HEALTH STATUS OF WOMEN IN RURAL INDIA : A SOCIOLOGICAL ANALYSIS

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

BIJAYA KUMAR BEHERA

CENTRE OF SOCIAL MEDICINE AND COMMUNITY HEALTH
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY
NEW DELHI-110067, INDIA
1986

JAWAHARLAL NEHRU UNIVERSITY

School of Social Sciences
Centre of Social Medicine &
Community Health.

Telegram : JAYENU
Telephones : 652282
661444
661351
New Delhi-110 067

Date: July 21, 1986

CERTIFICATE

Certified that the dissertation entitled "Health Status of Women in Rural India : A Sociological Analysis", submitted by Bijaya Kumar Behera is in partial fulfilment of six credits for the degree of Master of Philosophy of this University. This dissertation has not been submitted for any other degree of this University or any other university and is his own work.

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

Dr. IMRANA QUADEER
Chairman

CHAIRMAN
Centre of Social Medicine
And Community Health
Jawaharlal Nehru University
NEW DELHI-67

21.7.86.

Dr. S.K. SAHU
Supervisor

(S. K. SAHU)
Astt. Professor, Centre of Social Medicine
& Community Health (SSS)
Jawaharlal Nehru University
NEW DELHI-110067.

ACKNOWLEDGEMENT

I wish to express my deep gratitude to my supervising teacher, Dr. S.K.Sahu. His constant guidance and valuable help only enabled me to give shape to this work.

The members of the faculty of the centre of social Medicine and Community Health, Prof. D.Banerji, Dr.(Mrs.) P.Ramalingaswami, Dr. I.Quadeer, and Dr. K.R.Nayar have all encouraged me throughout this work, for which I am indebted to them.

My gratitude is due to Dr. Vina Mazumdar, Director, Centre for women's development studies, New Delhi, who has ungrudgingly extended all help including the use of documentation centre.

I must place on record the unstinted help of Mrs.Chandra Kannapiran, information officer, voluntary health Association of India, New Delhi, Mrs. M.D.Rastogi, Documentation officer, & Dr. Lakhan Singh of The centre of social Medicine and Community Health, JNU and Abha Bhaiya of Jagori - A women's Organization in New Delhi

I gratefully acknowledge the assistance rendered by the staff of JNU library, ICSSR, documentation Centre, National Institute of Health and Family Welfare, Library, and SAHELI - A women's resource Centre, New Delhi.

My special thanks are due to director, Research unit on women's studies, S.N.D.T. women's University who could help me by sending some of the much needed books and articles.

....

At the personal level, I acknolwedge my sincerest gratitude to my parents. My thanks are also due to all my friends and well-wishers who have given constant support to me.

Last, but not the least, I am thankful to Mrs. H. Mureli, who has patiently typed the whole dissertation.

JNU, New Delhi
21 July, 1986

Bijaya Kumar Behera
-- BIJAYA KUMAR BEHERA

CONTENTS

Page

INTRODUCTION 1

CHAPTER I - RURAL WOMEN IN INDIA : A SOCIOLOGICAL ANALYSIS 21

- Some Theoretical Considerations
- Social Factors Affecting Women's Health in Rural India.

CHAPTER II - HEALTH PROBLEMS OF WOMEN : AN ANALYSIS 75

- Women and Disease pattern in rural Areas
- National Programmes for Women
- Availability of rural health services

CHAPTER III - HEALTH STATUS OF WOMEN: A CRITIQUE 119

- Major Indicators
- Sex-Ratio
- Life-Expectancy
- Maternal Morbidity
- Maternal Mortality
- Nutritional Status
- Access to health services
- Health programmes for women towards a critique.

CHAPTER IV - WOMEN AND HEALTH : A PERSPECTIVE 168

BIBLIOGRAPHY --- --- --- --- --- 184

INTRODUCTION

INTRODUCTION

In the whole domain of social science literature, studies on women have occupied a significant place. The study of the position of women in various parts of the world has helped in the acquisition and dissemination of knowledge about women and for women in their own interest. But the United Nations Decade for women Created a new upsurge of interest and enquiry into their problems. It also stimulated new insights and directions to the women's question. As a result, social science studies on women have become a challenge.

In India, more systematic studies on women really began with the submission of the 'Report of the Committee on the status of women in India'[1] to the Indian Government in 1975. And social science studies gathered momentum through the ICSSR's programme on women's studies, research unit on women's studies, S.N.D.T. Women's University, Bombay and Centre for women's Development studies, New Delhi at the apex and other organisations. The above three organisations have played really a pioneering role in this direction. Because of this, there exists vast literature on Indian women.

---

1. Towards Equality (1974) - Report of the Committee on the status of women in India, Govt. of India, Deptt. of Social Welfare, New Delhi.

But a careful examination of the various studies on Indian women reveals that social scientists have lagged behind in the analysis of 'Women and Health'. It is true that sociology of knowledge of medical sociology, medical anthropology and other social sciences in health have become increasingly relevant. Also a lot of scholastic studies have been carried out to explore the social science issues in health. But, Prakash has very rightly pointed out, "Women's health issues have not emerged as a major focus of activity even within the women's movement".[2] There are some studies on women as providers of health care. But there is very little analysis on women as consumers of health care. "Even there is little hard-care data available to support any analysis on women's health status".[3]

Considering the importance of the study on 'women and Health', Shatrugna writes, "This area is very crucial because, women who work long hours in the low-paid unskilled jobs, they are the last to get organised. Hence, health problems related to the work place, hazards of pollutants on women working during childhood, adolescence,

---

2. Padma Prakash (1984) - "Roots of women's ill health. Editorial Perspective" in 'Socialist Health Review', Sept, p.50.

3. Ibid, p.52.

pregnancy and lactation could be dangerous to the women and the foetus".[4] The same tone has been raised by Jha. According to Jha, "The neglect of women's health emerges as the most fundamental crisis in the health development of this country."[5]

This sort of apathy for research on women's health by social scientists calls for critical examination. The main reasons for this may be discussed below.

