chosen period were listed. Land holding pattern and caste distribution were assessed. All useful information was gathered from the PHC and other sources and crosschecking was done wherever necessary. Simultaneously, life styles of different classes, particularly of women were observed. Qualitative data on MCH practices was gathered through observation and discussions with groups as well as individuals.

In the second phase(rest of the period) interview schedule was administered to collect data for quantification. Qualitative data, particularly concerning the health of women was also collected all through the study period.

2.7. Analysis and Interpretation

An assessment of qualitiative data was done to get a general picture of life in SJM. The quantitative data was first codified and then transfered into a master table. Required tables were prepared from it. Qualitative and quantitative data was finally put together and analysed.

Keeping in mind the agricultural production in the area, where soil is fertile and advanced technology is used for agricultural purposes, on the basis of land ownership the households were grouped into four basic classes. These classes were:

(1) Landless labourers (0-0.5 acres of land)
(2) Marginal farmers (0.6- 2.5 acres of land)
(3) Middle farmers (2.6-5.0 acres of land)
(4) Rich farmers (5 acres and above)

As the number of households of middle and rich farmers was small (though well in proportion to the actual size of these classes in the village), they were clubbed together for the purposes of our analysis. In some economic tables- those of possession of milch cattle and milk production and consumption- landless labourers and marginal farmers were clubbed together since they differed little. Our analytical effort was to look at health within the class context, relato

socio-economic factors to health status and accessibility of services and understand the correlation of forces which determine women's and children's health in SJM.

2.8 Limitations:

As already explained, we could not go for more than one village due to time and resource constraints. Even within this one village, study was limited to agriculturists. Firstly because, occupational groups were too many and small in size except agriculturists. Though employees and business people constituted 11 percent and 5.3 percent of the population respectively, we could not include them as it is difficult to put them in a suitable class and in themselves they were very heterogenous to be treated as one class.

We are conscious that our coverage is small to make any generalizations for the area and the numbers of middle and rich farmers in our purposive sample are also small. However, as we have already explained, firstly our objective was not to generalise for Tenali taluk. Secondly, we are very conscious of the small numbers of the middle and rich farmers. While for assessing trends in perceptions, actions, work patterns, social status, care of pregant women, delivery practices and child care, we have depended on them; in assessing trends in mortality and morbidity we have been very cautious. Even large differences of rates have to be treated with reservations. We have also not used any statistical tools.

CHAPTER III

MATERNAL AND CHILD HEALTH IN THE SOCIAL CONTEXT OF SJM

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MATERNAL AND CHILD HEALTH IN THE SOCIAL CONTEXT OF SJM

SECTION I

AN OVERVIEW OF LIFE IN SJM

1.1 District Guntur

The study village, Sangam Jagarlamudi(SJM) is in Tenali taluk of Guntur district in Andhra Pradesh. A few taluks of this district, including Tenali, are in the western delta of river Krishna. There is a high pressuro on land in rural areas with a high proportion of female agricultural labourers(78.2 percent according to 1971 census) to male labourers. 53.7 percent of the cultivated area is covered by canals.

The total number of land holdings in 1971 was 3.31 lakhs of which 52.3 percent were of below one hectare. Average size of the holding was 1.73 hectares. The main crops are paddy, pulses, chilli, banana, turmeric, ground nuts, citrus fruits, tobacco and cotton. Sugar cane and betel leaves are also grown. More than half of citrus fruit gardens of the district are in Tenali taluk.

1.2 The Village SJM

Geographical Outlines

SJM is situated on the Tenali-Narakoduru road, 16kms away from Guntur on its eastern side and 10kms away from Tenali. The main bus route (road) connecting Tenali and

Guntur goes through the village, dividing it into two parts. On one side of the road lies two thirds of the village comprising Brahmin, Kamma, Gouda and Yadava households. Palle (Harijanawada) also lies on this side of the village, but towards the peripheries. The Primary Health Centre, Bank, Post Office, Telephone Exchange and all the four Primary Schools are also on this side. This area is surroundod by lemon gardens. The other part of the village where Telaga and Muslims live is surrounded by paddy fields. On the main road there are a few small shops and hotels.

Buckingham canal goes through this village irrigating its lands. Dry land irrigation is through filter points utilising underground water which is available at a depth of 7-8 yeards.

Railway Station is 2.3 kilometers away from the village. The high school is also situated near the railway station.

The Harijanawada('Palle') is about 1.5 kms away from the village and is divided into two parts, Malapalle and Madigpalle for the two sects. One old temple- Sangameswara temple is situated on the canal bank near the railway station.

Terrain

SJM has got a command area of 58 acres. According to

the VDO of the village panchayat, paddy is grown in about 300 acres, lemons and Banana gardens cover about 186 acres and 70 acres respectively. Turmeric is grown in 10 acres, chilli in 5 acres and chikoo in about 2 acres of land. Grass lands and acasia etc. account for 5 acres while in about 6 acres fish farming is done.

The soil of SJM is very fertile and therefore it has high value. For instance one care of rice growing land costs Rs 70-80 thousands. Lemon orchards cost more than double to it.

Facilities available

SJM has power, postal, telphone, Bank and transport facilities. It has four primary schools run by the panchayat samiti and two are privately managed. Tenali which is just 10 kms away has junior and degree colleges.

Health Services

SJM has a model PHC which was established in 1949. There are three Registered Medical Practitioners(RMPs) of whom one goes round the village on a bicycle to treat the patients. In addition there are a number of private nursing homes in Tenali, which can be reached in 10 mts.by bus with a fare of Re.1/-. All these services provide allopathic treatment.

1.3 The People

Social Structure and Occupations

The inhabitants of SJM are mainly Hindus, Christians and Muslims. Among Hindus there are different castes with their own social customs and rituals. Table 5 profiles caste and occupational structure and land ownership.

Table 5: Castes, Occupations and land owning status in S J M

Caste	No. of Families	Percentage of families in the total No. of house-holds	Main occupation	Other occupations	Land owning status	REMARKS
Forward Castes						
Brahmins	30	2.4	Agriculture	Caste Profession	Own land and also do tenancy	
Kammas	150	12.2	"	Employment	"	Most dominant caste in every respect; a few among them agricultural labourers but work only for other Kammas
Reddys	20	1.6	"	"	"	
Vysyas	75	6.1	Small Business	"	No	
Backward Castes						
Tolagas	300	24.4	Landless labourers	"	only 10% own	Numerically the largest caste in the village
Goudas (Taddy tappers)	100	8.2	"	Caste Profession	No	intervention by contractors and government in liquor business forced them to become labourers
Chakalis (Washermen)	25	2.0	Caste profession		No	
Mangalis (Barbers)	20	1.6	"	Agricultural labourers	No	
Yadavas	140	11.5	landless labourers		No	

Schedule Tribes						
Sugalis (Lambadas)	25	2.0	"		No	
Boyas	20	1.6	"	Rickshaw Pullers	No	
Scheduled Castes						
Malas & Madigas	152	12.4	"	8 families are of employees	only 4 families own ranging from 2-3 acres	Mostly christians but have two seperate churches.claim to be S.C.s. even after conversion. All the 8 employees also live in the Harijanawada
Muslims	40	3.3	"	tailoring, fruit vending	No	
Outsiders	100	8.2	Employment		No	Most of them belong to other states.

Table: 6. Different Occupation Groups in SJM

	Occupation	Total Number of households	Percentage of total number of households
1.	Agriculturists	952	77.7
2.	Employees	136	11.1
3.	Washermen	23	1.9
4.	Barbers	20	1.6
5.	Business	65	5.3
6.	Carpenters	4	0.3
7.	Tapi work	5	0.4
8.	Women domestic workers	12	0.98
9.	Milk vendors	2	0.16
10.	Tailors	2	0.16
11.	Rickshaw pullers	2	0.16
12.	Depending on sons, no occupation of their own	2	0.16
	Total:	1225	100.0

If the population is seen in terms of its occupations (table 6) then it emerges that many castes share three major occupations i.e. agriculture, business and employement. Forward castes, Backward castes, Scheduled castes, Scheduled Tribes and Muslims are 22.3 percent, 47.7 percent, 12.2 percent 2.6 percent and 3.3 percent respectively.

Peasants in SJM

Out of the 1225 families, 952(77.7 percent), live on agriculture. Of them 653 families (68.6 percent) are either landless or own less than 0.5 acre; 120 families (12.6 percent)own land between 0.6-2.5 acres; 74 families (7.8 percent) own land between 2.6-5.0 acres and 105 families (11 percent) own land above 5.1 acres. Although there is a dispersion of land over both the forward as well as the backward castes, most of the village land is concentrated among forward castes while the rest are economically dependent upon these landowners. Table 4 gives the occupational breakup of the population. It also indicates that out of the ten occupations leaving out the agriculturists, seven are of the local artisans who belong to either B.C, S.C, S.T or Muslims. The remaining two-employees and business people- are the only occupation groups which do not depend on land owners. According to our data, they come, in the majority of cases, either from F.Cs or B.Cs.

Table:7. Different Classes and Castes among the sample in families of women who have given birth to a child/children during May 83-April 85.

Caste Groups	Landless labourers	Marginal Farmers	Middle Farmers	Rich Farmers	Caste wise Totals
Forward castes	3(3.2) (21.4)	4(22.2) (28.6)	3(30) (21.4)	4(57.1) (28.6)	14 (10.9)
Backward castes	57(61.3) (73)	12(66.7) (15.4)	6(60) (7.7)	3(42.9) (3.8)	78 (60.9)
Scheduled Castes	23(24.7) (92)	1(5.5) (4)	1(10) (4)	0	25 (19.5)
Scheduled Tribes	6(6.5) (85.7)	1(5.5) (14.3)	0	0	7 (5.5)
Muslims	4(4.3) (100)	0	0	0	4 (3.2)
Classwise Totals	93 (72.7)	18 (14.1)	10 (7.8)	7 (5.5)	128 (100)

Percentage given along the figures is percentage of that class and percentage given below the figure is percentage of that caste group.

The purposive sample of households that we took for studying MCH practices was well distributed over the village population(table 7). This is evident when we compare the classwise totals of the sample(table 7) with the distribution

of classes in the village as a whole. Except for the rich peasants where the sample has a lesser proportion of families (5.5 percent as against 11 percent in the general households) all other classes have comparable representation. An analysis of the age structure of the sample(table 8) shows that women in age group 30-39 years are slightly more in the middle and rich peasant groups. Many sons of this class who are better educated, would have gone out for jobs and as such become non-residents of the village; or they may not be yet married(see 'Marriage' on page 64). Thus births in recent years might have been fewer in this section.

Table: 8. Age group of sample women

Class	15-19 years	20-29 years	30-39 years	Total No. of women
Landless labourers	34 (36.6)	54 (58)	5 (5.4)	93
Marginal Farmers	7 (38.8)	10 (55.5)	1 (5.5)	18
Middle and Rich Farmers	7 (41.2)	7 (41.2)	3 (17.6)	17
Total	48 (37.5)	71 (55.5)	9 (7)	128

Majority of the women, 41 to 58 percent of different classes are in the age group of 20-29 years. Women aged 15-19 years are between 36-41 percent in all the classes.

Some additional Economic Indicators- Direct and Indirect.

Apart from looking at landholding of families, to get a more comprehensive picture of the economic status of families we present here data on possession of milch cattle, milk production, consumption and sale and then educational status of families.

Table 9 presents the distribution of families possessing milch cattle.

Table:9: Possession of Milch Cattle among the Sample Households

Class	No.of Households possessing milch cattle	Actual No.of milch cattle possessed	Per household possession of milch cattle
Landless Labourers & Marginal Farmers 93+18=111	26 (23.4)	34 (44.7)	0.3
Middle & Rich Farmers 10+7=17	14 (82.4)	42 (55.3)	3.0
Total 128	40 (31.2)	76	

Less than one third of the total households possess milch cattle, but its distribution among classes is something that should be noticed. It is about four times more in the middle and rich classes than in landless and marginal classes Per household possession of milch cattle makes the situation more clear- it is 0.3 in the former and 3.0 in the latter i.e 10 times more.

Out of the total milk production in the sample households(table.10) 60 percent comes from the middle and rich farmers; they consume 64.7 percent of their produce whereas the lower classes consume 45.5 percent of their total produce. Out of the total consumption 70.1 percent is done by the middle and classes whereas it is only 29.9 percent in the case of landless and marginal classes. Production as well as consumption levels have gone down with decrease in the size of land holding and proportion of sale has increased. The trend is much more clear if we look at per household consumption of milk. It is 0.2 litres in landless and marginal classes and 3.2 liters(16 times higher) in middle and rich classes.

Table: 10. Milk Production, Consumption and Sale among different classes.

Class	Milk Quantity in liters			Per household consumption (in litres)
	Produced	Consumed	Sold	
Landless Labourers & Marginal Farmers	50.5 (40.7)	23 (45.5) (29.9)	27.5 (54.5)	0.2
Middle & Rich Farmers	73.5 (60)	54 (64.7) (70.1)	19.5 (23.3)	3.2
Total	124.0	77 (62.1)	47 (37.9)	

Percentages given below the figures are of total production, consumption and sale; along the figures are of total production in that class.

Thus, consumption levels (of milk) are directly related to the size of their land holding. Those who have big land holdings, also own more milch cattle and get a big share in the total consumption. The size of landholdings possession of milch cattle and consumption levels of milk are directly inter related.

An interesting phenomenon was that some families of landless labourers and marginal farmers, bought a buffalo

calf and reared it up. When it growsup and breeds, the household can get some milk (and also a calf) which directly contributes to the family's economy. This has implications for the household in terms of added work burden for women since it is mostly women who take care of milch animals. (This is discussed in work patterns of women).

Among the sample households in the lower classes, 15 families owned 19 such animals.

Educational levels

Educational levels are low in general. However, there are about 10 families, all belonging to the rich farmers, whose children have gone for higher education like post graduation, M.B.B.S, B.E., Ph.D etc.

The landless labourers and marginal farmers did not show much interest in education. Reasons given are that they need children's help in day to day work at home and in the fields. Larger share of this burden falls on female children resulting in a still lower educational status. Yet another reason advanced for not sending children to school was that their children cannot perform well at school as they don't have any one at home to help them and so gradually they loose interest and drop out as they cannot cope up. Teachers tend to be partial towards students of better

off classes and this discourages students of poorer classes and increases their drop out rate. Poor parents also feel that it is better that the children start earning early and relieve them of financial burden. Some of the men in lower classes studied upto tenth class but still had to settle down as agricultural labourers as they couldnot get any job This also influenced the parents' decision not to send their children to school.

Among the lower classes, only those who belong to forward castes(like Kamma, Brahmin) show interest in getting their children educated though it is financially difficult for them. This is because they do not want them to settle down as labourers which is viewed as a lowly occupation among the upper castes. They want their children to settle down in jobs.

Rich and Middle farmers give importance to education. They also encourage girls to go to colleges.

Though the percentage of illeteracy is large and spread over all the classes(Table 11) it decreases with increase in the size of land holding and educational levels move up.

Educational levels in general are low and specifically so in case of women in all classes.

Table 11: Levels of Education among Men & Women of different classes of the sample

Level of Education	Landless Labourers		Marginal Farmers		Middle Farmers		Rich Farmers		Total	
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
Illiterate	67 (72)	74 (79.6)	8 (44.4)	9 (50)	4 (40)	2 (20)	2 (28.6)	3 (42.9)	82 (64)	88 (68.8)
Primary	19 (20.4)	18 (19.4)	6 (33.3)	7 (38.9)	5 (50)	6 (60)	4 (57.2)	2 (28.6)	33 (25.8)	33 (25.8)
Secondary	7 (7.5)	1 (1.07)	4 (22.2)	2 (11.1)	0	2 (20)	1 (14.3)	2 (28.2)	12 (9.4)	7 (5.5)
Higher	0	0	0	0	1 (10)	0	0	0	0	0
TOTAL	93	93	18	18	10	10	7	7	128	128

Cultural Aspects:

Marriage: Landless and marginal class people marry off their children earlier than the upper class people. Among them generally girls get married between 14 and 16 years and boys between 18 and 20 years. In middle and rich classes the situation is different. Firstly, most girls get married at the age of 18 years. Secondly, many more boys and even some girls go for higher education and then their marriages get postponed. It could be till 22-24 years of age for girls and upto 25-30 years for boys. Girls generally remain as housewives irrespective of their educational status.

Family Structure: As in any other Indian village, nuclear families are more in number in SJM. Joint family system is being continued widely only among middle and rich farmers. Even in cases where middle or rich farmers families live seperately, landed property is not divided. The data on sample families(table 12) shows that with increase in the size of the land holding, percentages of joint families also increased. It is six times more in rich farmers compared to landless labourers.

Table: 12. Family structure among the Sample Households

Class	No. of joint Families	No.of nuclear Families
Landless Labourers 93	13 (14.0)	80 (86)
Marginal Farmers 18	7 (38.9)	11 (61.1)
Middle Farmers 10	6 (60)	4 (40)
Rich Farmers 7	6 (85.7)	1 (14.3)
Total 128	32 (25)	96 (75)

1.4 Socio-Economic Dynamics

Rhythm of Agricultural Activity

Paddy Fields:

The coastal districts receive their rainfall in July and the agricultural activity starts immediately. Ploughing and preparing paddy nurseries go simultaneously. These

provide employment to men labourers whereas women labourers do the transplanting. Transplantation creates ample chances of employment for women- because traditionally it is reserved for them. Labourers are employed either as contract labourers or as wage labourers. In contract method, wage is around Rs 80-100 per acre. Under wage labour it is Rs.15 por head and one has to work from 9 a.m to 5 p.m with a break of one hour for lunch.

