AN EXPLORATORY STUDY OF SOCIAL DYNAMICS OF WOMEN'S HEALTH IN ADITYAPUR VILLAGE OF BIRBHUM DISTRICT

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

Certified that the dissertation entitled "AN EXPLORATORY STUDY OF SOCIAL DYNAMICS OF WOMEN'S HEALTH IN ADITYAPUR VILLAGE OF BIRBHUM DISTRICT", submitted by KRISHNA SOMAN is in partial fulfilment for the degree of MASTER OF PHILOSOPHY of this University. The dissertation has not been submitted for any other degree of this University or any other University, and is her own work.

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

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IN MEMORY OF **'AMMA'**

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[KRISHNA SOMAN]

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Chapter 1

INTRODUCTION

Over the past century a number of efforts have been made to validate and strengthen the notion that health is rooted in socio-economic structure of the society. Engels' classical work on the condition of the English Working Class was first published in 1845. He pointed out that the illness of the working class population in England was rooted in the organisation of economic production and in the social environment. Almost simultaneously, Virchow (1849) brought out the role of environment in causation of illness. He attempted to develop a multicausal theory of illness and explained that illness was a product of interactions between social, political, economic, geographic, climatic and physiological factors. But later due to the professional interests of physicicans, industrialists and the ruling elites of Britain, this concept was ignored in the formation of ideas, knowledge and their scientific rationality in the field of medicine.

Later on these ideas were further developed by researchers such as Dubos (1971), Navarro (1977), Brown (1979) and Doyal (1979) and others.

In the Indian context, these concepts have been explored by researchers like Banerjee (1982), Zurbrigg (1984), Qadeer (1985), Antia (1987) and Jeffery (1988).

Banerjee (1982) conducted a study in nineteen villages covering eight districts of India and illustrated that the

'health culture' of the rural population was intimately linked with changes in the overall way of life which was mediated by various social, economic and political forces.

Qadeer (1990) has shown that the social roots of ill-health do not only lie within the marginalised access to the resources or health services alone. It is also rooted in the environment in which people live and which is created by the interaction of socio-economic , political and ecological factors. In this concept of environment, man-made social realities play a vital role by influencing the objective and subjective conditions. Further, the variations within these environmental conditions are largely a function of the social structure, organisation of production and the ideologies that these generate.

Most of the above mentioned studies deal with the two sexes at the general level emphasizing larger economic, structural and political determinants of their health. The scope is too broad to deal with the details of the social processes which set women apart from men and which are responsible for differences in their health, its management as well as its perception by the society at large and the women themselves.

The social disadvantages of the women however, are well recognised in social science literature, not only in socio-economic arena but also in the area of health.

The 1991 census has reported an annual (exponential) growth rate of 2.11 percent (a decline of 0.11 from 1981), a sex ratio of 929 and female literacy rate of 39.4 percent as against 63.87 percent for males. This focuses upon the urgency of the need for a review of health and welfare for the women (Qadeer, 1991). The time trends in sex ratio, life expectancy at birth, differentials in mortality in the younger age group, maternal deaths especially due to abortion and anaemia reveal that the health of women in our country has throughout been a sorry state of affairs (Census of India 1971 to 1991, Govt. of India, 1971 to 1989).

Their participation in rural agriculture has been as high as 86.9% (Bose, 1991). Of these women, a large number belonged to poor households of agricultural labourers or marginal and small cultivators (Bardhan, 1981). These women often work for longer hours than men (Jain & Chand 1982) and spend more energy for equal duration (Batliwala, 1983). Their nutritional intake is much below the standards and also less than the men (Gulati, 1978). They are subjected to sex bias (Horowitz and Kishwar, 1982); Chen et al. 1981; Sen A.K., 1984). Investigations using indirect indicators provide strong evidence of sex differentials and discrimination (Sen and Sengupta, 1983; Taylor and Faruque, 1983) in this aspect.

Surveys conducted in the country in various states at different points of time revealed that, women and female children are more susceptible to illness and receive worse health care compared to the men and male children (Dandekar, 1975; Chakrabarty et al. 1978; Taylor and Faruque, 1983). Also, compared to men a larger proportion of women receive no treatment at all or are treated with traditional medicines instead of modern medicines. Women's ailments are usually ignored at initial stages and medical aid is sought only when the illness is either chronic or serious. This restricted access is illustrated by the ICSSR report (1977).

Although employed women are more undernourished compared to the men counterparts in Kerala (Gulati, 1978), their independent access to employment and cash becomes an important issue in the poor rural households as the nutritional shortfalls of especially female children are related more closely to mother's employment than that of the father who generally spends on personal needs (Gulati, 1978; Mencher & Saradamoni, 1982). Another study from Maharashtra by ILO (1979) further supports these findings.

Anthropological studies have also shown that food distribution within the households is also detrimental to women's health. The reason as argued by Khare (1976) and Appadurai (1985) lies in the inferior position of women within the family. This aspect is also reinforced by the

study of hunger, a perpetual companion of poor women which is considered an "euphemism for want and deprivation" by Barbara Harris (1989).

This brief review shows that the poor state of health of women is well documented but what still remains to be explored in greater detail is the relative state of her health compared to men and the factors which are responsible for this differential.

There have been a few studies which have attempted to explore these processes. Agarwal (1988) in her study titled "Neither Sustenance Nor Sustainability: Agricultural Strategies, Ecological Degradation and Indian Women in Poverty" points out that there are various interlinked historical, cultural and economic factors which underlie the differentials the Indian woman is confronted with. Sathyamala et al. (1986) while exploring women's health have argued that health problems of women in our society are primarily related to their social status in all sections of the society, whereas poverty is an additional risk for the poor women only, which she shares with the poor men. Portrayal of Rakku is a relevant endeavour by Zurbrigg (1984) to explain the marginalised position of women at family level within the interplay of poverty and other social factors. An area that has been studied in some detail is Mother and Child Health (MCH) services and

reproductive technologies for them. These have been extensively reviewed by Lakshmi (1985) and Patnaik (1991).

These areas are critical since these are the main junctures where social control is perceived as necessary by the existing power structures. But it is also important to broaden our scope of understanding by elaborating the very processes which makes her vulnerable to controls not only in her reproduction and maternal role but also in her role as a citizen. It is but natural that her health, education, general growth and development of intellect and skills are all dependent upon the levels of these controls and their forms.

In the process of this control, the external factors are not the only ones, the processes at family level and the acceptance by women of their prescribed roles and images also play a very critical role.

It appears then that in this process of subordination, family as an institution and women's up-bringing in it, play a key role. To develop a framework for our study of these microprocesses at the family level and their links with the larger social processes, it is important to understand the historical background of women's status in India. A summary of the texts and scriptures of ancient India by Bhattacharjee (1990) reveals the limited and confining role prescribed to the women as mother in the patriarchally

organised agricultural society. The glorified motherhood allowed women only self sacrifice and ritual practices for the well being of the father and son. The "mother goddess" and the human mother belonged to diametrically opposite planes. While the former discharged her functions "without any pain with divine light", the human mother lives a life full of roles and responsibilities imposed on her by the society. 'Sati' and 'Shakti' became the symbols of the traditional Indian women where 'sati' essentially was the pre-requisite for self-sacrifice in the service of others (Ramu, 1989). This suited best her domestic role.

During the last quarter of the 19th century the nationalist aspirations in Bengal reinforced this ideological legitimacy which made life more difficult for the women (Bagchi, 1990). Although the ideology rested on a show of empowering of women, it was ultimately a way of reinforcing a social philosophy of deprivation for them. Thus, being placed on the pedestal, women of Bengal only upheld the hierarchy of patriarchal control within the family.

At all levels of participation in work, this ideology provides the iron cage which they must never leave if they want the security of social support and family.

The reform movement of the late 19th century and early 20th century, fought for widow remarriage, abolition of

'sati' and of child marriage. Gandhi and the Indian National Congress brought women out into the social arena. The emergence of the socialist block further strengthened a nascent women's movement in India. However, despite the entry of women in the labour force, her education,and her participation in Indian politics (Devendra, 1990), the general lot of them continued to live in the iron cage of tradition. Though participating in social production the middle class women "manage to do their household work in lesser time" by increasing their efficiency (Devi et al. 1985) and thereby retained their role within the family.

Although women played a significant role in economic arena through their labour and productive activities (Gulati, 1975; Banerjee, 1982; Mencher and Saradamoni, 1983; Bardhan, 1985; Agarwal, 1985), the woman industrial labourer used her leisure time for household work and the housewife accepted the non- recognition of her labour (Government of India, 1988). By bringing work home, she created a category of 'invisible hands' (Agarwal, 1988; Duvvury, 1989).

In the agricultural sector too, women were not given their due. Over the last few decades a pattern of changes have been observed in the participation of female workers in the rural sector. There has been a shift in the composition of the work force. The percentage of total agricultural

labourers has doubled between 1961 and 1981 (Duvvury, 1989). Over 1971 - 1981, participation of women increased in the form of marginal workers and in rural areas. It was largely due to increasing number of women introduced to "the responsibility of managing subsistence agriculture" while men looked for other opportunities and boys got trained in better skills (Banerjee, 1989). Women were gradually converted into unorganised invisible labour which created new form of bondages and denied them opportunities and status of workers.

Historically then, there has been an essential process of adaptation of women to new situations in a way that the traditional role of a mother, or wife and a caretaker of the family remains unaffected and unaltered.

Within the household, women exhibit a great deal of adaptability to changing life situations (Thorner et al, 1985). Despite their significant contribution to the family income (Devdas et al, 1988), women are mostly seen as non-workers and are not considered as the bread-winners for the family. Providing employment to the women might change the situation to certain extent, but for the rest a change in the inherent cultural traits of the society is necessary (Sethi, 1988). Researchers who only emphasize the importance of the larger social issues (Menon, 1982), fail to highlight the relevance of cultural factors which mould women's

personality to maintain her subordinate position (Dietrich, 1983). In other words, though culture depends upon socio-economic realities, it plays an active role in shaping that reality as well.

The interplay between social class, family norms and values regarding the role and status of women and the different levels of development is a crucial area of social dynamics which interests us. We need to understand which levels of development or non-development begin to alter norms and values and upto which point in development traditional norms and values continue to exert pressures to keep the status quo. We are interested in this area because it is critical to our understanding of women's health and its relatively poor state in the Indian Context.

This study is a preliminary step towards understanding the health problem of women in a village, their perception and action towards it and the relative state of their health and health care compared to their men folk. At this stage, we do not intend to explore the impact of developmental differentials. The focus of the study is also not on quantification or epidemiological assessment but on the social processes and their impact on women's health.

We are fully aware that in the lives of majority of people, talking of positive health has no meaning as they perceive it as 'absence of illness'. It therefore, will not

be relevant to talk of positive health alone and not of ill health, the real problem of the people. Our study therefore focuses on illness as it is perceived and attempts to assess people's notion of health.

Chapter 2

METHODOLOGY

CONCEPTUALISATION OF THE PROBLEM

Women's health is shaped by certain factors which are rooted within the social dynamics of the family as well as the wider socio-economic structure within which, families are located and occupy specific economic or caste position.

The dynamics of family is located within a social category and these two levels can not be separated for exploration. The two together create for each family and its individuals, availability and access to services within different socio-economic categories. Alongwith information acquired from within and outside the family, all these aspects of life of the people give rise to their understanding of women's health. The actions taken by any social group or an individual in a particular situation therefore, is an outcome of the understanding created in this process. For the purposes of exploration therefore, two levels are critical - the family level and the larger social level.

At **the family level** the status of women in an Indian village is primarily determined by the patrilineal structure of the society. Sufficient literature has accumulated on women's dependent status which denies her economic power and position (Gulati, 1978; Jain, 1985; Agarwal, 1988). Despite

this economic dependence within families, individual women's status varies with the following:

- her socio-economic background
- her relationship with men and women in the family specially her in-laws and husband.
- her interaction with the outside world, and
- her educational status.

These factors, in interaction with each other, determine the status of women within the family as well as the state of her knowledge. Her experiences of life within the specificity of these factors mould her understanding of and action for her own health. Men's understanding of women's health is also guided by the same factors. The difference is that though experience in their case is only indirect, they are the main decision makers regarding action.

At the larger social level in a stratified village population where levels of resources are different in different socio-economic categories, the aspects that impinge upon women's health and its understanding within these different categories are:

- availability of resources and sustenance for a social group.
- women's participation in the economic activities, wages and terms of work.

- living conditions of each social group.
- access to information and education.
- exposure to the outside world.
- political contacts and affiliations.

These larger social factors act upon the family dynamics through changing access and availability of services, understanding of and family attitudes towards women's ill-health and her own perceptions and actions. The issue of women's health thus is a dynamic one determined both by the microlevel family influences and the macrolevel socio-economic determinants of the family dynamics.

OBJECTIVES

This study was designed to understand the social dynamics of women's health and illness. The main objective could be broken into the following sub-objectives:

- to understand the socio-economic structure of the village.
- to explore women's health problems and their understanding of it alongwith the actions that they take.
- to identify the factors at family and social level which determine this understanding and their actions.

DATA REQUIRED

Four sets of data were required for this study.

General qualitative information was collected on social, economic and political life of the people with specific focus on women. For the purpose, men and women above 14 years of age were contacted in groups at the households, teashops, youth clubs, bus stops and agricultural fields.

Through discussion and observation, an idea was developed regarding people's understanding of the health problems in different economic categories, their views of socio-economic aspects of life and their understanding of the social constraints. Available services like health, education and activities of related personnel were also explored to assess their role in educating people and providing information.

Quantitative information on the socio-economic status and health of the population were collected through a baseline survey of the village, covering the population above 14 years. This base line survey served the following purposes:

i) Information on social and economic status of every household was collected covering occupation, land holding and caste categories. In addition, the family size and demographic details about persons above 14

years age group, number of living rooms and source of drinking water were recorded.

ii) Information on ill-health was collected on the basis of reported chronic and acute illnesses of people above 14 years during the previous three years.

iii) Information on pregnancy, delivery and family planning practices, were collected from the women who were either pregnant or had children upto 1 year of age.

Indepth exploration and case reports were developed on women and men in all economic categories. Specific illnesses among them illustrating the mechanisms of coping and their determinants were purposively chosen for this purpose. Thus, insights were developed into their understanding of women's illnesses. How illnesses were handled, how experience of the event had led to change in women's understanding of their health and how the women recognised the role of their family members in this process and perceived their own limitations.

The qualitative information collected from the men who were ill during the same period served the purpose of exploratory comparisons between health behaviour of men and women.

DESIGN

Selection of the Study Population

Since this study attempted to explore and understand the social dynamics of women's health within limited time, only one village with adequate stratification was selected. This was to make it possible to have access to women of all economic categories within a manageable study population. The size of the study population was 971 of which, 456 were women.

Research Methods and Tools.

The main research methods used for the study were, as follows :

Qualitative exploration through group discussions, individual interviews and interviews of key personnels such as the panchayat members, medical practitioners and health personnel . Alongwith these, observations were recorded daily to note the validity of these interviews.

The baseline survey covered all households of the village. It was conducted only after a certain rapport was established with all classes. The schedule used, is appended (Appendix).

For the case reports repeated visits were made and apart from the women, all other members of the family were talked

to. When required, neighbours and health practitioners were also interviewed. A total of 29 women with history of selective illnesses (tuberculosis, gastritis, inadequate menstruation, anaemia, diarrhoea, dysentry, prolonged fever and obstetrical problems of still birth) were studied in depth. While selecting these women the maximum scope of exploring family dynamics was taken into consideration. Of the women, 15 belonged to the Poor section, 8 were in the middle group and the rest of 6 women were from the well-off categories. In addition, case reports on 10 men suffering from common illnesses were also developed. This helped to bring out the differences in attitudes and health-seeking behaviour between sexes.

Information on child birth and family planning practices were collected through personal interviews with 31 women (identified in the baseline survey) who were either pregnant or had a child upto 1 year of age.

Cross checking of every information was done at the possible levels.

Secondary sources, such as the district gazetteer, available literature on the village were also consulted during study.

DEFINITIONS USED

Household: A household was defined as the collection of people sharing the food prepared in the same 'Chulha" or oven. In our study, the term 'family' has often been used synonymously with the term household.

Chronic and Acute illnesses: A chronic illness was defined as any illness persisting for more than three months. An acute illness was defined as the one which led to being bed ridden for one week or more than that. Health problems of women during pregnancy, at delivery and upto one month after delivery were also included in the study.

Illnesses during preceding 3 years were recorded on the basis of reporting by the people. Subjective perceptions were cross checked with prescriptions or the village practitioners who provided the medical care. It is worthwhile mentioning here that, while doing the general qualitative exploration, women repeatedly reported of "backache, giddiness, dimness of vision and blackouts" preventing them from work. Few of them were already diagnosed as cases of "Bloodlessness" at some point of time. For the women who had reported such symptoms, an additional clinical (subjective) assessment for 'anaemia' was also conducted and if found positive they were treated as anaemic.

However, this study in no way attempted to explore the morbidity pattern. It only highlighted the reported illnesses in the study population.

ANALYSIS

Stratification of the study population was the basic necessity in order to locate women's health in the social dynamics of the village.

On the basis of the baseline survey, the surveyed population was classified into different economic categories. According to the land holding capacity in combination with other occupation, families were categorized into the Well-off, Middle and Poor economic categories (Table 1). All data collected was analysed with reference to these categories which are defined explicitly in the table.

The caste structure had two major components the scheduled castes and the non-scheduled castes. The latter was dominated by the Brahmins (the rest were various occupational castes as reported by the people) who also dominated the middle and the well-off economic categories (Table 1).

Table 1: **Distribution of Households in Different Economic and Caste Categories**

Economic Categories	No. of Households	Caste Categories: Scheduled Caste	Non Scheduled Castes: Brahmins	Non Scheduled Castes: Others*	
POOR		95	3	7	
Wage labourer with less than 1 acre of land or petti-business**	105 (38.6%)	90.5%	2.9%	6.6%	100%
MIDDLE GROUP					
Government services*** alone or with upto 2.5 acres of land with or without pettibusinesses or upto 5 acres of land with or without pettibusiness	126 (46.3%)	57 45.2%	47 37.3%	22 17.5%	100%
WELL-OFF					
Big business**** or more than 5 acres of land or land between 2.6 to more than 5) acres with government service with or without pettibusiness.	41 (15.1%	15 36.6%	14 34.1%	12 29.3%	100%
TOTAL	272 (100%)	167 (61.4%)	64 (23.5%)	41 (15.1%)	

* Included weaver, potter, goldsmith, blacksmith, barber, milkman, farmer, carpenter, oil pressor, betel leaf seller.

** Included selling fish or milk within the village, grocery or any other shop within the village, jewellery making, pottery, priesthood and doll making.

*** Included class III and class IV government employees.

**** Supplying fish or milk to the town or any big business there (e.g. liquor shop, stationery shop) and local health practitioners practising also in the surrounding villages and selling medicines there.

LIMITATIONS OF THE STUDY

Time was a major constraint and very often restricted the depth as well as the duration of follow up which would have generated more details. It also forced us to take a single village for study which does not permit exploring the variability of health perceptions and actions in the rural Bengal.

Indepth exploration was conducted within limited number of cases selected purposively. Crosschecking of such exploration with a larger number of samples was not possible. Therefore, the findings of this study are only suggestive and cannot be generalised.

Perception of caste by the residents of the village deviated from the traditional caste divisions. Explanations of this invite a historical analysis of the caste system, in the state as well as in the specific region, which was not possible within the scope of this study.

Because of a single village study, to have sufficient numbers of reported illness we took 3 years' retrospective data. This introduced problems of memory gaps and thus reduced the chances of adequate reporting.

Chapter 3

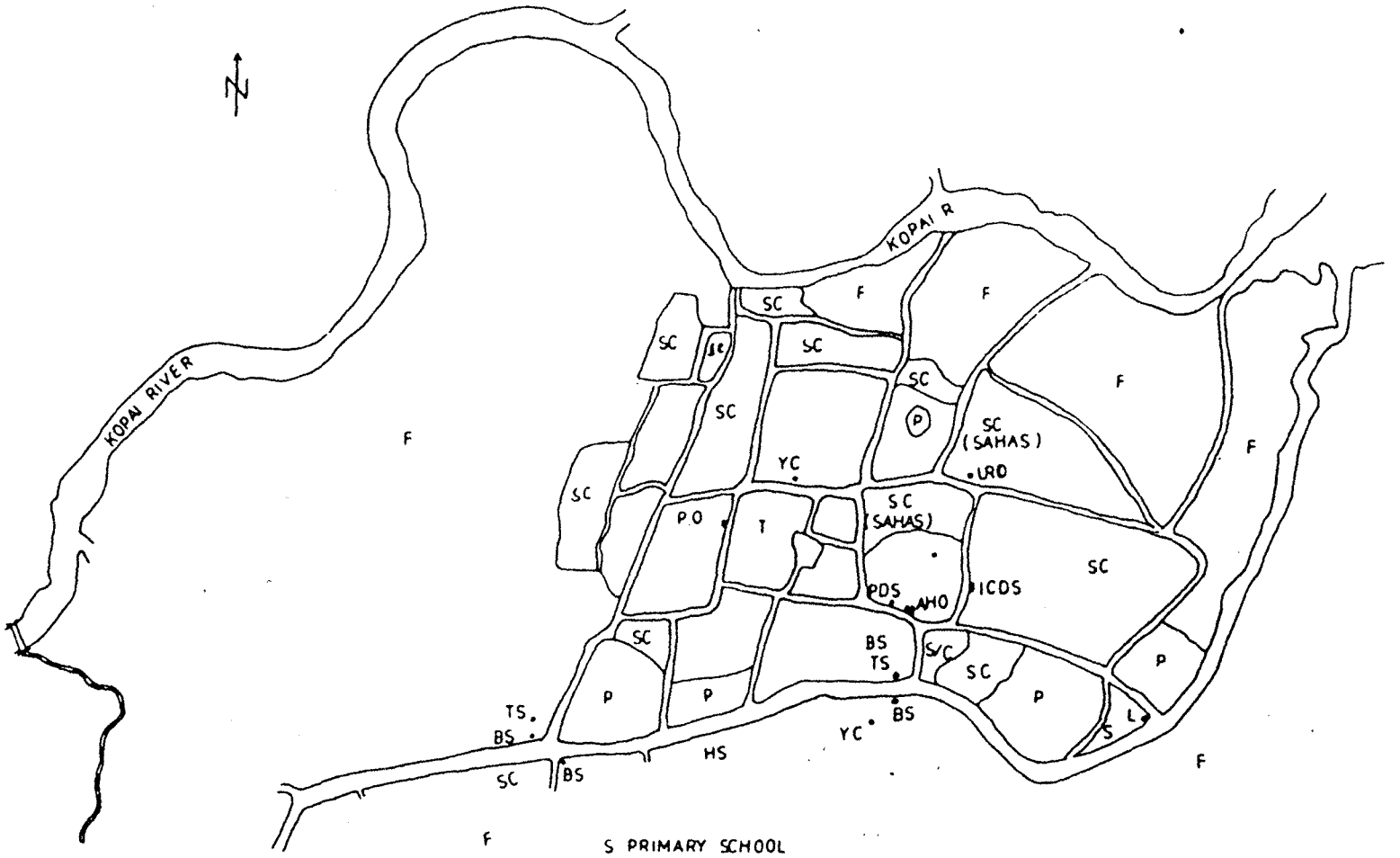
AN OVERVIEW OF VILLAGE ADITYAPUR

Village Adityapur was located in the picturesque landscape of Birbhum district in West Bengal. It was under the Konkalitola Panchayat of Bolpur administrative block. The population estimated by the Primary Health Centre (PHC) was 1560. During the present study, there were 971 people above fourteen years. Of them, 456 were women living in 272 households. The village was seven kilometers from the sub-divisional town Bolpur and was connected with it by metalled road and bus route. The nearest railway station 'Prantik' was two kilometers off the village. The village was bounded on the West by rail-lines, on the north by the river 'Kopai' and on other sides there were villages like Paruldanga on the South and Donaipur on the east.