SUBSTANTIVE REASONS:- The reasons for the apparent uninterest in health issues perhaps lies in the historical and economic roots of the women's movement in India. The real health needs of women are subordinated to the needs of capital, because they constitute a major component of the labour force. A woman's traditional role is to reproduce and sustain labour power. Just as in the work-place, the wokrer's health needs are subordinated to the needs of capital accumulation, women's health needs are subordinated to the need to maintain the work force

---

4. Veena Shatrugna - Women and Health, Current Information Series, Research Unit on women's studies, S.N.D.T., women's University, Bombay. p.3

5. Saroj.S.Jha (1983) - "Indian Women: Health status in the context of social development" in The Journal of Family Welfare, 29(4), p.3

at that level of health required for the generation of surplus value. Thus, "The needs of capitalist accumulation mediating through patriarchal relations supress women's real health needs and their reproductive freedom."[6]

Second, theoretically viewing, Medical sociology and Medical Anthropology of Contemporary India have not successfully dealth with women's health in Indian context due to their inability to explore new concepts, theory and methodology which can be best suited in Indian conditions. Further, the sexist nature of medicine was a stumbling block against any comprehensive theorisation on women's health. Because medicine rationalises social attitudes and beliefs about women (and men) whether they relate to their physiology or their social role. Medicine's 'model' of the normal human being is the upper/middle class male. This makes all women, by definition abnormal. Meanstruation becomes a disability, childbirth as illness. The normal woman of medical science is a 'feminine' woman or a mere reproductive machine. It has long regarded women primarily as mothers or potential mothers. Moreso, it was assumed that a woman was rendered "stupid by the functions of her uterus, was unable to develop her brain

---

6. Padma Prakash (1984), op.cit, p.49

talents, and higher cultural capabilities"[7]. The reproductive organs thus became the main focus of treatment for any and all of women's problems. These notions, were without a doubt, reflections of dominant class and the dominant sex in society. Moreso, medical science focusses the roots of ill-health from the existing living conditions to individual entity, where our social scientists haven't accepted it as a challenge.

Third, in India the approach to the study of women's problems for a long time was partial and unidimensional. For example, the common approach has been to look at women as housewives, usually within the confines of a single discipline. Medical anthropologists typically study the rituals surrounding the marriage, birth and death and they catalogue taboos that influence health, such as prohibitions of certain foods during pregnancy etc. But the problem is that it results in a static view of society, one that lacks reference to the historical past and political present, one that isolates the local economy.

Therefore, a multidisciplinary approach is needed for the study of women's question and their health in

---

7. Quoted by Padma Prakash (1984), op.cit, p.2 from E.Reed (1974) Is Biology Women's Destiny?

particular. Because, it combines the interests and insights of economics, Sociology, political science, Anthropology and other related social sciences. To illustrate, in our rural India women play multivarious roles as mothers, housewives, farmers and wokers. The study of their health must include the study of class issues, land tenure, food production, food distribution, prosessing, preparing meals, preservation, storage and consumption, housing pattern, employment, sanitation nutrition, and power-structure-in- rural India. Apart from that a social scientist has to analyse how much a woman gets access to different forms of health services. Banerji in his study[8] of nineteen villages in eight states of India during 1972-75 provides a classic example of health analysis from inter-disciplinary perspective. Sheila Zurbrigg in her work[9] has brought about the fundamental issues involved in the study of women's health in rural India. She argues that the major reasons for ill-health among rural women are poverty, unemployment and class nature of society. The poor rural working women can't afford the loss of time, the cost of treatment and the cost of travel. The 'culture gap'

---

8. D.Banerji (1981) - Poverty, class and Health Culture in India, Prachi, N.Delhi.

9. Sheila Zurbrigg (1984) - Rakku's story-structural of ill-health and the source of change, Madras.

between physicians and patients also poses a big threat.

Now, it can be safely stated that the research gap in the area of 'Women and health' can, at least be theoretically bridged up by undertaking studies in an interdisciplinary perspective. The present work is an attempt to sociologically analyse the health status of women in rural India with an interdisciplinary framework. Before going to analyse the main reasons and objectives of the study, a brief discussion may be devoted to analyse the key concepts like 'health', 'health status', 'health services' and health culture' which have been frequently used throughout the study.

HEALTH, HEALTH SERVICES, HEALTH STATUS AND HEALTH CULTURE

(1) Health touches every part of our lives. Various Scholars and organisations have defined it in various ways. Medical Science, by virtue of treating individuals as clinical entities defines "health as a purely individual or personal, biological phenomenon whose problems are to be solved at the individual level through medical technology."[10] Medical definitions of health are based on abstractions.

---

10. Imrana Quadeer (1985) - "Health Services system in India: An expression of socio-economic inequalities - 'Social Action,' Vol. 35, July-Sept, p.199.

Even a popularly accepted definition of health given by WHO speaks of health as biologically ditermined and medical technology as its outcome. According to WHO, "Health is a state of complete physical, mental and social well-being and not just absence of disease and illness."[11]

Health, in true sense has got the fundamental social concern. It is also determined by the perceptions of a group or community and therefore, differs from community to community. "The right to health means not only the right to be free from disease, it also means physical, emotional and mental well-being." It has to do with all aspects of our lives, from the kinds of food we eat to the kind of house we live in and the kind of work we do. It can't be separated from the political, economic and cultural systems of our societies."[12]

Thus, health is a dynamic concept, the health of women speaks of their status in society, the inbuilt social dimension reflecting the exploitation of one class by the other, the struggle of the oppressed against the oppression and their conscious, systematic and collective efforts to rebuild society. The concept of health and the approach to health problems depend upon existing body of knowledge, consciousness of the people and culture and

---

11. Preamble to the: Constitution of world Health Organisation.

12. Jane Cottingham (1983) - "Women and Health: An Over-view", Women in Development: A reasource guide for Organization and Action, ISIS, Geneva, p.143.

power of dominant class.)