After a month after transplantation, weeding work is taken up which is again reserved for women and gets them a wage of Rs 5-8 per head per day. When the crop ripens, during November-December harvesting takes place. Only contract labour is used for harvesting. Both men and women labourers cut the crop but women are preferred. Rs 50-80 is paid per acre and sometimes when the possibility of rains threatens the farmer, the wages up to Rs 100. Once the harvesting of paddy is over, in that mud itself, pulses or jute is sown. Some grow vegetables too. This will be the second crop. By the time of paddy threshing, small seedlings of the second crop are ready.

Paddy yield per acre is 20-30 bags of 75 kg. each. Some farmers get even up to 40 bags by using more fertilisers and manuers.

Only men are employed for threshing and both men and women for winnowing. Under contract labour Rs 40-60/- is paid and for a single labourer hired the wage is Rs15 per day.

The second crop matures by the end of February. Meanwhile weeding is carried out for which women labourers are paid Rs 5-6 per head per day. Again harvesting and threshing are carried out by women and men respectively.

From mid-March to June, these lands lie vacant. Again in July monsoon comes and the whole activity is once again repeated. Thus goes the cycle.

Lemon Orchards

This is a particular field in SJM's agricultre which continuously yields fruits and demands labour throughout the year. The kinds of work activity seen in lemon orchards are like making grooves around trees, supplying water, turning the soil, cutting off dry branches, weeding etc. Lemon-fruit plucking is done almost every day, more intensively in summer, during April and May. The amount of wages paid are according to the nature of the work. For weeding and fruit plucking which are done by women, Rs 5-6 are paid. And for all other works, which are carried out by men, it is between Rs 15 and 20. Of the total land under agricultural operations, banana, turmeric and betel leaves gardens occupy

proportionally less land and therefore offer fewer opportunities for labour.

These activities of plucking lemon fruits, cutting off dry branches of lemon trees or collecting betel leaves need special skill and only experienced workers are employed. Thus, though work is available round the year in these special activities, it is neither enough to provide work for all nor can unskilled workers do it. It is then only some families who work on these farms for their livelihood get work round the year. In addition men are preferred for most of these jobs.

Lemons, betel leaves, turmeric and banana are sold to middle men in nearby towns. Food crops like paddy and pulses are generally consumed by the farmers' families and if there is any excess it is sold to middle men either at SJM or in Tenali.

Implications

Due to the intensive agricultural activity, acute hunger and starvation deaths that haunt the rural areas of Bihar, U.P., M.P. etc. are not seen in SJM. People get enough food round the year. Some eat three times a day, others even 4 times. In our sample all families reported that they get enough food or atleast two square meals per day round the

year. Infact 86 percent reported that they ate three times a day and the rest 4 times a day(table 13).

Table: 13. Number of meals in a day among the families of the sample.

Class	3 meals a day	4 meals a day
Landless Labourers 93	87 (93.5)	6 (6.5)
Marginal Farmers 18	14 (77.8)	4 (22.2)
Middle Farmers 10	8 (80)	2 (20)
Rich Farmers 7	1 (14.3)	6 (85.7)
Total 128	110 (86)	18 (14)

Only in September and October when it rains heavily and in November, generally a month of cyclones and storms for coastal Andhra, employment opportunities decrease and labourers face problems.

Four answeres could be found to the question as to how the landless labourers manage to get enough food round

the year. 1) Some families managed it with difficulty by raising consumption loans from landlords during lean(rainy) season when there was not much opportunity for employment. However, they repaid the loans during peak season. 2) The system of working as a paleru. Under this traditional system of labour exchange, young men around the age of 18 years work under big farmers, and are paid in cash and kind, roughly a sum of Rs 1500 per a year and one bag of paddy in addition to three meals a day throughout the year. The payment varies according to the work needs of the employer. In such cases, this paddy is used by his family in lean seasons and money is used generally for other expenses.3) In some families, where there are no infants, both the couple work throughout the year to fulfil their minimum needs. 4) A few families own either a cart or a small piece of land, or do tenancy of one or two acres of paddy fields or lemon gardens or a small piece of betel leaf gardens. They save during peak seasons and use it during lean period.

However, there are very clear and large differences in the quality of food taken by different classes. Landless labourers eat rice with chutni and sometimes with dal.

Vegetables are rare. There won't be any milk, curd, good quantities of vegetables, fruits etc. Non-vegetarian food like eggs and mutton are unimaginable. Most cannot afford to buy milk even for small children.

It is a bitbetter for marginal farmers with added quantities of dal and sometimes buttermilk. Both these classes people eat only rice for all the three meals in a day.

In middle and rich farmers, the quality of food is quite good. Majority of the families consume milk. Vegetables, dal, curd, eggs etc. are regular features in their daily meals and also non vegetarian food. Besides break fast, lunch and dinner there are also refreshments in evenings. Various kinds of snakes are consumed for breakfast.

SECTION II

WOMEN IN SJM

2.1 Women's role in agricultural activity

In the previous section, we described the economic activity in SJM and the roles of men and women in it. This section deals with the specific roles of women in different classes and the nature of different kinds of work done by them.

Women's work can be divided into four broad categories, namely,

1) Agricultural work 2) Animal husbandary, (activity outside the house) 3) Household work and 4) Child care(activity inside the house).

The rich women do the last two only whereas in the other 3 classes women do all the four kinds of work though their proportion and intensity of work varies.

Agricultural Work: Transplanting, weeding and harvesting in paddy cultivation are traditionally reserved for women. All these three are back bending jobs and need to be performed in slush and mud.

Lemon plucking is also a very exhaustive job. Lemon trees are full of thorns and many times hurt the labourers. The plucked lemons(a few hundreds) have to be carried in a big cloth tied to their waist, which causes severe pain especially when it has also to be carried on their heads for long distances.

In betel, lemon orchards also, women's work is equally arduous. They do these jobs in a squatting position between extremely narrow rows of betel leave plants. After a day of such work, their body aches like hell.

Animal Husbandary: This includes cutting grass in the fields and carrying it home besides cleaning, feeding and milking animals.

If we look at participation of women from different classes in these activities it appears that there are discrepancies even among them.

90 percent of the landless and marginal women work as agricultural labourers and participate in transplanting, weeding, harvesting, lemon plucking etc. One third of these households possess milch cattle. Women of these households, in addition to their agricultural work also do animal husbandary completely.

In contrast to landless and marginal classes majority of the middle farmers' women don't work outside their house, though some of them do a little animal husbandary. Mainly they feed animals and milk them. Rest of the work is taken care of by their husbands or servants. The rich farmers' women work neither in fields nor do animal husbandary.

Almost all women agricultural labourers expressed dissatisfaction with their tedious work. With it, it became difficult to manage housework and children tended to get neglected. Moreover, none respected their work- neither husband, nor family members or the society. Women labourers themselves don't have respect for it. They feel that a teacher or a nurse can get respect but not agricultural labourer. Everyone says that they don't wish such a life (as theirs) even to their enemies.

2.2 Household Work:

Throughout India, house work is considered as synonymous to woman and SJM is not an exception. However, there are variations among classes and the amount and the quality of work is very different. Betterment in the economic position consequently provides them more amenities and the burden of household work is lessened though not removed completely. We describe below the nature of household work among different classes in SJM.

Magnitude and Intensity of Women's Work in Different Classes

Rich Farmers Class

These women do only cooking with the help of modern appliances like gas connection, mixy etc., and serve food to the family members. All other chores like washing utensils, cleaning house and courtyard, washing cloths, pumping out water from hand pumps, grain cleaning and grinding, getting firewood etc. are done by servants.

However, as most of the families in this class are joint families, mother-in-law's authority on daughter-in-law is evident. In such households, daughter-in-law cooks and in case the servants are absent, she has to perform some of their duties.

Child care is mainly mother's responsibility but she gets help from others in the family and servants. Many children are left with maternal grand parents till they became atleast five years old and start going to school.

Middle Farmers

Women of this class get help from servants only in washing utensils and clothes and in getting firewood. Cooking, cleaning house and courtyard, pumping out water from hand pumps, grain cleaning and grinding are done by women. Many of them have gas connections. Child care is completely the mother's responsibility.

Marginal Farmers and Landless labourers.

No servants. No modern appliances. All household work is done by women. Firewood is collected by men and women. Dung cakes are made by women to be used as fire wood. As almost all the labourers live in mud huts, plastering of the floor with dung atleast once in two weeks, is added to women's work. Daily shopping is also done by them. Child care is fully on women's shoulders. They don't get any sort of help from others in performing this job.

When women's household work is seen in terms of class differences, their rest period decreases with decrease in the size of land holding, and work burden increases. Women of rich and middle classes look healthier

and cleaner. They wear good clothes and look happy. Their children are healthy, well built, wear good clothes and go to schools. Their mothers are at home to take care of them. But all this is reverse in the case of marginal farmers and landless classes. Woemen bear a triple burden of agricultural labour, house work and child care. No good food; No rest; No good clothes. Work burden always haunts them.

A routine day in her life

A look at how a routine day passes for a woman of each class makes it easy to understand the various dimensions of women's life in different classes, their similarities and differences.

(a) A Rich Farmer's Household

Sita woke up at 6.30 a.m. Her husband, children and in-laws are still sleeping. She went into the kitchen. Their servant had already milked the buffaloes and kept it in the kitchen. Sita put the milk vessel on the gas stove and started preparations for making idly and coffee. The idly flour was ready as the paleru(agricultural contract labourer who also does household work) had grinded it last evening. She put it in idly plates and put the idly cooker on the gas stove. Within 15 minutes it was ready. She asked her paleru to grind chutni to be eaten with idly and gave him all the ingredients. The chutni was also ready by 7.30a.m.

Sita went into the courtyard. The water is already boiling; the paleru lit the fire under the big brass pot half an hour ago with firewood. He also brought cold water from boring pump and put both cold and hot water in the bathroom. Sita took bath. It is past 8 a.m, other members of the family also woke up and were busy with their morning rituals. After they got ready, Sita served idly to all, Coffee to elders and milk to children. By 10 a.m her husband and father-in-law went to fields to supervise their agricultural operations and children went to school. She gave last night's left over rice and some pickle to the paleru He ate it and ran to the fields. Now Sita is free. She slowly completed cooking for lunch. It is not very difficult for her as she has gas connection and a mixy. She thought of her neighbour who has to cook on firewood as per the wishes of men of her house who think that food cooked on firewood tasted better. They simply possess gas stove and cooker as status symbols. Sita silently thanked her men for not putting such conditions on her. She relaxed for sometime chatting with her mother-in-law. Around one in the afternoon, the men and children came for lunch. She served them lunch on the dining table and after they finished, she and her mother-in-law ate. She gave food to c-

paleru also. He ate sitting on the floor in the backside of the courtyard. After eating he washed the dishes. Now Sita was free till evening when dinner was to be cooked. For evening refreshment there were some sweets and fruits in stock. But she suddenly remembered that two women labourers will be coming to clean rice and pulses. Anyway her mother-in-law can deal with them. Sita went into her bedroom, read a magazine for a while and then slept for sometime. Her work started again in the evening when children came back home. She gave them milk and some fruit After that she cooked dinner. She finished her dinner after all the others had done so. Paleru ate and washed dishes. They had arranged a tution for the children, so Sita need not bother about their homework, It is her mother-in-law's duty to see that all the doors are closed. Sita went to bed at 9 p.m. She has to get up again at 6.30 a.m tomarrow.

(b) A Middle peasant's Household

Janaki woke up at 5 a.m. Her husband owns only four acres of land, so they cannot afford to have a paleru who also helps her in household work. Her husband employed a young man to help him in agriculture and graze the cattle. He helps her only in dish washing.

Janaki went into the cattle shed and milked her two buffaloes. She put the milk on her gas stove for heating and went back to feed the animals. Then she lighted the fire with coconut leaves to heat water for bathing purposes, and prepared dosa for breakfast. She had grinded the soaked green gram dal last evening itself and kept it ready. Meanwhile her 15 year old daughter woke up and helped Janaki in cleaning the house and the courtyard. They together pumped out water. Her husband and other two male children also woke up. They all use paste and brush whereas Janaki uses ash to clean her teeth. She says that she doesn't like tooth paste. But the real reason is that she thinks paste is costly and atleast she should avoid such expenses.

She helped her yong children to get ready to go to school. Once they all went away, she started cooking. When she finished cooking chakali came to wash clothes. If chakali doesn't come, Janaki has to do it herself. She relaxed for a while before everyone came for lunch. After lunch, they went out again. Janaki sat down to clean rice. She needed rice floor to make some special dishes for the coming festival. That should be cooked on firewood otherwise it would consume a lot of gas which her husband wouldn't like. After all, they got firewood free from their field

Why should she waste gas ?

By the time she finished grinding, animals came back from grazing. She washed and fed them. Then she again cleaned the house and courtyard. By this time her husband and children returned. She prepared dosa for them, with the morning's left over flour. She and her daughter together grinded wet dal for the next day's break fast. Her sons went out for playing. After that she started cooking. They took dinner at 9 p.m. after her chidren finished their homework. First she served food to her husband and sons. They eat on a small table which is converted into a dining table. She and her daughter ate later and slept after cleaning the kitchen sometime around 10.30 p.m. Janaki has to wake up again at 5 a.m. the next morning.

(c) A Landless Labourer's/Marginal Farmer's Household:

Mallamma woke up at 4 a.m. Her body is still aching with the beatings she got from her husband last night. But she has to hurry up, otherwise she cannot reach the field in time. Her husband and children are still sleeping. Mallamma has to spend about half-an-hour to go to the bushes to attend nature's call, as they do not have a latrine at home. After that, she pumped out water from the community pump and carried it home. While doing this work daily she feels happy

that she is not living on the other end of the village where women have to bring water from a canal and a well as it is not possible to put borings there due to the nature of the soil. After that she cleaned her cattle shed and fed her lone buffalo with some grass that she brought the previous day from fields. Meanwhile her husband also woke up. They cleaned their teeth with ash. Then she started cooking. They try to collect and stock firewood during summer but it is never possible to collect so many loge. Almost every alternate day they have to go out in search of firewood. Her husband went to the bushes, bath and then went out. He first went to a small wayside stall to take idly and coffee there. From there he went to the fields.

Mallamma cooked rice and made a chutni. She ate last night's left over rice. Packed rice and chutni for her husband and asked her seven year old son to carry it to fields for him. Sometimes she herself carries it if they both happen to work in the same or nearby fields. She woke up her youngest son- eight months old- and fed him. He is not yet eating solids. He looks smaller to his age. Mallamma avoided labour work for six months after he

was born. But then it was financially quite tight during that period. So she resumed work just two months ago.

Mallamma was out by 6.30 a.m. and walked fast to lemon orchards along with other workers of the neighbourhood. There she worked from 7-11 a.m. She plucked lemons, carried them in the cloth sack around her waist and then on her head for two furlongs up the road. By the time she reached home it was past noon. Her infant was crying out of hunger. As soon as she entered her hut, he plunged himself on to her and started nursing. After feeding him, she ate her food and then again started housework. She washed the utensils. Carried water from the community pump. Went to the canal which is a kilometre away and washed clothes. After coming back from the canal, she plastered her hut with dung. She went to fields, cut grass and carried it on her head for their buffalo. The buffallo is not yet producing milk. But when it starts producing milk, it helps to improve their economic position.

By then it was dusk; her husband also came back from fields. He took bath and relaxed in the open air sitting on a cot outside their hut and chatting with his neighbouring men. Mallamma cleaned rice and started cooking for their

dinner. Her husband did not help her but kept shouting at her that she should cook fast. Or else ! she knows ! She should obey him; outherwise she has to face dire consequences ranging from a beating to desertion. Mallamma silently finished cooking, while attending to her infant in between. Her husband ate first. Then she fed her children. She ate at the end, whatever was left in the vessal and does not want to think whether it was sufficient or not.

It was 9 p.m. by the time she went to bed.Mallamma has has to get up again at 4 a.m. next morning.

The purposive sample provided an opportunity to look deeper into the entirety of the work patterns among women (table 14). It provides information on different types of work in which women are involved.

Table: 14. Work Patterns of the Sample Women among different classes.

Class	Agricultural Labour	Animal Husbandary	Agricultural labour and Animal husbandary	Household work only
Landless Labourers 93	49+ (52.7)	0	28 (30.1)	16 (17.2)
Marginal farmers 18	1 (5.5)	4 (22.2)	2 (10.1)	11 (61.1)
Middle and Rich Farmers 17	1* (5.8)	0	2* (11.6)	14 (88.3)
Total 128	51 (39.8)	4 (3.1)	32 (25)	41 (32)

\+ One of these women actually sells fruits.

* These women belong to middle farmers class and supervise their own agriculture.

Eighty three percent of the women among the landless poor work as agricultural labourers. Some of them also do animal husbandary. Whereas, in the middle and rich farmers class 88.8 percent women do household work only. This shows the direct relationship between decrease in land ownership and increase in women's work burden.. It is obvious that they

all do household work too. Though few women(5.8 + 11.6 = 17.4 percent) among the middle and rich farmers work out sido, the nature of their work is mainly supervisory. Interestingly same proportion of women(17.2 percent) in landless labourers remain at home and dd household work only.

2.3 Social Status of Women

Decision making power:

It is notable that despite carrying as much responsibility on their shoulders as their men(if not more), women of all classes exercise very little power. It is a common feature in all classes and in the rich, in-laws exercise more power if their property is yet undivided. Only in the lower classes, where women also earn as labourers, some women have a say in household affairs. However, their number is very small. Even when a woman does have a say in family affairs it is more due to her individuality(ability to coerce or inspire confidence) rather than being a social sanction.

Women don't go out of their houses unless it is very important or urgent. They move freely in nearby towns like Tenali when they go there but not in their own village. Women, particularly young girls of the upper castes do not go to the other castes localities. Inside the house, every

thing including the number of children woman should bear is decided by man. Women do only one thing: reflecting the ideas of their men.