SETTLEMENT PATTERN

The settlement area of the village faced the bus road and was surrounded by paddy fields on three sides (Fig. 1). Households were located in clusters, separated from one another by small ponds or narrow lanes (foot paths). The scheduled caste households were located at the outskirts of the settlement, whereas many of the upper caste Brahmin households occupied the front of it (Southern side facing the road). In the rest of the settlement other Brahmins and occupational castes were distributed in clusters. Traditional houses were double storied, made of mudwalls and thatched roof. Sixty one percent of the households had, at

A MAP OF ADITYAPUR VILLAGE



F - PADDY FIELD
P - POND
SC - SCHEDULED CASTES SEETTLEMENT
S PRIMARY SCHOOL
HS - HIGH SCHOOL
PO - POST OFFICE
BS - BUS STOP
S/C - SUB CENTRE
ICDS CENTRE
LRO - LAND REVENUE OFFICE
AHO ANIMAL HUSBANDRY OFFICE
PDS FAIRPRICE SHOP
YC - YOUTH CLUB
T - TEMPLE
L - LIQOUR SHOP
TS - TEA SHOP

FIG - 1

the maximum two small rooms, the ground floor of which was often without any ventilation. In recent years, concrete constructions were replacing the traditional housing wherever resources were available. Nearly half of the village did not have electricity. They used Kerosene lamps.

Tubewells were the major source of drinking water and 15% of the households had tube well at home. The rest of them, collected drinking water from the community tubewells provided through the Panchayat. Ponds had significant importance in their daily life. They served the purpose of bathing and washing . Apart from the few big ones, there were numerous small ponds, each of them located at the centre of a cluster of houses. In addition to bathing and washing, the outlet of the wastes from every household led to these ponds. Except few better-off households who had private latrine, majority of the population used field or river bank for defecation. They preferred it to the community latrine provided by the Panchayat at the eastern locality of the village.

INSTITUTIONS

Certain institutional facilities were available at the village. Apart from the post office there were schools providing education upto eighth standard, a subcentre of primary health care network, an anganwadi centre of the

Integrated Child Development Services (ICDS) scheme, an office of the land revenue and a cattle reproduction centre. To treat the daily necessities of the family, there was a fairprice shop of the public distribution system, a dozen of the grocery shops and sales depot for fuels like smokeless coal and wood. For the religious offerings villagers often went to the temple located at the eastern side of the village. Besides all these, there were also an office for the local unit of the Communist Party of India (Marxist) and a functioning network of the Mahila Samiti.

CASTE AND ECONOMIC STRUCTURE

Present Caste Structure of Adityapur was perceived by its people as having three major groups (Table 1). According to them, the Brahmins formed the dominant caste, whereas all the non-Brahmins in the non-scheduled category were considered as the second group. This included occupational castes like farmers (sadgope), oil pressor, betel-leaf seller, gold-smith, blacksmith, carpenter, potter, weaver, barber and milkman. The rest of the population was considered under the scheduled castes which included the 'liquor-business' caste Sahas, Dases (Mochi), Lohars (Dom) and Dhibors who where fishermen. Despite the scheduled castes, the Sahas were not treated as 'untouchables' by the non-scheduled community. They occupied the highest community position in the village.

Our baseline survey revealed that 61.4% of the total households were in the scheduled caste community, whereas 23.5% were Brahmins and 15.1% were the other occupational castes. When caste was located in economic categories, representation of the Brahmins and other occupational castes were higher in the middle and well-off categories, whereas that of the scheduled castes was higher in the poor and middle categories. 13.8% of the total scheduled caste households was formed by the Sahas. The total 23 households of Sahas were distributed in the middle and well-off economic categories in a 1:3 proportion. The well-off position of the scheduled castes in our table was entirely due to the better economic position of the Saha. In the middle group of the 57 households, fortynine (86%) were of other scheduled castes who managed to raise their family resources through the implementation of land reform in the village. For the Brahmins and other occupational castes the bulk of the households (95.3% and 83% respectively) belonged to the better-off sections (Middle and Well-off). This main difference between these two caste groups was located in the middle category of households, where the latter were only 54% as compared to 73% of Brahmins. This reflected the better ability of Brahmins to make use of other opportunities in the job market and business.

SOCIO-ECONOMIC CHANGE IN PEOPLE'S PERCEPTION

Our information from different social groups and the available literature, indicated that over the last few decades, Social and economic life in Adityapur had undergone substantial transformation.

Previously jute, pulses and vegetables along with paddy were grown in the village. Agriculture was dependent on labour intensive technology and rain water. The crops were prone to damage due to scarcity of water and attacks by the pests. Over time although the traditional labour intensive system of cultivation remained unchanged in Adityapur, technology had overwhelmed the other components of agriculture. Multiple crop system was developed by introducing high-yielding variety of seeds, damages were reduced by better irrigation facilities by using shallow pump, pests were prevented by pesticides and fertilizer was used for stimulating the quantity of the produce.

With the arrival of agricultural technology, the pattern of crops (like jute and pulses), shifted to largely oil seeds and paddy. Implementation of local reform in the seventies had followed the adoption of newer technologies in agriculture. These together had influenced the relationships at the village level between the owner and the tiller of the land. The common view was that implementation of land reform had benefited the tillers of the land both by giving the

legal rights over the land as well as by increasing the share in the total produce.

Those who previously had no land sudden ly became marginally landed peasants. They had poor access to other technological assistances and therefore could not invest adequately on land. Therefore, despite having the full legal rights on the land, they had to compromise with the better-off land owning categories for favour of investments. The share-croppers too, sometimes had to compromise at much lower shares despite their entitlements for the same reasons. Few of the middle farmers who had smaller land holdings and did share-cropping at higher shares, often found trapped as their share-croppers were not keen to invest due to higher risks of small land and at the same time the farmer could neither legally sell nor use the land.

As a consequence to invest, many of the middle and the poor farmers felt that productivity of crops had suffered. A result of this readjustment in agriculture was that, in many families supplementary occupation were taken up. To understand the growth of other occupation in the village in addition to land reform measures, three major events which also affected the traditional caste cleavages need to be mentioned. They were,

i) The declaration of the act of Scheduled Castes by the British Government in India, 1935.

ii) Establishment of the educational and cultural institution Visva Bharati within 5 kms of the village.

iii) Special provision of education and employment to the Scheduled castes by the state.

The enactment of the British law put the Sahas (traditionally known as 'Suris', whose occupation was considered to be toddy making) together with Das, Lohar, Ankuri and Dhibars (the traditional shoemakers, tanners, and fishermen), were considered out-castes. All these together were known as scheduled castes. Amongst these, while all till date remained 'untouchables' within the social life of the village only the Sahas were not considered untouchables. Whether even historically the 'Suris' were ever considered as untouchables could not be ascertained, as no body in the village remembered that Sahas were ever excluded out of their social interaction.

When the residents of the neighbouring villages were invited to serve the Visva Bharati, the dominant Brahmins, and few from the farmer and milkman community achieved the benefit of it. Certain section of the village took advantage of the additional occupation of government services, which at later stage helped them to cope with the crisis created

by implementation of land reform. Later, when the state intervention for upliftment of the scheduled castes was initiated in the post-independence period, most of the traditional 'Suris' (Sahas) were already in a much better position of resources and power compared to the other scheduled castes. Since the Sahas of Adityapur dominated the scheduled caste community and availed of the facilities which came for the community as a whole, the others in that community remained uneducated and unemployed.

The land reform movement in the seventies, by changing the land holding patterns altered the importance of caste in the power structure. People began to identify themselves through occupation and became conscious of their economic position. By then the other occupational caste groups mainly known as 'Karmakar' started losing in their profession due to competition from industrial products. They started changing their profession according to the demand from the town. This was mainly because their family land was divided and the utilization of their services within the village declined with time. At the same time, the town created a market for business and small jobs. Sri Bhabesh Karmakar (now in his seventies) was the first person in the village who was taken to Visva-Bharati for clay work. Later, he introduced doll making in the village. By early nineties, this became a means of livelihood for 13 families.

Apart from government services, those people who had sufficient capital, had opened up stationary or liquor shops in the town. Those who produced extra milk or fish in the village, started supplying to the market in the town. Those who had less, supplied to the villagers who needed it. People opened up sweet shop, tea-stalls, bicycle repairing shop and grocery shop, within the village. Village level practitioners widened their practices and sold medicines in surrounding villages. Although business, service and handicrafts had opened new possibilities, agriculture still remained a major source of livelihood.

Agriculture was labour intensive and traditional with multiple crops in a year. Paddy, mustard and potato were the main crops. Mustard was preferred by the majority of the people, as it could be managed with comparatively less labour and maintenance. For irrigation, shallow pumps were used in addition to rain water and the river. Those who did not own a pumpset, had to buy water from others on hourly basis and the approximate cost of water for a three-monthly crop of paddy was Rs.400 per bigha or .33 acre of land. By a locally registered organization 'Tagore Society', a river lift pump lately started working under the supervision of a committee represented by the beneficiaries of the area. It brought down the cost to Rs.80/bigha. Fertilizers and seeds were available at co-operative of the town. The recommended rate of daily wage in the area was 28 rupees. For share

cropping the proportion of share of the produce was determined entirely on the basis of the relationship between the owner and the share-holder.

The village also increased in size. Within last 53 years, the number of households doubled and the population trebbled (Tagore, R.N., 1938). Forty- five years ago, Adityapur Youth Club had set up libraries for the villagers, there was enthusiasm for propagating education. Later, government educational institutions were established. But, the enthusiasm among the people had taken other forms. Remembering the excitment at the arrival of the first radio set in the village for collective usage at the youth club, 55 year old Smt. Shanti Ghosh (Khoorkhuri didi) said with sadness, "collective feelings have disappeared from the village. People are now more interested in themselves. Hardly they find time for sharing".

Over time, the village environment also changed. The mango groves in the village were auctioned off by the owner of the land to timber merchants in the town in order to grow more paddy. Women of the village who used this area for defaecation lost the shade and privacy of it. Instead, the trees under social forestry had been planted scattered here and there without bothering for their protection and survival. According to the people, previously ponds were used for specific purposes. But later due to indiscriminate

and over usage of the ponds, they have been polluted and lotus did not grow any more in them. The source of drinking water shifted from the river to tubewell. According to fifty eight year old Smt. Durgarani Hazra in earlier days Women of the village used to collect drinking water from the river following a particular technique of digging sand and finding out the best source of tasty water. Housing pattern of the village did not change much, except few pucca houses with facilities of toilet and drinking water were constructed. However, for majority of the population, the field or river bank still remained the places for defaecation.

During the years of 1937-1938, Adityapur was considered by the health co-operatives for providing medical relief (Tagore, 1938). Health care was provided to the villagers by a resident qualified doctor against epidemic diseases like measles, small pox,cholera and also for venereal diseases, asthma, and tuberculosis. After a period, this was discontinued. Later, around the year of 1950 some of the villagers started their practices and the PHC also opened a sub-centre. Dependence on traditional dai started declining as the PHC took roots. Older population of the poorer section said that unlike the past, people of their category didnot have to starve now. Due to their present economic situation which was not "so bad" as before, people could atleast open a credit system in the grocery shop and fill

their stomach. However, Sri Adyanath Ghosh, a middle category agriculturist said that, those who were daily labourers before, as a result of land reform, got some economic freedom. With that they had only adopted the "glamour of the upper section". The quality of their food remained unchanged. Sometimes it was worse as their relationship with the employer had worsened. He no more provided security of clothing and meals. Old women of the village said that, they witnessed changes in the village. They had seen the road and school buildings being constructed, they saw the tube-wells being dug, houses being electrified, "didimoni" (female paramedical worker) visiting households and the pregnant women now went to the town for delivery. The better-off identified communication with town by bus, introduction of smokeless coal in the kitchen and opening up of schools in the village, the poorer section talked of increased work load in the newer pattern of agriculture, and its negative implications for women's life. They also considered family planning as desirable, given the new strains and changes in life. Thus, the life in Adityapur had transformed considerably over time.

THE PRESENT POWER STRUCTURE OF THE VILLAGE

The power relationships within the village were formed on the basis of people's control over economic resources. The large peasants and businessmen controlled or influenced

the poor who worked for them. Their own political ideologies were also perpetuated through these links. In addition to their richness, their castes also served as means of mobilisation.

In this dynamics, the landed Sahas, Brahmins and the big farmers of the other occupational groups with different political associations had mobilised groups of poorer scheduled castes around them. This dynamics was further reflected in the decision making process of the village level committee of the panchayat.

The village level committee of the panchayat was quite active in Adityapur. It was responsible for negotiating daily wage rates, settling community disputes, imp-lementation of programmes including health and selection of beneficiaries for particular developmental programmes. It also helped individuals at the family level. Help was extended through recommendation letters and financial aid needed for the care of serious patients, house building etc. The panchayat had sufficient funds and therefore control over its activities was an important aspect of the power balance within Adityapur.

The panchayat represented all social groups. Although politically the panchayat was dominated by the Communist Party of India (Marxist), there was also one representative of the Indian Peoples' Front (IPF) from the village. Outside

the committee but within the village, there was a network of Congress (I) functioning in the village through the staff of the university. They influenced the opinions of their household employees and agricultural labourers as well as of their friends and neighbours.

Villagers often went for political alliances, depending on their vested interests. Though CPI(M) was the dominant party, people pointed out its weaknesses which were responsible for the entry of newer political groups into the village. They felt that the proportion of the population supporting the panchayat or its dominant political party was 60% where as the rest was against it.

HEALTH SERVICES

The PHC was located 8 kms off the village, in the sub-divisional town. There was a sub-centre in the village. the Voluntary Health Guide (VHG) scheme was nearly non existent. The VHGs stopped providing services since last 4 to 5 years. They did not like the idea of distributing medicines in their village (as it obstructed them from demanding fees) and they thought that their remuneration was too little for the job they were supposed to do. Both the VHGs belonged to the middle category Brahmins.

The sub-centre was manned by a female multipurpose worker (FMPW), a male multipurpose worker (MMPW) and a

trained dai. It was providing services to 5000 population including the population of Adityapur. This centre which was popularly known as "village outdoor" provided immunization and iron supplementation on every Wednesday mostly by the FMPW and the dai. Followup of diseases like tuberculosis was conspicuous by its absence. Collecting samples of blood from those who had fever, was a function of the MMPW which was rarely performed. Most of the villagers did not know about it. People considered the "outdoor" services only for pregnant mothers, their children and for family planning whereas the MPWs expressed that people should come and consult them at the sub-centre when they fell sick. In response, the people said that the "outdoor" operated only on Wednesdays for mothers and children. The staff of the sub-centre paid more attention and time towards filling targets of the family planning programme. For the rest of the services they felt that, to cover a population of 5000 spread over few villages quality of services had to suffer. The only referral service they had was sending the pregnant women to the PHC for delivery. However, since last few years the people prefered to deliver at the sub-divisional hospital at Sian, although it was meant to cover 45000 population in the municipality. They said that it was close by and offered better services. The auxiliary nurse cum midwife (ANM) at the PHC said that the reasons behind this were the smaller stock of medicines, inability of providing

specialized services and lack of modern equipments unlike the sub-divisional hospital. Moreover, for the villagers, it was easier to commute to the sub-divisional hospital which was located within a radius of 4 kms. Except for birth registration, the poorer section of population attended the 'village outdoor' mainly for immunization and family planning.

Maintenance of vital statistics was poor. Neither the people nor the staff themselves were aware of the relevance of such recording. According to the sanitary inspector at block level, registration of birth was done through the PHC staff whereas that of death was done only at the initiative of the family where death had occured. The Panchayat did not discuss and monitor the functioning of PHC and sub-centre. Despite this, both PHC and other welfare staff explained the lacunae in the implementation of health and discussed the implementation of respective programme.

There were two private practitioners in the village who were not formally qualified and were either self-trained or trained by senior practitioners like them, for symptomatic treatment of ill-health. In addition, they were selling medicines. Popularly known "Lala doctor" was trained in allopathic treatment by the late "Saroj doctor" of the same profession. Lala had gained 20 years' experience whereas 'Panu master', the other allopathic and homeopathic

practitioner had been more recent in the profession. Previously he was a private tutor in the village. There was another practitioner 'Mukul master' who was a teacher in the high school of the village. He had just entered the profession and started prescribing. His knowledge of homeopathy was acquired through self-reading and prescribing by applying "common sense". Apart from this, self-trained practitioner from neighbouring village visited the poor families regularly and often provided treatment and medicines on loan.

Qualified private practitioners (allopathic or homeopathic), were available only in the town. Some of them were also attatched to government institutions. The consultation fees varied between 2 rupees to 25 rupees per consultation.

Institution of professional dai was nearly non-existent in the village. Those who had the skill were not professionals and those who were from the families of professional dai, did not have skill and experience of conducting deliveries at home. As a result, services offered at the PHC and sub-divisional hospital were appreciated by many people.

A religious understanding of causality still existed for some diseases, people therefore often took recourse to

religious healing. Often this was linked with its lower cost compared to the modern system of medicine.

EDUCATION AND WELFARE

Government primary and junior high schools were the main educational institutions in the village. The dropouts amongst the poor were much higher at an early stage. For further education, schools were available in the nearby villages. However, the well-off and few of the middle categories preferred to send their children to the town. The wide practice of 'tution' made competition tougher for the poorer children who could not afford this extra burden.

Twenty eight of the 33 centres of the literacy mission were functional. They offered services to people of 9 years to 50 years of age but only younger adults made use of it. The Anganwadi centre of Integrated Child Development Services (ICDS) scheme was physically present but its services were restricted mostly to one half of the village. It's workers complained of supervision and assistance which led to irregular and inadequate services.

Two youth clubs existed in Adityapur. The older one was associated with developmental and cultural activities while the newer one concentrated on indoor recreation and occasional welfare activities.

This brief overview therefore shows that, the social structure of the village changed over time mainly due to land reforms. Due to establishment of the 'Visva-Bharati' in the neighbourhood of the village, agriculture was supplemented with other occupation. The village was communicated with town and people went out of the village. This also influenced the educational and health practices of the people.

WOMEN OF ADITYAPUR

It is important to note that despite visible transformation of the social and economic life of the village, the women of Adityapur were not very different from most other rural women of backward areas. We briefly sketch here their lives at different levels of social existence.

Work

Majority of the women shouldered the burden of household work, looking after the cattle, collecting firewood and water as well as sharing agricultural work outside the home or within. Their work could be divided into:

i) **Household work:** When household work for the well-off women meant mostly supervisory work at home, cooking and caring for other members of the family with external help from maidservant (if necessary), for the

middle group it was with or without such external help and often with the co-operation of other women in the family. Unlike the middle category women who often had to fetch water from outside, women in the poor section took much more hardships as they had to collect dry twigs and wood for fuel too.

ii) **Work for livelihood:** Apart from agricultural activities in different economic sections, some women in the middle category were also engaged in the household industry of doll-making and few women of the poor served as construction labourers.

When the well-off women did parboiling of rice with external help, the middle group of women had to do it on their own and in addition, they also worked in their own agricultural field during the season. Despite their contribution of labour to the livelihood of the family, these women were never paid. Where as, the poor women who worked as wage labourers in agriculture or at construction sites earned more compared to those of the middle group, who were engaged in doll-making.

Even though women were paid equal to their men engaged in the same activity, they did not have the freedom to spend their earning in the way they liked. The men controlled all their earnings. Work participation of women at home whether

in agriculture of the family or in the household, however much it might be, always remained unrecognized. It was taken for granted and did not give her any special rights over the total family produce or income. The women themselves did not seem to find this disturbing in any way. They considered their situation as something which had "always been like this". It was considered her duty to serve the family and to accept her deprivation as a norm of existence.

Food Practices

Food practices varied across economic categories. When the well-off had cooked and puffed rice, pulse, vegetables, milk and fish or poppy seeds everyday, for the middle group fish and milk were not regular items and for the poor, these were the items for festivals alone. In addition, the consistency of food were significantly diluted in the poor although number of feeds were more or less similar. As for the poor, variety of food was also little, to make it tasty lot of red chilli was added to it. Women were not only responsible for cooking but also for distributing and in scarcity always tended to distribute at their own cost.

Education

The educational status of the elderly women across economic categories was different from the rest. In the well-off they had studied upto school levels where as in the

poor majority were illiterate. In the middle category, women with the two extremes co-existed. This could be explained in terms of original diversities of this group. There were postgraduate and graduate women and there were illiterate women too.

However, the younger girls in all sections had some opportunities of studying in the school. They wanted to study further although they were not always sure of its economic utility other than 'knowing things'. The girls of the poor section, who often had to give up studies in order to earn for the family, had a tremendous attraction towards the night schools set by the Literacy Mission. They said that it was beneficial to them as they could count money in the shop and write letter to relatives.

Fathers in all sections were not against sending their daughters to school. At the same time, they did not postpone the marriages to allow their daughter to study further. Those who had resources and also encouraged daughters to study, generally compromised with the social norm of marrying them off at an early age. In the poor, where resources were limited often daughters were made to sacrifice their own education for the brothers. The preliminary exposure to literacy did not have much impact on the women above 20 years, most of whom had either forgotten whatever

they learnt as children or never had a chance to really use their skills.

Welfare Activities

Given the resources and time, women in the well-off section were inclined to do social work within the village. The Saha women of this category often managed repayable monetary help from their husbands for the needy women in the poor section. Smt. Kavita Devi, a well-off Brahmin lady was encouraged by her husband into such activities. With her free mobility, minimum understanding of ill-health and cure and contacts with qualified health personnel outside the village, she tried to provide mainly physical and moral supports to the poor women. The poor women also recognized her for such activities.