"'Health Services' is a part of the broad concept of health. "It is a complex of research, education and delivery systems (for preventive, promotive, and rehabilitative services and is only one of the many inputs required to improve the health of the people."[13]

The concept of health status is largely determined by social, economic and physical environment. The concept of health status can be used as a social status, although health must be understood as a bio-physical status first."[14] (The health status of women includes their mental and social condition as affected by prevailing norms and attitudes of society in addition to their biological and physical problems.[15]) The sources of indicators of women's health status in India are the Demographic trends and access to health services.[16]

Health Culture as a concept is central to understand the health status of women in rural India.

---

13. Imrana Quadeer, (1985), op.cit. p.201.

14. Andrew C. Twaddl (1974) - "The concept of health status", in 'social science and medicine' vol.8,p.29

15. Towards Equality (1974) op.cit, p.310.

16. Ibid, p.311.

"Health Culture is that complex whole which includes cultural perception and meaning of health problems and health behaviour of individuals in the context of available and accessible health institutions.[17] As any other cultural entity, health culture also undergoes change. Endogenous innovations, cultural diffusion and purposive interventions from outside form the major use of changing 'health culture' of a community.

Health status of woman is closely linked with the way a woman perceives various health problems and what these actually mean to be on the one hand, and her access to various institutions, on the other hand. For example, when a poverty-stricken agricultural labouring woman consults the village "Dai" for dealing with the problem of obstructed child-birth, she mayn't be bound by her 'traditional culture and she may not have resources to get help of the specialist obstretrician in the nearby town.

Having considered the conceptual clarification, a brief analysis may be made about the significance

---

17. D.Banerji (1985) - Health and Family Planning in India.

of the problem at hand. Because, in social science research, one is always tempted to ask how far the subject under study is socially relevant? What is its academic importance and how best sociological explorations will help in understanding the nature of the problem? In the following pages, a brief explanation is enumerated.

THE PROBLEM - ITS SIGNIFICANCE

India is a signatory to the Alma Ata Declaration (1978), Whereby it is committed to achieving "Health for All by 2000 A.D.[18] The Alma Ata Declaration clearly mentions Primary health care as the key to attain the goal. Women, as the main agents of primary health care, play essential role in maintaining family and community health. Most aspects of primary health care directly relate to women's reproductive functions and to those tasks which societies assign to them. Primary health care required the interation of preventive, promotive, curative and rehabilitative services with major emphasis on prevention. "Thus implies that adequate nutrition, clean water, sufficient hygiene, family planning, proper child care, early detection and response to desease and disability, all prime respon-

---

18. Seventh Five Year Plan (1985-90), vol.11.p.270

sibilities of women-are essential elements of primary health care.[19]

On 17th May, 1985, a resolution was adopted by the thirty-eighth World Health Assembly (WHA) which showed concern at the slow progress made by a number of countries in realising the objectives of the United Decades for women. "The WHA was very much concerned at the very high maternal mortality rates in many countries including India and its repurcussions on women's physical and mental health of certain practices, particularly during pregnancy or childbirth and also during puberty and childhood. It took serious view at the frequency of nutritional anaemia in many countries".[20] Although both men and women in many developing countries suffer from the consequences of underdevelopment and poverty, under these conditions "It is women and children who bear the largest burden of extreme disadvantage."[21] For women not only have their own health problems related to pregnancy and child-birth, but they customarily do most of the caring for their families,

---

19. Women, Health, and Development (1980)WHO Kits, II, p.22.

20. Women, Health and Development (1985) - A report by the director-general, WHO is offset Publications, No.90, WHO, Geneva, pp.VI-VII.

21. Ibid., p.1

so, if they are ignorant, malnourished, overworked and bear large numbers of children beginning at an early age, the health of their families as well as their own will suffer. It is really a paradox that, while societies so heavily depend on women to provide health care, women's own health needs are frequently neglected and their contribution to health and development is underestimated. For instance, "although women constitute half of the world's adult population and one-third of the official labour force, they perform nearly two-thirds of total working hours, receive only one-tenth of world income and own less then 1 per cent of world property."[22]

First, in India, we find altogether a grim picture. The plight of rural women in India is that eighty percent of them are engaged in agriculture and household activities under the severly exploitative conditions. According to Banerji, "It is true that women have to put up with menstruation, pregnancy, child-birth lactation, child-bearing and menopause etc. But unfortunately different cultural, social and economic situations

---

22. Ibid. p.10.

in India have given different focusses to their biological disadvantages.[23]

Second, "women's studies in the field of health, have to be identified against the background of the prevailing social situation in India.[24] Banerji In terms of health status as well as in terms of access to health services, there is a sharp polarisation between a small priveleged class, who controls the entire economic and political life, on the One hand, and the masses of people, on the other. Banerji has very cogently argued in his paper how women's health can't be analysed without understanding the class issues. Sheila Zurbrigg in her analysis of rural ill-health in the study of Tamil Nadu village has very clearly elaborated the political and ideological roots of women's ill-health. In her own words, "Ill health means the state of being "exploited" and in this sense must be re-enterpreted not as a 'problem' in itself, but rather as a symptom of deeper socio-economic injustice.[25]

Third, the sex differentials in morbidity and

---

23. D.Banerji (1981) - "Indian Women and the Health Services" - A paper presented at the National Conference on women's studies held in Bombay, April, 20-23 p.1.