Table: 15. Women's power in decision making

Class	Fully	Decide jointly	Not at all
Landless Labourers 93	4 (4.3)	30 (32.3)	59 (63.4)
Marginal farmers 18	1 (5.6)	4 (22.2)	13 (72.2)
Middle & Rich Farmers 17	0	7 (41.2)	10 (58.8)
Total 128	5 (3.9)	41 (32)	82 (64)

Among the sample almost two thirds(64 percent) of the women do not have any power in taking decisions. Their percentage in different classes varies between 60 and 70 percent. Only five women, (four of them landless labourers and one, wife of a marginal farmer) reported that they have full powers to decide. Their special status in this regard

may be explained in terms of their earning capacities and class background. However, among the four of the landless labourers, one is a widow and the other's husband is mentally ill.

About one third of the women reported taking decisions jointly with their husbands. Their percentage is more in the middle and rich classes(41.2 percent) and this can be attributed to better educational status of women in these classes and the dowry they bring.

According to our observations, despite being active paraticipants in economic activities, women are not only socially constrained but also economically dependent. This contradiction is well illustrated by the follwing case reports.

Case Report. 1

> Aruna belongs to a Sugali(Lambada-ST)landless labourers family. She is second wife to her husband who deserted the first wife with suspicion that she had developed illicit relation with someone else. Aruna was an agricultural labourer prior to marriage but after marriage she was not allowed to work. Her husband and mother-in-law fear that she may also learn the ways of the first wife. Aruna's parents preferred this match as there was no dowry, it being a second marriage to the groom. Aruna was never consulted, nor she herself even thought whether or not to marry this person. Her original name was Hanumayamma; it was changed to Aruna by her mother-in-law. Both her in-laws and husband work as labourers and also do a little bit of betel leaf farming as tenants. Aruna does all household work. Often beaten up by her husband even during late pregnancy, she feels that " it is a common feature in the lives of women". Aruna is not allowed even to talk to outsiders, and has no power in deciding any of the family affairs. It is "their"(husband and his mother)

domain.

Aruna gave birth to two daughters. Her husband had two sons from his first wife who live with their mother. Aruna wanted to have a son but her husband and mother-inlaw decided that she should undergo sterilisation. There was no one to hear and care for her cries. She was sterilised on the fifth day after hor second delivery. She doesn't have power even to select a name for her new born. Everything will be decided by "them".

Though her husband does not contribute either financially or otherwise for the growth of his sons(from his first wife) he claims a right and so thinks he doesn't need any more sons. He wants to get his sons back to him once they grow up. Then they can earn and help in his betel leaf farming. Both his wives are thus objects to be used but not subjects of his concerns.

Dowry

It is not infrequent to find that even girls with graduate degrees are prepared to marry anybody selected by their parents without any hesitation and give as much dowry as asked. Dowry varies from a few (3 or 4) lakhs in rich classes to a few hundreds of rupees among landless labourers.

Family Planning decisions:

In matters of family planning also women do not have any decision making power. Some women go for copper T secretely without the knowledge of their husbands and in-laws. They don't want another child immediately but are afraid to say it openly. Even the society looks down upon women

who go for temporary methods, though sterilisation is widely accepted. Though men take decisions, it is the woman who is sent for sterilisation. In SJM all cases of sterilisations are tubectomies.

Table: 16. Decision making power regarding Sterilisation

Class		Husband	Self	Both	In-laws	Husband & In-laws
Landless Labourers	93	55 (59)	7 (7.5)	21 (22.6)	3 (3.2)	7 (7.6)
Marginal farmers	18	8 (44.4)	0	7 (38.9)	2 (11.1)	1 (5.6)
Middle and Rich Farmers	17	4 (23.5)	0	6 (35.3)	2 (11.8)	5 (29.4)
Total	128	67 (52.3)	7 (5.5)	34 (26.6)	7 (5.5)	13 (10.1)

According to our sample(table 16), only 5.5 percent women can decide about sterilisation on their own. All of them belong to landless labourers class. In 52.3 percent

cases husbands only decide. But their percentage is more in landless labourers, gradually decreases when we move to middle and rich farmers and is replaced by in-laws and husband together. This shows the hold of in-laws in joint families. Obviously power of in-laws is more in middle and rich farmers. A vivid illustration of this is Ahalya, whose case report is given in the following paragraphs.

Case Report. 2

> Ahalya, a 20 years old girl had already passed through many major events in her life. She got married when she was 17 and just completed her junior Inter. After marriage she left studies and went to Tenali to live with her husband in a joint family. Though her father-in-law and sisters-in-law are well educated, her husband couldn't study well and stopped with Inter. Now he manages a fancy shop set up by his father. Neither he nor Ahalya has any power in decision making. Everything is decided by his parents. He being their only son inherits their property- some four acres of land. But the property is still under the authority of his father.
>
> Ahalya became mother at 18 years, within an year after marriage. It was a son. Again after another one and a half years she gave birth to her second child- this time a daughter. Her prents-in-law forced her to undergo tubectomy. She was not willing to it. She wanted to wait till atleast her daughter completed two years. Her parents also felt the same but couldn't do anything against the will of her in-laws. Ultimately Ahalya had to undergo sterilisation.

Her ordeal did not end there. Her daughter died at the age of 5 months due to dierrhea and fever. Ahalya was very sad as she had developed a strong attachment towards her lost infant. Even before she could come out of the deep felt sorrow, her in-laws decided that she should undergo recannalization so that she could have children again and started pestering her even though Ahalya didn't want. She felt she should satisfy herself with the lone son. But, she had to bow her head before her in-laws. Her abdomine was again opened for a second time within 6 months, this time to see if she could produce some more children whereas earlier it was to end her reproductive capacity.

Ahalya accepted defeat at every step. She gives the reason as a lack of economic security if she is shunted out of the house. She is also afraid of social stigma. Her husband is voiceless. The property is still in the hands of in-laws.

Wife beating

Wife beating is quite common among landless labourers, marginal farmers and it also exists among the middle farmers. We could not elicit any information on this aspect from the rich class women. However, everyone takes it as quite normal. In this regard some landless labouring men said " wives should be beaten up. Otherwise they turn unfaithful." Most of the men labourers drink liquor and beat their wives; it is routine for them.

Remarriages

Though second marriage is socially allowed for women in lower castes, many women did not show interest in it. They feel that every man is alike in drinking, beating his wife and not sharing housework or child care responsibilities. In fact, because of the social and cultural enviornment, no woman would think of asking her husband to share house work. Their only wish is that they should be spared from being beaten up.

Many of these women expressed dissatisfaction with their lives. They are not happy with their men, wages, housing conditions and scarcity of food, adequate care and education for their children.

SECTION III

HEALTH STATUS OF MOTHERS

SJM has its normal share of diseases which are common in rural India. The women not only share these but also have their special problems like gynaecological and obstetrical. However, we could explore details about these special problems only among the sample. It certainly helps us to understand the general situation to some extent.

There was a question in the interview schedule which enquires whether the respondents have/had any serious/chronic illness. Many women of the landless labourers class reported that they were suffering from weakness. It indicates their health status and also their perception about disease.

3.1 SPECIAL PROBLEMS

Gynaecological Problems

The various complaints reported by women are presented in (table 17). If we take the interclass differences then it is obvious that the differences are not significant either of total diseaseload or of specific diseases. If anything, the former seems to be high. However, what is revealing is the distribution. While the middle and rich farmers' women complained of abnormal discharge and menstrual problems only, the landless and marginal farmers' women reported more of prolapse and post operative problems. These are obviously much more serious and it is quite possible that it also reflects the poor obstetric and post-operative care that these women get from the PHC after deliveries and Family Planning operations. While they may even go to Family Planning camps, the middle and rich farmers' women go to private nursing homes, where they are charged more but are provided with better services.

Table: 17. Gynecological Problems among the Sample Women

Class	Abnormal discharge	Prolapse	Menstrual Problem	Post operative problem	Failure of F.P. operation	Total No.of women suffering
Landless Labourers 93	14 (15)	6 (6.5)	2 (2.1)	3 (3.2)	4 (4.4)	29 (31.2)
Marginal Farmers 18	0	1 (5.6)	1 (5.6)	1 (5.6)	0	3 (16.7)
Middle and Rich Farmers 17	4 (23.5)	0	2 (11.8)	0	0	6 (35.9)
Total 128	18 (14)	7 (5.5)	5 (3.9)	4 (3.1)	4 (3.1)	38 (29.7)

Among the sample, four labourers' women reported that their sterilisations(three tubectomies and one laproscopic) failed and they conceived again.

Pregnancy Wastage

Here again given the small size of the middle and the rich peasants, interclass differences have to be assessed cautiously. It is notable that still births are reported among landless labourers and marginal farmers only, and difference in total pregnancy wastage between landless and middle and rich peasants is almost 24 percent.

Table: 18. Life experience of sample women regarding pregnancy wastage(still births & abortions)

Class	Still Birth (one each)	No. of Women with 1 abortion	2 abortion	3 abortion	Total No.of stil births and abortions
Landless Labourers 93	5 (5.4)	10 (10.7)	3 (3.2)	2 (2.1)	27 (29)
Marginal Farmers 18	1 (5.5)	2 (11)	0	0	3 (16.7)
Middle and Rich Farmers 17	0	4 (23.5)	1 (5.9)	1 (5.9)	9 (52.9)
Total.128	6 (4.7)	16 (12.5)	4 (3.1)	3 (2.3)	39 (30.5)

Complications during pregnancy

In terms of interclass differences, however, the prevalence of all problems among the landless and absence of serious complications in landowning classes is worth noting.

Table: 19. Complications during pregnancy among the sample

Class	Bleeding	Swelling feet & body	Fever just after deli-very	Cramps in legs	Total
Landless Labourers 95	9 (9.5)	11 (11.6)	2 (2.1)	2 (2.1)	24 (25.3)
Marginal Farmers 19	0	5 (26.3)	2 (10.5)	0	7 (36.8)
Middle and Rich Farmers 18	0	3 (16.7)	0	0	3 (16.7)
Total 132	9 (6.8)	19 (14.4)	4 (3)	2 (1.5)	34 (25.6)

Everyone reported that they went/would have gone to a private doctor in case of any complications at the time of delivery.

Swelling of feet and body is the most common complication during pregnancy in our sample. However, it was reported from all classes. Bleeding is prevalent only among the labourers(table 19). Many of them consider it 'normal' and do not even seek medical help. Similarly fever just after delivery was also confined to the landless and marginal peasant women.

Hysterectomies:

A striking feature in SJM is the high frequency of hysterectomies. In majority of the cases it was felt to be an aftermath of tubectomy. After tubectomy, many women complain of stomach ache and attribute it to tubectomy While the PHC medical staff say that stomach achos are in many cases a normal occurance which can be due to even amobiosis, the villagers do not believe them and consult private doctors in Tenali. The latter often identify it as uterine complication of tuberctomy and advise them to undergo hysterectomy. The poor villagers faithfully follow their advise. Among the sample, three women, one from each class underwent hysterectomy. Another three from landless labourers class were advised to do so and they were yet to mobilise resources. It is really a costly affair, involving

Rs.1000/- in all. Even if they go to taluk government hospital in Tenali, they have to pay Rs.600/- to the doctor there.

According to the estimates of the female multi-purpose worker(MPW(F)) about 50 women of SJM underwent hysterectomies. No official data is available. In fact, many started assuming that hysterectomy is an unavoidable consequence of tubectomy. With this kind of understanding, some developed an attitude of opposition against sterilisation. Some others feel it is better to go straight away for hysterectomy.

Case report of Annapurna is indicative of how more and more women are opting for hysterectomy for wrong reasons and that too on the recommendations of doctors.

Case Report 3

> Annapurna belongs to a middle peasant family. After about a year after their third child was born they decided that she should go for tubectomy. But as she began to inquire in the neighbourhood about the proposal, she gradually came to learn that the tubectomy operations invariably cause complications leading to hysterectomy.
>
> In fact Annapurna had come across a few women who had straightaway preferred hysterectomy avoiding tubectomy due to their doubts and fears. For Annapurna, it looked to be a simple solution. She can save some money and time too. Moreover she can 'get rid off' the 'monthly nuisance'. Her husband also agreed with her. The MPW(F) advised her against such decision and tried to assure that tubectomy created no

complications. But the family had already made up its mind. Even the mother-in-law who felt slightly hesitant after the MPW(F)'s advice ultimately fell in line. Actually she too did not see anything wrong in it, except that the MPW(F) advised against the same. On the top of all this, a private doctor strongly recommended the expensive hysterectomy to Annapurna. He impressed upon her that it was almost a must.

Annapurna underwent the operation in a private nursing home in Tenali, paying Rs 1000/-

3.2 Accessibility and Utilisation of Medical Facilities

All classes show awareness of health, recognize health problems and respond to them within their limitations and sometimes beyond that .

Rich and Middle Farmers

The rich and middle farmers consult private doctors in Tenali and are prepared to get admitted in private nursing homes. If necessary they go to even far off places for treatment. They don't prefer to go to the local PHC as they feel that its services are substandard.

Marginal Farmers and Landless labourers

The marginal farmers and landless labourers try the PHC first and if it is found to be no use then go to private doctors. They also use the services of the Registered Medical Practitioner(RMP) who goes round the village, particularly in localities of the poor, on a bicycle. Gives injections and prescribe medicines to patients. He uses

the same needle for many patients without sterilizing every time. Inspite of this the majority opinion among the poor was in his favour. The reasons forwarded were "he goes to their doorstep when they are at homo"; he is more sympathetic; friendly and obliging. Very often he gives them injections which is considered a great therapeutic measure and which the PHC staff do not give them. The PHC is open only in the mornings when labourers go to work. If they somehow manage to go to the PHC, they are generally dispensed with either a red syrup or red white or yellow tablets. As these are given for many of the common problems, villagers have lost faith in them and are prepared to buy medicine outside. The PHC staff also many times prescribe medicines, particularly injections and ask them to buy these from outside. Villagers also know about "white"(pencillin) and "yellow"(B.Complex) injections. They know that the "yellow" one gives them strength and so always request for it.

The PHC staff do not treat the poor people with care and consideration. Such discrimination pushes them more towards the RMP. However, if his treatment fails, then they go to the PHC and from there to private doctors.

If they have to spend money, they even raise loans. Non-working mothers respond immediately to their own and their children's health problems compared to working mothers.

If they go to a private doctor in Tenali, they have to pay Rs.20 to 25 as consultation fee to the doctor, Rs4/- as bus fares and another Rs.4/- for rickshaw from Tenali bus stand to the doctor and back. All this amounts to about Rs 30/-. In addition to this they have to buy medicines often quite expensive and many in number. At the same time they(parents of the child or atleast the mother) have to forego their wages for that day as they have to leave work. Or, for a normal delivery, sometimes they spend Rs.200/- to Rs.300/- which is a very big amount to them. Our qualitiative data shows that the marginal and landless families spend large chunks of their total income on medical care.

In comparison, expenditure on other items like education, housing, clothing etc.is not in proportion with the expenditure on health. To put it the other way round, this expenditure cannot be taken as an indication of their economic position. They are forced to spend so much out of sheer fear for life. The class differentials

in seeking medical help are clearly reflected in our sample(table 20).

Table: 20. Visiting the PHC/Private Doctor as reported by the Sample.

Class	For every small Problem	For ailments like fever	For major diseases only
Landless Labourers 93	2 (2.1)	80 (43)	51 (54.8)
Marginal Farmers 18	1 (5.5)	15 (83.3)	2 (11.1)
Middle and Rich Farmers 17	6 (35.3)	11 (64.7)	0
Total 128	9 (7)	66 (51.6)	53 (41.4)

Though all reported that they seek medical help, interclass differences reflect their accessibility to medical services and at what stage they try to get in touch with them. The landless and marginal classes cannot go to health personnel as soon as they identify problems because of their preoccupation with work burden.

3.3 Some Observations on the PHC and its health personnel

The three important health personnel of the PHC- the male Chief Medical Officer(CMO), lady doctor and the staff nurse do not live in the village. The CMO lives in Tenali and the other two in Guntur. They come to the PHC in the morning and go back home in the afternoon. No doctor is available till the next morning. In case of any emergency, villagers have to run to Tenali.

Somehow, only the CMO performs all the tubectomies and abortions with the help of the female MPW. He openly charges for these services. A woman who undergoes tubectomy is paid Rs 145/- by the government as incentive. However, out of it, Rs.35/- is paid back to the PHC staff. The CMO also charges Rs.100/- per abortion, a fixed rate, and it fluctuates to higher levels if the pregnanacy is in an advanced stage. The female MPW and the helpers (two ayahs) charge for attending deliveries. Rs20/- and Rs5/- each respectively are their minimum charges. In fact the poor people are angry with the PHC staff for such practices but are not in a position to protest and change it.

The lady doctor blames the villagers for all wrong practices. She says villagers, particularly the poor,

seek medical help only when the problem becomes acute. They give more value to their elders' words rather than to medical staff's advices. It is more difficult to convince the poor and uneducated. When questioned about the role of health services in checking the superstitious beliefs, she said,"people do not care though we tell them".

Many allege that the MPW(F) shows concern only for pregnant women as she can get some money later, when she attends their deliveries. About MCH, she herself has many unscientific beliefs. She defends superstitions followed by postpartum mothers, like 'nadumkattu'(tieing a cloth around the waist), wearing muffler etc.(see table 42). She never bothers to advise about feeding colostrum or not to feed caster oil but, blames the women. She has many funny ideas about pregnancy and abortion. According to her," many women loose their first babies because whatever 'rubbish' is there inside the mother's body effects it and the latter babies will be alright". She also believes that since the labourers eatalot of mirchi in their food, it causes 'heat' in the body and sometimes leads to abortion. Their babies are born with white jelly like layer all over the body due to this 'heat' only and it can be cured if the woman takes good amount of fruits and fruit juices

during pregnanacy. Babies born to those who eat fruits are "soft, smooth and shining bright".