Panchayat and Politics

There was little evidence that in Adityapur, women were interested and active in the working of the panchayat. Panchayat was considered the domain of men and though women did expect that support in the time of crisis will come through the panchayat, they never really expressed their opinion on the working of the panchayat. Kalyani Lohar of 23 years of age was a nominee in the panchayat. She was educated , despite having family support she become ineffective. She had to face obstacles created by the women

of the middle group who in general blamed her for freely moving around. Her women employer threatened to throw her out of the job of a maidservant. These objections and threats had demoralised her and she avoided participating in panchayat. There were around 15 women in Adityapur who were members of political parties (mostly CPIM), and were articulate about it. Through the period of the study not much political activity was visible except their participation in a Mahila Samiti meeting.

Institutions for Women

Mahila Samiti had a net-work in this village and mostly functioned in crisis. Women only with relevant political associations and interests participated in it and they represented the poor and middle groups. Their recent action was to intervene in the family violence against a middle category woman by her husband and mother-in-law. This women's organization occasionally mobilised women to rally on specific issues. The women were mostly apathetic to it as they were not able to relate to the issue which were not related to problems in their day to day life.

At the village level, panchayat and the veteran youth club involved women in certain activities which the women also liked to do. During the study period, a group of 'Saha" women and girls of Adityapur were recommended by the panchayat for training in machine-knitting and tailoring.

According to women, such activities not only gave them the skill but also a temporary economic freedom and further possibilities in future. The youth club involved the women in 'night schools'. Women of the middle and well-off categories participated in teaching as they were educated, where as those of the poorer section to learn.

Festivals of women in the village which were specific to castes and economic levels, brought some relief and recreation through collective activities.

Social Interaction between Women

In the eyes of the better-off women, women from the poorer section and outcastes were considered as 'chotolok'. By 'chotolok' they indicated poverty, ignorance of having many children, attitude of imitating the behaviour of upper economic categories and the 'dirty jobs' which their ancestors used to perform (eg. cleaning dead bodies, tanning etc.). The poorer section visualized the better-offs as "Barolok" irrespective of their castes and indicating the dominance and resources. They also said that, the upper category women could not accept the poor women living with a "smiling face", dressing in a sari (cloth) in the way they did it or wearing a pair of slippers while moving out of the village.

Competition and jealousies around possessions and standards of living were two common subjects for discussion among women of the well-off and middle categories. The poor women given the constraints of resources and time were too busy eking out their daily bread.

Despite these tensions between economic categories, there was a kind of solidarity specially among the scheduled castes. Thus the rich Saha women helped the poor more than the Brahmin women in times of distress or crisis. There was also a system of support at the caste level in general.

Thus, the changes over time had only touched lightly the women of Adityapur. They continued to perform labour without actively participating in decision making processes. Even those who had joined the ranks of the employed or the social activists, curtailed their activities to the minimum required and remained within the bounds set by tradition.

Chapter 4

ILLNESS AND HEALTH OF WOMEN IN ADITYAPUR

WOMEN AND HEALTH

Located as they were in the social structure, the women of Adityapur did have numerous health problems. It was therefore, not surprising that any discussion on health generally percolated to health problems and illnesses rather than their positive concept of health. For the better-off women's illness was not a major problem in their lives and health meant good food, comfortable living, cleanliness, absence of disease and less number of children. They also recognized the importance of information and access to it for keeping healthy. According to them, in addition to poverty, the poor were also "dirty, ignorant, produced many children and tried to imitate the lifestyle of the upper classes".

For women belonging to the poorer sections, health was an alien concept and at most it meant absence of disease. Illness was recognized only when it interfered with their work and earning. They clearly related their illness to their workstyle and conditions of poverty. Even men recognized that women's health was linked with sufficient food and comforts. The poor amongst them grudgingly acknowledged that their women could not be healthy because of their own deprivation. The poor women thought that the economic crisis forced them to add more chilli to the food

to make it tasty, sell the last drop of milk or the last egg produced at home which made them more prone to illness.

Another aspect of ill-health was that despite serious obstetrical problems , anaemia and inadequate nutrition during pregnancy were considered a part of health rather than ill-health. Most of these problems were taken for granted in the village, specially, in the poorer sections. The women in the better off sections considered minor gynecological disorders "disturbing" but not an 'illness' necessitating medical assistance. The poorer women had no access to effective medical care even when they needed it badly.

Women belonging to different economic cate gories related their ill-health to various causes and implications. The well-off women recognised that ingestion of "foreign bodies" through food and water lead to diarrhoea or dysentry. High work-load and irregular timings caused gastritis or anaemia. They were also aware that irregular menstruation if untreated, might lead to complications such as cancer. But, women in the poorer sections in general, did not have any knowledge of specific causality of ill health. They related it to their degenerate circumstances. Mira Dasi said, "with the suffering of the last twenty years, my life has become like a decayed leaf in the pond. The insides of my body are rotten like it"! The poor women

often associated diffused aches, mild fever, general fatigue with "evil eye" or "spirits" and went to the religious healers. Not infrequently, resorting to religious healers was in response to the economic constraints rather than staunch belief.

Though it is obvious from the previous section that the notion of causality was varied and also to some extent vague, people had well-formed ideas when it came to talking about therapy.

Concept of preventive care was extremely limited in all sections but curative measures were well accepted. This was not confined to allopathy alone but, applied to homeopathy and religious healing as well. Home remedies were conspicuous by their absence.

Before we go into the nature of treatment sought by women and the reasons behind their choices, we would first have an overview of the pattern of illness in Adityapur.

PATTERN OF ILLNESS

We attempted identification of ill health in the study population. These are presented here according to economic and sex categories (Table 2)

The reported load of illness was higher among women in the poor section compared to other categories. For the poor

Table 2: Distribution of Perceived Illnesses in Economic and Sex Categories

Expressions of Illness	Identified Illness	Total Cases			Economic Categories					
					Well-off		Middle		Poor	
		No.	F	M	F	M	F	M	F	M
1	2	3	4	5	6	7	8	9	10	11
Persistent fever & cough	Tuberculosis	7	4	3	0	0	0	0	4	3
Resp. Spasm and fever	Bronchial Asthma	13	5	8	2	2	3	4	0	2
Pain at joints and difficult movements	Rheumatic Pain	8	7	1	4	1	2	0	1	0
Sugar in blood	Diabetes	3	1	2	1	0	0	2	0	0
Slowness and Lethargy	Hypothyroidism	2	2	0	1	0	1	0	0	0
Back-ache and giddiness	Spondyloses	1	0	1	0	0	0	1	0	0
Madness	Schizophrenia	1	1	0	0	0	1	0	0	0
Hyperirritability, heaviness of head, loss of patience	Hypertension	20	15	5	6	2	6	3	3	0
Weakness, Low pressure	Hypotension	11	9	2	2	1	4	1	3	0
Hyperacidity, indigestion, Nausea, Vomiting	Chronic gastritis	30	23	7	2	2	8	2	13	3
Irregular, inadequate or excessive menstruation	Gynaecological problems	19	19	-	1	-	12	-	6	-
Giddiness, dimness of vision, blackouts, lassitude	Anaemia	47	47	0	2	0	17	0	28	0
Still Birth	Obstetrical problems	2	2	-	0	-	0	-	0	-
Wilful wastage of foetus	Induced Abortion	1	1	-	1	-	0	-	0	-

Table 2 (Contd..)

1	2	3	4	5	6	7	8	9	10	11
Loose Stool with or without mucous and fever	Diarrhoea/ Dysentry	9	5	4	0	1	4	1	1	2
Persistent fever not responding to single treatment	Prolonged Fever	4	3	1	0	0	1	1	2	0
Fever keeping bed-ridden for 7-10 days	Acute Fever	5	4	1	1	0	0	1	3	0
Persistent cough with or without fever	Bronchitis	6	3	3	0	2	2	2	0	0
Secretion of eye, losing eye sight	Eye Problems	8	4	4	0	1	2	1	2	2
Difficulty in lifting heavy articles, bleeding while defaecating	Hernia/Piles	6	1	5	0	1	1	3	0	1
Sore at feet	Sepsis, feet	2	0	2	0	0	0	1	0	1
Snake bite	Snake bite	2	0	2	0	0	0	0	0	2
Physical disability	Physical handicap	1	0	1	0	0	0	1	0	0
Total Population Reporting Illness		198	156	52	23	13	64	24	62	13
Total Population		971	456	515	88	114	230	258	138	143
Percentage of Population Reporting Illness		20.4	34.2	10.1	26.1	11.4	27.8	9.3	44.9	9.1
Annual Percentage of Reporting Illness		6.8	11.4	3.3	8.7	3.8	9.2	3.1	14.9	3.3

F - Female; M - Male

women, problems of tuberculosis, chronic gastritis, hypotension, anaemia, fever, diarrhoea and dysentry were more prevalent. Comparatively, the well-off women reported systemic illness like bronchial asthma, rheumatic pain, diabetes and hypertension.

It was interesting to note that women in the middle group had illnesses which were common to both other groups. In addition to the problems of the well-off women, they also suffered from hypotension, chronic gastritis, anaemia, diarrhoea, dysentry and eye problems like the poor. This peculiar finding provoked us to further analyse the middle group households on the basis of their origins.

Table 3 shows that women belonging to those middle households which were in the past better-off had a pattern of illness similar to the well-off women. Whereas, those who originated from the poorer sections, followed the disease pattern of the poor category. This again reflected the social basis of certain diseases. The broad range of pattern of illness within the middle category women could possibly be due to inheritance of resources (or lack of resources) and health cultures originating form the socio-economic strata where they previously belonged.

In all economic categories women reported more illness compared to men. In other words the load of illness was

Table 3 **Distribution of Illness in the Middle Group According to the Origin of Households**

Identified illness	Origin of Household			
	Better-off Section		Poorer Section	
	F	M	F	M
Tuberculosis	0	0	0	0
Bronchial Asthma	2	2	1	2
Rheumatic Pain	2	0	0	0
Diabetes	o	2	0	0
Hypothyroidism	1	0	0	0
Spondyloses	0	1	0	0
Schizophrenia	1	0	0	0
Hypertension	5	2	1	1
Hypotension	2	1	2	1
Chronic Gastritis	3	2	5	0
Anaemia	5	0	12	0
Gynaecological Probs.	4	-	8	-
Obstetrical problems	0	-	0	-
Induced Abortion	0	-	0	-
Diarrhoea/Dysentry	2	0	2	1
Prolonged Fever	1	1	0	0
Acute Fever	0	1	0	0
Bronchitis	1	1	1	1
Eye Problems	1	0	1	1
Hernia/Piles	0	1	1	2
Sepsis of Feet	0	0	0	1
Snake-bite	0	0	0	0
Physically Handicapped	0	1	0	0
Population Reporting Illness	30	15	34	10
	F M			
Total Population	230 258	148	156	82 102
Percentage of Population Reporting Illness.	27.8 9.3	20.2	9.6	41.4 9.8

F - Female; M - Male

much higher in women in general, compared to men. This trend seemed to be more intensive in the poor. Though more men suffered from bronchial asthma, diabetes, hernia, piles and occupational disorders, the occurrence of these diseases was too infrequent to affect the distribution of total load of illness. In all other illnesses women suffered more. The difference was marginal in bronchitis and eye problems. It was marked in tuberculosis and diarrhoea. Gynecological disorders and obstetrical problems further enhanced the disease load of women.

COPING WITH ILLNESS

Weaving the experience of twenty nine women who suffered from a variety of illness, etched out the processes at the family level which were responsible for their coping with illness. It also highlighted the differences between and the transformations within these processes across economic categories, revealing thereby the influence of the larger social and economic forces within which individual families existed and functioned. We first present some of the case reports illustrative of mechanisms of coping and then identify the mechanisms of coping by abstracting the common trends observed in all the 29 case reports.

Case Report No.1

Thirty seven year old Smt. **Milan Lohar**, diagnosed as a case of **tuberculosis** was always found sitting in the courtyard of their mud hut. Her head touched the knees and her wrinkled skin wrapped the bones with little flesh on them. Her eyebrows were always raised with wrinkles on the forehead expressing her painful existence. This picture of Milan did not seem to improve during the period of this study. According to neighbours she had been timid, apathetic and disinterested in her surroundings for the last four years. She hardly made the effort to talk or bother others.

Milan lived with her husband (who was also a case of tuberculosis), a married son with his family and the daughter who had to return with a child after marriage. They were marginally poor. Apart from ten cottah* of land, Milan's children and daughter-in-law worked as wage labourers and maid servant respectively.

The mud hut they lived in had two small rooms and the verandah was used for cooking. The environment of the household was dirty, full of flies and vessels littered here and there. Milan's grand children were rarely taken care of. They used to play around Milan, fell on her, gave her a hug and went away.

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* 1 Cottah = .05 Bigha

Five and a half years ago, at the beginning of her illness, Milan had symptoms like fever every night. But, she was not in a position to express it since she had to work hard to cope with the family crisis created by her ailing husband who was already suffering from tuberculosis since the previous year. Milan attempted to manage her own illness with the help of a talisman, collected from a neighbourhood healer. But, after suffering for fourteen months, she entered a crisis situation and had to be hospitalized. With the temporary help from the local youth club both Milan and her husband were refered by the PHC to the district hospital for treatment. Within the next three months Milan's husband who was already on a treatment could go back to work but Milan could never do so. Soon after this, the treatment had to be discontinued as the donation from the youth club was not available on a longterm basis.

By then, Milan's son got married, her daughter had returned after a separation from her husband. Although the earning capacity of the family had increased since the size had also increased, it had no impact on Milan's ill-health.

Since 1990, Milan visited the hospital many times with her husband and often they had to return as there was shortage of drugs. This resulted in further wasting and

weakness of Milan and during the course of the year she became a defaulter of treatment.

During the study period, whenever a visit was paid to the family, Milan was eager to receive treatment. When the information of receiving treatment from the nearby sub-divisional hospital, with a letter of recommendation from the panchayat, was made available to the family, the members did not show much interest in it. Her children were busy in earning rather than caring for the mother Milan's husband prefered to chew tobacco and relax in the winter-sun rather than taking initiative for his wife's treatment. But in early '92, when the initiative was taken by a close relative and neighbour for Milan, her husband did not hesitate to take the advantage of starting his own treatment again.

The neighbours described Milan as being very active before the onset of the disease and it was only the illness which had arrested her movements. They said that the deterioration of her health was partly due to negligence at family level. According to them Milan always worked equally hard at 'babu's' (employer's) house and in the field. At home, she cared for others but in return "she was only neglected by her own people". Although, there had not been any bitterness in the family relationships the neighbours felt that without of Milan's presence the family might split. Within the limited availability of food in the

family, Milan's untimely hunger was not taken care of. Often she was found at a neighbour's or close relatives place asking for puffed rice and tea. This was probably because Milan felt much more free with her neighbours than with her 'own people'.

Despite wanting to seek treatment Milan was never taken to the hospital. Gradually she lost all hope. Milan expressed herself as follows: "ever since I have fallen ill, I have become a burden on others. I don't want to disturb anybody. When I am hungry, there is no food and when they eat, I do not feel hungry". This was illustrative of the isolation that Milan faced within the family which determined her state of mind and body which was one of dejection.

Case Report No.2

Fifty seven year old **Sourabhi Dasi** and her youngest daughter Nando, 32 years of age, had experienced acute attacks of **loose motion** during September 1991. Sourobhi's illness was diagnosed by the visiting self-trained practitioner as dysentry. Nando who also had headache and abdominal cramps was cured with medicines from the family-stock of her employer. Both of them were too weak to move and remained bed-ridden for eight to ten days with no one to help.

Prior to her illness Sourobhi lost her appetite and suddenly one night, she had an attack of frequent watery motion which, "did not let the water dry on my hands". The nearest bank of a pond served as the place of defaecation. Treatment was sought only when the visiting self-trained practitioner paid his routine visit the following day. She was prescribed four types of medicines ("pills of black and yellow colour, white capsules and a bottle of medicine like milk"), a part of which was provided by her well-off employer and the rest was purchased from the same practitioner, on loan.

For the first two days, Sourobhi drunk only the water after soaking a fistfull of puffed rice in it. Later, she reduced the proportion of water in it and she had conjee after two weeks.

Sourobhi is poor. She lost her husband when her youngest child Nando was five years old. She also had to bring up another four children. Since then she has been working as a maid servant. Later, due to economic insecurity, except Nando all the other children refused to look after their mother. As a result, Sourobhi was left alone with Nando who, in contrast to her brothers and sisters supported her mother at the cost of her own future. She serves as a cook a family in the town. In despair she said, "I do the duties of both, the son and the daughter. My

days pass in earning and looking after my mother. She is like my child".

They lived in a single-roomed thatched hut and mainly depend on their employers for food and clothing. Usually the night meal was cooked at home on twigs collected by Nando on her way back from the job. The water used for cooking and the food was of poor quality.

Carrying the burden of Sourobhi, who repeatedly fell ill, Nando sometimes expressed her disgust and anger. After repeated attacks of "loose motion, Sourobhi once desired to have "at least a tiny piece of fish with hot conjee". She complained to a neighbour and said, "over months, I have been requesting Nando to get me fish. I do not have liking for conjee and potato anymore". Nando immediately retorted, "we are poor and isolated, we should not have such mouth-watering desires".

Burdened with responsibilities and economic constraints, Nando was not only unhappy but, often she herself became ill trying to cope up with her mother's illness and her job. She either received medicines from her employer or had to wait for treatment till the self-trained practitioner arrived during his routine visits. Often people commented on her single status and her lonely trip to and fro. But Nando could not afford to worry about these. She said, "my life would continue like this".

Case Report No.3

Thirty two year old Smt. **Sabitri Dasi** is a case of **chronic gastritis.** She is the second wife of Sri Jyotish Das. After her marriage, she has been living in this village for the last fifteen years. They are a marginally poor family. For the last eight years Sabitri has been suffering from symptoms varying from discomfort at the mid-chest to hyperacidity, indigestion, vomiting etc. She started irregular treatment for the last three years but her symptoms reappeared.

The family owns eight cottah of wasted land, distributed through the panchayat. They cultivate one harvest of paddy, some potato and mustard, which are consumed at home.

They also have a cycle rickshaw which was purchased on loan. This brings the family around seven-hundred rupees per month. As and when there is extra flow of money, it is invested in purchase of domestic animals since rearing them ensure high returns.

Crisis is generally managed by taking loan on temporary basis from well-off families in exchange for bronze vessels or little gold assets which Sabitri brought from her parents place at the time of marriage.

Sabitri had joined in the activities of a local political party with the hope of getting an employment, which had not materialized.

At the time of Sabitri's marriage, Jyotish had one daughter and a son left behind by his first wife. Sabitri herself gave birth to two children. Later, the daughter was married off and Sabitri's own son died of measles. She now lives with her husband, the previous son, now sixteen years and her own ten year old daughter.

They live in a mud hut with a thatched roof and a small room without any windows. In one corner of the small courtyard there is a temporary shed for animals. The outlet of waste water leads across the courtyard to the nearest pond outside. Matresses, stitched out of gunny bags and stuffed with locally available coconut fibre, are used for sleeping.

Conjee and mashed potatoes with lot of red chilli and occasionally with other vegetables or egg, constitutes a meal. Two major meals are consumed a day and supplemented by small helpings of puffed rice soaked in water, to reduce the hunger, in between. Only the youngest child has access to milk produced at home, which otherwise is mostly sold. Sabitri eats last and least. She says, "Husband and children should eat properly; I can manage without much". She

correlates her illness with consumption of red chilli in the diet.

Due to the economic constrain faced by her parents, Sabitri could study only upto second standard, whereas, her husband can only sign his name. Due to economic constraints of the family, her son had to stop his studies at fifth standard. Sabitri wishes to continue with her daughter's study as long as possible. In her opinion the daughter should not get married before the age of eighteen years, although the norm in their community is not so. Sabitri's personality is strongly influenced by her mother, who despite being illiterate was knowledgeable and bore a character reflective of struggles and courage in real life situation.

Sabitri had access to certain kind of information which the women of her class in Adityapur did not have. Her comments on the present research work substantiated this finding. She told the neighbouring women that, "information collected like this would reach the capital city. Such information from many other places would be brought together and then only change in the existing 'Sarkari' (government) systems would be made. If not me, my daughter would be benefited in the future".

Sabitri has been suffering from gastritis over last eight years. In the beginning for four or five years she did

not take any action and continued to perform the routine household work including child care. She had discomfort at the midchest associated with hyperacidity and indigestion. During those days, the family was under economic pressure to repay the loan already taken for the rickshaw. Therefore she could not take any action.

During this crisis, her child died of measles without any medical attention. Few intermittent loans taken from rich families, were accumulated and as a consequence, Sabitri had to take up a part time job with the Saha's family. Often the cup of black tea in the morning was followed by a late afternoon spicy meal and the night meals were curtailed. At a later stage, the old symptoms aggravated and were associated with vomiting.

Her brother, who has always been worried about Sabitri's ill health came to know about this. He collected information of "Boddinath doctor", who lived far off. Sabitri, accompanied by her brother visited him. Describing the doctor, she said, "Boddinath did not become a doctor after passing college examinations, but he is popular for his treatment. Sabitri was given allopathic tablets, a talisman with dietary restrictions. She continued to have boiled vegetarian food for around two years and started recovering. Gradually, getting bored of the monotonous taste of Conjee with boiled potato and salt, Sabitri started

adding red chillies to the diet. She said, "without chilli, how one can eat the same potato every day?"

By then, the loan of rickshaw was repaid and they had purchased two buffaloes with another loan. Their son also started working irregularly as a daily labourer to support the family. Suddenly, one day she vomitted blood and started having severe pain in the stomach. Neighbours contacted 'Panca master' (village practitioner). Sabitri was treated with injections and capsules for few days. They had to keep one bronze vessel with the Saha women to get money for the treatment. Sabitri could not repay this loan as she had lost the ability of doing extra work. Symptoms of ill health started reappearing in the next few months.

After three months, considering it less expensive and more effective, Sabitri went back to Boddinath doctor; whom she had visited earlier with her brother. Previous experience increased her faith in his advice. However this time instead of dietary advice or medicine he advised her to treat twenty one children of the village with a meal prepared from a sacrificed goat. Since Sabitri had good relationship with her neighbours, ultimately the total number of children to be fed went upto sixty. She had to sell out a bronze vessel for one hundred rupees. However, the symptoms aggravated further within next few weeks. This

time, she contacted Smt. Kavita Devi (who on occasions of ill-health, had helped women of Sabitri's neighbourhood).

Sabitri paid her own rail fare and was accompanied by Kavita Devi to the district town. Doctor advised a pathological investigation and assured a free surgical treatment. Sabitri thought of asking for her husband's permission to mortgage the gold earnings and get the investigation done.