24. Ibid., p.3

25. Sheila Zurbrigg, (1984) - op.cit. p.127

mortality, the acute problem of malnutrition and hunger, the special health needs of women due to their biological construction, occupational health hazards, the traditional practices of circumcision of girls, uncontrolled fertility, age at child-bearing, abortions and other related problems speak of undertaking research on women's health. The demographic picture of Indian women with regard to sex-ratio and morbidity pattern is alaraming. ("The health status of women is always worse in rural than in urban areas and that the neglect of female infants is higher in rural areas because of ignorance, superstitions and anti-daughter bias.[26]) (The female mortality is higher for all the age group of women in rural areas. It is due to the consistent neglect of female health.[27]) Moreso, most of the measures proposed and implemented for successful family welfare services for rural women like sterilization, abortion, Oral contreceptives, copper 'T', etc. have affected women's health adversely.[28] The changing patterns of economic development have put a heavy burden on women which effect their health status. The marginalisation of

---

26. "Women's Health Status" (1984) - India Country Papers, Govt. of India, p.38.

27. Towards Equality (1974), op.cit. p.312.

28. Padma Prakash (1984) - op.cit, p.5

farmers, landlessness and forced migration have effected their health.[29] Not only that the number of 'workers' among women is estimated to be only 20.01 percent. But the census definition of 'work' does not include cooking, collecting fire-wood, fetching water etc, which take up half of the energy expenditure of women.

Fourth, the importance of research on 'Women and Health' as an area has been identified clearly in a national conference on women's studies held between April, 20-24, 1981 in Bombay. Desai and Patel in a recent book very cogently identified three issues regarding women's health which acquired considerable attention between 1975-85. They were:

i. Adverse sex-ratio of female:male,

ii. Very high female mortality and morbidity rate as compared to their male counter parts,

iii. Harmful implications of various techniques of population control on women's health."[31] Kulkarni states, Neglect of women's health was testified

---

29. Ibid, p.52.

30. S.Battiwala (1984) - "Rural Energy Situation: Consequences for women's health", 'Socialist Health Review', Sept, p.72.

31. Neera Deai and Vibhuti Patel (1985) - Indian women: change and challenge in the international Decade (1975-85), Popular Prakashan, Bombay, p.17.

through the factors like female infanticide, neglect of female's infant life, pre-mature co-habitation resulting in early child-bearing, over work and malnutrition.[32]

Fifth, even the Government of India has confessed, "The health problem of women in society at large is another crucial area to be given the required attention. Due to predominantly patriarchal order women are confined within an oppressive environment.[33]

All these clearly emphasise the importance of the study of health status of women from sociological point of view. Following are some of the substantive reasons, which also justify our study.

- women's health is streessed because health is a human right,
- the state of health of women in India gives rise to great concern.
- healthy women can make more useful contribution to their families and communities;

---

32. Suresh N.Kulkarni - Demographic and Nutritional background of the Health status of women in India, IEG, Delhi University, p.12.

33. Seventh Five Year Plan, op.cit, p.321.

- the better health of women is in itself a considerable step in development.
- as mothers they are responsible for the health of children and families, for providing food for them and caring for them when they are sick.
- as potential mothers, they face the problems of repeated pregnancy, of contraception and abortion;
- as workers both in production outside the home (usually concentrated in low-paying jobs) and within the home they are overworked, over-tired, subjedt to poor working conditions and exposed to a multitude of health hazards,
- as objects of desire or possession, they are expected to respond to certain ideas of beauty and womanhood; thus being vulnerable to encouragement by industry.
- women are looked upon as a mere reproductive machine rather then as a human being.

Now, having considered the usefulness of the study on women's health, the objectives of our nalysis may be enumerated below. As the whole analysis is based on secondary sources, no claim has been made to provide some new research output, except exploring out some of the challenging issues and neglected facts. After studying the existing body of literature, the

following objectives have been identified. They are as follows:

MAIN OBJECTIVES:

1. An analysis of sociological factors which affect women's health. Social circumstances which affect health status of women in rural India are class, caste, family, agrarian social structure, powerstructure and cultural norms etc.

2. Identification of basic health problems faced by women from child-hood to old-age, their nature, causes and extent of health needs.

3. A critical analysis of the health status of women in rural India in terms of their sex-ratio, life-expectancy, morbidity, mortality, nutritional status and access to health services.

4. Identification of key dimensions relating to ill health of women and chalking out a perspective.

In order to deal with the objectives outlined above, the following scheme of chapterisation have been made.

SCHEME OF CHAPTERISATION:

In chapter One entitled "Women in Rural India: A sociological Analysis", the main focus will be to critically discuss different theoretical tenets of women's problems and the factors which are directly or indirectly associated with women's health.

In the second chapter, entitled "Health problems of women - An analysis", health needs and problems of rural women will be analysed. Also, the available health services, disease pattern, different national programmes will be discussed.

In the third chapter - 'Health status of women: A critique", the health status of women will be measured in terms of major indicators like sex-ratio, life-expectancy, morbidity and mortality pattern, nutritional status and access to health services. Also a critical analysis will be made with regard to different national health programme for women.

Last chapter entitled 'Women and Health - A perspective' will deal with the summary of issues identified, the important research areas for further research, the theoretical perspective and some alternative general considerations for providing meaningful health service to raise health status of rural women.

CHAPTER - I

RURAL WOMEN IN INDIA: A SOCIOLOGICAL DIAGNOSIS

The status of women in any society is a significant reflection of its cultural, religious, social, political and economic systems. It is one of the most important criteria for estimating with precision the degree of civilisation attained by a particular society in various periods of its history. One point that strikes a sociologist at the very first instance is that in India, sex-inequality can't really be differentiated from the variety of social, economic and cultural inequalities. The inequalities inherent in our traditional social structure based on Caste, Class and Community etc have a very decisive influence on the status of women in different spheres. Then again, there are those processes like modernization, industrialization, democratisation and urbanization etc. which have all shaped the position of women in differing degrees.