How Sivaparvati reacted to her child's sickness and tried to get her cured is typical of a poor family in the agrarian society of rural coastal Andhra.

Case Report. 4

> Sivaparvathi has had one son and two daughters. The last child was eight months old at the time of our study and was seriously sick. It did not look like any particular disease but the girl was generally too weak and lean for her age. The mother never had sufficient breast milk and would feed her children for not more than ten days. Theirs was a landless family. Husband was a labourer who also took an acre of lemon orchard on tenancy. Sivaparvathi did not go out to work. They had a buffalo at home that gave milk and added to their income, and they could afford to feed milk to their children. They also tried feeding the third child with Farex in her sixth month. But as it did not suit her the baby was vomitting it out.
>
> Sivaparvathi approached the PHC to get her daughter cured. But she was soon fed up with the PHC, due to the callousness of the staff. They always asked her to buy medicines outside; did not treat her kindly and always tried to dispense her with some syrup which never cured her daughter's illness. Then she approached three godmen and purchased three amulets, first in their own village, then at Ponnuru and Tenali at a cost of about Rs 40

in all. But, by now the child began to have fever every evening. Then they consulted a pediatrician in Tenali. He charged them Rs20/- and prescribed medicines which cost Rs.60/- more. With this the child looked slightly better, but, it proved to be only momentary. Her condition further deteriorated during the next month. She developed diarrhoea coupled with fever. As the first private nursing home in Tenali where they admitted the child for ten days spending about Rs.200/- proved to be of no use they grew desperate, borrowed more money and went to another private doctor.

The doctor told them that all the medicines prescribed by the earlier physician were"utterly useless". They spent Rs.200/- more. Fortunotely, this time, the girl's condition became normal. She said, by giving a "pensalu"(Penicillin injection) the doctor brought the pulse of her daughter "from elbow back to the wrist".

This is a clear case of severe malmutrition but none of the health personnel whom Sivaparvathi approached, did tell her this.

Case report of Rajeshwari, a landless labourer, reflects that people are aware of their health problems, do seek medical help and spend money beyond their limits if necessary. It also reflects how the private doctors misguide them to squeezemoney.

Case Report: 5

Rejeshwari underwent the harrowing experience of three continuus abortions and a still birth in the eighth month of her next pregnanacy. After the third abortion she took sufficient care during the last pregnanacy and accordingly

avoided heavy work load from the fifth month onwards. She was also in continuous touch with the MPW(F) since there was no lady doctor in the PHC at that time. Inspite of all this care her pregnancy ended up in a still birth, whereafter Rajeshwari went to Tenali, to consult a lady physician.

Then began a different kind of problem for her. The private doctor impressed upon Rajeshwari and her husband that since their blood groups did not match with each other, even more abortions were likely. She, after charging a good amount as consultation fees, advised them to take certain medicines(Rubraplex(Iron, B complex and B 12 vitamine), Elixir and Dumex capsules) for a month and completely avoid sex while the wife took full rest.

Rajeswari, or her husband,who are illiterates were never to know that no doctor could identify or compare their blood groups without having them actually tested in a laboratory not to speak of their matching and its implications, if any. They only had their faith in the physician and took all the medicines prescribed by her.

Being very poor they had to raise substantial loans to pay the doctor and buy medicines while foregoing daily wages for weeks together on account of the "rest" advised by the doctor and several trips made to her place. But all this hardly improved the health of Rajeshwari, because the doctor never advised her to take better food. Had she not cashed upon the gullibility of Rajeshwari, it may be that her health would have improved with better food intake. In the present situation what would be the fate of Rajeshwari's next pregnanacy, in case it does happen, is anybody's guess.

SECTION - IV

MATERNAL AND CHILD HEALTH PRACTICES

It is revealing that maternal and child health problems are not as neglected in SJM as the general impression seems to be in the academic world. In fact the MCH care and people's initiatives in taking care of these problems match their actions in other health problems. Data on MCH practices is presented under three headings namely,

(1) Practices during pregnanacy(prenatal);

(2) Practices at the time of delivery and postnatal period;and

(3) Child care practices.

4.1 Practices during pregnanacy:

Under this heading data on perceptions about pregnancy, shifts in work patterns, food patterns, medical care, availability of the MPW etc. is persented.

Percetions about pregnanacy:

Pregnandcy is considered the most natural thing for a woman. Girls conceive early and temporary methods to prevent conception are not socially accepted prior to their first babies. In their over worked conditions women take pregnanacy and motherhood as an opportunity to get some power in household affaris. If a baby boy is born in the

first delivery, the woman can definetely exercise more control.

Care for pregnant women: Among the rich and middle classes pregnant women are treated with more care and affection. They are provided with special foods, good medical care, rest etc. But in marginal farmers and landless labourers, pregnancy is treated just as a biological process that need not be paid any special attention. Their triple burden of work, beatings from husband, less intake of food- everything continues as usual.

Work Patterns: There is not much shift in work patterns during pregnancy. Most of the women continue to do heavy work till the day of delivery. However, as already described in the work patterns of women(table 14) landless and marginal farmers' women do very heavy work at home and in the fields with little rest. They continue the same work during pregnancy while the middle and rich farmers' women do minimised household work. Therefore the inter-class differences that are observed in the general work patterns continue to persist here as well. Only a few can afford the luxury of avoiding heavy work prior to pregnancy.

In the sample, all women continued their usual work (including rich farmers) (see table 14), during the first six months. Only in the last trimester some could afford to avoid their heavy work but most of them continued to do their household work till the day of delivery. On these patterns data for each class is analysed separately. All these tables(table 21 to 23) taken together give an idea of interclass differences.

Table: 21. Avoiding heavy work prior to delivery in landless labourers

Kind of work	Total No.of women doing this work*	0days	10 days-1 months	1 month-3 months
Agricultural labour	51	42 (82.3)	5 (9.8)	4 (7.8)
Animal husbandary	0	0	0	0
Agricultural labour & Animal husbandary	28	19 (67.8)	3 (10.7)	6 (21.4)
Household work only	16	10 (62.5)	6 (37.5)	0
	95 (100)	71 (74.7)	14 (14.7)	10 (10.5)

* Figures in this column do not exactly tally with figures in table 14 because two of the women in this class had delivered twice between May 83 and April 85 and as such total number of pregnant women in that period becomes 95.

As seen from the table (21), 74.7 percent of the landless women continued to do their heavy work till the day of delivery. If the number of those who do household work only is excludeed, 64.2 percent of women did agricultural labour and/or animal husbandary and household work till the day of delivery. Only 25 percent could avoid work prior to delivery; within that 14.7 percent could avoid it from ten days to one month whereas the percentage of those who avoided it from one month to 3 months is still smaller(10.5 percent).

Out of the total 95 pregnant women, 79(83.1 percent) used to work at the house as well as in the field. Out of them(77.2 percent) could not avoid any of their work even for a single day prior to delivery. Only 18(22.8 percent) could afford that luxury, i.e., 8(10 percent) women avoided working outside from 10 days to one month and 10(12.6 oercent) could avoid it from one month to 3 months. However, these women had to continue with household work till the day of delivery. Though some of them went to their parents' home to deliver, there also they had to do household work.

So, in offect only 6 out of 95 women(6.3 percent) could avoid all kinds of work and avail full rest from 10 days to one month prior to delivery.

Table: 22. Avoiding heavy work prior to delivery in Marginal farmers.

Kind of work	No. of* total women doing this work	0 days	10 days-1 month	1 month-3 months
Agricultural labour	2	2 (100)	0	0
Animal Husbandary	3	3 (100)	0	0
Agricultural labour & Animal Husbandary	3	2 (66.6)	1 (33.3)	0
Household work only	11	7 (63.6)	3 (27.3)	1 (9.1)
Total	19	14 (73.7)	4 (21)	1 (5.3)

* Figures in this column do not exactly tally with figures in table(14), because one woman of the class had delivered twice between May 83- April 85 and as such total number of pregnant women in that period becomes 19.
All those who were doing agricultural labour, animal husbandary and two thirds of those doing both these works, could not avoid them even for a single day prior to delivery.

Out of this total, only 12.5 percent(one out of eight) could avoid working outside upto one month. However, they continued household work till the day of delivery.

Of those who do household work only(57.9 percent of the total), about two thirds continued it till the day of delivery. 27.3 percent could avoid it from 10 days to one month and another nine percent could avoid it between one month and 3 months.

Table:23. Avoiding heavy work prior to delivery in Middle and Rich Farmers.

Kind of work	Total No. of women doing this work*	0 days	10days -1 month	1 month- 3 months	4 months
Agricultural labour	1+	1 (100)	0	0	0
Animal Husbandary	0	0	0	0	0
Agricultural Labour & Animal Husbandary	2+	0	1 (50)	1 (50)	0
Household work only	15	6 (40)	2 (13.3)	2 (13.3)	5 (33.3)
	18 (100)	7 (38.9)	3 (16.7)	3 (16.7)	5 (27.8)

* Figures in this column do not exactly tally with figures in table 14, because one women in this class delivered twice between May 83-April 85 and thus the total number of preganant women becomes 18

\+ These women actually superwise their own agricultu

Of the two who supervise their agriculture and do animal husbandary, one avoided them from ten days to one month and the other one did so from one month to three months. Those who supervise only agriculture continued it till the end. Of those who do house hold work only, 61 percent could avoid it from 10 days to four months. The other 39 percent contined it till the day of delivery.

Table:24. Avoiding heavy work(all kinds) prior to delivery in all classes.

Class	Total No.* of women	0 days	10 days-1 month	1 month 3 months	4&5 months
Landless labourers	95	71 (74.7)	14 (14.7)	10 (10.5)	0
Marginal Farmers	19	14 (73.7)	4 (21)	1 (5.3)	0
Middle and Rich farmers	18	7 (38.9)	3 (16.7)	3 (16.7)	5 (27.8)
Total	132	92 (69.7)	21 (15.9)	14 (10.6)	5 (3.8)

* Figures in this column do not tally with figures in table(14), because four women falling in different classes delivered twice each during May 83-April 85 and so the total number of pregnant women becomes 132.

When the differences are seen in terms of interclass, the trend is much clear. In landless labourers and marginal farmers 74 percent could not avoid their heavy work till the day of delivery. Percentage of such women drops to 38.9 percent in rich and middle farmers but as such is still large and deserves attention. However, percentage of those who could avail more rest increased with increase in the size of land holding.

Food Patterns:

Landless labourers and marginal farmers don't know that they should eat more during pregnancy. Some eat as much as they eat otherwise and some eat less. Reasons for eating less are that " it facilitates easy delivery", and "more food cannot be digested by pregnant women". Many reported that they eat less food as they feel very uncomfortable when they eat more or even usual quantities. Many sleep without food at night for this reason.

Eating less is mainly because of false beliefs but not due to financial problems. They can afford atleast as much as they eat otherwise.

The rich and middle farmers' women are better in this regard. Many of them know that they should eat more and do actually eat. Moreover they also take special foods.

In our sample, except 1.6 percent of the women who come under middle class, all reported that they do not follow any food restrictions. However, papaya fruit is universally prohibited during pregnancy with a fear that "it causes abortion".

Our sample data reflects the unscientific perceptions and practices regarding food intake.

Table: 25. Perceptions about food intake during pregnancy among the Sample.

Class		More food	less food	Usual food
Landless labourers	93	5 (5.4)	45 (48.4)	43 (46.2)
Marginal Farmers	18	3 (16.7)	7 (38.9)	8 (44.5)
Middle and Rich Farmers	17	8 (47)	8 (47)	1 (5.9)
Total	128	16 (12.5)	60 (46.9)	52 (40.6)

Table: 26. Actual food intake during pregnancy among the sample

Class	More food	Less food	Usual food
Landless Labourers 95	2 (2.1)	48 (50.5)	45 (47.4)
Marginal Farmers 18	3 (15.8)	7 (36.8)	9 (47.4)
Middle and Rich Farmers 17	6 (33.3)	4 (22.2)	8 (44.4)
Total 132	11 (8.3)	59 (44.7)	62 (47)

Half of the landless labourers reported that they ate less during pregnancy. The percentage of those who reported eating less decreased and the percentage of those who ate more increased from landless labourers to middle and rich farmers' women. Very unscientific reasons were suggested for 'less' intake of food. 24 percent thought that it is difficult to digest if they eat more; 25 percent believed that it facilitates easy delivery; another five percent

thought pregnant women must eat less. As many as 46 percent felt uncomfortable whenever they ate more and hence reduced food intake. There was no one to tell them that they should eat less but more number of times.

However, the percentage of those who reported that they ate as usually remained almost same in all classes (47 percent).

Special foods like milk, fruit, sweets(as per customs, a pregnant woman is supposed to eat sweets, all her desires be satisfied and she be happy throughout the pregnancy) and tonics were taken only by a less number of women. However, our sample data reveals an interesting fact, tonics were taken by more number of women compared to all other special foods including milk. However, quantity of and regularity in taking these foods differ in different economic classes.

Table: 27. Special foods taken by sample women during pregnancy

Class	Kind of special foods taken			
	Milk	Fruits and fruit juices	Sweets	Tonics
Landless Labourers 95	4 (4.2)	0	0	6 (6.3)
Marginal Farmers 19	4 (21)	5 (26)	0	4 (21)
Middle and Rich Farmers 18	14 (77.8)	14 (77.8)	10 (55.6)	16 (88.9)
Total 132	22 (16.7)	19 (14.4)	10 (7.6)	26 (19.7)

Cultural beliefs which are opposed to scientific knowledge exist in all classes. But their influence lessened with betterment in economic position and consequent interaction with health personnel.

In Telugu, there is a saying that a pregnant woman must eat as much as two persons eat- one meal for herself and the other one for the unborn child which is growing in her womb. But it seems this does not have much impact on the public.

Maternity Care

Landless labourers and marginal farmers generally consult the MPW(F) or the PHC doctor. They also go to the private doctors but only in times of trouble. Middle and rich farmers generally go to private doctors in Tenali regularly.

Consulting the MPW(F)

This generally takes place during the MPW(F)'s house visits. She asks them to come to the PHC and take Tetanus Toxoid(TT) injections. No physical examination is done at home. If it is their third trimester, she gives them Iron tablets to be taken one a day and advises them to eat fruits. If they complain of any problem such as bleeding, she advises them to consult the lady doctor at the PHC. If the lady doctor is not available at that time, the MPW(F) advises them to eat 'cold' stuff to tackle 'heat' that caused bleeding.

Those who consult the MPW(F), pay just tow or three visits to the PHC throughout their ante-natal period, to get TT injections, Beyond this she gives no special care or advice. In the PHC of SJM there was no lady doctor for the past one year. One was appointed only in February 1985. However, she was not always available as she had to

often go out to attend training programmes. During the three and half months the researcher spent in the village she was available only for a period of one month.

Ante-natal Clinic at the PHC : This is conducted every Wednesday. Generally the MPW(F) and the Staff Nurse manage it. There are no physical check-ups, BP testing, heart beat and foetal growth assessments. The effective services one can get are T T injection and Iron tablets. Blood test and urine test are done but not regularly. The PHC doesn't have supply of Calcium and only Iron tablets are distributed to pregnant women which they get for a month or two. Even if the lady doctor is available the routine does not change except that she did frquently internal examinations for women.

Consulting Private Doctors: Generally middle and rich farmers go to private doctors right from the day of confirmation of pregnancy. They prescribe many tonics containing vitamins, Calcium and Iron to be taken till the day of delivery. Our sample data reflects some interesting variations.

Table: 28. Medical consultation during ante-natal period among the sample.

Class		Medical Consultation			
		No Consultation	Private Doctor	Govt. Doctors	MPW(F)
Landless Labourers	95	29 (30.5)	15 (15.8)	9 (9.5)	42 (44.2)
Marginal Farmers	19	2 (10.5)	8 (42)	3 (15.8)	6 (31.6)
Middle and Rich Farmefs	18	2 (11.1)	14 (77.8)	2 (11.1)	0
Total	132	33 (25)	37 (28)	14 (10.6)	48 (36.4)

25 percent of the women did not consult anyone during ante-natal period and understandably most of them (29 out of 34) belong to the landless labourers class. Of those who consulted, 92 percent reported that they did it regularly and only eight percent said they did it only in times of trouble.

Only landless labourers and marginal farmers' women consulted the MPW(F) where as majority(77.8 percent)of the middle and rich farmers' women consulted private doctor. Government doctor was also consulted by all the classes th ough their utilisation is comparatively less than that of the private doctor(10 percent against 28 percent). Interestingly though nine of the 14 cases going to government doctors come from landless class, they constituted only nine percent of the total landless women whereas 15.8 percent of them consulted private doctors. This shows the differences in the accessibility of a government doctor for different classes and also their relative ineffectiveness in providing care. Landless labourers and marginal farmers consulted government doctors only when they faced acute trouble. The middle and rich farmers did so in case of urgency or out of confidence that they did not suffer any complications and that this consultation is only routine.

When the preventive services provided by all medical institutions and private practitioners are taken together, the T.T, Iron and Calcium taking rates kept increasing with increase in land holding size. In fact they all

reached cent percent in rich farmers class indicating lesser utilisation of services among the landless and marginal farmers. One interesting point is that many of those who did not seek any medicab consultation, took TT injections. Sample population shows the following trends.

Table: 29. Content of preventive services provided by the medical institutions.

Class	Taken TT	Taken Iron	Taken Calcium
Landless Labourers 95	87 (91.6)	55 (57.9)	9 (9.5)
Marginal Farmers 19	19 (100)	13 (68.4)	6 (31.6)
Middle and Rich Farmers 18	18 (100)	16 (88.9)	14 (77.8)
Total 132	124 (94)	84 (63.6)	29 (22)

Thus, though only 75 percent sought medical care, 94 percent took TT injections. In landless labourers, 30.5 percent did not seek any medical care, but only 8.8 percent didn't go for TT injections.