At this point, Jyotish intervened. One day he said that he had already consulted a doctor at the PHC and took her there by his own rickshaw. She was operated and came back within a week. In the name of abdominal surgery, Sabitri was tubectomized at the primary Health Centre. Sabitri with an expression of resentment, said, "that time itself it struck me that the pain was in upper abdomen but why did the doctor open it up at such a lower level"?

Sabitri said, "After the death of my son when I wanted to have another child, I shared my thoughts with my husband, who, then got very agitated and told me the truth. I was very upset and did not eat for two days". She felt angry and helpless and had no place to go except to her brother who is also married and having his own family.

Sabitri continuously remained sick with occasional treatment from the village practitioner. During last few months,

the buffaloes and hens died putting them at a greater economic loss. She explained, "the animals died of a gastric trouble and their doctor said that it could be prevented with some injection. When we cannot manage the treatment for ourselves, how can we buy medicines for the animals?"

These days, she adds less chilli in diet but due to economic constrains she cannot have more then two meals a day. Her daughter Kakoli has started helping Sabitri in household work. she cuts grass for the goats and breathlessly carries drinking water in a big pitcher.

Sabitri's frequent illness has come to the notice of her brother again, who took her to the private clinic of a doctor who is also employed at the sub-divisional hospital. Laboratory investigations have been done with economic help from her brother and the report is normal. For the purchase of prescribed medicines, Sabitri has to consult her husband and decide upon the source of loan as the recent treatment is beyond their capacity. Despite her experiences of ill health within the supportive net work of her brother, daughter and other women of the village, Sabitri has been helpless. Still she wants to live with dignity. She says, "I am trying for a small job in the hostel of the university (in town) but I do not know any one who can help me in this matter".

When Jyotish was questioned regarding Sabitri's tubectomy, he was not only casual about it but also had his own logic. He said that whatever he had done was for the good of the family. Under the economic pressure in which they have been living, he did not feel it wise to have another child when they already had one son and a daughter. He himself had to take the decision as, he believed that Sabitri would never have been able to agree to this.

Case Report No.4

Thirty two year old Smt. **Ganga Dhibar** complained of blackouts, giddiness, headache, backache and lassitude over last two and a half years.

For these, she had to seek intermittent medical care from both, selftrained and qualified private practitioners. At the time of the study the symptoms were associated with pallor of mucosal membrane suggesting anaemia. Smt. Kavita Devi (the well-off woman and social worker) who had accompanied Ganga to the qualified medical practitioner, reported it as a case of **"blood-lessness"**.

Ganga's husband is Sri. Setai Dhibar. They belong to the middle income category and 'fishermen' group of the schedule caste community.

Two and a half years back, Ganga had occasional problems of giddiness, headache, sensation of burning feet

and diminished vision. It was also associated with a mild pain at the chest. Within next six months, attacks of blackouts and giddiness were so frequent that she was forced to stop work in the fields. She also felt the need for medical care.

First she visited the selftrained private practitioner of the village for one week, spent ten rupees and had few tablets. But she did not notice any improvement. Later, she went and discussed with Smt. Kavita Devi, who then took her to a doctor of the primary health centre who also practiced privately. He advised chest x-ray, thirty capsules and a bottle of tonic. Ganga spent around seventy five rupees and was able to take only seven of the expensive capsules and the bottle of "red coloured" tonic. However, the Chest X-ray was not done. According to her, it would have been too much of an expenditure on herself.

With the partial treatment, Ganga kept well for another ten months during which she resumed her duties in the field. But over the next three months, symptoms other than the chest pain reappeared. She tried to cope with it by reducing her work in the field, but it did not work. Even while being at home, she had continuous giddiness and frequent blackouts.

To minimise the cost of treatment, this time, she visited a private homeopath in the town thrice over two months. She spent thirty rupees in total. As a result of the treatment Ganga said that her apetite increased and she felt better. However, this was sustained only upto another five or six months.

Over the recent four months, in addition to the old symptoms, she is also having insomnia. Since last ten months, Ganga has not been able to go to the field. Prior to the period of the study, she desired to visit a doctor but could not decide upon the source of treatment. Her tendency of minimising the expenditure on ill health and her recent state of willingness to seek medical care associated with inability to decide, can be explained by the dynamics within her family.

Ganga lives with her old parents-in-law, husband, only daughter of ten years, a fourteen year old brother-in-law, married niece of 18 years and her husband. Her husband acts as the head of the family although, decisions are taken in consultation with her father-in-law. The family owns 4 bighas of agricultural land. Ganga's husband supplies fish to the town. Neighbours and friends reported that they save money in the bank. Ganga's brother-in-law takes animals of the well-off households to the grazing field and earns a wage of forty rupees a month along with a daily meal. The

family lives in a mud hut with two small rooms. The environment of the house is dirty compared to the houses in the neighbourhood. The bed room they use and the clothes they wear, the place where they cook, reflect an unhealthy environment within the household. According to Ganga this was a result of too many members living in a small space and fewer women to clean and maintain the household.

Within the family, men get the larger share of the diet compared to the women. However, due to her illness Ganga eats even lesser. Unlike her niece who takes three full meals a day, Ganga takes two meals supported by a small helping of puffed rice.

Ganga is illiterate but she holds a different view on rationalization of having children. She herself gave birth to the daughter after a long wait for six years. Like the women, she does not have any fascination for a son. She does not believe that sons alone look after parents. This, she has learnt out of her own experience of adopting the niece who even after marriage is in a position to look after Ganga to some extent.

Ganga considers her old parents-in-law as only a burden on the family. This is mostly because they do not earn for the family and also, Ganga has to look after them. Her relationship with her mother-in-law is not bitter.

Explaining this she said, "Mother-in-law cannot do any work and therefore, she does not show any temper".

The niece who has been brought up by Ganga, has gradually taken over Ganga's heavy household duties like boiling paddy, carrying water, etc. she also cooks and distributes food in the family. Ganga only collects dry twigs and carries food to the field for other male members of the family.

However, she feels that her niece has not been otherwise sympathetic to her. For example, one day Ganga had backache and requested for a hot oil massage. But her niece blankly refused. According to Ganga, her husband cooperates with her. Due to so many members sharing limited resources and the burden of parents-in-law, it is not always possible to seek expensive treatment.

When the information of the services available at the subdivisional hospital was made available to Ganga, she liked it because of the low cost. Her husband showed interest and within few days, collected the letter of recommendation from the panchayat. After that, without bothering her husband, Ganga took the initiative and visited the hospital with a neighbouring woman and started her treatment.

Case Report No.5

Thirty year old Smt. **Madhobi** suffers from **gastritis** for the last twelve years. Her husband Sri Anando Saha is an agriculturist and also an active member of a political party. They belong to the middle income category and the scheduled caste community. They have two sons.

One-fourth of their agricultural land is given out to share cropping and the rest is cultivated with agricultural labour. The land produce serves as their major source of income. Apart from the crops grown in land, milk produced at home, the rest of the food ingredients are purchased.

Madhobi mentioned that she follows the practices of cooking set by her mother-in-law as her husband prefers it. Except taking occasional help from maid servant, she does all the household work. Explaining the nature of her work she said, "Walking and working are the major characteristics of my household duties". Her tight schedule of work and responsibilities of the household are supplemented by extra jobs in harvesting time. Due to these, in addition to her daily religious rites and waiting for husband, Madhobi's morning tea is often followed by a late afternoon meal and she eats last.

Before marriage, Madhobi was brought up in a village where she studied upto IX standard. Despite her father's

encouragement in studies, she had to stop it because of her mother's illness. Madhobi's husband being a busy person, she herself guides the children at home till they go out of the primary school.

Madhobi relates her present illness to the low availability of food during pregnancy and also due to her mother-in-law's constant domination over her emotional and physical existence within the family. She said that, since after marriage she had to take up active responsibilities of household work. She said, "the next day of marriage, I was handed over the brass pot to carry water from the river. My mother-in-law used to curse me everyday without any specific reason. She used to disorganise my plans in the kitchen. She disliked my resting in the afternoon. My sister-in-law, who was unmarried used to join her". As a result on many occasions, out of disgust, Madhobi lived without food for a day or two. Her husband's position was also critical despite understanding mother's attitude. He could not support his wife openly and solve the problem. However, through experience Madhobi learnt and instead of only crying, she also started opposing her mother-in-law.

Narrating her first pregnancy Madhobi said, "till the fifth month of pregnancy, I had tremendous aversion to food. My grandmother had told me that the food consumed by a mother during this period goes to the mother and after that,

it nurtures the baby". At a later stage, she had severe complaints of "acid indigestion" after the first delivery. It was treated by a qualified allopath at his parent's place over a week. Once she was back to her in-law's place, in addition to her routine duties, she also had to take care of the baby under the same old agonies created by mother-in-law. The symptoms of "heart-burn" and "acid-indigestion" reappeared and taking treatment even from village practitioner was also nearly impossible. However on few occasions, she did collect medicines from the village practitioner through her husband by hiding it from her mother-in-law.

Her situation continued like this for another 6 years till Madhobi delivered her second child. After this the symptoms of illness aggravated and were associated with occasional vomiting. Her husband was worried and called the village practitioner home as and when Madhobi felt it necessary. Any medical consultation for Madhobi made her mother-in-law agitated as she always wanted the same attention from her son.

However, after sister-in-law's marriage, her husband managed to get a small job, on Madhobi's advice some more agricultural land was purchased and the house was extended. But Madhobi continued to fall ill frequently. At the advice of a rich neighbour, her husband took her to a

private practitioner in the town who, along with medicines, advised frequent small feeds and lot of water to drink. Following this single visit, Madhobi never went back to him. She continued to have same medicines from the village shop as and whenever she felt it was necessary.

Two years back, her mother-in-law suddenly passed away and following the period of related rituals, she fell sick again. Describing the sickness, she said, "I could not do any work at home; always pressing against the stomach to get relief from the continuous pain". Accompanied by her own husband, Madhobi again went to the private practitioner. She visited him four times over last two years with occasional support from the practitioner. The last visit was paid six months before. The reason of the delay was explained by Madhobi, "I wish we had enough savings; one visit costs nearly 100 rupees and Doctor would never leave you in less than two follow-up visits". She also narrated how vulnerable their economic position is, due to poor harvest and uncertainity of her husband's job.

The alternative of visiting the same doctor at the govt. hospital was ruled out by her, as it invites extra expenditure, time, and travel over long distance to take a "holy dip in the river Ganges to remove the unholiness gathered by visiting a hospital". Thus, ultimately one village practitioner became the source of necessary care.

Besides the present illness, in the past Madhobi also had the problem of a lump in the right breast. It persisted for 6 months or so. Madhobi, with the rich neighbours family went to the private practitioner who advised 'biopsy' and referred her to a surgeon in a distant town. But Madhobi never went, she said, "instead of spending on surgery, my husband promised sacrifice of animal at the temple and within one year of the sacrifice, the lump disappeared". Thus, with the help of traditional and religious beliefs, Madhobi rationalized her tendency to minimise the expenditure on ill-health.

The other problem which Madhobi has, since her first delivery, is inadequate menstruation associated with white discharge. She has never taken any action for that, "I don't worry for it as it does not do any harm".

Although Madhobi's husband is a busy person, he has always been sympathetic towards her ill-health. He made health care available as and when Madhobi had asked for it. His statement was, "we have plenty to eat. Madhobi should follow doctor's advice and take care of herself."

Case Report No.6

Twenty two year old Smt. **Saroma Karmakar** is the third daughter-in-law of Sri Bhobesh Karmakar. Her husband is a

skilled carpenter. They are well-off and belong to the occupational caste group.

Due to multiple crop system, throughout the year Saroma's mother-in-law is busy in processing paddy, drying them, puffing rice for every alternate day for family consumption. She also rears animals, feed them and cleans the shed. Therefore, Saroma has taken the responsibility of the kitchen, she cooks and serves food to everybody according to individual needs. There is no maid servant appointed by the family. They use smokeless coal as the fuel for daily cooking.

Regarding the timing of meals Saroma said, "I cannot afford to have fixed timing. My meals are adjusted according to the moods of my children and convenience of the men". It was observed that Saroma and her mother-in-law always had their meals following the men. Saroma being responsible for cooking and distributing the food, treats herself as the last priority. All adjustments of inadequacy in the daily requirements are done by curtailing her own food.

Saroma has passed 'Madhyamik examination' at the state level after studying upto X standard. She married by her own choice. She, unlike other daughters-in-law, is very warm in her behaviour towards her in-laws. She looks happy and well adjusted.

Saroma has been suffering from giddiness, headache, and black-outs over last two years. She was diagnosed as a case of anaemia by the medical officer of the PHC whom she had consulted for tubectomy. Later, it was also detected by the village practitioner.

After her second delivery, she was unable to do continuous or heavy work and lost her appetite. She also had burning sensation in the soles and felt very weak. At that time Saroma stayed at her parent's place in the same village. Once the one-month's rituals after child birth was over, Saroma's father collected some roots from a religious healer for consumption. He spent forty rupees for one week's treatment but Saroma did not feel better.

Then, Saroma's mother thought that consulting a qualified specialist would be more beneficial. At her suggestion, Saroma was taken to a gynaecologist in the town. Sixty rupees were spent for one consultation and medicines for 10 days. According to Saroma, this also did not improve her health.

Saroma had to return to her husband's place to rejoin her household duties. Her husband's family was missing her a lot. Within one month of her return her condition deteriorated further. She became weak, restless and unable to take the load of household work as well a child care. Her

mother-in-law relieved her to certain extent from household activities specially cooking. During those days, Saroma used to cover her feet with wet cloth. She had severe 'burning' sensation in her feet. Within a week's time when at the initiative of her in-laws, village practitioner Lala was consulted. He pushed daily doses of intra-muscular injection over five consecutive days. "Still my condition remained unchanged", said Saroma.

Her kind father-in-law who hardly involved himself in family matters, consulted 'Panu master', the other practitioner of the village. He diagnosed Saroma as an advanced case of "lack of blood". He treated her over one month during which thirty two injections of different colors were pushed daily in different doses. He also advised Saroma vitamin tablets and three bottles of tonic.

Within a month, (by April '91) Saroma felt better. she said, "I could move freely without any weakness. The body felt it". Following this, Saroma had undergone tubectomy. This she planned to do immediately after the delivery of the son but was refused by the Medical Officer at the PHC as "the doctor said I had less blood in my body". But she was never advised iron supplementation by the doctor. This gave her an idea that "bloodlessness" had to be treated by a private practitioner.

In September '91, when the present study was launched, Saroma again fell ill. Giddiness, headache and blackouts reappeared. She missed her periods for two months and felt weak and restless. She shared this with her husband, who then decided to have his wife treated. During this inquiry, they learnt that locally grown plants could cure anaemia if included in the daily diet.

Saroma associated her illness with the additional stress of child-birth. In addition, she thought that the irregular timings of her meals alongwith hard work at home were the main reasons for her illness, "Not only I have irregular timing for eatings, after doing so much of work I do not feel like eating too". Keeping a maid servant may help her to a certain extent but she was hesitant mostly due to two reasons. One ,that she considered it her duty to perform the present workload when the rest of the family was working so hard. Secondly, she was hesitant to deviate from the family norm of not employing servant.

Case Report No.7

Thirty eight year old Smt. **Shankori Saha** has been a case of **gastritis** over ten years. Her husband Sri Golaknath Saha is an agriculturist. They are rich and belong to the scheduled caste community. They own thirty seven bighas of land which is farmed on share basis with the help of

agricultural labour. Their own sons go to college and two daughters are married.

Shankori's main responsibilities are agricultural work at home and looking after her family. Often, she skips breakfast and takes a late afternoon meal following her husbands irregular timings. It is therefore very often that she does not eat anything except for her morning cup of tea till as late as 2-30 p.m. Two meals are cooked in a day in fixed quantities. Husband and children take their meal fully and whatever remains is taken by Shankori. Though she eats twice, it is difficult to be sure that she gets an adequate share because of the fixed quantity cooked and the varying needs of the family.

Shankori got married at the age of 16 years. Before marriage, she had to stop her studies at fifth standard as her parents did not agree to send her alone to the high school of the next village. Shankori has high respect for formal education. She kept her younger sister with her family and helped her to pass school - leaving examination. She has been living in this village for last twenty - two years and except for going to her parent's place she rarely went out.

Shankori's illness started in 1982. During the first four to five years of her illness, she had indigestion and

heart burn. She thought that this would subside automatically in course of time and therefore neglected it.

One morning, she felt severe pain in the mid chest and started vomiting. It was difficult for her to bear the pain. Her children called the village practitioner who gave her injections for five days, gave some tablets and cured her for the time being. The symptoms, later started reappearing at a gap of every two to three months. Before reaching the acute stage as before, at Shankori's advice, her children used to collect medicines from the practitioner. Shankori considered this practice as more efficient a mechanism to minimise the family expenditure than neglecting it and taking an expensive treatment at advanced stage.

Within the next two years, her elder son Sushanto collected information through his college friends and took his mother to a private practitioner in town six times. Shankori said that five hundred rupees were spent for this. She kept well with frequent feeds and lot of water to drink, as suggested by the private practitioner and also by experienced friends in the town.

However, since last four to five months Shankori has again started getting heart burn and acid indigestion almost everyday. She finds it difficult to breathe. When she feels it necessary, she takes pills collected from the village practitioner.

According to Shankori, "my disease is the consequence of my responsibility of household work and irregularity in having food". She pointed out that she has never taken help from maid servant even during harvesting season when she processes large bowls of paddy and dries them in the sun. On the otherhand, she is deprived of timely food by the irregular routine of her husband. She added, "moreover, we were never taught to take care of ourselves. We were told that women should live for husband and children".

Shankori is reluctant to pay routine visits to the private practitioner as it involves expenditure. To her, daughter's marriage and son's education are more important investments than intermittent health check-up for herself. Economically, Shankori feels insecure as the source of their income is only through land. Shankori's husband is a very busy person and is hardly seen at home. Major decisions like daughter's marriage is taken by him in consultation with his brothers and Shankori has no scope to express her views. Her interaction with her husband is minimum. Her elder son who is concerned about his mother, decides upon the treatment for Shankori, in occasional consultation with his father. He alone knows the details of treatment and medicines prescribed for Shankori. Shankori is totally dependent on her son and is not even in a position to take out the prescriptions to tell the names of medicines.

These case reports along with the others high=light the following.

- Women's initiative in health care
- Family initiative in health care
- Health care - source and quality
- Impact of men's ill-health on women
- Women's illness and adjustments within the family
- The legacy of "Labour for Love", and
- Breaking of bondages

Women's Initiative in Health Action

Women who suffered from illnesses, differed widely in their health seeking behaviour. There were those who sought help immediately and those who kept quiet about it. There were also those who sought help but the family did not take any initiative and watched them suffer quietly. A number of factors were responsible for these varying responses on the part of women. These were:

- Women's own perception of severity and knowledge about illness,
- Economic constraints and men's illness,
- Women's ability and family attitudes.

i) **Perception of severity and knowledge:** While coping with illness, women reflected their own concept of severity which was closely related to the desire for initiating

health action. Unlike the medical concept of severity which is based on the virulence and the extent of the disease, 'severity' in the women's perception was a changing concept. It varied across economic categories according to women's knowledge of the implications of a particular illness, the degree of their work and availability of resources at the family level. It was also determined by the health situation of men in the family.

Majority of the women in Adityapur rarely had knowledge and information regarding the possible implications of a particular illness. However, few in the well-off category who had knowledge, linked some illness with severity. For example thirty-five year old Smt. Tripti Banerjee was a high school educated Brahmin housewife of a well-off agriculturist. She was suffering from irregular menstruation since last two years and was aware that this condition might lead to 'cancer'. She thought that her condition might put her children in a worse situation and because of this Tripti considered her illness to be 'severe' although it did not cause any disturbances to her work.

The women in the middle and poor categories who did not have much knowledge or information considered chronic illness severe when it caused prolonged suffering and hinderance to their work.

Smt. Dolly Mukerjee of the middle category was a school teacher. Unlike Tripti, she knew very litle about the implications of irregular menstruation and therefore for her, severity developed only when she had acute cramps and pain and her work was affected.

In the poor category, 38 year old widow Annobala, who had persistant fever and cough over two months (since her husband passed away) thought that it was due to her "husbands spirit watching over her". Anno's neglect was partly due to her dependence as she had to seek help either from her son-in-law or the elder son who was a bonded labourer. She considered her illness severe only when she was unable to move out of the mud hut.

With their poor knowledge of causality, women in this category considered tuberculosis "not so severe" as, through their community experience they acquired the 'knowledge' of keeping the illness under control by intermittent therapy. This was all they could manage within their deprived existance.

Women's concept of severity was also determined by the extent to which they suffered. Even among the well-off category not all women were as fortunate as Tripti. They suffered till the disease became acute or their work was affected.

Thirty - eight year old Shankori Saha who belonged to a well-off family considered her illness 'severe' only when an acute attack of gastritis led to a near collapse. Twenty-two year old Saroma Karmakar also of a well-off household who was educated upto high school, suffered from anaemia for last two years. She considered her illness severe only when she could no longer sit up and feed her baby. Similarly, the same illness in 36 year old Bijoli Ghosh (of well-off family) was considered 'severe' by her when it disrupted her household and agricultural activities.

In the middle category also, the concept of 'severity' was closely associated with impediment to work. This notion of severity as 'interference with work' became stronger as we moved from the middle categories to the poor. The poor women suffered longer even in acute illness. Fifty-seven year old Sourobhi Dasi, who had an acute attack of loose motions, considered it severe when the security of her job as a maid servant was threatened. Smt. Ganga Dhibar, 32 years of age and from the middle category suffered from giddiness, blackout, headache etc. for over two and a half years. She considered it 'severe' when it stopped her from sowing paddy in the field. Thus, this close link between perception of severity and work disruption was an important factor in all economic categories. Only exceptions to this rule existed in the well-off where some women had more information and greater freedom for seeking treatment.

ii) **Economic constraints and men's illness :** Economic constraints and men's illness were two more factors that influenced women's perception of 'severity'. Twenty year old Putul Pal of a poor household was prevented from doll making (the major economic activity of the family) as she suffered from pain and irregular menstruation. She described the pain as that of "a goat being sacrificed". It had been there since her adolescence. Given the economic constraints of the family and Putul's position in it as a daughter, the father's understanding of 'severity' of her illness changed over time. It was considered severe as long as resources were adequate. Later on,an economic crisis resulted in scarcity. In addition, preferences for treatment of ailing father and education of her only brother gradually reduced the medical attention given to her and the 'severity' of her illness was lost to the family. But the sufferings did not decline and Putul herself was still keen to find a cheaper cure in the neighbourhood. Putul's experience demonstrated how the 'severity' in the poor is determined not just by suffering but by interference with work, availability of economic resources and men's health situation in the family. Interesting to note here is the fact that though Putul and her mother continued to consider Putul's illness as severe, they were helpless against the changing perception of the father.