Hence, it can be safely stated that 'women's Question' is a vast and complex one. Here, in this chapter, the main objective is to identify and analyse the social factors which are involved in women's health in rural India. We have stated earlier that health can't be treated in isolation. It has to

be seen through social structure, cultural norms and value-systems. The whole chapter deals with rural women because, according to 1981 census,[1] rural women constitute 76.69% of the female population. The productive activity of rural women includes a series of agricultural tasks performed in the fields and at home. Ethnographic and archaeological data has attributed the initial development of agriculture and agricultural implements to women. Hoes, stick, sickles, the art of sowing, winowing, threshing, the quern were all the discoveries and inventions of women as gatherers and providers of food. As Childe points out, "All the foregoing inventions and discoveries were judged by ethnographic evidence, the work of women. To that same sex, too many by the same token by credited the chemistry of pot-making, the physics of shinning, the mechanics of the bom and the botony of flax and cotton."[2]

Rural women is both farmer and home-maker. She takes on both these responsibilities together and contributes in reality more than a man contributes to the rural economy; she works for twelve to fourteen.

---

1. Census of India (1981)

2. Gordon Childe (1964) - What happened in History, Penquin, Middlex p.66.

hours continuously.[3] She starts work much earlier in the day by cleaning out the cattleshed, feeding the cattle etc. Then she also does some cooking before she starts the farm work. She leaves for the farm to work as a farm labourer where she has to contribute at least nine to ten hours of work. In order to enable the members of her family to live, she has learnt to supress the pangs of pain caused by physical strain. After a hard-day's labour at the farm she returns home and without any complaint she starts out again in order to get water for the household chores. She may have to start the cooking on return. In times of shortages, especially where food is concerned, it falls to her lot to get a smaller share. She gets few hours of sleep before she starts her routine the next day. She even finds very little time to take care of children. Even in village festivals, she has to work for long hours in order to entertain guests The plight of rural housewife is deplorable. They are greatly subjected to drudgery. Cooking in smoky environment in time consuming cooking process creates severe health hazards. Walking long distances to

---

3. T.Padmasini Asuri (1976) - 'Rural Women in India To-day', 'Religion and Society', Vol.23, p.27.

fetch water, collecting paddy are their daily works. Cultural norms like purdah, seclusion from the family, dowry system, early marriage etc have made their life miserable.

Moreso, "They have to give birth to children (under the distressed environment), nurse them, care for them at any cost without adequate diet and nutritional input. The drudgery for subsistence even during advance periods, sometimes cause abortion and premature births. It continues during the lactation period and due to malnutrition infant mortality is very high upto one year of age.[4]"

In many scheduled tribes and hill tribes, it is the responsibility of adult women to do most of the work right from plantation, harvesting and processing to marketing. They have to pound the rice and the maize, grind the wheat and berley into floor and the mill the pulses etc. Women also milch the cattle, maintain piggery, poultry, sheep and goat. All these tasks entail much outlay of energy by women and cause excessive physical and mental burden.[5]

---

4. J.C.Srivastava, (1982) - 'Technology for Development of Rural Women', Khadi Gramodyog, Vol.XXVIII, No.4, Jan, p.201.

5. Ibid, p.201

The above description underlies the fact that a study on rural women is very important considering their oppression and conditions. Before going to analyse social factors which affect women's health a brief attempt may be made to analyse the theoretical aspects.

SOME THEORETICAL CONSIDERATIONS

Much literature has been generated to highlight the problems of women-their oppression etc. But a critical examination of these reveal that the attempts have been rather sporadic. Of late, social scientists have done systematic efforts on women's studies. As a first step, let us analyse how sociologistists have tried to analyse the position of women. Then, we can analyse some important theories provided by psychologists, anthropologists and philosophers. After a brief analysis of conventional theories, we can throw some light on emerging trends including the women's movement. Towards the end, our main preoccupation will be on India and how different schools of thought have looked at the problems of women in Indian Context.

The fundamental ideas of western sociology

are largely the responses to the problem of order created by the forces of industrialization and the French revolution. These two revolutions revolutionised the thought pattern and classical sociologists extensively talked of relationship between individual and society. This had also important implications for the role and status of women. Auguste Comte, a french sociologist who is commonly regarded as the father of sociology was concerned with social order and he linked women's role to a vision of progress by confining her to domestic sphere. He saw women as inferior by reason of their "biological childishness", but regarded them as morally superior to men. According to Comte, there is a relation of authority-obedience between husband and wife and he advocated for the restoration of the full patriarchal authority that the revolution had taken away.[6] Thus, he romanticised women's role in society but regarded biology as determining the role of women.

Like Auguste Comte, Emile Durkheim postulated

---

6. Nisbet (1970) - The Sociological Tradition, Heinemann, London, pp 60-61.

a sexual division of labour proceeding from natural, physiological and emotional differences between the sexes. Durkheim's views on women emerge very clearly in his empirical work on suicide. He explains differences in suicide rates between men and women as a function of women's less complex and sensitive emotional character, requiring lesser dependence upon society and social control. According to him, "generally speaking, her mental life is less developed. Being a more instinctive creature than man, woman has only to follow her instincts to find calmness and peace.[7] He points, "both men and women have different needs, the former being the product of society and the later to a great extent the product of nature.[8] Thus, he talks of differentiation, not inequality. He implicity accorded a low status to woman and saw her needs and functions as emunating from her biological makeup.

Max Weber hasn't directly touched upon women in her writings. But his treatment of women is implicity subsumed within his general theories of

---

7. E.Durkheim, (1952) - suicide: a study in Sociology, The Free Press, New York, p.272

8. Ibid, p.385.

social change. In his essay[9] on the Evolution of sex-roles stats that sexuality as one of the most irrational forces in life. He thinks that the social control of sexual desire is a necessary condition for the institutionalization of rationality. Thus Weber implied that sex-roles have undergone changes in different periods of time as a result of changes in the economy and social structure.