In marginal farmers and middle and rich peasants', all those (10.5 percent and 11.1 percent respectively) who didn't seek medical care, took TT injections, showing thereby the awareness of people regarding prevention of tetanus. However, Iron and Clacium taking rates are not so high as TT rates. Only about two thrids of the women took Iron. This means that all those 75 percent who sought medical care did not take Iron.

Superstitions followed during pregnancy:

During pregnancy women are not supposed to see eclipse. If they do so children will born with a rift in the upperlip".

They are not supposed to see dead bodies or visit the homes of dead or post-partum mothers and newborn children. These superstitions are believed by all. There are certain other practices like- grinding should not be done by pregnant women. If a pregnant woman desired to eat something or to buy a new saree or to visit a relative,

that desire should be satisfied. Otherwise she will get swelling in feet and face. But the poor women are not bothered with all this because they simply cannot afford to. Another belief is that two bananas inside a single peeling or an egg with two yolks is not accepted by pregnant women for it could cause the birth of twins.

4.2 Practices at the time of delivery and post partum period.

Under this heading, data on place of delivery, important issues in home deliveries, food of post partum mother, food restrictions during lactation, work patterns after delivery, concept of pollution etc. is presented.

Place of delivery:

Deliveries among landless labourers and marginal farmers households are usually conducted at the PHC and are attended by MPW(F). In those households where delivery is conducted at home, the M.PW(F) is called to act as birth attendant. Some call the only untrained dai of SJM. These people go to private hospitals if the MPW(F) cannot manage it or she is not available. Those who go to their parents' home to deliver, mostly deliver at home and are attended by local untrained dais. This happens

because many of these belong to nearby interior villages which do not have any medical facilities.

The middle and rich farmers usually go to private hospitals in Tenali. But within private hospitals also they receive different treatments according to their financial capacity. Rich farmers' women are attended by doctors and the others by nurses. Rich and middle class women take special rooms and pay high rents whereas landless labourers and marginal farmers stay in 4 bedded/ 6 bedded rooms and pay less rents. For a normal delivery, for the rich it costs about Rs 500/--Rs600 whereas for the landless, it costs about Rs200-Rs300. The latter are attended by doctors only in case of sevre complications like where ceasarean is necessary.

Our sample data shows signifcant differences in the place to which women from different classes go for deliveries (table 30).

Table:30. Differences in place of delivery

Class		Home	PHC	Private Hospital
Landless Labourers	95	43 (45.3)	34 (35.8)	18 (18.9)
Marginal farmers	19	5 (26.3)	6 (31.6)	8 (42.1)
Middle and Rich farmers	18	4 (21)	4 (21)	10 (58)
Total	132	52 (39.4)	44 (33.3)	36 (27.3)

Poorer the background more the deliveries take place at home. Similarly more deliveries took place at the PHC in landless labourers and marginal farmers. The rich families clearly opt for private nursing homes (58 percent). While even the landless and marginal peasants'

women use private doctors their primary access is to PHC and M.P.W's or dais. Out of 96(91.7 percent) deliveries conducted at home and PHC 88 come from these classes. The PHC takes care of 33.3 percent of the total deliveries and 91 percent of these are from poor and marginal households. With improvement in their economic position, percentage of deliveries at private hospitals also increases.

Expenses Involving deliveries:

Women from all sections took expenses at the time of delivery for granted. Only those who got their deliveries conducted by close relatives had it free. For the dais payment was a norm and so it was for the MPWs. For the private practitioners deliveries were a source of profits and they fully exploited the traditions of the village. Only 5.3 percent had not paid for deliveries. Two(one from the rich peasants and one from the landless,) of those women were attended by private doctors but were not charged as they were relatives and known to the doctors. The rest, were attended by close relatives in case of emergency, and so there was no question of payment.

Table: 31. Expenses at the time of delivery among the sample

Class	Rs. o	Rs15-30	Rs31-100	101-300	301-500	above Rs500
Landless Labourers 95	6 (6.3)	63* (66.3)	10 (10.5)	9 (9.4)	5 (5.2)	2+ (2.1)
Marginal Farmers 19	0	8 (42.1)	4 (21)	4 (21)	3 (15.8)	
Middle and Rich Farmers 18	1 (5.5)	5 (27.8)	3 (16.7)	3 (16.7)	4 (21)	2++ (10.5)
Total 132	7 (5.3)	76 (57.6)	17 (12.9)	16 (12.1)	12 (9.1)	4 (3)

* Of these, one woman paid Rs 5/- only and two others paid Rs 10 each.

\+ Of these two women one paid Rs 800/- and the other paid Rs 1500/(cesarean & tubectomy)

++ Paid Rs 1000/- each.

57 percent paid between Rs 15 and Rs 30, 25 percent paid between Rs 31 and Rs 300 while 12½ percent paid over Rs.300. However, it is worth noticingthat among the landless, though the majority paid Rs 15 to Rs 30, there were seven cases where families had paid over Rs.300/-(as much as Rs.800 and Rs 1500 in two cases). This only reasserts that even the poorest are ready to pay much beyond their capacity if deliveries become difficult beyond the skill of the M.P.W(F).

As a custom, expenses for the first and second deliveries are borne by parents of the woman and later on by her husband or in-laws. In our sample, for 56 percent of the deliveries, expenses were borne by parents, 38 percent by husbands and the rest six percent by in-laws.

Preferences and actual use of Birth attendants

The utilisation of doctors, MPW(F) and dais is not different from what we observed during pregnancy. In landless and marginal farmers, majority prefer M.P.W(F). Dai is preferred only by a few. This is so specially if the M.P.W(F) is not available or when it is multiparons woman where delivery is expected to be easy.

Middle and rich farmers' women clearly opt for a private doctor. Few prefer to use the services of M.P.W(F).

But in case of emergency where a private doctor cannot be reached in time, preference is in favour of M.P.W(F) but not dai. In SJM the low utilisation of traditional dai is very obvious and the reason is primarily their understanding that M.P.W(F) is better trained. Since they pay both, they prefer the M.P.W(F). In appendix II we present profiles of the village dai.

Table:32. Preference for Birth attendant.

Class	Dai	M.P.W(F)	Private Doctor
Landless Labourers 95	30 (31.6)	57 (60)	8 (8.4)
Marginal Farmers 19	2 (10.5)	11 (57.9)	6 (31.6)
Middle and Rich Farmers 18	1 (5.5)	4 (22.2)	13 (72.2)
Total 132	33 (25)	72 (54.5)	27 (20.5)

Preferences for birth attendants thus change, according to paying capacities. As seen in the table(32)

preference for M.P.W(F) is more in landless labourers and marginal farmers(60 percent) as against middle and rich farmers, where the marjority(72 percent) use private doctors. Preference for dai is just one fourth of the total in all and it decreases with increase in the size of land holding. At the same time preference for private doctors increases as we move from landless to richer classes.

Table: 33. Type of actual birth attendant

Class	Relatives	Dai	M.P.W(F)	Private Doctor/ Nurse
Landless labourers 95	5 (15.2)	33 (34.7)	37 (38.9)	20 (21)
Marginal Farmers 19	0	3 (15.8)	5 (26.3)	11 (57.9)
Middle and Rich Farmers 18	0	3 (16.6)	5 (27.7)	10 (55.5)
Total 132 (100)	5 (3.8)	39 (29.5)	47 (35.6)	41 (31)

As seen from the tables 32 and 33, though only 8.4 percent of the landless women preferred to go to private doctors, 21 percent had to go in actual practice. Similarly

while 60 percent prefered M.P.W(F), only 38.9 percent could avail her services. Same trend is seen among marginal farmers too. However, in middle and rich peasants, though 72.5 percent opted for private doctors, only 55.5 percent could go to them; Dai and M.P.W were called in cases of emergency though they were not preferred. These shifts will be discussed later.

Home Deliveries

Our general discussions revealed that home deliveries were not popular. In our sample home deliveries constitute only 39.4 percent of the total deliveries. Even with these the impact of the economic factor is clearly visible. Most of the home deliveries(82.7 percent) were in the landless labourers(72 percent of these were attended by dais whose role decreased with increase in ownership on land from 60 percent in marginal farmers to 50 percent in middle and rich peasants).

Table: 34. Birth attendants in Home deliveries

Class	Total no.of home deliveris	Relatives	Dai	MPW(F)	Pvt.Doctor/ Nurse
Landless labourers	43	5 (11.6)	31 (72)	5 (11.6)	2 (4.6)
Marginal Farmers	5	0	3 (60)	2 (40)	0
Middle and Rich Farmers	4	0	2 (50)	2 (50)	0
Total	52	5 (9.6)	36 (69.2)	9 (17.3)	2 (3.8)

Home deliveries were generally conducted in unhygenic conditions. Neither the dai(who conducts majority of the home deliveries) nor the villagers give importance to hygine. Generally blade is used to cut the cord, mostly unboiled one. The untrained personnel do not take this precaution as much as the trained. In all cases where relatives acted as birth attendants, instrument was

not boiled. All such cases were among the landless labourers.

As far as the after-care of the cord is concerned, in 40(76.9 percent) cases the cord was cut and left to dry as is usually practiced in institutional deliveries. All home deliveries conducted by M.P.W(F)/private doctors used this method of after-care.

In 10(19.2 percent) and 2(3.8 percent) cases caster-oil and face powder were used respectively. Out of these 12 cases 5(41.7 percent) were attended by untrained relatives. It is significant that 80.6 percent of the dais were using correct practices for after care of the cord.

Food and water to post-partum mothers:

It is widely believed among all classes that post-partum women should not take either water or food immediately after delivery. Water is prohibited but hot coffee is allowed. If the delivery takes place in the morning, that night the mother can take bread after a minimum gap of eight hours. Next day also she should continue with bread and boiled water for drinking. If she doesn't develop any problems like fever, from the third day onwards she will be given rice for lunch but bread continues for

dinner till the tenth day. However, even for lunch she can get only half of the rice quantity what she usually eats, and that too with strict restrictions. Dal, subji and curd are not allowed. Only a special mirchi powder (fried red mirchi, dhaniya seeds, lahsun and salt grinded together) and a local kind of soup(thin boild tamarind juice) are allowed. From the eleventh day onwards they can take usual quantity of rice but still many vegetables and green leaves are not allowed.

These observations show that fluid intake is not restricted customarily if families can afford coffee, nor is food if they can eat bread. Bread in this area however is considered food for the sick and is therefore not easily available in villages except from medical shops. The food practices therefore do restrict fluid and food intake to some extent.

These practices are more or less similar among all classes and castes except in Sugali(Lambada) caste who form part of landless labourers. Among the Sugalis immediately after delivery, the mother and child will be given bath and then the mother is given as much rice as she wants to eat. Water is also not prohibited. Except this

caste, which comes under scheduled tribes, all others- Hindus, Muslims and Christians, follow the practices described earlier. However, Sugalis who settled down in the village a few gnerations ago, started adopting the practices of rest of the village. But those who were in 'thandas' earlier and settled down in village during this generation only, still follow their own practices like giving head bath and staple food to eat(rice, maize or jowar) immediately after delivery.

Food restrictions during lactation:

Many vegetables like cucumber, bitter gourd, bringal, gongoora(a kind of green leaves considered as a good source of iron) etc. are avoided for two to three months. It is assumed that these cause 'cold' or 'heat' to the nursing baby. Some people avoid all green leaves. Non-vegetarian food is also avoided. "It causes heat to the child". However, papaya fruit which is prohibited during pregnancy due to its 'potentiality to cause abortion' is prescribed during lactation. It is supposed to help increase production of breast milk.

Confinement:

Confinement is the period following delivery during which a post partum woman takes full rest except attending

her new born. In our sample data, half of the landless labourers(53.7 percent) could afford a confinement of 10 days or less, while among the other two classes, women in this category were 31.6 percent 5.5 percent in marginal farmers and middle and rich farmers respectively. 24 percent of the other half of landless women could afford full rest upto one month and 12.6 percent upto two to three months. None from this class was able to afford rest beyond three months.

In marginal farmers majority(47.4 percent) could take full rest from ten days- one month and 21 percent upto 2-3 months. However, in this class also, none reported confinement for more than 3 months.

Only in middle and rich farmers class, majority(66.6 percent) took rest from 10 days- 3 months and 27.8 percent could afford it even upto 4-5 months. Only one out of 18 women maintained confinement for less than 10 days. This again shows the impact of class positions on confinement practices. However, those who belong to landless or marginal classes and maintained confinement upto three months reported that they underwent tubectomy after delivery and so were forced to maintain longer periods of confinement.

Table: 35. Period of Confinement after delivery among the Sample.

Class	Less than 10 days	10 days- 1 month	2 moths- 3 months	4 months- 5 months
Landless Labourers 95	51 (53.7)	32 (24.2)	12 (12.6)	0
Marginal Farmers 19	6 (31.6)	9 (47.4)	4 (21)	0
Middle and Rich Farmers 18	1 (5.5)	6 (33.3)	6 (33.3)	5 (27.8)
Total 132	58 (43.9)	47 (35.6)	21 (15.9)	6 (4.5)

Resuming heavy work after delivery:

In landless labourers and marginal farmers, though household work is resumed soon after delivery, outside works (agricultural activities) are postponed for sometime. However, most of the women resume animal husbandary work from the 21 st day onwards, Agricultural labour is postponed mostly till about six months. This is borne out by our sample data(table 35).

In marginal farmers too the pattern is the same as for the landless (table 37)

Table: 36: Avoiding heavy work after delivery among landless labourers

Kind of work	Total no. of women doing this work *	Upto 1 month	1 month- 3 months	3 months- 6 months	6 months- 1 year
Agriculatural Labourers	79 (51+28)	3 (3.8)	3 (3.8)	52 (65.8)	21 (26.6)
Animal Husbandary	28	17 (60.7)	9 (32.1)	2 (7.1)	0
Household work only	16	13 (81.2)	3 (18.8)	0	0

* In this class, during pregnancy 51 women did agricultural labour and 28 women did both agricultural labour and animal husbandary. But when they resumed these works after delivary, they did so at different points of time. Therefore figures in this column do not exactly tally with figures in table 14.

In marginal farmers too the pattern is the same as for the landless (table 37).

Table:37: Avoiding Heavy work after delivery among marginal farmers.

Kind of work	Total No of women doing this work *	Upto 1 month	1 month-3 months	3 months-6 months	6 months-1 year
Agricultural Labour	4 (1+3)	1 (25)	0	2 (50)	1 (25)
Animal Husbandary	7 (4+3)	5 (71.4)	1 (14.3)	1 (14.3)	0
Household work only	11	7 (63.6)	4 (36.4)	0	0
Total		13	5	3	1

* In this class, during pregnancy one woman did agricultral labour, four women did animal husbandary and three others did both agricultural labour and animal husbandary. But when they resumed these works after delivery, they did so at different points of time. Therefore, figures in this column do not exactly tally with figures in table 14.

In the middle and rich farmers, of the 18 women, only two were doing agriculturo and animal husbandary, and one was doing agriculture alone. All of them resumed these works only after six months. While in the landless and marginal classes animal husbandary was resumed much earlier compared to agriculatural labour; in the middle and rich peasants classes, both were resumed at the same point of time, i.e. after six months. Even among those who do household work only, majority(12 out of 18) resumed it between 3 months and 6 months. Only three out of 18 resumed it within a month, the time when the majority of landless (81 percent) and marginal(63 percent) farmers' women are back to the grind.

Family Planning Practices:

It is interesting to note that sterilisations are very popular in SJM. By the end of June 1984, 56 percent of the target couples were covered by sterilisation, mostly after two or three children. There are many women particularly from landless labourers, who undergo sterilisation by the age of 20 years, after giving birth to two children. However, temporary methods to prevent conception are not popular.

Table: 38. Sterilisations among the Sample- parity wise

Class	Total No.of women steri lised	with 2 childr en	With 3 childr en	With 4 or 5 children
Landless Labourers 93	37 (39.8)	17 (46)	13 (35.1)	7 (18.9)
Marginal Farmers 18	6 (33.3)	3 (50)	3 (50)	0
Middle and Rich farmers 17	6 (35.3)	5 (83.3)	1 (16.7)	0
Total 128	49 (38.3)	25 (51)	17 (34.7)	7 (14.3)

Table: 39. Willingness for sterilisation among the sample-parity wise

Class	Total No. of women willing for sterilisation	After 2 children	After 3 children	After 4 children
Landless Labourers 93	50 (53.8)	27 (54)	22 (44)	1 (0.5)
Marginal Farmers 18	12 (66.6)	6 (50)	6 (50)	0
Middle and Rich Farmers 17	11 (64.7)	8 (72.7)	2 (18.2)	1 (9.1)
Total 128	73 (57)	41 (56.2)	30 (41.1)	2 (2.7)

Out of the 128 sample women, 49(38.3 percent) underwent sterilisation. Another 73(57 percent) women expressed willingness for sterilisation. Only six women (4.7 percent) who are landless labourers expressed unwillingness for sterilisation. Three of them are Muslims and reported that though they want to get sterilised, their husbands do not allow them due to religious beliefs.

Two women, Hindus, are afraid that they may face post-operative problems and consequent hysterectomy. Another woman is a widow. Though a few others are also afraid that hysterectomy may become necessary later on, they feel that they can't afford to have more children.

Table: 40. Statement showing parity wise couple data as on 30.6-84 in SJM

With	No.of Target Couples	No.of Sterilised	Percentage of sterilised
0 children	82	0	0
1 Child	177	12	6.8
2. children	226	219	96.9
3 children	237	212	89.4
4 children	90	78	86.7
5children	34	17	50
6 children	6	3	50
7 children	0	0	0
Total	952	541	56

Soruce : PHC, SJM.

Our sample data also feflects facts worth noting on the reasons for sterilisations.