In the middle and well-off categories, the economic constraints and men's illness were not significant influences determining women's concept of 'severity'. Compared to women's understanding of their own illness, their understanding of their men's illness was very different, specially in the poor and middle categories. When 45 year old Sri. Aswini Lohar, a poor wage labourer, who was the bread winner of the family had tuberculosis, his wife despite being equally ill with tuberculosis was a portrait of tolerance. Upto 14 months she asked for nothing and at the end ot it she had to be hospitalised. During this period she ignored her own illness in order to let her ailing husband get all the resources and care.

Our data revealed that women's concept of 'severity' was largely a subjective notion detemined by their socio-economic and cultural constraints and it was closely linked with the action they took.

iii) **Women's ability and family attitude :** In addition to women's perception of severity, economic constraints, and men's illness and their attitudes towards illness among women, women's inability to take initiative also affect their health seeking behaviour.

Women across all economic categories lacked initiative. Hesitation, self restraint, attempts at self management or even self-denial were the common features of these women. As

a result, they accepted suffering and the duration of this was determined mainly by how much time they took to communicate with their husbands or family. This gap was more among poor women due to their additional limitations.

Women in various economic categories had different reasons for their lack of initiative. The well-off women's lack of initiative was primarily rooted in their acceptance of their subordinate position in the family. They tried hard to maintain the patrilineal family norms which promoted the domination of mother-in-law and their own subordination. Moreover, women like Shankori Saha pointed out that "we were never taught to take care of ourselves". Describing her own hesitation, ever charming Saroma, previously referred to, said that she felt hesitant to talk about her illness to her husband or anybody else in the family. "All other members are working hard from sunrise till the sunset and it would have been something 'odd' to draw their attention to oneself".

Bijali said that the heavy work load was forced upon her by her mother-in-law and had become a family norm. The reduced work capacity due to illness (anaemia) was noticed by her husband only when she was unable to perform her duties. According to her, the only effective way of communicating with the husband was "to be bedridden".

Mostly the husbands came to know about their wives' illness when they were acutely ill. Thirty-four year old well-off 'Suri', Mira Saha, suffered from gastritis for over twelve years and during the first five years she had restrained herself from communicating with her husband as she did not want to "disturb" him. She attempted to cope with her illness by skipping meals or by replacing a full meal with small helpings of puffed rice, sugar and water. Her husband was always busy in agriculture and business. When Mira's symptoms persisted she collected medicines from the village practitioner through her children. It was only three years back when the symptoms aggravated further, that her husband came to know about her illness. There were very few exceptional women who did not hesitate to communicate with their husbands and initiate action.

The women in the middle category were worse off. They kept their ill-health to themselves as they wished to minimise the family expenditure by avoiding expenditure on themselves. Their insecurity forced them to be less demanding and less of a 'burden'. Also, the unpleasant expreriences with husbands who considered wife's illness as a 'disturbance in the family". The harsher attitudes of men in the middle category was either linked to their tighter economic position or their own self-centred personalities.

Thirty eight year old Ashalata Ghosh suffered from gastritis for fourteen months. In order to avoid the scorn of her husband she attempted at self management by collecting medicine from the village practitioner occasionally through her son. She did not tell her husband and it was the son through whom he came to know about it. Still he remained reluctant to take any further action. Similar was the situation of 32 year old Suvankari Dhibar whose husband had leased in some land for share cropping and Suvankari had to work on it. As a result of her illness she could not work. Her husband blamed her of neglecting work. As a result, when she later had irregular menstruation with severe cramps and pain, she was not able to speak out and continued to suffer for more than a year.

In the poor category, the economic roots of women's lack of initiative were most obvious. The present illnesses of the women were often a repetition or continuation of a number of previous events which were hardly diagnosed and treated. Once sick, they continued to live a life full of miseries. Forty year old Mira Dasi of 'Mochi' community had been perpetually ill for the last eighteen years. Mira said that nearly eighteen years ago she fell ill for the first time. She hid her illness so well from her husband that he could realise it only when her "whole body was swollen up and she could not go out of their mud hut".

Sabitri Dasi had to bear the death of an 8 year old son without any treatment. Communicating her own illness to her husband was not at all possible in such a situation. Only in acute suffering such as severe gastritis of Sabitri, severe acidity and constipation of Mira Dasi, cramp and pain in irregular menstruation of Putul Pal, was some kind of help sought.

Thus we see that behind the lack of communication lay a disciplined and a self-willed woman whose strengths had been weaned towards undermining herself. The self imposed restraint made her a submissive personality unable to take initiative. This common cultural trait in all categories of women was rooted in their economic insecurity and family tensions arising out of dominant and insensitive family relations.

Family Initiative in Health Care

In the well-off section, irrespective of the controlling authority of the nuclear and joint families, health seeking for the ailing women was generally not delayed on the part of the family. Husbands were busy in agriculture or business but had no objection in organising health care for them. Parents-in-law were also sympathetic. For example, 23 year old Ratna Chatterjee was the fourth daughter-in-law of a well-off woman Kavita Debi. Kavita Debi

controlled the decisions in the joint family where Ratna lived with her husband and one year old son. During her second pregnancy, within a very short period of the first delivery, it was her mother-in-law who advised her to go for induced abortion "to avoid health hazards for Ratna and her child." Ratna was happy at this suggestion.

In the middle and poor categories the in-laws dominated health care for women. Husbands were not able to take independent action for their wives. However, there was no objection from the in-laws when parents took initiative and responsibility for their daughter's health care. This arrangement did not put extra economic burden on the family and "mother-in-law's domination over her son remained". Twenty-five year old Jharna Dhibar suffered from the symptoms of anaemia and had to wait for treatment for four years till her dominant mother-in-law's death.

There were husbands in this category who were directly engaged in production or supervision. In these households women did not get enough attention from them during illness. Thirty-eight year old Ashalata Ghosh suffered from gastritis for over fourteen months.She wanted to be completely cured of her illness. But when her agriculturist husband was contacted, he did not recognise Ashalata's illness at all.

In the middle category, health care for acute illness like diarrhoea was delayed as it was considered a common

ailment and the knowledge of oral rehydration or treatment seeking was not available at the family level. As a result, 18 year old Purnima had to be hospitalized due to neglect of early symptoms.

Among poor households, health care for women was sought only when the symptoms were acute, kept them bed ridden and impaired from work. For 38 year old Anno, the lack of knowledge and information at the family level was the major factor behind the delay. For Mira Dasi of 'eastern locality' and Sobita Lohar of 'northern locality' of Adityapur the delay was due to scarcity of resources at the family level. Twenty-two year old Sobita was prevented from working due to anaemia. She had to wait till the harvesting was over during which her daily wage earning husband could make some savings for "consulting a doctor". There were few women who were so poor that they had to wait for the roaming practioner who provided treatment and medicines on loan. For 30 year old Laxmi Dasi who was suffering from irregular menstruation with a history of anaemia, seeking health care was not possible due to additional economic scarcity created by her husband's illness of tuberculosis.

Thus, we found that the delay in health care for women was a feature in the middle and poor sections of Adityapur. While for the middle group, it was the result of relationships and economic stringency at the family level,

for the poor it was more due to economic scarcity. The families of the middle and poor groups were extremely lacking in knowledge and information on the implications of certain illnesses like diarrhoea, severe anaemia and even for "persistent fever with cough".

Despite the relative hold on resources, the poor working women's perpetual struggles for survival of the family were too overwhelming to care about their own illness. In the poor families, men's inaction was linked with helplessness and when action was sought, often it was to save the breadwinner of the whole family rather than just the women.

Use Patterns and Quality of Health Care

We saw that health care for women's illness was often delayed by the family even after they had communicated to their husbands and in-laws. Alongwith this delay the source, nature and regularity of health care varied in different economic strata and men's illness in the family acted as an additional factor in determining quality of care.

i) **Self management :** Before the family intervened there was a varying period of self management by restricting the quality and quantity of food intake, physical activities and lastly seeking help from the village practitioners. Home

remedies were not practised. For the well-off and middle category women, village practitioners were the last resort of self management whereas for the poor, it was mostly restriction of physical activities. Mira Saha of the well-off category had consulted the village practitioner for gastritis as she did not want to disturb her husband for 'herself'. Similar was the practice of Ashalata of a middle household, who also suffered from gastritis. For her the reason was the attitude of her husband who "never recognised" her illness.

ii) **Sources of health care :** The **well-off** women consulted qualified private practitioners (preferably an allopath) in the town, after taking consent from the husbands who were busy but provided full cooperation in health care.

Women in this category had completed the preliminary intensive course of treatment with the doctors in the town. However, once the symptoms subsided, they never went back to the practitioner. They felt that "further treatment was not necessary". However, even when the symptoms reappeared majority of them did not prefer to go back to the town. Instead, to keep the illness under control without disturbing their husbands, they occasionally collected medicines from the village practitioner on the basis of old prescriptions.

Like the women in the well-off section, a tendency of consulting qualified private practitioners in the town, was also observed in the women, of **middle category.** But, unlike the former, majority of the middle category women were shunted back towards the village practitioner mostly due to economic stringency or lack of imformation regarding long-term treatment. In acute illnesses like diarrhoea or prolonged fever, these women did not know of oral rehydration therapy nor did they use home remedies. At advanced stage when village practitioners were consulted many of these women were referred to government hospitals.

The comparatively better-off women of this group who had some advantages, went to the qualified private practitioner more often compared to the relatively poorer women in the same category. Those who did not have these advantages confined themselves to village practitioners. For example, Ashalata, due to her non-cooperative husband sought treatment for gastritis from the village practitioner who lived in her vicinity.

Women like Dolly Mukherjee (suffered from irregular menstruation), who lacked in knowledge, were throughout guided by their ill-informed fathers or husbands. The health care varied from "pain killers" to Yoga, homeopathy or even irregular consumption of pills without any medical consultation. Sometimes, even if they could manage some cash

from the family, they were often guided by the supportive network of the well-off women and landed up at the expensive clinic of a private doctor in the town. Ultimately they had to look out for "less expensive" sources like homeopathy.

There was yet another group of women in the middle category who were deprived of all family help and continued to suffer. Whenever women wanted to avoid the "expensive or harassing" investigations for simple illnesses advised by the qualified private practitioners, they chose religious healing which was a "one time affair". Many women like Ashalata did not find it beneficial and their suffering continued.

The level of information within families regarding government services at diffeent levels were inadequate. Very few families knew of the national programme against diseases like tuberculosis, malaria or diarrhoea.

Thus the choice of source was also determined by the same factors which governed action-taking by the family such as resources, information and knowledge of the family and relationships within it.

For the women in the **poor category**, families chose a range of sources for health care. In chronic illness, women often had more than one health problem and received treatment from multiple sources, one after another. The

reasons behind such shifts were i) failure of a particular source to cure and ii) finding the sources inconvenient, expensive, therefore not suitable. Men's illness in the family also marginalised health care for the women.

Twenty year old Putul Pal who suffered from irregular menstruation associated with cramps and pain since her adolescence tried out the village prectitioner, qualified homeopath and allopath (only once) and many less expensive 'one time affair' of religious healers without any relief. Her search for yet another new and cheaper source was still on.

Many of those who had tuberculosis considered fever and cough in the beginning as common ailments and got treatment from the village practitioner upto six months. They then switched over to the government institution or qualified private practitioners. The latter was often due to the influence of the well-off employers or villagers. The poor either copied their health behaviour or were advised by them to go to private clinic. As continuous longterm treatment was not possible, they either discontinued treatment or went to the government hospital. For other chronic illnesses people did not use government services as they often had to buy medicines like in private clinics.

Thirty-nine year old Aroti Ankuri after receiving treatment from the village practitioner for her persistent

fever and cough, was taken by the employer to a private clinic in the town. After being diagnosed as tuberculosis it was realized that the treatment was expensive. So she was referred to the district hospital through the PHC network, for collecting drugs. She became a defaulter due to many reasons such as long distance to travel, husband was reluctant to forego daily wage and accompany her to the hospital, none to look after the young children, irreglar supply of drugs and physically less active dependent mother-in-law at home. However, after two years of no treatment when Aroti felt worse, her grown up daily wage earning son took her to an expensive private clinic in the town. Aroti was willing for a less expensive treatment from the recently established and close-by subdivisional hospital. But, Aroti could not say 'no' to her son, who was fascinated by the variety of 'pills' and 'prescriptions' of the private specialist. As a result the treatment was only sought when there was money in hand i.e. roughly once in three or four months.

The more recent cases of tuberculosis reached the subdivisional hosptial on their own or were referred by a qualified private practitioner. In these cases the drugs were provided in such a manner that the treatment was discontinued every week for two days. Often treatment created economic pressure within the family. Thirty-two year

old Anjali Dasi reached a qualified practitioner after suffering for three months. Anjali arrived at the sub divisional hospital for 'free treatment'. She was supplied with ampules of 'free injections' which were to be pushed at her own expense . Anjali was already removed from her job of maid servant. Her husband owned only eight cottah of land and earned irregularly as daily labourer. They also sold out the little amount of milk produced at home. Her only daughter was studying at school. Under these circumstances, Anjali did not consider it wise to spend two rupees a day for the injection. Instead she gradually adopted another strategy. She took treatment for a month from the "doctor in town" as and when she became too sick to work and move.

Thus, poverty affected the choice of health care for the poor women. Even in acute illnesses like diarrhoea, women had to wait for uncertain periods till the visiting self trained practitioner from the neighbouring village paid his routine visit and provided some medicines on loan. Women in these households were also provided with some medicines by the employer in order to keep the household of the latter going. Home remedies for certain illnesses like anaemina, mild gastritis and irregular menstruation if available, were prefered by these women.

Thus we find that choice of health care for the poor women also, was directly dependent on availability of

resources, information at the family level, and family attitudes.

iii) **Quality of Treatment:** The quality of treatment for women's illness varied with the sources such as government hospital, private practitioner within and outside the village and religious healing.

Although the hospitals were supposed to provide free services, the actual practice was a little devious. The government doctors had their own private practice and therefore those who could afford to go to their clinics (the middle category or the well-off) got preferential treatment in routine care as well. Very often the hospital staff themselves failed to communicate with villagers specially the poor women who thought that "hospital is not for us but it is for the Bhadrolok*" . In the process, health education and follow-up advice was extremely lacking. In addition, very often organisational problems such as delay in procurements and scarcity of drugs, fewer doctors and inadequate supervision because of internal conflicts affected the health care provided by hospitals especially to the poor.

Thirty-eight year old Anno Dasi was a case of tuberculosis. Due to lack of organization and short supply

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* People from upper economic categories with decent dresses.

of drugs, Anno's treatment was discontinued every fifth day of the week for two days.

Private practitioners were of different types. Practitioners available at the village were self-trained. They provided symptomatic treatment and medicines, without any preventive, management and educational component in it. They referred acute and advanced cases to the hospital and practitioners in the town respectively.

Qualified practitioners in town were of two major categories. In one category, there were doctors with higher fees (Rs. 10 to Rs.25). They wrote a prescription, sometimes provided dietary advice but did not explain the need for long term treatment or preventive measure of illness. In the other category, there were doctors who charged very little (Rs.2 only) for consultation but the medicines had to be purchased from the medical store attached to this clinic. This was crowded mostly by the poor people who were often kept on an unexplained and "never ending" treatment.

Forty year old Mira Dasi changed the source of treatment mostly depending on the availability of information and resources. During last two years she had been receiving treatment for gastritis from such a clinic. The doctor did not mention about the diagnosis in his prescription. On every visit, before even consulting the doctor, Mira was pushed injection by the compounder in

exchange for eight rupees. This was followed by a brief consultation with the doctor and Mira spent another fifteen rupees for enzymes, liver tonic and occasional antibiotics. However this medicine was actually given for ten days but Mira used to stretch it over a month till her next visit was feasible. She herself explained the treatment as "the policy of the doctor is neither to kill us nor to let us die".

There were other women too who received similar treatment where even an estimate of expenditure was provided by the practitioner and treatment was started once the amount was deposited. A practitioner was reported to have said, "If you don't have money, you better go to the cremation ground". These doctors had no time for any educational or preventive advice.

The variety of religious practices were reported to have either no value or sometimes consoled people who could not really afford treatment. Some infact reported traumatic experiences.

The data on self-management, sources, quality of services and duration of treatment as described above show a clear difference in each of these aspects of health care for women in different categories. We took up ten men from different socio-economic categories (five poor, three middle and two from the well-off categories) with illnesses which

could be matched with women in our case reports. Case reports of these men very clearly brought out the differences in the above aspects of health care between the two sexes. None of these men were found to have attempted any degree of self-management, once their disease was diagnosed or it caused any inconvenience. Only the men with tuberculosis in the poor category sought diagnosis and treatment after gaps of two to three months which still was much earlier compared to women with tuberculosis. In the men that we studied though there was no difference in the sources used for health care the time at which care was sought was significantly different. Illness in men was considered severe at a much early stage and hence resort to care was faster.

The mobilisation of family resources both in terms of money and personal care was much higher for the men. This automatically tended to improve the quality of care as compared to women.

Apart from these differences in the use pattern and quality of care between the two sexes, men's illness had a direct impact on health care of women.

iv) **Impact of Men's Illness on Women:** Except for the well-off category, men's illness had serious implications for women's health care. Women not only sacrificed their own

treatment but also took up extra physical and economic burden to replace men's reduced ability to earn.

In the middle category, women like Anima, the wife of Swapan Karmakar received irregular medical care for hypotension, compared to her husband who was under continuous treatment for gastritis.

Another woman of the same economic category, Ashalata Ghosh was a case of gastritis and was advised by the village practitioner to avoid 'chapati' and eat 'rice'. Her husband Adyanath was advised to take chapati and light meals for his bronchial asthma. However, to reduce work load and cope up with her own illness, Ashalata compromised her diet. Moreover, when her husband went to the town and received continuous medical attention from qualified private practitioner, Ashalata, could only visit the village practitioner when necessary.

Amongst the poor, men's illness not only delayed and discontinued women's treatment, it some times did not even permit it. Women however, went out of their way to provide care and support to their men.

Twenty - two year old Sobita's medical care for anaemia was discontinued as the result of increased ecoomic burden caused by her husband Arjun's problem of gastritis (case report follows). Thirty year old Laxmi Dasi suffered from

gynaecological disorder associated with anaemia. It was not possible for her to seek medical care due to her husband Bonsi who was suffering from tuberculosis.

Very few women like Mamota (wife of Biswanath, a case of tuberculosis) did not report any illness and they were able to hold on to their strength. She said, "as long as we have hands moving, we would work and live, we have diseases in the family (i.e. tuberculosis of her husband and malnutrition of the child) as we are poor but it could not stop our meals yet".

But, unlike most of the men in this category, Biswanath recognized the disadvantageous situation of women. He said, "They are tied to the family with husband, children and hundreds of problems, not in a position to take care of themselves. Such understanding of the husband and his co-operation with wife in household work and childcare, probably provided the strength to his wife.

The following case reports provide details of the situation of women's health which was also determined by men's illness.

Case Report No.1

Sri **Arjun Lohar** of twenty eight years, has been a case of chronic gastritis for over a year. He suffers from indigestion and flatulence and vomits often after a meal.

They are marginally poor. They own one bigha of infertile wasted land distributed through the panchayat. They grow paddy, potato and mustard in ten cottah land of the Sahas and collect 50% of the share of the produce.

Arjun is basically a daily labourer. His wife Sobita is a maid servant and earns fifty rupees a month and a daily meal for herself. Arjun's old father is handicapped, occasionally brings some money by begging. Otherwise he rears the cow and looks after Sobita's child whenever necessary.

Arjun has been suffering over one year. In the beginning he did not care for three weeks or so and thought it would stop automatically but it did not. Due to the severity of his symptoms he could not go out to work for one week. This pushed the family into an economic crisis. So he borrowed money from the employer and took expensive treatment from the village practitioner for one month. Sobita said, "We had to pay seventy-five rupees to the doctor". After this Arjun kept well and continued to work for another three months. Gradually he started having the same problems again. He was afraid of losing like the last time but at the same time they did not have cash to seek treatment from the self trained practitioner for one week. As a cheaper alternative, Arjun collected local commercial preparation 'Amlagirna' which is available with the hawkers in town. It costs them

twelve to fifteen rupees a month. He has been continuing it for last six months. Initially it was effective but lately it did not work well.

Sobita is worried about her husband's ill health. She too has the problem of general weakness to the extent that it prevents her from going to work sometimes. But, she cannot share it with husband for the fear of worrying him. She helplessly says, "There is no second person at home for help when my husband falls sick. Father-in-law is old, handicapped to do anything." Though she has now been suffering for one and half year, as yet she has not sought any continuous treatment or improved her dietary intake.

Case Report No.2

Thirty five year old Bonsi was a marginal poor and belonged to the 'Bayen' (Scheduled caste) community of Adityapur. He was a daily labourer and owned twelve cottah of agricultrual land. In the year of 1990, he was detected as a case of tuberculosis.

During the month of April, he had persistent fever with cough for three or four days. He immediately consulted Lala doctor (the village practitioner) for one month and then was referred to Dr. Susovan in the town, who also failed to cure Bonsi. Thus during next five weeks he received treatment from many sources and ultimately was admitted at the

subdivisional hospital when he vomited blood. After diagnosis of tuberculosis he was referred to the district hospital where he had to spend a month during July-Aug '90.

Treatment was free. He was refered back to the PHC with supply of drugs for three months, PHC was not able to supply his drugs and he also could not afford twenty rupees a month to collect the drug from the district hospital. Through a known person, he purchased expensive drugs from a pharmacy in the town and ultimately stopped the treatment after twenty days.

When the old symptoms reappeared and the free services at subdivisional hospital was made available to him, he restarted the treatment again.

Laxmi, thirty year old wife of Bonsi explained how Bonsi's sickness has pushed herself and their fourteen year old son Kalicharan to a miserable life, "too much to bear since last two or three years. He (Bonsi) stopped working. Kalicharan had to leave his studies and started working at babu's place. I worked as a maid servant and now started working in the field also. We go through hardships to give good food to Bonsi in time". She has been suffering from gastritis, gynaecological problems, indigestion, and blackouts with giddiness, but Bonsi's sickness does not given any scope to seek treatment. She said, "How to treat

the disease which has originated in our life style itself. We are poor".

She explained "Before hospitalization we had to call "Lala doctor', till now we have not paid the price of his medicine even. My sister came to see the local festival with fifteen rupees. I took all the money from her and sent it to him in the hospital". This also had increased her debt to the grocer who gave some money on loan. Hearing his wife narrating her helpless situation, Bonsi could not stand there any more and immediately left the place. However, in December 1991 neighbours reported improved health of Bonsi as they observed him threshing paddy.

Case Report No.3

Thirty six year old Sri. **Swapan Karmakar** is a case of chronic gastritis. He lives with his old mother, two brothers, wife and a child. They belong to middle economic group and occupational caste group. They own 50% share of eight bighas of land. The other sources of income are his wife's job at the village Anganwadi centre and also a collective profession of doll-making at family level.