Talcot Parsons in his analysis of the American family system provides a functionalist interpretation of the women in the family. He argues that a women's fundamental and appropriate status ought to be that of 'her husband's wife and the mother of her children. According to Parsons, "in the nuclear family everywhere there is an instrumental role (mediating between the family and outside) and an "expressive role concerned with relations within family. The father usually has the farmer, the mother, the later and this is functional for the parents, children and the society.[10] Thus, Parsonian functionalism implicitly had the effect of 'justifying the sexual status quo.

---

9. H.A.Gerth & C.W.Mills (1970) - From Max Weber - Essays in Sociology, Routledge and Kegan Paul, England pp 343-50.

10. T.Parsons, (1956): "The American Family: Its relations to Personality and to the Social Structure", in T.Parsons and F.Bales" Family, Socialization and Interaction Process, Routledge Keggan Paul, London, pp.22-24

Apart from the above classical Western sociologists Marx and Engels have very extensively written on women, which will be discussed in a bit details later on.

Social anthropologists have also done enough ground work on women's status. The British school of Anthropology as represented by Redcliffe Brown and E.Evans. Pritchard, the American School of Sociology and Cultural Anthropology and also the French School of Structural Anthropology succumbed to the lop-sided presentation of social reality. These Scholars studied women considering family, descent and kinship as functional categories. For Levi-straus, human society is and has been essentially masculine. In his theory of exchange he states how in certain societies wives were exchanged as commodities. "The relationship of exchange which constitutes marriage is not established between a man and a woman...but between two groups of men and the women figures, only as one of the objects in exchange".[11] This is because, according to him, "political...or social authority always belonged to men and even in matrilineal societies, he sees women nothing more than

---

11. C.C.Levi-Strauss, (1969) The Elementary Structures of Kinship, Bacon Press, Buster, p, 115.

symbols of their lineage.[12]

Sigmund Freud gave a deep recognition to the place of sexuality in society and traced the inequality between men and women to their psycho-biological growth. He wrote Libide is masculine, thus assuring man's natural superiority over women. "She has little or no super-ego.[13] He labelled women who moved into arts and letters suffering from penisenvy.[14] He believed that women's role in life is to stay at home, be passive in relation to men, bear and raise children. In a separate article, Fread argues, Man's essential nature was in conflict with civilization for all time and place, but women's essential nature was harmonious, it seems, tailored to fit in with man's civilization.

Philosophers like Simon de Beavoir, Erickson and kate Millet have also done theorisation on liberation of women. Their theorisation may be succinetly laid down for our purpose.

Simone de Beavoir, an existentialist philosopher in her famous work[15] writes about 'women's liberation'.

---

12. Ibid, pp.116-117.

13. S.Freud, (1952) The Major works of Sigmund Freud William Benton, New York, INC, p.863

14. Ibid, pp.116-117.

15. Simone de Beavair(1953) The Second Sex, Penguines London

Drawing from historical materialism, psychoanalysis and existentialism, Beavoir seeks to build a theory of women's opression. The first question she asks: is there anything in the physiology of women which has made for her to second sex? Having viewed the facts of biology in the light of an ontological, economic, social and psychological context, she concludes that women's status was determined by an interplay of these factors throughout history.

Kate Millet in her distinguished work[16] studies mythology, religion, the history of the family, the treatment of women in the legal system etc. According to her, oppression of women is enforced through the organisation of society on the basis of the patriarchal family. She talks of 'sexual revolution' but fails to analyse how it can be achieved.

E.H.Erickson in the book[17] speaks of women's liberation in a most descriptive fashion. Erickson says, "Liberation is always reciprocal. In fact, the chance for true liberation would occur when both men and women

---

16. Kate Millet, (1971) Sexual Politics, Hart-Davis, London.

17. E.H.Erickson, (1974): Dimensions of New Identity Light and Life Publishers, New Delhi.

need it.[18]

Among all these Social Scientists, perhaps nobody has so systematically written on 'women' as Marx and Engels have done. In the following pages, their theorisation in connection with women's liberation be examined succinctly.

Marx stressed the sub-ordination of women under capitalism. Marx and Engels have emphassed on 'Labour process'. According to Marx, labour is the prime basic condition for all human existence, and this is to such an extent that in a sense, we have to say that labour created man himself.[19] He saw that mechanisation is a major cause of the exploitation of women since machines made muscle power unnecessary and women's labour cheaper. As a result of the introduction of machinery, the labour of women and children is being exploited by the capitalists. But on the other hand, he also argued, "Modern industry creates a new economic foundation for a higher firm of the family, and liberated the women and children from the tyranny of the

---

18. Ibid, pp.114-15.

19. K.Marx & F.Engels (1958): "The Part played by Labour in the Transition from Ape to Man" Selected Works" Vol.II, Foreign Language Pub.Moscow, p.80

traditional familial authority.[20] However, Marx considers status of women under capitalism as beast-like.

Following Marx, Friedrich Engels gives a clasic exposition of women's oppression. His famous work[21] explains in utmost clarity about the history of the female. He examines the position of women as reflected in different family forms which are determined by changes in the relations of production. He argues that there is a dialectical relationship between private property and monogamy. The origin of the family leads to the subjugation of one sex by the other. According to him "Division of labour was a pure and simple outgrowth of nature, it existed only between the two sexes.[22] He analyses throughout history, the first class opposition coincides with the development of the antagonism between men and women in monogamous marriage and the first class oppression coincides with that of female sex by the male. At first, mother-right was the descent and later on father-right was established. "The overthrow of mother-right was the world's historical

---

20. K.Marx, (1977) Capital A critque of political Economy (Moscow Publishers, Progress, Vol.I, p.460.

21. F.Engles (1968) The origin of Family, private property and the state, progress, Moscow.

22. Ibid, p.155

defeat of the female sex. The man took command in the home. But women became slave to his lust and mere instrument for the production of children.[23] In this way woman lost her independence and was forced to be an in-equal partner. The rise of private property was the main reason for this.