Table: 41. Reasons for Sterilisation as reported by the sample

Class	Cannot feed more children	To Keep up mother's & children's health	Child rearing is difficult	Children won't allow mother to work
Landless Labourers (87 out of 93*)	78 (89.7)	3 (3.4)	2 (2.3)	4 (4.6)
Marginal Farmers 18	13 (72.2)	3 (16.7)	1 (5.6)	1 (5.6)
Middle and Rich Farmers 17	6 (35.3)	3 (17.6)	8 (47)	0
Total 122	97 (79.5)	9 (7.4)	11 (9)	5 (4.1)

* Out of the total 93 women in landloss labourers only 87 expressed willingness for sterilisation. Some of them already got sterilised. Only their statements are considered here.

Economic factor is suggested as reason in majority (79.5 percent) of the cases. Sterilisation is felt necessary to keep up mothers' and children's health only by ailing mothers. When difficulties in child rearing is suggested as the reason, landless labourers' and marginal farmers' women saw it more in terms of finances to keep up a child healthy. Middle and rich farmers' women saw it in terms of work burden. Only labouring women reported that children become an obstacle for working mothers. Given the poor economic situation in such families women are forced to go in for employment and it is not surprising that child rearing is viewed as a hindrance .

Concept of Pollution:

Only Brahmins consider post partum mother and the new born as polluted and others do not touch them for ten days. On the eleventh day mother and child take head bath and then are considered to be pollution free. In other castes, this kind of untouchability is not practiced but mother is supposed to take head bath before she resumed house work, which may take place on any odd day between fifth and eleventh day.

However, on the twenty-first day mother and child again take head bath and are considered completely free

from pollution. From then onwards women resume work outside house, like cutting grass in the fields or going to canal for washing clothes etc.

The first 20 days are considered as a big leap forward in the life of the infant because many infants used to die within this period earlier. The twenty-first day ritual is observed throughout Andhra.

Superstitions followed by Postpartum Women

All over rural Andhra there are certain superstitions followed by post partum women of all classes and castes and the SJM women are not exception to this. They tie a cloth around their waist('nadumkattu') believing that it checks the growth of abdomen after delivery and helps in contracting the uterus to its original size. They wear mufflor around head and put cotton in ears to prevent air entering into body and causing headache. Also wear chappals day and night to prevent'cold' entering their bodies. Usually labouring women do not possess chappals, but during this period they somehow manage either to buy a pair or borrow one from their men.

Our sample data reflects that women of all classes irrespective of their economic position believe and practice these superstitions.

Table:42. Superstitions followed after delivery

Class	Avoided water immediately after delivery	Wore Nadum kattu	Wore muffler and cotton
Landless Labourers 95	78 (82.1)	71 (74.7)	82 (86.3)
Marginal Farmers 19	18 (94.7)	15 (78.9)	18 (94.7)
Middle and Rich Farmers 18	11 (61.1)	12 (66.7)	16 (88.9)
Total 128	107 (81.1)	98 (74.2)	116 (87.9)

Majority of those who didn't wear 'nadumkattu' reported that they did so as they underwent tubectomy. Otherwise they also would have gone for it. Majority believe that water should be avoided for a postpartum woman immediately after delivery. However, their percentage decreases as we move from landless labourers to middle and rich farmers. This is due to their interaction with better health services.

4.3 CHILD CARE PRACTICES

Under this heading, data on first feed, colostrum feeding, breast feeding, weaning foods, vaccination, care of small children of mothers who also work outside, small children's food etc. is presented. Superstitions followed in cases of small children are also dealt with.

First Feed: As in other parts of South India, in Andhra Pradesh too, pre-lactation feeds are quite common. SJM women reported having fed their new borns with various items, the most common being castoroil and glucose water. Till lactation established, they give these different kinds of feed to the infant.

Table: 43. New borns' first feed-various kinds

Sl.No.	Kinds of First feed	Landless Labourers	Marginal farmers	Middle & Rich Farmers	Total	Percentage
1.	Castoroil	52 (55.3)	7 (36.8)	4 (22.2)	63	48.4
2.	Saline/Glucose water	35 (37.2)	11 (57.9)	12 (66.6)	58	44.2
3.	Sugar water	1 (1.1)	0	0	1	0.8
4.	Foster Mother's Milk	4 (4.3)	0	0	4	3.0
5.	Cow's Milk	0	0	1 (5.5)	1	0.8
6.	Honey	0	0	1 (5.5)	1	0.8
7.	Breast Milk	2 (2.1)	1 (5.3)	0	3	2.2
		94	19	18	131	100

In landless labourers, majority(55.3 percent) of the new borns were fed casteroil and in other classes it was glucose or saline water, which was also the second choice among landless. Thus 92.5 percent of the landless labourers', 94.7 percent of marginal farmers' and 88.8 percent of the middle and rich farmers' babies were fed with either of these. The other kinds of feeding were less frequent. Among landless only, the practice of using foster mothers' milk for ursing infants was also observed. Only 3 children got their mothers' milk as first feed.

Castor oil is a traditional feed while glucose water was given on medical advice. Sugar water, other mother's milk, cow's milk, and honey were given on elders' advice. Breast milk was given either on medical advise or elders' advise.

Feeding Colostrum:

Many mothers do not feed colostrum to their new borns. In fact, majority of them do not have any idea about colostrum- what it looks like, its functions etc. Usually, they feed their children from third day onwards, that too after removing the first white milk, which is suppoed to be 'rotten'milk. Even the medical personnel seem not to bother much about this.

Table: 44. Type of Birth Attendant- Feeding Colostrum

Type of Birth Attendant	Total No. of Births Attended	Colostrum feed	Colostrum not fed
Relatives	5	0	5 (100)
Dai	39	1 (2.6)	38 (97.4)
MPW(F)	47	10 (21.3)	37 (78.2)
Private Doctor/ Nurse	41	7 (17)	34 (83)
	132	18 (13.6)	114 (86.4)

If we group the birth attendants as untrained (relatives and Dai) and trained (MPW(F) and Doctor|Nurse) personnel the first group advised to feed colostrum only in 1.8 percent cases whereas the later did so in 19.3 percent. Though there is a difference it is not very marked.

Breast Feeding:

It generally starts on the third day and infants are kept exclusively on it till about six months by the majority in all sections. Early weaning with pre-cooked foods like Farex and Cerelac is prevalent among the middle and rich farmers who always consult private doctors. A small proportion of women believe that a boy should be fed for a longer period, upto eight months and a girl upto six months(see table 45).

Table: 45. Beliefs regarding length of exclusive breast feeding

Class	Boy 8 months Girl 6 months	Boy & Girl both 6 months	Boys and girls both 6 months - 1 year
Landless Labourers 93	11 (11.8)	74 (79.6)	8 (8.6)
Marginal Farmers 18	1 (5.6)	17 (94.4)	0
Middle and Rich Farmers 17	3 (17.6)	14 (82.4)	0
Total 128	15 (11.7)	105 (82)	8 (6.3)

It is important to note that among those who fed for less than four months, three landless women could not fed for long despite wanting to, because they had not enough milk while others did it deliberately. Secondly though 82 percent said breast feeding is desirable for six months, in actual practice 43 percent fed uptoeight months to one year and only 45 percent till six months. This only shows that breast feeding is still the mainstay of infant nutrition in the village for at least the first six months(see table 46).

Table:46. Period of exclusive breast feeding-actual practice

Class	Upto 4 months	Upto 6 months	8 months-1 year
Landless Labourers 90	3 (3.2)	43 (46.2)	44 (47.3)
Marginal Farmers 18	2 (11.1)	7 (38.9)	9 (50)
Middle and Rich Farmers 17	6 (35.3)	8 (47)	3 (17.6)
Total 128	11 (8.6)	58 (45.3)	56 (43.7)

Among the landless labourers three(2.2 percent) women (with 2, 2 and 3 children respectively) never breastfed their children as they could never produce it. They all used powder milk as substitute.

The delay in weaning which is maximum among the landless is due to lack of time women can spare to feed solids. A lot of patience and time is required initially for weaning babies to solids. Due to their already over loaded work burden, many mothers cannot do so. This is evident from the table 46, that as many as 47.3 percent and 50 percent children in landless labourers and marginal farmers remain on exclusive breast feeding up to eight months to one year. Their percentage is much smaller (17.6 percent) in middle and rich farmers where mothers usually remain at home.

Landless labourers' and marginal farmers' women breast feed their children upto about two years or till they get next pregnancy. This period is much shorter in middle and rich farmers' classes ranging from six month to one year. As many as 80 percent women almost equally spread over all classes reported that they do not have any idea about the influence of breast feeding on the onset of menstruation.

Vaccination:

Mothers' knowledge about prevention of diseases is very poor. Only polio vaccination is widely known, but 90 percent of mothers assume that it is given in the form of injection. (they mistake DPT injection for polio

vaccine, as these two are usually given together.) Vaccination rates fall down very sharply in Summer as mothers and the MPW(F) believe that it causes high fever in an already hot atmosphere. Another reason is that the PHC cannot preserve it properly in Summer as they have a very small fridge and it is enough just to keep water bottles and very important medicines.

Table: 47. Knowledge of mothers about preventionof diseases

Class	Doesn't know at all	Polio only	Polio and TB	Polio and Tetanus	Polio, TB and Tetanus
Landless Labourers 93	37 (39)	53 (56.9)	1 (1.1)	2 (2.1)	0
Marginal Farmers 18	3 (16.6)	14 (77.8)	0	1 (5.6)	0
Middle and Rich Farmers 17	9 1 (5.9)	13 (76.5)	1 (5.9)	1 (5.9)	1 (5.9)
Total 128	41 (32)	80 (62.5)	2 (1.6)	4 (3.2)	1 (0.8)

Though 32 percent of the women do not have any knowledge about vaccination, knowledge rates increased from landless labourers to marginal farmers and still more in middle and rich farmers. This is due to their better educational status and interaction with health services. Whoever knows about vaccination, knows about polio. In

addition to that 2(1.6 percent) and 4(3.2 percent) persons know about TB and Tetanus vaccines respectively. Only one person knows about polio, T.B. and Tetanus. Diptheria, measels, etc, vaccines are not at all known. DPT is not known as a single vaccine.

To collect data on against what all diseases children were vaccinated, the researcher had to explain to the respondents about the kind of vaccination(injection/oral drops), how many time it is adminstered etc.

Table: 48. Percentage of Children Vaccinated

Class	Total No.of Children alive	No.of Vaccinated Children		
		BCG	DPT	POLIO
Landless Labourers	179	34 (19)	85 (47.5)	85 (47.5)
Marginal Farmers	32	12 (37.5)	19 (59.4)	19 (59.4)
Middle and Rich Farmers	28	21 (75)	23 (82.1)	23 (82.1)
Total	239 (100)	67 (28)	127 (53.1)	127 (53.1)

Vaccination rates are high in middle and rich farmers compared to landless and marginal farmers. Polio and DPT rates are same as they are given together. BCG rates are poor in landless labourers and marginal farmers compared to middle and rich farmers and also to their own polio an d DPT rates. This is because, home deliveries and PHC deliveris are more in these two classes. As BCG is generally given within a few days after delivery, they don't get it. The PHC somehow always lacks BCG vaccine. The middle and rich farmers' women go to private hospitals for deliveries and their new borns get BCG there.

Foood for small children

The landless labourers' and marginal farmers' small children get only rice with dal or 'chutney' as their elders eat. Occassionally they get a biscuit, banana or guava fruit. In middle and rich farmers class, children get many more nutritious foods. Milk, precooked cereals, different kinds of fruits like apples, grapes, bananas, and sweets etc are regularly fed to them. Once they cross the age of one year they also get egg.

Caretakers of Small Children

Mothers who work in the fields face a big problem regarding care of their children, particularly landless labourers' and marginal farmers', as their families are nuclear in structure. However, grand parents(mostly grand mothers) of the child, if they live nearby take care when the mother goes out to work. But certain points should be noted in this regard. Old women who are unable to work in fields only stay back at home. Such women cannot really provide good care for small children. Moreover, they have to take care of children of all their sons(often 3 or 4) living in the same locality. This again affects the quality of care they can provide. In reality, what they do is, just feed these children. Children are left in streets to play in mud. Even to give them bath, mothers have to come back. In some cases young relatives take care of small children. These are mostly children's paternal aunts (between 8 and 13 years) who are not yet going to fields to work as labourers. Elder children, who are four or five years older to the infant also do this job. But in terms of quality their services are very inferior because they themselves are young enough to be taken care of.

Sometimes children are left alone at home, when there are neither relatives nor elder children. There won't be anyone to attend to their necessities. Whether they are hungry, dirty or to be washed, they have to wait till their mothers come back. Usually they are left in extended verandahs of their one room locked-up huts.

Table: 49. Caretakers of young children while mother is away on work

Class	Left alone at home	Elder son/ daughter	Old parents	Yonger relative	Husband
Landless Labourers 77	5 (6.5)	12 (15.6)	51 (66.2)	8 (10.4)	1 (1.3)
Marginal Farmers 7	0	0 (	4 (57.1)	3 (42.9)	0
Middle and Rich Farmers 3	0	0	3 (100)	0	0

Leaving children alone at home or under the care of elder children which are the most inferior ways of taking care of children prevail only among landless labourers. Among the rest, majority depends upon their old parents. In fact, only among the marginal peasants three women (43 percent) depend on young relatives. Among middle and rich farmers only old parents take care of small children. Quality of their services is much better than that of the

same category in landless and marginal farmers classes. Moreover, these women supervise their own agriculture and come back in a few hours whereas the landless and marginal classes women have to work for longer hours in the fields. Though there is a nursery school in the village run by the local Mahila Mandali, labourers' children are not allowed there.

Ways of feeding the baby while mother is away on Work

Most of the women labourers claim that they work only in lemon orchards when they initially resume field work after giving birth to a baby. This is in order to come back soon and to feed the child. Out of 84 labourers 70(83.3 percent) reported this. But what happens in reality is worth noting. They work for four hours in lemon orchards and need one to one and half hours time to walk to the work spot and back. Altogether the baby is left without milk for almost six hours. Those mothers who work in weeding go back home during their lunch hour to feed their babies but this is possible only with an interval of about five hours and it involves a long walk for the mother. Those who work in transplantation or harvesting also do the same. But those who do it under contract labour, which is the most prevalent method, cannot do so. They can come

back only in the evening. However, their fellow labourers are considerate and let them go an hour earlier than others. But still, mothers can come back only after six to seven hours and the child remains hungry till then. Of the rest 14, six(7.1 percent) women reported that buffaloes' milk is given, and the other eight (9.5 percent) reported that they come back during lunch break. If the child crosses eight months of age, by that time usually they get used to solids and sc rice is fed.

Infant deaths:

Among the children(132) born alive between May'83 and April'85 seven died as infants. All of them belonged to the landless labourers class.

Table:50. Details of infant deaths who were born between May 83 and April 85.

Sl.No.	Class	Caste	Sex Male	Female	Age at the time of death	Cause of death
1.	Landless Labourers	B.C		F	13 days	Weakness
2.	"	"		"	5 months	diarrhea
3.	"	"		"	1 day	premature
4.	"	"		"	6 months	Heart disease, brain fever
5.	"	S.T		"	1 day	Premature
6.	"	S.C		"	1 month	weakness
7.	"	S.C		"	1 month	weakness

They all were female babies. Four of them belonged to Backward castes, one to scheduled Tribes and the other two to scheduled castes. Of them two died on the day of birth and cause of death was pre-maturity. One died before competing one month and cause of death was weakness. Three more died between one and six months of age- two died due to weakness and the other due to diarrhea. Another died just after completing six months due to brain fever and heart disease. All the causes of death are linked with malnutrition and poor environmental conditions (except the heart disease case). Thus, infant mortality rate(infant deaths per one thousand live births) among the agriculturists of SJM is 53.

Life Experience of Sample women regarding infant Deaths

Out of 128 women who formed the sample, 28 women reported to have lost infants at some point of their married life. One of them lost two infants and a one and half year old child. Apart from these 28 women, another woman lost a 10 year old child. In middle and rich farmers' classes, there were three infant deaths. All three died on the day of their birth due to prematurity (see table 50).

In marginal farmers class, five women experienced

one infant death each. Of these infnants three died on the day of birth and another on second day due to prematurity. The fifth one died on third day due to a tumor on her head.

Table:51. Life Experience of the sample women regarding Infant deaths

Class	Total No.of children born alive	Infant deaths			Average infant deaths per woman (infant death/live births
		Male	Female	Total	
Landless Labourers	211	15	15	30	0.14
Marginal Farmers	37	2	3	5	0.13
Middle and Rich farmers	31	1	2	3	0.09
Total	279	18	20	38	0.136

Among the landless labourers, three families suffered two infant deaths each, one family experienced five infant deaths and another lost two infants and one child. Fifteen families lost one infant each. Altogether in this class eight infants died on the day of their birth,

seven died before they completed the age of one week and three died before completing one month. Nine died before completing six months and another three died before completing one year. For all the children cause of death was prematurity/weakness/diarrahea/infection.

This shows that while among the rich, prematurity and neonatal deaths were seen, among landless and marginal farmers households, infections due to poor environment during post neo-natal period offered an additional hazard. However, this data has to be taken with caution given the small size of the middle and rich farmers' households. The same is also true for the class difference which is visible between average infant deaths per woman in labourers', marginal farmers' and middle and rich farmers' classes.

Superstitions in Child Care

Feeding casteroil regularly upto a minimum of six months and branding the stomaches of small children are harmful superstitions though there are many others like the one that children should not be brought out into courtyard at dawn, and belief in amulets, or saving them from 'evil eye' etc. If children are attacked by jaundice, their wrists are branded to "cure" it. If they suffer convulsions, forehead is branded. However this branding

treatment is not that much prevalent these days. Though this was sporadically observed, no quantitative data was available on it.

Feeding castor oil is spread over all the classes. Among the sample, 90 percent children were fed casteroil. Of these 19.2 percent of the children drank it upto three months. 62.4 percent upto 3 to 6 months and the rest of eight percent upto six months to one year. Only 10 percent of the children were fortunate enough to escape from it but, for them it was replaced by gripe water or milk of magnesia.