Swapan has been suffering from severe acidity, indigestion and occasional vomiting since last five years. From the very beginning, he has started consulting a village practitioner who provided him homeopathic treatment. During the

first year he used to consult the village practitioner at the time of acute problems like severe discomfort associated with hyperacidity or vomiting. Later on at the advice of the practitioner Swapan continued a regular treatment and thus he said that he was able to control it. He visited the practitioner twice a month on an average and spent around 10 rupees every month. With her limited knowledge, his wife tried to take all possible care of her husband including special nonspicy frequent feeds. But, she had to control his frequent consumption of black tea.

Anima herself often fell sick with acute giddiness which prevented her work. It was diagnosed as hypotension by the village practitioner. She consulted him once in two or three months whenever she considered it necessary. There was no special care for her own diet. Her criteria for 'necessary', were qualified. For example, "other members of the family should be healthy", "there should not be any serious problem within the family". She "should get time to go to clinic" and above all, she had to be "completely incapable of performing her role" in the family.

Thus, given the lower status of women in the society and the norms and values around it, obviously men's illness acted as an important factor in determining women's health specially in the poorer section of the village.

Women's Illness and Adjustments within the Family

While the burden of the adjustments fell upon the women, the families also made some degree of adjustments to cope with the women's illness. These adjustments varied with the economic status of the family and its ability to cope without the labour of the women. The adjustments attempted by women affected them personally such as their reduced dietary intake, extending their rest periods, reducing physical work to the extent possible and seeking help from the daughters and other women in the family wherever possible. These attempts obviously affected the balance within the families where help was not forthcoming. In such families women tried to stretch themselves as much as possible at their own costs.

In this section we concentrate on the adjustments made by the families.

In the well-off families the women essentially performed the household as well as agricultural functions through supervisory activity. At the most they were doing cooking and sometimes parboiling and puffing of rice. In these families firstly the illness was never prolonged and incapacitating (this could be due to smaller numbers that we had). Secondly in the event of illness most of these families were able to employ maid servants as labourers. The financial burden of treatment was also not detrimental to

the family's economic status. Women's illness therefore did not disrupt family activities and the family adjusted temporarily without any major strains. Irrespective of the nuclear or joint nature of the family, illness of women did not have any unpleasant impact on the existing relationships in the well-off category. Adjustments were done between women and their mothers-in-law, husbands or children in terms of work and responsibilities.

In the middle category, household resources were limited compared to the well-off. Risk of wastage of crops in this category was more critical as most families had limited produce. Women were mostly participating in agricultural activities at home as well as outside. Their labour was critical. In addition they physically looked after all the household work and the children. The family balance therefore, was much more vulnerable in the middle category families. Here too, the attempt was to depend upon other women in the family; very few employed help on a temporary basis. Women curtailed their own treatment to avoid 'wastage' of family resources. Despite all this, these families had higher levels of family tensions. It was not uncommon to find reluctant husbands who refused to treat their wives' illness seriously and angry mothers-in-laws who resented taking over the physical work.

Most middle category families even when they provided treatment, attempted to restrict expenditure by either one time consultation or encouraging the women to use local practitioners. However, they did not mind when women's own families stepped in to help out their daughters or sisters. Where the tensions between the women and her in-laws were greater due to economic stringency and a subteranean struggle for control, when women fell ill and the functionality of the household was disturbed, the tense relationships became worse.

For the poor, the adjustments often left permanent impact on the economic structure of the family. The family sometimes was forced to take loans, sellout assets, stop work in order to get women cured. For example during the eighteen years of illness of Mira Dasi, the family had gradually sold off their goats, bronze vessels and bicycle.

In these families then illness had serious implications for the very survival of the family. In addition, the impact of women's illness on relationships was also far reaching. Unlike the women in the Well-off and middle categories, they did not get the support of other women of the family except for their daughters. The reason for this was primarily the extreme economic insecurity of all nuclear units in which women's labour was critical. Thus the niece of Ganga Dhibar who was adopted as a daughter had little time for Ganga when

she fell sick. While Ganga felt hurt by this negligence, the niece felt that her work was more important. Similarly, Mira Dasi's daughter-in-law Sobita felt that her mother-in-law should look after her own problems as Sobita had enough on her hands.

Thus in illness most poor women felt isolated and neglected. While they had given priority to their family requirements at the cost of their own health, when they fell sick there was no one to help. Even when families intervened to help it was more to get her back to work. As a result, women like Laxmi Dasi felt disgusted with their husband Bonsi whose illness was cared at the cost of his wife's ill-health. Milan Lohar was helpless, she drained herself out for her husband and now even he did not show interest in her health care. Sabitri was angry yet helpless at her husbands trick of getting her tubectomized in the name of "surgery of gastritis". Mira felt sad for her sons who did not care for her.

Poor women in despair sometimes attempted to mobilise their own resources by saving. Mira Dasi developed her own strategy of saving the small change which was returned after buying the daily needs. When she could make twenty five rupees, she paid a visit to the private clinic in the town. Thus, for initiating health care she always had to wait to first collect her fees.

These adjustments left the women completely exhausted. The impact of illness on her own health was best expressed by Mira Dasi of the poor category, "There is nothing left within my body. Within the outer covering, it is like a rotten leaf which had fallen into the pond". To the poor women of Adityapur, the concept of 'rest' was in the "peace which was obtained only after closing our eyes for ever".

The Legacy of 'Labour for Love'

To the women of Adityapur, the concept of ideal existence was related to her "union with husbands family" which was normally to be followed by the event of reproduction and activities like rearing of children and caring for other members of the family. To fulfill these household duties, women were ready to bear hardships. To be a wife and a mother (of a son) was to be a complete woman. Within such an ideal of womanhood they accepted their own labour as love and not as process in production.

The nature and degree of such 'labour for love' varied according to the position of the family in the specific socio-economic structure. Each category transferred these skills from "fathers side" in order to help the daughter adjust with "husband's family". It was the women through whom this legacy was passed on from one generation to the other.

Thus women at a young age learnt not only household skills but also to accept their problems as secondary and their desires as unimportant. For example, twenty year old Putul Pal, due to economic constraint had to stop her studies to give way to her brother's education. She also accepted the negligence of her illness at family level in order to seek treatment for her father. Mitali Hazra, who belonged to a middle category joint family learnt to ignore her own illness given the perpetual family feud in which the elders were engaged. Despite having desire for seeing the world outside, she supressed herself. She said, "we are fish of small ponds, how do we know about the taste of sea water"?

Not only were they forced to accept suffering and give up hopes but they were also the first to get affected by the illness of their mothers. Sabitri Dasi's young daughter of ten years had to carry breathlessly a huge pot of drinking water and participate in other household work to bring relief to her mother who was ill.

Twenty - one year old Kaberi was the only unmarried daughter of Subarno Saha (suffering from acute diarrhoea and chronic rhematic pain) in the middle category. Kaberi repeatedly stated that due to her mother's sickness, she had to take up the whole load of household work. She had to stop

her studies at IX standard which according to her was an obstacle to her wish of "standing on my own feet".

In the poor and middle categories, daughters between the range of ten years to 30 years, provided physical and mental support to the ailing women. They also dreamt of being economically independent and leading a "happy life". Nando could not marry and had to work to be able to feed her mother. Thus from a tender age the girls were taught to serve and to sacrifice their dreams.

Breaking of Bondages

It is important to note that simultaneously with the 'legacy for love' a potential for change was also visible, indicating a trend against the bondages in which women lived. Even though a weak trend, it certainly was visible in Adityapur.

Majority of the women who had adolescent unmarried daughters wanted to see them "capable' of being independent in accordance with the norms of the 'changing society'. The daughters too wanted to study and acquire a job of atleast a "school teacher". In all categories mothers and daughters were enthusiastic about education and employment even though the priorities of women were kept behind those of men by the family as a whole. Well-off woman Mira Saha and her school going daughter Chhanda, Smt. Bhattacharjee of middle

category and her college going daughter Purnima and Anjali Dasi of the poor section with her daughter Sumitla studying in the high school were the examples of this.

Direct attempts by women to stand on there feet were also observed in the well off and middle categories. Either they went for training and found employment (Bula Saha, dauther of Smt. Phullora Saha of the well-off section), or they opted for some training which creates the possibility of employment such as Kabiri Saha, Protima Saha, Mitali Hazra who went for training in tailoring and music. In the poor, except for those who were engaged in studies other girls had to choose jobs of construction workers or house keepers in the town.

Eighteen year old Purnima, by watching the miseries of women like her mother and elder sister decided that she wanted to live with "a job and less number of children".

While girls in the middle category still dreamt or hoped, those in the poor categories were forced to struggle for survival given their poverty and lack of family support. Thus the social situation itself pushed the women out of her traditional role like Nando, the daughter of Sourobhi Dasi who did not receive any help from her brothers or sisters in looking after her ill mother. She took up a job of maid servant in the town in order to earn more than in the village and looked after her mother as her 'child' by

sacrificing her own desires. Despite facing such adversities in life, mother and daughter retained a tight bond of understanding and sharing.

It was also interesting that in this category very often women expressed their preference for daughters over sons. They had learnt through experience that sons do not necessarily look after parents. These findings do indicate a weak but definite trend towards change.

Chapter 5

PREGNANCY, DELIVERY AND FAMILY PLANNING PRACTICES

Our baseline survey identified eight pregnant women and twenty three mothers with children upto 1 year of age. This set of 31 pregnant and lactating women provided the opportunity to study the pregnancy, delivery and family planning practices across economic categories and explore reasons for the differences between different categories. The number of women belonging to the well-off section was very small and had to be assessed with caution (Table 4).

Table 4 **Distribution of the Study Women in Different Economic Categories**

Description of Women	Economic Categories			
	Poor	Middle	Well-off	Total
Total Number of Women above 14 years	138	230	88	456
Percentage	30.3	50.4	19.3	100
Pregnant Women	5	3	0	8
Women with upto 1 year child	9	8	3	20
Women Experiencing Still birth	2	0	0	2
Women Experiencing Infant Death	0	1	0	1
Total	16	12	3	31

PREGNANCY PRACTICES

We explored practices such as place of stay before delivery, work load and extrafood intake and found the following:

Place of Stay

Majority of women from all sections dreamt of going to their parents' place for the delivery. If not all through the pregnancy they certainly wished to be there during the advanced stages of pregnancy. Women in all economic categories expressed this desire in different ways. For the well-off and the middle categories, it was the pleasure of being in a comfortable environment where they can rest and feel free. For the poor, it was the hope that being away from in-law's place would provide an opportunity to break away from the strenuous routine of daily duties. One poor woman said, "How can in-law's place be one's own home. They are others. Women can never be free to eat, laugh and relax there".

The dreams however were very different from the hard reality of choices that women made, specially those in the poorest section. Ten out of 16 had to choose to stay with the in-law's or the husband for reasons which were basically rooted in their poverty (Table 5). These women worked from sunrise till sunset to supplement the economic resources of

Table 5: **Pregnancy Practices of the Study Women** (N=31)

Economic Categories	Place of Stay Parents	In-laws	Physical Work Reduced	Same	Extra Food Qual+Quant	Quant.
Poor n=16	6	10	4	12	0	16
Middle n=12	8	4	4	8	9	12
Well-off n=3	3	0	3	0	3	3

Qual - Quality; Quant - Quantity

the family. Most of them belonged to nuclear families which were economically unstable and therefore needed women's labour for survival. The women also managed their households and took care of other members of the family, who depended on them for cooking, washing and caring. Some of the poor women could not even dream of visiting parents who were in a worse economic position compared to themselves and therefore, were unable to keep their daughters with them. In addition to being poor, sometimes health services were not available at their parent's village. This also sometimes acted as a deterrent.

In the middle category, a much smaller proportion of women faced problems in fulfilling their desire to stay at their parents' place. Also, the reasons for their inability to go to their parents, were slightly different. They were

either responsible for running of the households or lived in families where the mother-in-law did not permit them to go. The latter was often the case in those households where women did a lot of agricultural work at home.

The well-off women, although few in number, had no problem in this matter as staying with parents during pregnancy was a well accepted norm in their community. In fact, the status of the family of origin of a woman was assessed by, whether her parents were able to keep their daughter with them during pregnancy.

Thus, we see a shift in the practice of going to the parent's place from the poor to the well-off. While the latter could afford this luxury, the poor could not.

Workload

The physical workload of women remained unaltered in more of the poorer households compared to those of the middle category. The well-off avoided physical work by going to their parents' houses. The proportion of women whose physical workload was reduced during pregnancy increased along with the economic status of the family (Table 5). It was clearly a result of staying away from husbands' family.

At the husband's place, a large proportion of poor women had to work not only at home but, also in the paddy

fields, till the day of delivery. These women rationalized their workload by saying, "it helps in keeping the body fit during pregnancy and makes the delivery easy". This was also the view of the older women of the community. However, all 31 women prefered to be exempted from work during the period of infant care. There were husbands in this group, whose inclination towards reducing the outdoor workload of the pregnant wife was linked with the fear of extra expenditure in case of a mishap. Twenty-two year old Rekha used to collect cowdung and twigs from the field. When she became pregnant, she was advised by her husband to stop the outdoor work as it might cause threatened abortion and invite expenditure on medical consultation!

A common explanation in the poor and part of middle categories (landless beneficiaries of the land reform) was that in nuclear families, household work not only meant physical exertion but also the stress and strain of responsibility of keeping the household going through their earnings. This did not provide these women a scope to reduce their work load.

The rest of the women in the middle group did only household work, often with the help of a maidservant and in a more organized and less laborious fashion than the other sub-group.

Extra Food

According to the women, during pregnancy hunger increased. Therefore, the quantity of food intake automatically increased across all economic sections. Women generally said that eating at the in-law's place was not the same as eating at their parents' place.

Twenty year old Phooltusi from the middle group farmer family stated, "till the day of delivery I had to go to the field for harvesting at my in-laws place. After working for long hours during pregnancy I never felt like eating to the full". It is worthwhile mentioning here that this woman delivered a premature baby and experienced neonatal death.

The diet of poor women was also poor in quality compared to those in the better off categories. While the middle and well-off women could afford rice, dal, poppy seeds or fish, vegetables and milk, the poor mostly lived on conjee and potato rarely with an egg or other vegetables. For the poor women, the need for better quality of food during pregnancy was an unrealistic idea. They neither talked of it nor practised it. At the most they said that they consumed more than the normal.

Majority of the middle category women (75%) received a supplement of milk and/or egg to their normal diet. Around one tenth (11%) of these received it despite being at their

husband's place. In contrast, 25% of the women belonging to the same economic category who did not receive any qualitative supplementation (Table 5) stayed at their husband's place.

Presence of the mother-in-law in the family however, did not make much difference in both the groups. Women's secondary position and the attitude of self-sacrifice in order to minimise the family expenditure played a major role in this.

The well-off women stayed at parents' place and had better quality of diet. They were also able to correlate the quality of the diet to the health of the new born. One woman said, "A plant has to be cared with fertilizers in order to get good fruits in the future". However, the concept that additional food in addition to giving birth to a healthy baby also protects mother's health, was absent even in these women.

All these three features that we looked into, that is, practice of giving relief to the women, extra food and reducing her work load are thus linked with the economic status of the family. Only those families who had resources and did not critically depend on the labour of women could afford to give the above luxuries. The women themselves accepted the risks of pregnancy and their own deprivation as a necessity for the survival of the family. In addition to

the economic factors or degree of alienation from the in-laws, a lacking sense of rights and a sense of responsibility of the women also acted as added social reasons for their existing practices.

AWARENESS AND CHOICE OF ANTENATAL CARE

Services

Majority of the women from all sections had information regarding immunization and iron supplementation during pregnancy (Table 6). The well-off women and those of the middle group who interacted with private doctors also knew about physical examination. For the poor, antenatal care

Table 6: **Awareness and Utilization of Antenatal Care** (N=31)

Economic Categories	Source					Services	Personnel		
	Govt.		Pvt.		Not Aware	Immunization & iron supple.	Paramedics	Doctors	None
	A	U	A	U					
Poor n=16	13	13	13	0	3	13	10	3	3
Middle n=12	12	9	12	3	0	12	7	4	1
Well-off n=3	3	0	3	3	0	3	1	2	0

Govt. = Government; Pvt. = Private; A = Awareness; U = Utilization

meant two visits to the village outdoor (sub-centre) to receive "two injections and fistful of red pills". One poor woman who experienced three pregnancies, remembered the "checking of tummy at home" by the "didimoni of the outdoor" during her first pregnancy. Her understanding of the change in quality of services was quite insightful. She said, "those days, didimoni did not become permanent at her job". Women from all sections who had information, had either received or decided to get immunized from the government institution. Women visiting private clinic preferred "health tonic" over the iron pills provided through the government institutions as the latter created discomforts.

Fifty eight percent of women belonging to the middle category farmer group and the poor had collected it from the sub-centre but did not consume it. Twenty one year old Aroti said, "I got the pills and I threw them in the pond after five or six days. I had gas inside the tummy. After taking those pills I lost appetite and passed hard stool". However, despite having minor problems, 13% of the poor women consumed the "red pills" over two months. Among those who did not consume the "pills", were very often women who rejected it simply on heresy and not because of a negative experience. For example, Kamola, a middle group housewife give away the 'red pills' to her maid servant Anno. Instead, she bought a tonic. This behaviour left a negative

impression on Anno who had to consume the pills which had already been rejected by her better-off employer! During her pregnancy Anno collected the 'red pills' but never consumed them even though she could not afford the 'tonic'. The PHC Staff rarely emphasized the importance of the iron pills.

Sources

Majority of the women across all economic categories knew that services for pregnant women were available at the government institutions and private clinics as well. Women from different sections referred to these according to their own experience and knowledge (Table 6).

The well-off and traditional land owning middle group (one fourth of the total middle category) had visited a private clinic of qualified practitioners, who were also attached to the sub-divisional hospital. These women had no economic constraints. They felt that paying "little money" to such a doctor would draw extra medical attention during delivery at the hospital. In addition, they would receive a "check up" (physical examination) which would reduce the avoidable problems during delivery.

The remaining three-fourths of the middle category women preferred to visit the "village outdoor" than a private clinic, although they knew that the latter had additional facilities. The reason for this was because of

their role in the agricultural activity of the family. In their daily work schedule, they hardly had time to spend for themselves. A group of women said, "we do the sowing, harvesting and boiling of paddy. We puff rice. Besides these, there are household jobs. Where is the time for us to go to a private clinic in the town? It takes away at least four to five hours a day".

Despite being attracted towards private health care facilities, thirteen out of sixteen poor women could not avail of it given their poverty (Table 6). They said, "We are 'Chotolok'" (i.e. people with inferior status). Village outdoor is the best suited for us." It was evident that the notion of 'Chotolok' was based on the lowest economic position of the poor and not by their caste, as the Sahas were exempted. Three poor women between the age of fifteen and 16 years had no previous experience of pregnancy. They were unaware of antenatal care and therefore of the source also.

Personnel

All the women who had information regarding antenatal care, talked about the health workers of their choice who either provided services or whom they had decided to contact (Table 6). Two third of the well-off and one third of the middle group women primarily talked of the doctor followed by paramedics.

The poor who preferred government institutions mostly referred to the services of a 'didimoni' (female paramedical worker). Three out of 16 of them however, preferred a doctor as they had already experienced still birth or difficult labour.

Majority of the women across economic categories were aware of fetal wastage, still birth and infant death as a result of experiences in the community. However, very few knew about maternal death during delivery. The last experience of maternal death was of Amiya Mandal around 45 years back.

Our data thus showed that economic position solely determined access and use of MCH services and the response of the practitioners was equally dependent upon the economic status of the clients.

PREFERENCES FOR PLACE OF DELIVERY

Old women of Adityapur recollected their deliveries at home only. They remembered it as a long procedure with many dos and don'ts. One woman in the middle group said, "over the last fifteen years or so, since the village has been connected with the town by pucca road, delivery at the hospital (including PHC and sub-divisional hospital), has become popular in the village. In this connection, a general statement by the traditional potter, who also farmed a piece

of land seemed to be relevant. While describing the transition of his own profession, he expressed that easily accessible, more beneficial new technologies which suited the current life situation have been always accepted by people.

The popular professional dai had passed away a year before. Her sister had not been able to gain faith of the villagers and was called only for cleaning and caring after delivery. Another dai of the middle group and scheduled caste community, was not professional but had the experience of conducting twenty one deliveries among her own family, friends' and relatives' house. Over time, the traditional system of home delivery had declined in the village. Sixty five year old Smt. Sarola Saha of the well-off community also had the skill of conducting deliveries at home. She said that people of the new generation are afraid of home deliveries by a dai. Another middle category old woman, Smt. Durgarani Hazra, felt that lack of patience and time have taken the younger generation towards institutional deliveries.

Existing non-professional dais in the village claimed that people wanted to curtail expenses by institutional delivery. However, the younger women expressed a different view. Despite ANM's home visits and the delivery services provided at the PHC, younger women prefered the sub-

divisional hospital. With the experience of often being referred to the sub-divisional hospital by the PHC, these women thought that the former was a better place for delivery.

Smt. Kattayani Sarkar, an ANM at the PHC confirmed their assessment. According to her a much larger proportion of drugs was provided to the sub-divisional hospital. Due to comparative scarcity of medicines, people were often forced by the PHC to buy it in the market. Moreover, the hospital was better organized with modern equipments to handle delivery cases.

Majority of women from all sections of the village, preferred institutional delivery over delivery at home (Table 7). All the well-off and 9 of the 12 middle category women appreciated the medical care at the time of delivery in the hospital. Eighty one percent of the women who preferred hospital delivery could not buy the prescribed medicines. The major reason given for the preference was "to minimise the complications and for the protection of the new born".

Another 22 year old middle category woman said, "suppose the baby is too big, the doctor would immediately operate and take it out". Three others said that they could not trust Shanti Dasi, the non professional dai. Despite

Table 7: **Preferences for Place of Delivery and Sex of Child**

(N = 31)

Economic Categories	Institution	Home	Baby Girl
Poor n=16	13	3	5
Middle n=12	9	3	2
Well-off n=3	3	0	0

having experience of conducting twenty one deliveries, Shanti was called only to cut the cord if the delivery had already occured at home. In addition, shorter distance of the sub-divisional hospital was an added advantage.

For six women (Table 7), it was the convenience of home delivery which attracted them most. By 'convenience' they meant that there was no necessity for travelling to the institution and waiting there till the delivery took place. Causing inconvenience to the other members of the family by hampering their daily earning was the major factor. These women also learnt from their experienced friends that PHC was crowded and there was scarcity of space. Moreover, they thought that the stiches provided at the institution were the result of forceful and unsympathetic handling of the institutional staff which was not so in case of dai. These

women also mentioned about the services rendered by the dai as "humane" against the same provided by the institutional staff such as ANMs or nurses who were generally known as "didimoni". However, it was found that the dai was also a close relative or neighbour in these families. Jharna, a 17 year old woman who was in her second pregnancy said that the best way was to combine home delivery and institutional immunization. The poor did realise that, "the hospital is a place with higher capacity of handling difficult delivery". Thus reasons for the shift to institutional delivery seemed to be due to the security offered by hospitals to handle complications better, if they arose. In addition, loss of skills of traditional dais and economic factors also influenced the change in delivery practices.