Engels also perceived materially different relations between the sexs for members of different social classes. Like Marx, he also regarded bourgeois family as a form of legalised prostitution where the wife is her husband's keep for the reproduction of legitimate heirs.[24]

Thus, both Marx and Engels believed that the liberation of women can only come about when the whole female sex is brought back into public industry. They emphasised on female employment for their high status. Both are of the opinion that abolition of private property and the capitalist mode of production would necessarily lead to an end of the patriarchal relationship between men and women. They generally felt that in a classless society -

---

23. Ibid, p.155.

24. K.Marx, and F.Engels (1977): Manifesto of the Communist Party, Foreign Language Press, Peking, p.56.

women would achieve true equality and liberty.

Now, having identified and analysed the writings of eminent social scientists in general and sociologists in particular, on Women, their status, oppression, etc; We can very briefly examine the present approachs on women's status, as far as theory is concerned.

PRESENT APPROACHES

The study on women had taken a new stride particularly after the declaration of 1975 as the International Women's year and the following decade as Women's decade. The women's liberation movement took a new turn as women's issues were taken up in a lot of forums. Women's organisations, non-government organisations, feminist centres and different governments made efforts to alleviate women's conditions. As far as health is concerned, women realised their demeaning and dehumanising experience in the health system. In Western countries it took the form of the Women's health movement.[25] This has over the years generated several analyses of the medical system.

---

25. Helen Marieskind, (1975) "The women's Health Movement", 'International Journal of Health Services Vol.5 No.2, pp.217-223.

Elizabeth Fee characterises these in terms of three forms of social criticism, the liberal feminist, radical faminist and marxist famemist". Liberal feminists seek equal opportunity "within the system", demand equal opportunity and employment for women in health care, and are critical of the patronnizing attitudes of physicians. Radical feminists reject "the system" as one based on the oppression of women and seek to build alternative structures to better fill their needs. They see the division between men and woman as the primary contradiction in society and patriarchy as the fundamental institution. They have initiated self-help groups and women's clinics to extend the base of health care controlled by women in their own interests. Marxist-feminists see the particular oppression of women as generated by contradictions within the development of capitalism. Women's unpaid labour at home and underpaid labour in the workforce both serve the interests of the owners of the capitalist. The health care system serves them some interests.[26]

The recent trends in women's movement have been beautifully analysed in Indian context in a special issue

---

26. Elizabeth Fee (1975) "Women and Health care: A Comparison of theories", In International Journal of Health Services, Vol.5, No.3, p.397.

of social Scientist.[27] Nina Rao in her article "The women question: Perspectives for today" in the same issue elaborately discusses the main points of references between feminists and Marxists and argues how there is no original theoretical framework for feminism. "The feminist movement, by its expression of individualism has divided the International Women's movement, but the debate it has generated has helped in brining back into theoretical focus the nature of the inequality that we see around us.[28]

However, there is much theoretical haziness in this field. It is a welcome sign that a lot of literature on women is coming up day by day. But the quality should be given more weightage.

We have very briefly outlined above some of the major theoretical tenets of women's problems. Now, for our purpose a brief review may be attempted to analyse the studies on rural women in India and its theoretical implications. This will help us in understanding the problem at hand in a systematic way.

---

27. Social Scientist (1985) A monthly Journal of the Indian School of Social Sciences, October-Nov. (149-150).

28. Nina Rao, (1985): "The Woman question", Perspectives for tday" in "Social Scientist", Vol.149-50,p.9

Much ink has been used to describe, analyse and interpret the status of women in India. Our main purpose here is to show how far the Social Science Studies which have been conducted on Indian Women in rural areas have tackled women's problems theoretically. Sociologically speaking, there has been much insight into the problem of women in a substantive fashion. But in case of theorisation, there is really much to be done.

Any theory in social science is determined by the social forces prevelent in a particular period of time. For example, the focus and trends of women's studies in Indian Sociology have been largely determined by the major socio-political and economic changes following the establishment of British regime. Both the British and French Social Scientists who first conducted sociological studies in India focused mainly on tribe, and village community. With the help of descriptive or functional model.[29] The issue of women was largely neglected during this period. Inspired by the Western ideology of equality and liberty, social reformers wrote on women by using the Vedas, epics, Dharamashshtras

---

29. Y.Singh, (1973): Modernization of Indian Tradition, Thomson Press India Ltd, Faridabad, p.4

extensively. Most of the writings during British regime are elite-oriented and don't present comprehensive view.

After independence, the issue of woman was mainly studied on empirical lines. There were two major types: 'Structural-Functional' and 'Dialectical-historical' approach.

There has been really very little studies on women in Indian context by following dialectical-historical model. Mukherji (1951)[30] and Mies (1980)[31] have explicitly written on women by adopting a historical dialectical framework. There are also a large number of area-specific studies on women's issues in India. The committee on the status of women (1974) is a landmark in the history of women's studies in India. It has influenced a lot of scholars to undertake researches on women. It is not our purpose to review the studies in details. But some of the important studies have really provided much theoretical insight. Because of this women's movement in India during the International Decade of Women got enough impetus and women's questions were taken up at all levels.