Some people believe that if children are branded on their stomachs within ten days after birth, it helps increase their digestive power. This is an age old practice in rural Andhra which was very common some 30-40 years ago. However, it still persists in SJM(see table 52).

Table.52 Branding of Children

Class	Total No.of Children alive	No.of children branded
Landless Labourers	179	17 (9.5)
Marginal Farmers	32	1 (5.3)
Middle and Rich Farmers	28	2 (7.1)
Total	239	20 (8.4)

Our quantitative data on branding makes it clear that it is spread over all the classes, though not in large numbers.

Our data indicates that superstitious practices do not exclusively mean avoiding modern medicine. People use both.

Ceremonies during pregnancy and After child birth

Only the middle and rich farmers classes have the luxury, of practicing ceremonies. They perform 'seemantam' where the pregnant woman is treated with many gifts and the invitees (women who are not widows and mostly belonging to their own caste) are treated with fruits and sweets. After birth, on the mother's bathing day, lunch is hosted. On the twenty first day, naming ceremony takes place. Later in the evening the child is put in a cradle amidst the invited women. Then in the third month, when the child turns on her back and later when it walks, talks, many such celeberations take place. On all such occassions the invitees are only women but 'suhaagans'. During the eigth month, when they introduce rice (appropriately the function is called as 'Annaprasana'- Annam means rice), it is celebrated again at a large scale with lunch and all.

In contrast to these festivities the vacum in the social life of landless women is illustrated by Kopalle Mariyamma, a young landless mother.

Case Report

Kopplle Mariyamma does not know what her age is just as several others in her neighbourhood. She never had any occassion to try to guess about it either. May be she is around 25.

Mariyamma is very weak . She has three young children. They all look weak and smaller in size for their age. She and her husband both are agricultural labourers. They own no land or any other source of income. Fortunately, in this area of the country, they find some work or other round the year. Still, they can hardly feed themselves well. They borrow money even to thach their small hut once in three years.

After the third child Mariyamma had gone for tubectomy operation. She could afford no rest after that. She suffered from prolapse, white discharge and post-operation stomach-ache. As this persisted for over a year, she underwent hysterectomy. For this, the labourers' family somehow raised a loan of Rs.1000/-on a high interest.

Mariyamma looks dirty. Her children are dirty. They play in dirt on the road and are mostly naked. They live in a mud-hut. They are Harijans and live in 'palle'(Harijanawada). Mariyamma and her children are dirty because they can afford no soaps.

The name Mariyamma is the corrupt version of goddess Mary in Andhra. Mariyamma is a Christian. Of course, the missionaries have not neglected them. Everytime they went to preach the family, Mariyamma was asked to keep herself and her children clean. She always agreed. But nobdoy ever told her how to get a soap.

Mariyamma looks restless, uninterested. She doesn't show much interest in her children either. She cooks for them in the morning. The old mother-in-law who lives nearby, feeds them in the "lunch time". Mariyamma is utterly tired when she returned home after work. Somehow she cooks the 'dinner'. "Where is the time to look after my children? When should I love them ?"- She pleads remembering those whorecommended her the use of soap and necessity to be clean.

Mariyamma, who doesn't know her age, who underwent tubectomy and hysterectomy by her mid twenties, who looks weak and dirty is fully aware of the plight of her children, though she encounters them only for a few hours in the day. " But what can I do ? "She querries. She knows that " they also would become labourers like us".

The barrenness of the life is too glaring to need further explorations. It only helps us to ask the question "given her conditions could things ever be different ?"

CHAPTER IV

DISCUSSION AND CONCLUSIONS

DISCUSSION AND CONCLUSIONS

CLASSES, WORK PATTERNS AND IMPLICATIONS FOR THE HEALTH OF WOMEN

In SJM, as in the other villages of the block, developed technology is being used in agriculture. Tractors, sprayers and fertilizers are used. Canal irrigation and availability of abundant ground water for dry land irrigation and the fertility of soil not only increases productivity but also makes multiple cropping possible. Despite the use of machinery, agriculture still demands intensive labour. Thus more and more people are being absorbed in agricultural work. This is reflected in the census data which shows not only an overall increase in in the total agricultural work force but also rising number of women agricultural workers. While the number of men almost remains constant(in fact there is a slight decrease in their numbers) number of women workers increased by 60 percent between 1971 and 1981.

	1971		1981	
	Male	Female	Male	Female
Cultivators	409	11	413	50
Agricultural Labourers	574	307	549	495

Source: Census of India, 1971 and 1981

This has to be seen in the background of high productivity in the area. It perhaps means that women's employment is primarily dependent upon full absorption of men workers. Only when men are mostly employed and labour demands are high still, more and more women are slowly being absorbed into agricultural economic activity. This indicates the weaker position of women in SJM's social network and suggests that they will be taken in or thrown out of employment depending on the exhaustion of men labourers.

It is a positive indication that more women are being absorbed into employment. However, the kind of work they perform in the fields demands lot of energy and time. For example our data shows that most of their jobs are back bending, to be performed in the midst of knee low water and mud, whether it is transplantation, weeding or harvesting. They carry heavy loads on their heads. Their work demands hard physical labour. All their jobs are of long duration without rest and no time even to feed their babies. Even in the lemon and betel gardens, as we have already seen, the working conditions are not very different. The implications of this intensive labour demand is very negative on women's health. The long working hours and

intensive work makes higher demands on their energy outputs and leaves them completely drained out and fatigued. They cannot find time for rest or for relaxation. Moreover, the long working hours and the resultant fatigue leads to neglect of children and their homes.

It is recognised that most women work harder and for longer hours than men. Yet the fatigue factor has not been considered as an important determinant in the health studies. But who are these 'most' women? Where do they come from ? How their lives are different from the other women and why ? Very few have looked into these questions.

As seen from our data, work patterns of women are very different among the different classes. Women of the landless class work throughout the day throughout their lives. Their struggle for survival forces them into an intensity and long duration of work which increase with their poverty. The constant and cumulative fatigue affects their own and their children's health. On the other hand, the women workers in the middle and rich farmers classes are not as overburdened with work. Firstly their number is small. Secondly even those who work, do

mostly supervisory work and not actual physical labour. The number of workers and intensity of work increases among the marginal and is maximum in the landless women.

The plight of women in the landless labourers and marginal farmers still gets magnified when we impose the social reality on their economic lives. Our exploration of the social life shows that women have no power in decision making process in the family affaris nor can they spend the money that they earn the way they would like to. Though in these classes people get three meals a day, the quality of food is poor. However, our data shows that women, because they eat last, may not always get adequate quantity. Though the social status of women in the well off classes is not different, they do not suffer from lack of food at least because of the economic prosperity of the family.

We see then that women specially from landless and marginal farmer classes are not only forced to work beyond their physical capabilities but that they also do not get enough rest or food to recoup.

It is worth noting that the changing seasons increase or decrease the work of agricultural labourers; women's work in the household goes on irrespective of seasons.

Household work is an additional demand on the physical energies of women. We have seen in SJM that this aspect of women's life is also clearly related to her class position.

Our explorations of this aspect of women's life has revealed that in all classes women are fully responsible for the maintenance of the families(homes). Depending upon their access to resources, women from different classes spend different amounts of time and energy into household work. As illustrated by our case reports, those who have little money primarily depend upon their own labour whereas those who can afford not only use others' labour(servants) but also tools which make their work easy, like gas connection, grinder etc.

Here we would like to point out that household work which is generally treated as non-productive or uneconomical activity, is in fact very much a part of the family economic activity. In neoclassical economy, exploitation is understood to be a process which is a creation of the markets. This school of thought believes that the essence of labour exploitation lies in the difference between costs and prices based on the theory of marginal utility. They

ignore the processes of labour exploitation taking place in the process of production as well as at the level of the household which is a part of the total production process.

Our data establishes the importance of production and household work in the process of appropriation(economic exploitation). This is obvious when we impose the patterns of household work and economic activities on each other in different classes. It is clear that the families which are the poorest and most exploited in the field are also the ones whose women have to work the hardest at the household level. This means that the class of labourers which is putting in the most labour in agricultural production is getting the least amount of wages. Obviously then they are not being paid for the hours of work that they put in but only for subsistence. Subsistence in SJM means eating rice with mirchi, six hours of sleep, a roof on their heads and a pair of clothing. In other classes where both men and women are putting comparatively lesser hours of work as well as energy, they are getting higher returns, primarly beceuse of their greater access to land and other resources. Within this pattern of exploitation at the level of production, household work

plays a crucial role. Free labour of women is used to keep a family alive at a level which is a sheer necessity for survival. This exploitation of a woman's labour is in fact necessary for the economic exploitation of her class and has therefore been given social sanction. House hold work therefore cannot be seen in isolation from the total economic activity of a family.

The additional load of animal husbandery that women take has elements of both the traditional understandings, i.e.economic activity and household activity. It is interesting to observe that according to our data the poorer families use it more to enhance their incomes while the richer families use it to improve their living standards. The interclass differences in this too are quite understandable given our earlier understanding of production processes, classes and the role of individual families.

As far as social status is concerned all women share the lower status. Neither of them have power in taking decisions at family level or regarding sterilisations which effects their health either way. Dowry and wife beating are spread over all the classes though at different degrees. By making them subordinate to men who also

control their labour use, women are pushed into a state of dependency from where they can neither avoid the situation which make them sick nor can they seek help when they do fall ill.

Our discussion upto this point highlights inter-class differences in the patterns of different types of work and its basis. The implications of these for the health of women are primarily in terms of her energy expenditures, her nutritional status, and her ability to recoup her energies. Different levels of these will give different levels of vulnerability. We shall now see how class differences regarding these factors might influence maternal and child health status.

Status of Health in Different Classes

Being conscious of the limitations of our data, we do not want to make any conclusive remarks. However, certain points need to be noted. The dangerous complication during pregnancy, bleeding, was prevalent only among the labourers. Fever just after delivery was also confined to landless and marginal classes. Prolapse and still births were also confined to them. Among the sample childdren seven infants died and all of them belonged

to landless class. When the life experience of sample women regarding infant deaths was considered, average ~~infant deaths was considered, average~~ infant deaths per woman was higher in landless and marginal classes (0.14 and 0.13 respectively) than in the middle and rich farmers class(0.09). Concentration of all these among the marginal and landless could be an indication of the impact of the already vulnerable health status and heavy work that they do in the farm. This data is reinforced by another observation in SJM, that is, acceptance of family planning comes only after 3 or 4 children among the majority of landless women.

Perceptions and Action

Our data throws up some very interesting clues to question the conventional beliefs as given in text books. It is generally believed that people in villages prefer magical and traditional systems and do not go th PHCs and that this is specially so where diseases of women and children are concerned since their perceptions are not scientific.

IN SJM 60 percent of the poor preferred the MPW(F) to be their attendant at birth, but only 38.9 percent could get her services. This was explained either as unavilability of the MPW(F) or difficult labour. Though only 8 percent of the labourers opted to go to a private doctor, 21 percent went to them. 17 percent of them spent more than

Rs 100/- of whom two spent more than Rs 500/- This shows that even the poor go beyond their limits and spend monoy to get health services.

33 percent of the total deliveries took place at the PHC of which 91 percent are from labourers or marginal classes. Though 75 percent of middle and rich classes women opted for a private doctor, only 55.5 percnot could actually go and the rest fell back on MPW(F). The MPW(F) who was many times not available to the landless or marginal classes was readily available to the middle and rich classes whenever they needed her. MPW's positive inclination towards the well off classes is quite obvious.

It is interesting to note that though only 75 percent did make any kind of medical consultation during pregnancy, 94 percent took TT injections. Even among the labourers it was 91.6 percent and in the other classes reached 100 percent. However, hardly anyone knows about tetanus vaccine for children. This could be due to their expreience with neonatal tetanus deaths. More children(82 percent) were vaccinated among the middle and rich classes reflecting their better interaction with health services.

Among the middle and rich classes 77.5 percent either got sterilised or wanted it after two children, whereas 50 percent of the labourers wanted it after 3 or more children. This may be linked with the prevalence of infant deaths among the labourers. Among the sample seven infants died and all of them belonged to labourers class. Problem of child survival and expectation for more earning members could be the reasons for labourers opting for three or more children. What is important however is the fact that 122 women out of 128 of all classes expressed willingness for sterilisation or were sterilised and that the rate of sterilisation was not higher than the rich among the poor. It was perhaps the pressure on land and the falling mortality rather than the pressuring tactic of the health bureaucracy.

Though 80 percent of the landless and 94 percent of the marginal classes believe that weening should be introduced at the age of six months, only 46 percent and 39 percent respectively could do it in actual practice. Others kept their children on exclusive bre-ast feeding upto eight months to one year. Reasons were lack of time for mothers to get their children accustomed to solids, poor quality of food they can afford and the inadequate caretakers of children. The middle and rich farmers'

women, firstly stay at home in most cases, secondly even if they go out to work, leave their children under the care of old parents.

This data brings home the fact that human perceptions are not always bound by class differences. That a class may be poor but since it lives in a dynamic social system, it cannot be deprived of the active process of innovation interventions like PHC or diffusion of ideas of the private practitioners. However, despite wanting and attempting, the poor cannot get what others get easily.

It needs to be emphasized that it is the objective condition which either do not allow women of poorer classes to do what they like to do and create barriers in their access to health services. Apart from the data that we have already mentioned, some additional evidence of constraints of objective reality on MCH practices are the interclass variations in patterns of work during pregnancy. Majority of the landless women(74 percent) continued to do heavy work- agricultural, animal husbandary and household work- till the day of delivery. No special foods, no tonics nor even proper medical consultation is within their reach and the reason is certainly not a lack of perception about medical care.

However, a marked difference is seen in the middle and rich farmers' classes. Pregnant women are treated with love and care. They regularly consult private doctors and go to private nursing homes for deliveries. Pregnancy and child birth are celebrated with fanfare. 28 percent of them could avoid their routine household work prior to delivery for a period ranging upto five months.

This difference is seen even after delivery. 54 percent of the labourers' women could avail full rest up to less than 10 days only, whereas such a percentage among the marginal farmers is 31.6 and just 5.5 in the middle and rich farmers. ~~respectively.~~

The other side of the subjective realities in SJM are the prevailing superstitions regarding MCH. Whether it is first feed to the child, feeding colostrum, care for post-partum women by wearing nadumkattu, muffler etc. and food restrictions, castor oil feed to children, branding them, all are uniform among all the classes. Though the PHC was there since 1949, it seems that it has done nothing to check these superstitions. In fact, some of its personnel support these practices. The private practitioners of Tenali have been no different either. All health personnel have taken advantage of these superstitions rather than question them and lose their money.

MCH practices depend upon people's perception of it and their needs, the kind of institutions that they can go to(dais, PHC, private doctors) and the quality of their interactions. Hardening or change of attitudes will be an outcome of these interactions or of outside influences.

Our data reflects that people have very specific needs as far as MCH is concerned and that they seek medical help. Despite all this, not all get a positive feed back from the health services- whether it be MPW, PHC, lady doctor, medical officer or private doctors. The services that they get are not uniform in quality(even though they pay for it) and also the treatment meted out to some is quite different. The health services in SJM then are not based on science alone but more on social inequalities and stratification. Neither the quality of the services nor the behaviour of health personnel can be described as conducive to a positive and a rational change in the attitudes of their clients. For example, despite the fact that the PHC has been there since 1949, no effort has been made by the health workers to question the prevailing superstitions regarding MCH. The entire set of professional workers in fact promotes wrong MCH practices.

For examples, 89 percent of the middle and rich farmers women were prescribed various tonics, calcium and special foods like sweets during pregnancy. Secondly, 78 percent of the MPWs and 83 percent of the private practitioners did not bother about advising the mother to breast-feed the baby right from the beginning and allowed her to reject the colostrum. They were therefore in no way different from untrained birth attendants. Yet another example is the immunization services. Though majority of the poor were going to MPW for ante-natal care, not even 50 percent children were immunized for DPT, Polio or BCG. A glaring example of the inactivity of the PHC is the high rate of hysterectomies in very young women which was being promoted by private practitioners. While the PHC was indifferent, the private practitioners went out of their way to misinform and exploit people. In addition to this it is also worthwhile noting that many women in their early twenties get sterilised. Though sterilisations are so popular, temporary methods to prevent conception are not widely known. This reflects the failure of the PHC in making the people aware of less coercive measures.

Our data thus indicates that far from fighting superstitions of the people, the private practitioners

go out of their way to spread misinformation and indulge in wrong practices while the PHC through sheer indifference participates in the perpetuation of superstitious practices. The differential treatment to different classes by all kinds of medical practitioners is also very evident from our data.

The PHC's MCH programmes were technocentric. They were confined to distribution of iron tablets to pregnant women, provision of TT injections and providing MPW to act as birth attendant, and vaccination for children. Unless people volunteer, the PHC does not take any initiation even in providing these. Otherwise, it does not have any programme to improve the general health status of women and children nor to improve the environment. Unpurified underground water is being used for drinking purposes. Majority of the population do not have facilities for excreta disposal.

It can be concluded on the basis of our data, then that every level and process of production has its own labour demands which are met by men and women. That given the lower social status of women, while they do work as agricultural workers they do not enjoy the respect due to a worker.

The hard physical labour required of them and the triple burden of agricultural labour, household work and child care have serious implications for the health of women. The prevailing social stratification only adds to the burden of those women who are at the lowest rung of the hierarchy. These interclass differences are reflected at all levels- work, household activities and child care- as well as health status, access to services and attitudes of the health workers.

The most important of our findings is the fact that perceptions are not contained by the boundaries of socio-economic classes and that men and women of the poorer section despite their class constraints seek help and health.

That they get what they do not deserve is also a reflection of the socio-economic reality wherein both quality of services and access to them are determined by the class position of families.