BIRTHING CARE

Majority of the twenty three women had normal delivery and gave birth to full term babies (Table 8). Among women belonging to the well-off section, premature delivery, difficult labour with medical intervention or death of the baby was not reported. In the middle category, one out of 9 deliveries was premature. The baby died on the seventh day after birth. This was the first delivery of the mother. The symptoms before death were, "high temperature with irregular and frequent breathing". This was a case of home delivery by non-professional dai. Women in the family considered it as

Table 8: **Delivery Services Received by Women During Previous Year**

(N = 23)

Economic Categories	Term		Nature		Death of baby	Days of Stay at institution			Delivered by		
	Full	Pre	Normal	Diff.		< 3	4<6	>6	Dai	Nurse	Doctor
Poor n=11	11	0	9	2	2	6	1	2	2	7	2
Middle n=9	8	1	9	0	1	5	2	0	2	5	2
Well-off n=3	3	0	3	0	0	1	2	0	0	0	3

Diff. = Difficult delivery with intervention

the "influence of evil eye" whereas, the dai indicated a premature delivery and small size of the baby.

Among the poor, two out of all women experienced difficult labour leading to still birth despite medical intervention. According to the descriptions given by the women, these deaths were due to delays in taking decision of intervention either by the members of the family or by the doctors. To cope with these experiences, the rationale offered was best expressed by fifty seven year old Kutturi Dasi. She said "Does the first fruit of a tree always survive"?

In case of normal deliveries, a larger proportion of the well-off women stayed in the hospital for a period of four to six days. These women had consulted the doctor before delivery at the private clinic and thus acquired rights for better hospital care. The largest proportion of the women in the middle group stayed in the hospital for three days only. The poor stayed even for one day. Only women with difficult deliveries and still births, were kept in the hospital for a longer period (i.e. six days).

At the hospital, majority of the women in the poor and middle categories were delivered by the nurse. Only two women each in both the categories were delivered by doctors (Table 8), the poor due to difficult labour and the others

due to previous consultation with the doctor at his private clinic. The well-off and middle group had to buy all the required medicines. For the poor however, some medicines and saline were provided free. Only in 18% to 22% of the women in the poor and middle households, deliveries were conducted at home by the dai.

On discharge, unlike the well-off and middle category women, 55% of the poor women could afford only a part of the prescribed medicines and 22% could never purchase any of it. There was only one woman who managed it from the money received by undergoing tubectomy.

Those women who delivered at home did not receive any medicine after delivery except a drink made of sugar and puffed rice sometimes with ginger.

To illustrate the problems of the poor we have two case reports of Smt. Chhobi Mal and Smt. Aroti Dasi.

Case Report No.1

Twenty eight year old Smt. **Chhobi Mal** experienced a **still birth** during early September 1991. She and her husband are landless poor and belong to the scheduled caste. Chhobi has two daughters and this time, she had the hope of a son.

After completing five months of pregnancy, when the baby started moving within the womb, she visited the sub-centre

at the village. According to the advice of female multipurpose worker, she took two doses of Tetanus Toxoid in the eighth and nineth months of pregnancy. Along with this she also took iron tablets for around two months.

During the tenth month, one early morning she had pain, Her husband immediately took her to the primary health centre, by a rickshaw. At the primary health centre, she was attended by a nurse who put her on a saline drip. At the end of the day, Chhobi was referred to the sub divisional hospital. There, they were told that the baby was too big and was not in a normal position. The doctor referred the case to the district hospital. She was sent by an ambulance and advised to carry two thousand rupees which may be necessary.

Chhobi's husband borrowed some money from a well-off household and accompanied her to the district hospital. Chhobi was attended by a doctor who put her on saline drip.

According to Chhobi, they had to spend around two thousand rupees for buying all the medicines and 3 bottles of saline. The rest of thirteen bottles of saline were supplied by the hospital authorities. Describing the delivery, Chhobi said, "they used forceps to pull the baby out, while doing this, the baby did not survive. In addition, the sac of urina was hurt. The doctors made a hole

in it". As a result, she lost control over micturition. Since then, she has been using small pieces of cloth to absorb the continuous dripping of urine.

Chhobi mentioned that the Congress(I) boys of the youth club made enquires regarding her health when she was hospitalized.

At present, Chhobi needs treatment for her illness but, she is afraid of visiting a doctor any more. One of her close relatives consulted a visiting private practitioner of the city. With his recommendation, a surgery has been fixed in a private nursing home at the district town. This requires an amount of 2,500 rupees even at a concessional rate. Chhobi is afraid of the uncertain consequences of the surgery. In their economic crisis, the village panchayat gave them a letter of recommendation with the help of which the family was advised to collect donations from villagers in order to organize the second surgery.

Chhobi was not convinced of the explanations given by the doctor about still-birth of her baby. With heavy work load during pregnancy and lack of adequate nutrition she had delivered two normal babies before. Why should the third baby be big? The possibilities which she associated with it are mainly lack of physical examination by the female multipurpose worker and carelessness of the doctor at the district hospital. Her husband too criticised the late

detection and carelessness of the government doctors. He said that due to such carelessness, poor people like them have to suffer and spend so much of money. However he carefully hid the fact that Chhobi's parents rendered all monetary help in this incidence.

At present Chhobi cannot work in the field any more. This creates an additional scarcity of resources within the family. Throughout, the family has been supported by Chhobi's parents who do not even mind borrowing money from others. During the recent delivery, they provided the whole amount of money. In this crisis, Chhobi's nine year old daughter is also dragged into the work force of the family. She collects cow dung from the field and makes cake out of it, which are sold in the village.

As a result of the whole experience, Chhobi has decided to have no more children. While she felt the need for a son to inherit the name of the family, she said, "I have learnt a lesson now. I have been thinking of operation (tubectomy) along with the surgery of urinary sac. It will prevent an extra incision".

Case Report No.2

Sixteen year old Smt. **Aroti Dasi** experienced a **still-birth** during September 1991, at the district hospital. This

was her first pregnancy. They are landless poor and belong to the 'Bayen' community of scheduled castes.

When her menstruation stopped for two consecutive months and it was associated with aversion to food, Aroti recognized her first pregnancy. Immediately she and her husband went to her parents' place to share the excitement with them. Although, her parents-in-law stay in the hut next to them, they did not feel like sharing it with them. Their relationship had soured due to the economic control over the married son. The bitterness later separated the parents from their son.

Since then, Aroti stayed with her parents till the 6th month of pregnancy. Then she came back to her husband's place in order to get the antenatal care which consisted of complete immunization and iron supplementation. However, Aroti did not take the iron tablets. She said, "I did not feel like taking them. They were all discoloured. I threw them all into the pond".

After this, Aroti again left for her parents who lived in an interior village near the district town.

At her parents place, all the members were then engaged in the field for saving paddy. In the beginning, Aroti had mild pain for one day. She told her mother who thought that the pain would increase before delivery. Next day also Aroti

had the same type of pain and continued to perform the household duties allotted to her. She cooked for all and served them food when they came back from the field. She again reminded her mother of the pain. At around 5 PM, she was taken to the district hospital by a rickshaw. Her mother and maternal uncle accompained her.

It took two hours to reach the hospital where she was immediately admitted. The doctor examined her and informed them that the baby had turned round within the womb, and he advised for a caesarian delivery.

Aroti's mother was very nervous. Her maternal uncle did not agree to it at all. Aroti said, "when I came back to my senses, I found the baby was already dead. It was a thin baby boy".

She was discharged from the hospital on the following day with an advice of tonic and a diet of fruits and milk. All the expenditure on the occasion was born by her parents who are well-off. It came upto five hundred rupees. Within fifteen days of delivery her husband brought her back. He said, "I found her depressed and pale like paper. Durga Puja was also coming closer. I called Panu master (the self trained village practitioner) home and requested him to cure Aroti before the festival. Panumaster advised fifteen penicillin injections and four bottles of tonic". They could afford only ten injections and two bottles of tonic.

However, Aroti's husband was very satisfied with the treatment as Aroti became normal before Durga Puja. They had to spend around 25 rupees.

Aroti considered the incidence of still-birth as a mishap. She had a high opinion of their own general health and said, "We do not have any sickness except my mishap. In the village, people do have diarrhoea or fever in season, but we do not have".

However, Aroti associated this incident with a fall she had during her ninth month of pregnancy at the pond side while washing clothes. Her husband who was very considerate and caring, felt that the delay in help caused the loss of their baby.

Aroti has again missed her periods since December 1991. She anticipates it as a pregnancy. This time, she is determined to be extra cautious in terms of antenatal care from better sources like the subdivisional hospital. Her husband wants to keep her with him.

Aroti knows it well that when they become three in number, the expenditure would also rise. For this reason, she wants to remain happy with one child, whether it is a girl or a boy.

AFTER-DELIVERY CARE

It was an accepted norm across all economic categories in Adityapur that the mother and new born should be isolated for 30 days.

Period of isolation of the mother and newborn was directly related to the economic resources of the family (Table 9). All the well-off women could rest till the maximum, while for 75% of the middle group women, the period of rest was restricted to twenty one days as they had to resume their household and agricultural duties.

The poor said that economic constraints, women's vital role in the household, and the demands of child rearing in nuclear families made it impossible for majority (91%) of the women to rest beyond nine days. One of the women had to

Table 9: **Isolation of the Mother and Newborn**

(N = 22)

Economic Categories	≤ 9 days	10 ≤ 21 days	22 ≤ 30 days
Poor n=11	10	1	0
Middle n=8	2	6	0
Well-off n=3	0	1	2

start working immediately after returning from the PHC on the third day of delivery.

PREFERENCE FOR SEX

Majority of the women across economic sections desired to have one son and a daughter to become a "complete mother". Preference for a baby girl was secondary to a baby boy.

None of the women in the well-off category, preferred a baby girl (Table 7). Two of the three women did not want a girl as they already had one daughter each. The third women had a retarded baby girl and therefore, could not think of having another child. One of them said, "I want a boy but my husband is hesitant. He is not ready to take the risk of another daughter because, one needs to spend more than one lakh rupees for a daughter's marriage".

A similar opinion was expressed by the women in middle group. A woman with two sons said, "More the number of children, more your property would be divided, on top of that if it is a girl - we would be finished".

On the other hand a larger proportion of the poor preferred a baby girl (31%) irrespective of the existing social norms. Women arrived at such a decision as they found that given the economic insecurity prevailing in their economic category sons did not necessarily support their parents. On the

other hand, mothers such as Anjali found her grown up daughter Shantona to be a great help in reducing the physical work load at home. Fifty seven year old Saurobhi Dasi had been looked after by her 32 year old daughter Nando who remained unmarried. Twenty two year old Aroti after experiencing a still-birth desired to have only one child of either sex. However, she said, "if it is a daughter, she would probably be able to understand her mother". Thus, experience in the same class, developed the understanding in a proportion of women that giving birth to a baby girl is no less insignificant compared to a baby boy.

FAMILY PLANNING PRACTICES

Besides the thirty one study women, four old women distributed over economic categories were interviewed to get a general idea about the family planning practices of the previous generation of Adityapur.

A fifty-five year old Devi from the well-off section said, 'I never knew how to limit my family. By the time we realized it, there was already a football team at home! Moreover, who would think and speak against the husband?! It would have been a great sin! However, later on, when the children grew up, we maintained a distance". The older women said, "In our time, a women could never predict how many children she was going to have".

Forty year old Mira Dasi of the poor section, said, "As such I had been sick through out. After delivering four children we (i.e. with husband) decided to go for an operation". She showed the scar of tubectomy and said. "This has brought relief since it reduced our worries".

Awareness of family planning was high among the women across all economic categories. All the 31 women confirmed this finding. Decision of family planning practices was universally governed by the preference for sexes and the desired family size" Methods preferred by the women varied across categories.

Only one of the three well-off women did not practice any method as the desired norm was not fulfilled. However, she had decided to undergo tubectomy immediately after having a son. Another couple, despite fulfiling the desired norm accepted oral pills as a longterm measure. This behaviour was influenced by the male friends of the husband. The third woman who had a retarded daughter, out of fear of having another child like this, was practicing abstinence with mutual understanding with her husband.

Women in the middle category said that they would prefer tubectomy as a permanent method of family planning, once the family is completed. However, till then, some of them also practiced spacing. For example, Kamola Chatterjee was continuing with "Ovral' for spacing. Her husband was

advised so by his friends. Another woman, Minoti, rejected the method of copper-T because of the possible complications already experienced by her neighbour. She preferred oral pills. Minoti chose the method for herself as she felt hesitant to share this with her husband who might not consent.

The poor women preferred only tubectomy as it was "one time business". Further, women thought that this was the least complicated method. They specifically rejected the "electric operation" (Laproscopy) as, to their knowledge it was not reliable. A general nurse of the sub-divisional hospital informed them that probably this was not due to the failure of the method but a wrong assessment of the last date of menstruation.

Women chose a particular method for themselves as they were convinced that it would be a stress on men who worked harder in the field.

Thus, there was general acceptance of family planning methods in Adityapur and it was closely linked to the desired family size, preferences for sexes and economic status of the families. It was an area of health practice which had widely penetrated the family as it was closely linked to survival and had been encouraged by men.

Our data on pregnancy, delivery and family planning practices reflected a degree of change not observed in the previous chapter dealing with the general illness of women and the way people dealt with them. While economic factors continued to determine behaviour patterns and the differentials in economic categories were visible in all aspects of pregnancy, delivery and family planning practices, a shift towards modernisation was visible even among the poorest of the families. This was indicated by the popularity of family planning methods and by very high proportion of women seeking ante-natal, natal and post-natal care from government or private medical institutions. Our data also showed that to a very large extent cultural practices tended to rationalise economic constraints as in the case of choice of place for delivery or working and eating practices during pregnancy. The process of diffusion of cultural practices often acted negatively when the poor attempted to emulate the well-off and rejected government hospitals as well as iron tablets offered by them. The differential attitudes of professionals in health care towards women of different categories also played a critical role in the process of transition from traditional to modern medical care. On the one hand they attracted people by their skills and on the other hand they discouraged them by their indifference.

Chapter 6

SOCIAL DYNAMICS OF WOMEN'S HEALTH

While studying restructuring of life that takes place around illness, Kleinman (1987) argued that the meaning and experience of illness is nested in a complex personal, socio-economic and political nexus. The emphasis however was on personal. Anderson et al. (1991) argued that treating culture as a static "objective fact" that determines illness - meanings, illness - behaviour and the restructuring of life, glosses over the harsh reality of poverty and oppression. They agreed with Brittan and Maynard (1984), who thought that culture doesnot have a free-floating reality independent of any structural constraints. In their own empirical study of immigrant women in Canada they showed that the experience and meaning of illnesses were actually determined by the material conditions, social relations and restructuring of life. They proposed that illness experience of women were definitely not rooted in culture but within social, economic and political aspects of Women's life.

All these authors emphasized one or the other end of the scale. Our study pointed out that though culture certainly had socio-economic context, it was not necessary that changes at that level always changed cultural practices. In other words, once created culture by itself becomes a critical force in determining the context itself. Our study also pointed out that cultural practices have two kinds of influences. Firstly, they maintain the status quo

by keeping alive the traditional ideologies and their hold over generations. Secondly, through this they act as barriers for the external forces of change, both political and socio-economic.

This study of Adityapur could neither be used for generalisations nor did it quantify the trends in perceptions or treatment seeking behaviour of the study population. However, within its limits it did highlight certain social processes which determined women's ill-health, their understanding of it and health seeking behaviour of women (as individuals) as well as their families. These processes were found to be active both at the larger socio-economic and family levels and they were constantly interacting with each other.

The differential impact of socio-economic development is clearly visible in the national figure on literacy. While 39.42% is the female literacy, 63.86% males are literate (Bose, 1991). West Bengal slightly improved the situation but still the gap remained with 47.15% literate women as against 67.24% men. This gap is indicative of the inadequate penetration of social changes in traditional structures as well as norms. In this chapter, based on our findings, we put together the reasons of similar gaps in health and health care which put women at a disadvantage in the village of Adityapur.

SOCIAL TRANSFORMATION AND WOMEN

Significant transformation took place in the village over the last five decades because of socio-economic and political changes in West Bengal. The village has been well connected with the town by road. This opened up opportunities for people to seek jobs and business outside the village. The women however, were least affected by this process. At the time of study only 6 women were going out of the village for jobs, apart from the construction workers.

Land reform also brought major changes in the social structure. However, as the ownership patterns did not change the transformation affected mostly men. Except for a few widows, the others continued to depend on their men thus benefiting only indirectly. Introduction of multiple cropping did increase opportunities for work and it benefited the women. However, the general condition of women agricultural workers did not change much as they did not received cash in their hands which was often given to their husbands and their leisure time also got curtailed as they had more work to do. Due to better transport and communication while the men went out for better entertainments, the women lost their only recreation of going out in groups to collect water from the river bed as the tube-wells were dug in the locality.

Though the panchayat had been active in the village and was a major instrument for change, the participation of women in it was limited. Those women who wanted to be active were looked down upon by other women.

Despite the popularity of education and a significant increase in girls' education, the village junior school teacher still felt that the participation of the poor, specially girls, was very poor. "Their drop out rates were higher as the custom of marrying them off early continued". Also they were sent out to petty jobs instead of the school.

The socio-economic transformation in Adityapur thus touched women only lightly. Unlike the reported equal health status of men & women in Kerala (Kannan et al 1991), Adityapur presented a very different picture. Here women were not considered earning individuals even when they worked on family farms. Also, education had not as yet made women capable of standing on their own. Thus despite the relative increase in work participation specially in agriculture, and some increase in educational levels, women's health status had remained relatively poor. The factors which were identified by Kannan et al. (1991) as major contributors to improved health status of women, did not seem to be adequately effective in Adityapur.

HEALTH DIFFERENTIALS

Even though our study did not estimate morbidity, the estimate of reported illness was 6.8% per year (in the age group above 14 years). This was comparatively higher than the annual morbidity figure of 2.8% for the state reported by the National Sample Survey (NSS), 1974. Using the same methodology of NSS (i.e. assessing perceived morbidity over two weeks prior to the study), the Kerala Shastra Sahitya Parishad (KSSP) recorded a morbidity of 20.6% per year (Kannan et al, 1991), which was even higher than our findings. The higher rate compared to the NSS data could be explained in terms of the methodological differences. Our study provided a larger scope of making good rapport with the population where in, people felt more free to talk about their serious health problems. We spent much longer time for a much smaller population. Lastly a gap of almost 20 years existed from the last NSS data on perceived morbidity.

Our data on reported illness indicated a trend similar to that of the impact of transformation on the women across all economic categories and reported more illnesses in women compared to men (table 2). Thus alongwith an economic category differential in the total reported illness, there was also a sex differential in all categories (table 2). It was 11.4% per year in the female as against 3.3% per year for the male population. The two were certainly inter-linked

as the sex differential seemed to decline as we move from the poorer (14.9% per year) to the better-off categories (9.2% per year for the middle and 8.7% per year for the well-off).

In addition, a differential trend was also observed in the distribution pattern of illnesses in the various economic strata. Tuberculosis, chronic gastritis, anaemia, diarrhoea and dysentry were the diseases of poverty (to validate this however, we need a larger number of sample). Even here women suffered more from these illnesses compared to men.

Our data pointed out that though socio-economic stratification was critical in determining women's health, it alone did not explain the state of health of women. These other social factors which added to the women's burden of ill-health in various degrees across economic categories were largely located within the family dynamics and the prevailing norms and traditions of these units. Their strength lay in the fact that they were unquestioningly accepted by both men and women.

HEALTH AND FAMILY DYNAMICS

Alongwith the low self-image of the women across all socio-economic categories, the other factors that we found the most critical were her subordinate relationship with

her in-laws, husband and son, criticality of her performance as 'unrecognised' worker for the survival of her family as a unit, her lack of access to family resources and information, her inability to initiate health care and go out of her home for seeking health care.

Across all economic categories women considered themselves of lower status compared to men. The differentiation started right since they were born. The ceremony following the birth, the delay in weaning of girls, lack of importance given to their studies, the way girls were presented in the marriage market and the local festival of women revealed the demeaning ways in which women were treated in the society. The only thing all these events could do for the women was to glorify their marital and mothering status. Moreover, within the norms of the society, women themselves desired sons and perpetuated the myth of their own uselessness in society.

Woman's various roles within the family (daughter, mother, sister or mother-in-law) were shaped by the norms of patrilineal society. She was submissive and subordinate to husband and in-laws, dependent and sympathetic to son compared to daughters from whom often she got more help and support. As a result, she shared the maximum burden of economic scarcity, physical work and emotional tensions within the family. She adjusted her own needs to the minimum

to accomodate other's hunger and desires. This feature was more common in the middle category women who lived in joint families characterised by dominance of mothers-in-law and reluctance of husbands.

Within the scarcity situation of the poorer families, women's relationships specially with earning sons and daughters-in-law were often permanently strained and led to a split in the family unit. At times, it was only the daughter who acted as the last resort of ailing mothers by giving up her own hopes and desires.

Though women were pivotal in keeping the family going, the criticality of their role in household work as well as their work for the livelihood of the family, was hardly recognised. The pressure was maximum in those middle and poor category women who had to work at both levels without any external help. It made women much more vulnerable to stress and ill-health.

Even though women earned in the poor sections, they had no right to spend it according to their needs which often received the lowest priority at family level. The doll makers of the middle economic category or those who participated in family's agricultural activity were no different. These women who lived in stringent or scarcity situations had little or no access to cash. As a result they had to attempt self-restraint, compromise on source and

quality of treatment and even suffered in silence. The poor women being the worst victims in terms of illness, often developed their own mechanisms of savings secretly or borrowing for seeking treatment. The well-off women who had better supportive relationships within the family, received economic support for treatment. Even then they themselves were hesitant to use it.

The social forces that regulated women's mechanism for coping with illness were multiple. Her mindset where her primary duty was to serve the family gave her the strength to curtail or ignoreher health needs. 'Neglect' thus became a 'norm'. In case of illness this led to a twin gap between realisation of ill-health and seeking out treatment. One part of the delay was contributed by the women and the other by the husband or in-laws. The delay on the part of the women was directly linked to her notion of severity, her sense of responsibility towards family and hence her in ability to take initiative, family attitudes, others' illness and economic constraints of the family. The delays by the family was generally contributed by actual economic constrains, negligent attitude of men towards women's illness and often lack of information about sources.