Certain new trends were observed in SJM. One is food sufficiency. All the households reported that they get enough food round the year, which is quite different from the hunger prone areas of UP, Bihar, MP etc. However, when the quality of life of the poor was observed, we found

that added to the inferior quality of food they didn't have proper housing and sanitation facilities, nor even sufficient clothing. Then, enough food doesn't mean that everything is fine. Only important fact is that there is no starvation.

Secondly, families in general and women in particular are going in for sterilization voluntarily. Though it is a desirable trend, this change in fertility behaviour is being exploited by private practitioners using it as a mechanism to make money by advising women to go in for hysterectomy.

Lastly one would like to emphasize that superstitions do prevail but that they are not a major hindrance in people's health-seeking actions. What is important is the fact that the medical man-power does nothing to erase them atleast in SJM.

APPENDICES

APPENDIX I

INTERVIEW SCHEDULE USED IN THE FIELD WORK FOR COLLECTING QUANTITATIVE DATA

1. Name :
2. Age(years):
3. Religion :
4. Studied upto which Class ?
   Wife : Husband :
5. Whether

   (1) Joint Family (2) Nuclear Family
6. Do you own any land ? If yes, how much ? YES|NO

   Wet: Ac Dry: Ac

   (1) Food crop (2) Cash crop ( )
7. Are you doing tenancy ?

   If yes, how many Acres / Crop
8. A . How many milch animals do you have ?

   (1) Cows: (2) Buffaloes:

   B. Who looks after them ?

   (1) Self (2) Husband (3) Both

   (4) Others in the family (5) Servants

   C. How much milk do you get from these animals ?

   Liters:

   Of it Liters consumed:

   Liters sold:
9. How many times do you eat normally in a day( )

   (1) Once (2) twice (3) thrice (4) Four times

B Do you get two full meals all through the year ?

Yes/ No

C If not, for how many days ?

10. Do you / any woman have any power in determinig( )
distribution/sale of wages/produce ?
(1) Fully (2) Decide jointly (3) Not at all

11. A. What was the result of your last pregnency ? ( )
(1) Male child (2) Female Child
(3) Still birth (4) Abortion

B If alive, Age:

C If Dead, at what Age ?
Cause of Death:

D Cause of still Birth:

E Cause of Abortion:

12 For the questions below, use numbers as
(1) Agriculture (2) Animal Husbandary
(3) Agricultural Labour (4) Selling Fruits etc
(5) House hold work only (6) Nothing

A What kind of work were you doing before pregnancy( )

B What kind of work you did during pregnency
First six months ( ) Last 3 months ( )

C What kind of work you started after pregnency ( )

13. How many days have you taken rest before pregnency

14 How many days you have taken rest after delivery ?

15. How long were you in confinement after delivery

16. Do you think that a pregnant woman has to take( )
(1) more food (2) Less food (3) Usual food

17. A. When you were pregnant with this particular child have you taken
(1) More food (2) Less food (3) Usual food

17. B . If the answer is 'LESS' Why ? ( )
(1) Financial problems (2) Facilitates easy
(3) Pregnant woman must eat less
(4) Felt uncomfortable
(5) Other reasons(specify):

18: A. Are there any food restrictions for pregnent woman ? YES/ NO

B If yes, what foods shall be taken/shall not be taken ?

Shall be taken :	Shall not be taken:
1.	1.
2.	2.
3.	3.
4.	4.

C Were you able to take these? YES/ NO
If not, why ?

19. A. Have you taken any Medical advice during pregnency? YES / NO

B If yes, from whom ?
(1) Dai, (2) ANM (3) Govt Doctor (4) Pvt.Doctor

C. Have you taken advice regularly/ ~~only in~~ ( )
(1) Regularly (2) Only in times of trouble

20. Have you taken
(a) Tetanus Toxoid Injection YES/NO
(b) Calcium YES/NO
(c) Iron and Folic Acid YES/NO

21. Place of delivery
(1) Home (2) PHC (3) Private Hospital
(4) Other(specify)

22. A. Type of Birth Attendant ( )
(1) Preference (2) who came
why
B. (1) Dai (2) Trained Dai (3) ANM
(4) Pvt.Doctor (5) Govt.Doctor (6) Nurso

23. If the delivery was at home:
A) What instrument was used to cut the Cord ?
B) Was it boiled before using ?
C) If it was put on fire why ?
D) After cutting, how was it dressed ?

24. What and how much was given to the Birth Attendent ?

25. A. Do you think that a woman can take any food and water immediately after delivery? YES/ NO
B. Were you allowed to take ? YES/NO

26. A. Did you ware 'Nadumkattu' ? YES/NO
(A Cloth tied around the waist)

B. If yes, how long ?

27. A. Did you ware mufflor and put cotton in ears ? YES/ NO
B. If yes, how long ?

28. Who paid the exponses of delivery ? ( )
(1) parents (2) in-laws (3) Husband
(4) self (5) Any other

29. What have/would have you done in case of any complication ?

30. Was the clostrum fed to the baby YES /NO

31. Explain in either situation

32. When was the baby put to breast for the first time ?

33.A. What was the first feed ?

B. Why

(1) Medical Advice (2) Custom

(3) Elders' Advice

(4) Nothing else was available

(5) Other reasons

34. How long a baby should be exclusively on breast feeding

Boy : Girl:

35. How long your babies were exlusively on breast feeding ?

36.A. If any of your babies were not breast fed, what was the reason ?

B. What feed was given ?

(1) Cow Milk (2) Buffalo milk (3) Powder milk

(4) Others(specify)

37.A. How do you feed the baby while away on work( )

(1) Do not feed while working

(2) Carry the child to the field/work place

(3) come back to provide each feed

(4) Any other

37.B. If the baby is left back at home, while mother is away on work, what is usually fed to the baby?

38. Who looks after the baby when mother is away on work ?

(1) Left alone at home

(2) Elder son/Elder daughter

(3) Old parents (4) Husband (5) Nursery School

(6) Any other

39. In your opinion, what are the important food items a woman must eat /not eat during lactation ?

Must Eat	Must not eat
1.	1.
2.	2.
3.	3.
4.	4.

40. Do you think that Breast feeding influences the onset of menstruation ? YES / NO

41. Till what age did you give castor oil to the child regularly ?

42. In your opinion, at what age one should regularly introduce solid food to the child ?

43. What foods should be given for small children

44. Have you burnt the skin on the stomach of your babies YES/NO

45. were your children vaccinated YES/ No

(1) BCG (2) DPT (3) Polio

46. Do you know what diseases can be prevented ?

1) 4)
2) 5)
3) 6)

47. A. How many children have you ever given birth to:

Male: Female:

B. How many dead

Male		Female	
Age	Cause	Age	Cause

C. How many are alive? Male: Female

48 You had how many

Still births :
Abortions :
Miscarriages :

49 Do you visit the PHC/Doctor ( )

(1) for every small problem
(2) Ailments like fever (3) major diseases

50 Do you have any serious or chronic illness in the past ? (Like TB, Asthma etc.) YES/ NO

51 Did you have any complications during pregnency ? ( )

(1) Bleeding (2) Swelling feet and body
(3) Fever just after delivery (4) Cramps in legs

52 Do you have any Gynaec problem? ( )

(1) Abnormal discharge (2) Prolapse
(3) Menstrual problem (4) Post operative problem

53 A. Have you underwent Tubectomy? OR YES/ NO
Has your husband underwent Vasectomy? YES/NO

B After how many children ?

54. A. Do you want to be sterilised ? YES | NO

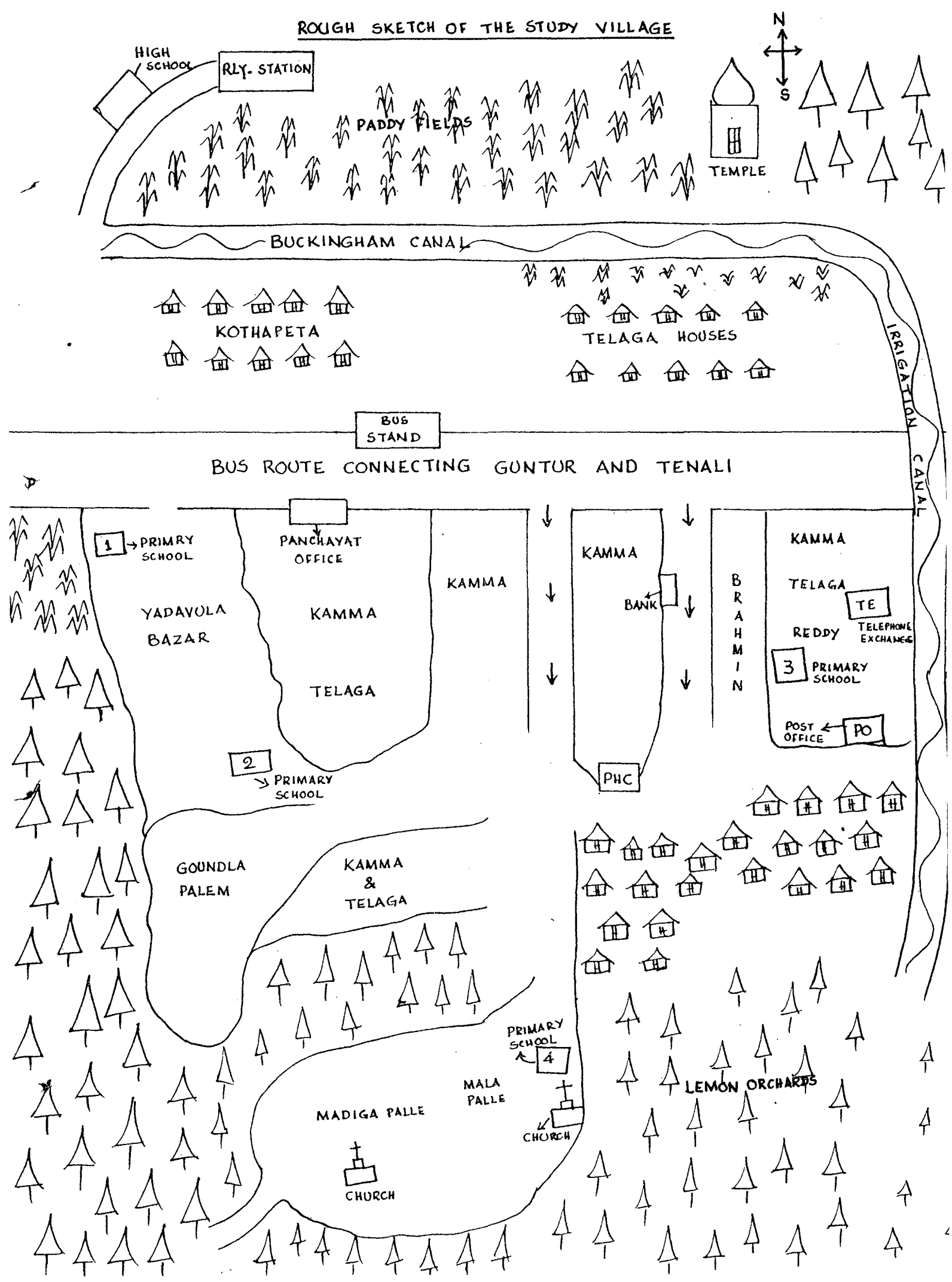
B. After how many children?

55. Who decides about sterilisation ? ( )

(1) Husband (2) Self
(3) Both (4) Inlaws (5) parents

56. Why did or do you want to be sterilised? ( )

(1) Cannot feed more children
(2) To keep up mother's and children's health
(3) Child rearing is difficult
(4) Children wnn't allow the mother to work.


ROUGH SKETCH OF THE STUDY VILLAGE
N
S
HIGH SCHOOL
RLY. STATION
PADDY FIELDS
TEMPLE
BUCKINGHAM CANAL
KOTHAPETA
TELAGA HOUSES
IRRIGATION CANAL
BUS STAND
BUS ROUTE CONNECTING GUNTUR AND TENALI
1 PRIMRY SCHOOL
PANCHAYAT OFFICE
YADAVULA BAZAR
KAMMA
TELAGA
KAMMA
KAMMA
BANK
BRAHMIN
KAMMA
TELAGA
TE
REDDY
TELEPHONE EXCHANGE
3 PRIMARY SCHOOL
POST OFFICE
PO
2 PRIMARY SCHOOL
PHC
GOUNDLA PALEM
KAMMA & TELAGA
PRIMARY SCHOOL 4
MALA PALLE
MADIGA PALLE
CHURCH
CHURCH
LEMON ORCHARDS

APPENDIX III

PROFILE OF THE DAI

Pathan Fatima, aged between 40-45 years became dai by family tradition. Her father's mother, and sister who is also Fatima's mother-in-law used to attend births. Fatima's mother-in-law who had been trained was doing this job for a long time in SJM. As shen became old, lost her eyesight and had to stop attending the delivery cases. At that stage, two years ago, Fatima took up this job. She borrowed the 'Elima(sic) dabba'(enema can) from her mother-in-law and bought a pair of scissors on her own. Till now she attended to about 50 deliveries in SJM and another adjacent village.

Fatima claimed that she was not taught by anyone how to handle a delivery case but learnt it on her own. Once she decided to take up the profession, she went and observed two or three deliveries at the PHC. Her mother-in-law being a 'dai', Fatima was immediately accepted by the society.

Fatima is illeterate. Her husband works as an agricultural labourer. They have two buffaloes. Fatima takes care of them and the milk is sold to supplement the family's income. She said she was not able to attend all deliveries she was called for, because of her preoccupation with

buffaloes' care. They have been living seperately from their in-laws, since the very beginning. She gave birth to a lone daughter, who is now married off and lives in another village.

Fatima gets into contact with her patient only at the time of delivery. She was never consulted during antenatal periods; she is called only when labour starts.

Once she reaches her patient she looks for dilatation, to confirm whether they are real labour pains or false (pains due to 'heat'). If there is dilatation she will get into work; goes home, brings her equipment(enema tin and scissors), gives enema to the woman and tries to make her feel comfortable by rubbing on her abdomen and on waist. She puts castoroil into the birth way to make it more slippery. This, she observed and learnt from the PHC deliveries.

She prefers a delivery in sitting position. She makes the delivering woman sit on a low wooden stool putting her legs apart. Fatima sits facing her and coils her legs with that woman's legs, to help the woman open the birth way widely. One or two women(depending on availability) hold the shoulders of the delivering woman strongly, thereby helping her to push the child out. When the baby's head come out, she is made to stand up slowly and the midwife holds the baby. She waits till the placenta comes out

on its own but do not resort to any harsh methods to see that it is out.

Fatima uses her own scissors to cut the cord. She ties a thread on the cord three inches away from the navel and then cuts there. Before cutting, she puts the scissors in boiled water, wipes it with a cloth and then uses it. If it is urgent and there is no time to go home and get scissors, then she asks the delivering woman's relatives to get a new blade, puts it in boild water, applies coconut oil on it with hand, and then uses it.

She feels that if a child is born with the cord around its neck, then such a child should be taken care of immediately. She removes the cord from around the neck, sprays cold water on the face and chest of the child to see that the cord doesn't harm the child.

Fatima strongly believes that water should not be given immediately after delivery. After birth, a little water can be given if the mother asks for. But this should be before the placenta's expulsion. If any thing goes wrong that will effect the placenta and it comes out any way. Once the placenta is out, "the whole system inside becomes raw". And if the woman takes water in that stage

it will damage the system inside(On the contrary, if the delivery takes place at the PHC, the M.P.W(F) prescribes hot coffee to be given after delivery. Fatima, however, doesn't agree to that.)

She allows a cup of cold coffee only after seven or eight hours. After birth, she tells the relatives of the woman to buy tablets from the village medical shop, to remove her body pains. She does not know its name, but "the shopman himself will give the required tablets if the situation is explained to him". Obviously, it must be the pain killers.

The post partum woman can take food on the second day if she does not have any body pains. It should be postponed till the third day if she suffers even from a headache or neck ache. Fatima does not have any idea about colostrum what it is or when it does secret etc. But never advised to remove first milk.

After giving bath to the child she feeds castoroil 2 measure of Uggu Ginne* (about 10 spoons), so that it cleans the stomach of the new born. Puts one drop each in its eyes and on navel. Till the post-partum woman's bathing day(seventh or ninth or 11th day), Fatima goes to her house every alternate day to give bath to the new born. And at every bath she puts castor oil in its ears,

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* the small traditional cup used for feedinng infants in South India.

eyes and nose. Also puts it on anus and presses it so that it(the place around the anus) "becomes hard". And for girls one castor oil drop is put on vagina also. According to Fatima, this castor oil treatment should continue till 21st day and however, castor oil feeding should continue till at least 6 months.

Fatima knows that breast milk establishes soon if the post-partum woman takes food on second day itself. If her food is delayed, breast milk is also delayed. Till breast milk establishes, foster mother's milk is given to the child. However, " castor oil also provides some food".

On the bathing day Fatima gives head bath to both the mother(who has not taken bath till then after delivery) and the baby. Plasters the floor with cow dung where tho cot of the woman was kept. She also takes head bath and lunch there. She will be paid Rs 20/- for attending the delivery, and another Rs 2/- for cutting the cord.

On the day of birth, after bathing, the baby is made to lie in a cheta (soop) filled with rice(about 650 gms) and that rice also goes to the midwife. With the lunch on the bathing day, the midwife's work comes to an end.

Fatima said till now she had not faced any difficult case; she also attended 6 primy cases. The word 'dai' is not known to the villagers except to the PHC staff.

A traditional mid-wife is termed as 'Mantrasaani' and Fatima is generally referred to as Boobu or Boobamma, a synonym for 'Muslim Woman'. Her services are used by both Hindus and Muslims.

Now Fatima is looking forward to undergo training and the PHC people had already promised to recommend her name. Fatima believes that she can get more cases and a bit more fee if the formality of training is done.

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