These same factors which influenced initiation of action, also influenced health care and its quality. Our data showed that though socio-economic status played a

critical role in deciding access and quality of service, there were clear differences between sexes also. Less evidence of self-management, early seeking out of treatment, greater expenditure and mobilisation of all resources to help the sick were major features of men's illnesses. A sick man made women's illness worse and the burden of adjustments fell largely upon women. Poor families often broke down under the pressure of illness.

Thus we found that the state of women's health was critically determined by the family dynamics moulded by factors which were not always specific to economic categories. In other words, these micro level processes were found to be at work in all categories though in different degrees.

INFLUENCE OF SOCIO-ECONOMIC FACTORS ON FAMILY DYNAMICS

Critical for our understanding was the finding that even though certain family level processes were observed in all the categories, their manifestations varied in different socio-economic categories. For example, though women were generally less informed about health and health services, information levels were not uniform in all categories. The poor were the most disadvantaged. Similarly, though in all categories women's illness received comparatively lesser attention, access to services, type of services used, follow

up of treatment and duration were influenced by economic status of the family. Most importantly, the subservient self-image which was the strongest common denominator among women, also changed its articulation to some extent within different categories. As a result the degree of self-denial and self-management of illnesses and the expression of her need for treatment also varied from category to category. While the poor women controlled themselves the maximum, the better-offs did take some liberties. In addition, the attitude of the family towards women's illness was also influenced by the family's economic status as we found that the well-off families did not delay women's treatment while the middle and the poor categories took longer time in initiating action.

The fact that these common processes manifested in different degrees within different economic categories pointed out the influence of the larger socio-economic forces on the family dynamics.

Our data showed that the interaction between the micro level family dynamics and the macrolevel social processes took place largely through moulding the following aspects of family dynamics:

i) As the stability of the family increased with improved economic status, the criticality of women's labour

also reduced. Since survival of the family as a unit no more depended upon her unrecognised labour, she began to achieve some freedom as she was no more required to destroy herself to save the family. While the well-off women did mostly supervisory work within the household with external help, the middle category women were often engaged in agriculture within the household and also in the field. The poor women were basically wage earners, in addition, they had to keep their households going. Their labour therefore was more indispensible and even illness could not be permitted to relieve them of their burden.

ii) With improved economic status, the ensuing security for all members of the family, specially women, reduced the level of intra-familial tensions arising out of women's insecurities and generated more caring relationships between women. In the poorer sections, sharing of limited resources with other women created tensions in the relationship. Attitudes of the men towards women illnesses also changed to some extent with economic security.

iii) Better access to resources and social status automatically improved access to information, education and health care. This was not only a function of money but also better contacts and social access. This differential in access to services was also augmented by the biases within

the health services itself. While the private practitioners were motivated purely by profit, the responses of the medical officers in government institutions were equally dependent upon the economic status of their client. Banerjee (1982) also reported similar findings and described that the ANM of a PHC in rural Uttar Pradesh was considered by the poor Harijan as "Mem saab" who visited them only when her" fees (illegal)" were paid.

It needs to be pointed out here that despite the evidence of positive socio-economic transformation within Adityapur, it was also evident that the position of the poor had been affected only marginally with only the Sahas getting the maximum benefits. With unchanged power relations within the family, marginal increase in common resources (even if they were due to the agricultural labour of the women) did not necessarily improve women's access to health services. On the other hand as shown by our case studies, men always had the advantage of an earlier and a more appropriate medical care.

The economic hierarchy generally matched the social hierarchy. The Brahmins and the non-scheduled castes dominated the middle and well-off economic catatories. The scheduled castes largely constituted the poor and middle categories with the only exception of the Sahas who belonged to the well-off and middle categories. These

economic categories were more or less culturally homogeneous and therefore there were not many differences between social groups within a single economic category.

iv) Improved family environment and education was associated with improved attitudes among women towards their own illnesses. However, it was not possible to comment whether the change was permanent or it was simply a fact that women in better-off households were not required to practice the values of self-sacrifice.

The general practice of self-management and delay in informing the family indicated that these self images were too deeply engraved and could be depended upon by the family in situations of crisis. The practice of teaching these values to girls even in the well-off households and the contradictions of practices and proclamations of the educated women further supported this possibility.

The family per se was a critical necessity of the larger social structure which interacted with it through the above interphases. Two interesting findings of our study that brought out the centrality of family as a unit in consumption and survival mechanisms were worthwhile noting. These were the difference between popular methods of dealing with general health problems of women as against obstetric and family planning practices at one level and the

difference between eating patterns of men and women at another level.

Our study revealed that though the pregnancy and delivery practices of the women were constrained by their economic status and were often rationalised by the cultural norms within the families, still the pattern of utilisation of services for these problems had modernised to a much greater extent as compared to the problems of general illnesses in women. Thus even among the poor, while for general illnesses, local practitioners and religious healers were consulted, they preferred the government institutions for antenatal, delivery and family planning services.

This highlighted the fact that in a male dominated social structure threat to reproductive functions of women generated greater concern compared to her ill-health and lower outputs. Perhaps from the point of view of the head of the family firstly, she on her own restrains her health needs and never asks. Secondly, even when she asks she is dispensible. But the loss of progeny is a loss of the 'self', threat to survival and therefore worthy of attention.

The family not only functioned as a unit of production, it also was a means of rationalisation of use of resources. Thus women and children (specially girls), the so-called "non productive" members, not only worked twice as hard but

also were obliged to curtail their consumption and to let the needs of men be fulfilled who at their cost not only consumed better but also received other services such as washing, cooking, cleaning, and massages. These functions of the family made it a necessary component of the larger social structure within which women were allocated very definite social roles.

Transformations in the larger social and economic structures and proceses were constantly influencing the family dynamics and setting up limits for its manifestation. Thus the negative aspects of the traditional ideology were most required among the middle categories where scarcity pushed its mechanisms to work at the maximum. Greater security softened them and made them more tolerant and encouraging towards women in the well-off categories. In the poor, compulsions to earn a living introduced some degree of manoeuvérability for the women.

POTENTIAL FOR CHANGE

Despite a very slow process of change in the women's health situation and her condition in general, there were some visible trends in Adityapur that indicated possibilities of change. Among the well-off and middle category families not only girls' education was accepted and encouraged, there were women who had gone out into jobs

like nursing and teaching. These women and other educated housewives were categorical that "economic support and attitudes of the family mattered more in their education and not so much their will power".

The significant shift in the use of civil hospital for deliveries and popularity of family planning methods has already been mentioned. The women were not only given consent to use hospital or the PHC network (which were otherwise not so liberally used in illnesses) she was also pushed into permanent methods of sterilisation.

Among the poor women, the quality of change was quite different. They neither were encouraged to pursue their studies nor the families were capable of providing it for them. Forced by the circumstances, some of these women not only had to go out of the village as construction workers or maid servants but they also bore the brunt of their ailing mothers or younger sibs. The experience made them break the traditional norms of the society and mode of living. Nando and Padma were good examples of such women. It was interesting to note that among these families, very often mothers did not differentiate between daghters and sons when the question of preferences was raised.The close ties that developed between these mothers and daughters very often made the mothers also change their views on having a daughter.

Though differentials in socio-economic categories brought out the role of larger forces in bringing about change, it was also clear that the given level of transformation was not adequate to uproot the hold of traditional ideology. Education and economic independence seemed to be the only means of breaking this hold but the present level of social transformation in Adityapur was certainly not adequate for this role. It was not surprising then that the potential for change though visible still left much to be desired.

Chapter 7

SUMMARY AND CONCLUSIONS

The study of Adityapur village in the Birbhum district of West Bengal was based on:

- A complete census of socio-economic status and health of the population above 14 years.
- General qualitative information on social, economic and political life of people.
- Information on pregnancy, delivery and family planning practices, from all pregnant women and those who had children upto 1 year of age.
- Indepth exploration and case reports on specific illnesses in different economic categories.

The major findings of the study were the following:

- Fifteen percent of the households belonged to well-off category whereas 39% were in the poor and the rest formed the middle group. The village was dominated by the scheduled castes (61.4%). Majority of the non-scheduled caste households (90.5%) belonged to the middle or well-off categories whereas 86.2% of the scheduled caste households were from the middle and poor categories. The non scheduled castes were dominated by the Brahmins, who overtime made full use

of other educational and employment opportunities. Among the scheduled castes, however, only 13.8% Sahas who were traditionally linked with big business and own large landholdings were able to use the special facilities provided for the scheduled castes in general and improved their education and employment status.

Despite significant transformation in different aspects of life in the village, the life of women was least affected. They continued to stay within the boundaries of their households and performed labour without actively participating in decision making process. Even those who were employed or did some social activities, did it to the minimum required and remained within the bounds of tradition.

The estimate of annual reported illness of women showed differentials in economic categories (8.7% in the well-off, 9.2% in the middle group and 14.9% in the poor section). Women were more ill than their men folk in corresponding economic categories and the gap was maximum among the poor (14.9% against 3.3%). Certain diseases like tuberculosis, gastritis and anaemia were very prominent among the poor.

An important finding of the study was that majority of the women even after fully realising that they were ill, did not seek help. Instead, they attempted self-

restraint and at the most tried to compromise their food and activities to manage their disabilities. Only when their problems became unmanageable they communicated with their family.

There was thus a twin gap between realisation of ill-health and seeking out treatment. The delay was contributed by the woman herself as well as by the family.

The reasons for women's restraint were her perception of severity, her sense of responsibility towards her family, relationships within the family, and its economic conditions along with the health needs of men in families where their illness was an added factor. For the delays at the family level the same factors were active, however, the most visible among them were economic status of the family, men's attitude towards women's illness and the balance of power within the patrilineal structure of the society.

While seeking health care women were in a much more disadvantageous position compared to their men folk in corresponding categories. They were dependent upon local practitioners even if the initial consultation were with allopathic private practitioners in town, their follow-up was inadequate and very often in a family with an ailing man they had to wait for treatment specially in the poor and middle categories.

Women's illness created a differential impact on the economic structure and relationships within the family. The impact was often permanent for the poor where scarcity pushed them to sell resources or go in for loans. In the middle categories women's illness accentuated economic and personal tensions. Only among the well-off, the impact was easily handled.

The pregnancy and delivery practices such as extra food, rest, utilisation of health services among women were constrained by the economic status and were often rationalised by their cultural practices. Still, the pattern of utilisation of services for these and family planning practices had modernised to a much greater extent compared to that of general illness of women.

Health services provided through the government and private network differed in quality and within each of them biases were observed depending on the economic ability of the clients. This was most visible in allopathic services.

Macrolevel social processes interacted with the micro-level family dynamics of women's health by moulding the

i) criticality of women's labour for families,

ii) ensuing security for family members, specially women,

iii) access to resources and facilities,

iv) men's attitudes towards women's illness, and

v) women's own attitudes towards their illness.

- In a patrilineal social structure, threat to reproductive function of women generated greater concern compared to her ill-health and lower outputs.

- To change the situation of illness and health care the cultural forces of status quo at the family level were influenced by socio-political interventions and the slow process of transformation.

It either created a situation conducive to the health of women as in the well-off or it made existence so impossible that the poor women had to break the norms and values of the given status quo.

Our study thus highlighted the social processes that influenced health and illness among women. It emphasised the need for a greater pace of socio-economic transformation, sensitive to the needs of women and their contributions to the society. This alone would make health a meaningful concept for them.

REFERENCES

Agarwal, Bina (1985). Work Participation of Rural Women in Third World: Some Data and Conceptual Biases, Economic and Political Weekly, Vol. 20 Nos.51 and 52, pp.A155-A164.

Agarwal, Bina (1988). "Neither Sustenance Nor Sustainability: Agricultural Strategies, Ecological Degradation and Indian Women in Poverty", Structures of Patriarchy: State, Community and Household in Moderning Asia, Kali for Women, New Delhi, pp.83-120.

Anderson, Joan M., Blue Connie and Lan Annie (1991). Women's Perspectives on Chronic Illness: Ethnicity, Ideology and Restructuring of Life. Social Science and Medicine, Vol. 33, No.2, pp.101-113.

Antia, N.H. (1987). Health for All: Concept and Reality. FRCH Newsletter, Vol. 1 No.2. The Foundation for Research in Community Health, Bombay, p.3.

Appadurai, A. (1985). "Dietary Improvisation in an Agricultural Economy" in Sharman et al, (eds). Domestic Life in Society, quoted by Harris, Barbara (1989). "The Intrafamily Distribution of Hunger in South Asia" in Dreze, J. and Sen, A. (eds), The Political Economy of Hunger, Vol.1. pp.351-424.

Bagchi, Jasodhara (1990). Representing Nationalism: Ideology of Motherhood in Colonial Bengal. Economic and

Political Weekly, Vol.25, Nos. 42 and 43, pp.WS-65 - WS-71.

Banerjee, D. (1982). Poverty, Class and Health Culture in India, Prachi Prakashan, New Delhi, India.

Banerjee, N. (1982). Women in the labour force - The Bengal experience, Paper presented at the Technical Seminar on Women's Work and Employment, New Delhi ISST.

Banerjee, Nirmala (1984). Why they get a worse deal - Report on unorganised women workers in Calcutta, Manushi No.20. pp. 15-23.

Banerjee, Nirmala (1989). Trends in Women's Employment 1971 - 81: Some Macrolevel Observations Economic and Political Weekly, Vol.24, No.17, pp.WS-10 - WS-22.

Bardhan, P. and Srinivasan, T.N. (1981). Rural Poverty in South Asia as quoted in Agarwal, Bina (1988), Op.cit.

Bardhan, K. (1985). Women's work, Welfare and Status - Forces of tradition and change in India.Economic and Political Weekly Vol. 20, No.50, pp.2207-17, Vol.20, No.51, pp.2261-69.

Batliwala, S. (1983). 'Women in Poverty': The Energy, Health and Nutrition Syndrome, paper presented at Workshop on Women and Poverty at the Centre for studies in Social Sciences, Calcutta, March 17-18.

Bhattacharji, Sukumari (1990). Motherhood in Ancient India. Economic and Political Weekly, Vol. 25, Nos.42 & 43. pp.WS-50 - WS-57.

Bose, Asish (1991). India's Demographic Snapshot, 1991, Health for the Millions (December), Voluntary Health Assocn. of India, New Delhi, pp.2-8.

Bose, Ashish (1991). Population of India. 1991 Census Results and Methedology, B.R. Publishing Corporation, Delhi, pp.58 and 70.

Brittan A. and Maynard, M. (1984). "Sexism , Racism and Oppression, Basil Blackwell Publishers, Oxford" quoted in Anderson et al. (1991). Womens Perspectives on Chronic Illness: Ethnicity, Ideology and Restructuring of Life, Social Science and Medicine, Vol.33, No.2, pp.101-103.

Brown, E. Richard (1979). Rockefeller Medicine Men, University of California Press, Berkeley, Los Angeles, London.

Census of India, (1971). General Population Tables Series I, Registrar General, New Delhi.

Census of India, (1981). Geneal Population Tables Series I, Registrar General, New Delhi.

Chakraborty, A.K. (1978). Health Status of Rural Population of Singur as Revealed in Repeat General Health Survey 1975, Indian Journal of Medical Research, Vol.68, No.1, pp.41-74.

Chattopadhyay, K. (1987). Some Real Issues Facing Women, Economic and Political Weekly, Vol.22, No.12, A Sameeksha Trust Publication, Bombay, p.496.

Chen, Lincoln C., Huq, E and D' Souza, S. (1981). Sex Bias in the Family Allocation of Food and Health Care in Rural Bangladesh, Population and Development review, Vol.7, No.1, pp.10-17.

Dandekar, Kumudini (1975). Has the Proportion of Women in India's Population Been Declining, Economic and Political Weekly, October 18, pp.1663-1667.

Devadas, R.P., Ramathilagam, G. and Subasree, S. (1988). "An Evaluation of the Contribution of Women in Household Work" in Women and Work in Indian Society, Dak, T.N. (ed), Discovery Publishing House, New Delhi, pp.191-198.

Devendra, Kiran (1990). Status and Position of Women in India, Vikas Publishing House Pvt. Ltd., New Delhi, pp.1-30.

Devi, D. Radha and Ravindran, M. (1985). Working Women and Household Work, Social Change, Vol.15, No.2, pp.20-24.

Dietrich, Gabriele (1983). Women and Household Labour (A Critique of Usha Menon's Article), Social Scientist, Vol.11, No.117, pp.55-63.

Doyal, Lesley (1979). The Political Economy of Health, Pluto Press, London, Chaps I, II and III, pp.9-137.

Dubos, Rene (1971). Mirage of Healh. Perennial Library. Harper & Row Publishers, New York, Evanston, San Francisco, London.

Duvvury, Nata (1989). Women in Agriculture: A Review of the Indian Literature, Economic and Political Weekly, Vol.24, No.43, pp.WS96-WS109.

Engels, F. (1977), The Conditions of the Working Class in England. From Personal Observation and Authentic Sources, Progress Publishers, Moscow.

Government of India (1971 to 1989). Survey of Causes of Death (Rural) - Annual Reports, Registrar General, Ministry of Home Affairs, New Delhi.

Government of India (1988). Occupational Health Issues of Women in the Unorganised Sector, Report of the Task Force on Healt Prepared for the National Commission on

Self- employed Women by Ministry of Human Resource Development, New Delhi, p.22.

Gulati, Leela (1975). Sex Discrimination in Work and Wages, Social Scientist, Vol.4, No.4&5, pp.155-60.

Gulati, Leela (1978). Profile of a Female Agricultural Labourer, Economic and Political Weekly, Vol.13, No.12, pp.1215-1218.

Harris, Barbara (1989). "The Intrafamily Distribution of Hunger in South Asia" in Dreze, J. and Sen, A. (eds.), The Political Economy of Hunger, Vol.1, pp.351-424.

Horowitz, B. and Kishwar Madhu (1982). Family Life - The Unequal Deal, Manushi, No.11, pp.2-18.

Indian Council of Social Science Research (1977), Critical Issues on the Status of Women, ICSSR, New Delhi.

International Labour Organisation (1979). The Impact of Women Workers of the Maharashtra Employment Guarantee Scheme, ILO, New Delhi.

Jain, Devaki and Chand, Malini (1982). Report on a Time Allocation Study - Its Methodological Implication, paper presented at a Technical Seminar on Women's Work and Employment, Institute of Social Studies Trust, April 9-11.

Jain, Devaki (1985). Women's Economic Roles and Women's Employment - The Linkages and Policy Implications, Paper presented at the International Seminar on Women and Development, Jaipur (ISST).

Jeffery, R. (1988). Politics of Health in India, University of California Press, Berkeley, Los Angeles, London.

Jeffery, Patricia, Jeffery,Roger and Lyon, Andrew (1989). Labour Pains and Labour Power, Manohar, New Delhi, 2.

Kannan, K.P., Thankappan, K.R., Kutty, V.R. and Aravindan, K.P. (1991). Health and Development in Rural Kerala, Published by Integrated Rural Technology Centre of the Kerala Sastra Sahitya Parishad, Trivandrum, Kerala.

Khare, R.S. (1976). Culture and Reality: Essays on the Hindu System of Managing Foods, Indian Institute of Advanced Studies, Simla.

Kleinman, A. (1987). "Illness meaning and Illness behaviour" quoted in Anderson, J., Blue Connie and Lan Annie (1991) Op.cit.

Lakshmi, Goparaju (1985). Socio-Economic Context of Maternal and Child Health Practices - A case study of an Andhra Village. M.Phil Dissertation Submitted to Jawaharlal Nehru University, New Delhi.

Mencher, Joan and Saradamoni, K. (1982). Muddy Feet and Dirty Hands: Rice Production and Female Agricultural Labour, Economic and Political Weekly, Vol.17, No. 52, pp.A149-A167.

Menon, Usha (1982). Women and Household Labour, Social Scientist, Vol.10, No.110, pp.30-42.

Navarro, Vincent (1977). Social Security and Medicine in the USSR: A Marxist Critique, Lexington Books, Toronto.

Patnaik, Renuka (1991). Social Implications of Reproductive Technology with Special Focus on Indian Women, M.Phil Dissertation submitted to the Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi.

Qadeer, Imrana (1985). Health Services System in India: An Expression of Socio-Economic Inequalities, Social Action, Vol.35, No.3, pp.199-223.

Qadeer, Imrana (1990). Beyond Medicine: An Analysis of Health Status of Indian People, Think India, Vol. 2 No.1, pp.93-107.

Qadeer, Imrana (1991). Integrally Women. Health for the millions (December), pp.11-13.

Ramu, G.N. (1989). Women's Work and Marriage in Urban India, Sage Publications India, p.99.

Saradamoni, K. (1982). Work at Home: What It Means, Mainstream, Vol. 20, No.48, pp.29-31.

Sathyamala, C., Sundharam, N. and Bhanot, N. (1986). "The Health of Women", in Taking Sides: The Choices before the health Worker, ANITRA, Madras, pp.143-151.

Sen, Amartya and Sengupta, Sunil (1983). Malnutrition of Rural Children and the Sex Bias, Economic and Political Weekly, Annual No. May, pp.855-864.

Sen, A.K. (1984). "Family and Food: Sex Bias in Poverty" in Resources, Values and Development, Basil Blackwell: Oxford.

Sethi, Raj Mohini (1988). "Status and Power of Working Women within the Family: A Test of Marxian Perspective" in Dak, T.M. (ed), Women and Work in Indian Society, Discovery Publishing House, Delhi, pp.139-154.

Tagore, Rathindranath (1938). Health Cooperatives, Visva-Bharati, Bull No.25, Institute of Rural Reconstruction, Sriniketan, p.15.

Taylor, C.E. and Faruque, R (1983). Child and Maternal Services in Rural India: The Narangwal Experiment, Part I. Baltimore and London, Johns Hopkins University Press.

Thorner, Alice and Ranadive, Jyoti (1985). Household as a First Stage in a Study of Urban Working-Class Women,

Economic and Political Weekly, Vol.20, No.17, pp.WS9-WS14.

Virchow, R. (1849): As quoted In Howard Waitzkin (1981): The Social Origins of Illness: A Neglected History, International Journal of Health Services, Vol. 11, No.1, pp.77-103.

Zurbrigg, Shiela (1984): Rakku's Story: Structures of Ill-health and the Source of Change, Centre for Social Action, Madras.

APPENDIX

SCHEDULE FOR BASIC INFORMATION ON THE SOCIO-ECONOMIC CONDITIONS OF THE FAMILY

Date:
Serial No.:

1. Head of the Family :
2. Occupation :
3. Land holding :
4. Caste :
5. Source of Drinking water :
6. No. of Rooms :
7. Resident family members > 14 yrs. :

Sl. No.	Name	Age/ Sex	Relationship to head of	Chronic illness (3 mths.)	Acute illness bed ridden 1wk.	Obst. probs- 3 yrs. P/D/Pn.	Gynae. probs.	Remarks

P - Pregnancy
D - Delivery
Pn - Post-natal