---

30. D.P.Mukherji (1951: "The Status of Indian Women" in 'International Social Science Bulletin' Vol. 3, No.4 pp.790-80.

31. M.Mies (1980) : Indian Women and Patriarchy, Concept, New Delhi.

However, there has been a lot of view points to the issue of women. Some activists with elitist bias have glamourised the concept of 'good wife', good mother etc and believe that phillanthropic or social work activities will uplift the status of women. Some scholars with Marxist orientation argue that socialism will solve all the problems of women. They highlight mainly economic exploitation. Others view the exploitation of women is due to the patriarchy. They have the impression that women from the very beginning are oppressed sex. They consider economic independence of women is one of the steps for women's liberation. They argue that emancipation of women is possible only when, through struggle women's rights in the field of social, cultural, educational and political will be established. They are broadly termed as 'feminists'. There are also three main groups of femists. They are liberal feminists, radical feminists and socialist feminsts. Liberal feminists emphasise on changes in legal and political field, radical feminists consider men as the most important enemy of women and socialist feminists believe in establishing proper linkages between women's movement and mass movement. In this way, the later speak of autonomous women's movement.

Having analysed some of the important approaches with regard to Women's movement in India, let as look at these in these following writings:

"The women's movement in India was an offshoot of the social and reform movement of the 19th century and the freedom struggle. While the reform movement attempted to improve the status of women through removal of oppressive customs like Sati, Child-marriage, Purdah etc, and education, it failed to expose the nature of oppression that affected women in different sections of society and women's emancipation remained confined to the urban middle class root.[32]

Suma Chitnis's in her article[33] provides a documented overview of the participation of women in the economy and their integration in the process of national development, participation in political life and the promotion of social equality in the family and the wider society. She feels that to bring equality between men and women,

---

32. Muzumdar,V (1976) : "The Social Reform Movement in India from Ranede to Nehru" in B.R.Nanda' (ed) Indian Women from Purdah to Modernity, Vikash Publication, Delhi, p.66.

33. Suma Chitnis, Suma (1975): "Re-definition of Sex-roles" in the ed.book Jain, 2 Indian Women, Govt. of India Publications.

the sex-roles have to be redefined.

According to Mazumdar, the belief that women's oppression was to be found in tradition and culture rather than socio-economic and political structure of society has led to questioning of women's status as a non-political issue. This has led to differential impact of development in different classes of women with the women from urban middle classes be refitting the legal political and educational rights which were irrelevent for the lower class women.[34]

Omvedt in her work[35] has analytically exposed the potentiality of women power in rural India. In another article,[36] she also lucidly analyses the rural origins of women's liberation in India. She has talked of the rising tempo of militancy and role of women's organisations. Desai and Patel in their recent book[37] has very analytically analysed the different approaches to women's movement in India during 1975-85 and also exposed the

---

34. V.Mazumdar, V and Kumud Sharma (1979) "Women's studies New Perceptions and challenges" EPW Vol.15 No.3, p.115.

35. G.Omvedt, We will smash this Prison, Orient Longman, New Delhi.

36. G.Omvedt, (1975) "Rural origins of women's Liberation in India", in Social Scientist

37. Neera Desai & Vihuti Patel (1985): Indian Women: Change and Challenge in the International Decade 1975-85, Popular Books, Bombay.

Problems systematically. In their own words, "Feminists are placed in a peculiar dilemma. On the one hand, they recognise that in a backward capitalist country the movement has to be in collaboration with men. However, due to patriarchal values prevailing among male comrades, they are compelled to organise separately."[38]

From the above discussion, it is clear that women's movement in any country has to base on a particular set of ideology, particular fundamental issues and organisational power. Chattopadhyaya's work today opens our eyes for a women's movement in India. According to her, "It is class that determines the fate of women, not sex"[39] She argues that sex-attitudes are not independent of social and economic milieu but are shaped by the control instituted by the classes that are dominant in society.

A PERSPECTIVE FOR ANALYSIS

In an unequal, class-divided and male-dominated society like India women of the lower classes are subjected to double oppression of the class exploitation the one hand and male domination on the other. The

---

38. Ibid, p.71

39. Kamladevi Chattopadhyaya, & Others (1939). The Awakening of Indian Women, Everyman's Press, Madras, p.3

outlook of treating women as saleable sex-objects has spread on a large scale following the growth of monetization and commercialisation. The virus of consumerism from the imperialist countries has entered into our social structure in such a manner that, today our system has considered women as a mere commodity, glamourized sex object and as source of pleasure. We have not treated them as dynamic factors of development.

In such a situation, our approach should't be uni-dimensional. We can't locate the social roots of women's problem as a result of mere male dominance and oppression. They are rooted in social institutions and values of which both men and women are victims. Women's problem in India is a human problem. It is also a problem of male-ego, fed on centuries of superstition, perversion of religious technique, caste, ignorance and these flouder on the hard rock of dialectics. Therefore women's problems are rooted in today's socio-economic structure of India. Women, who are 'socially productive' can lead a women's movement in this country. It must come from the working women.

Therefore, the perspective is very clear. Most of our women's problems stem from mass poverty and general

backwardness, which is a product of imperialism, colonialism, neo-colonialism and unjust economic relations in the international sphere and capitalism in national sphere. A correct theoretical perspective on women's issues should locate in class not in sex. The illusion of masculine superiority can be tackled if equality can be achieved in society. It is a recognised fact that roots of patriarchy are very strong. Therefore, a powerful and systematic movement against patriarchy must be fought.

SOCIAL FACTORS AFFECTING WOMEN'S HEALTH IN RURAL INDIA

After analysing some of the important theoretical formulation for the study of women in India, our main task now, is to clearly identify and examine social science issues involved in women's health in rural India. The key issues may be located in social structure, cultural norms and value system. India being largely an agrarian society, one must study women's place in different agrarian strata. Beteille in his article[40], points out that although some changes may be taking place in the position of women in India, these changes can't be of major significance unless the conditions of work in

---

40. Andre Beteile (1975)"Position of women in Indian Society" in Jain, D (ed) Indian Women, Govt. of India, Publn. div, N.Delhi

agriculture and industry are themselves radically changed.

About rural women's conditions, Myrdal says, "There have been revolutionary changes in the legal status of women in India, but only on the exceptional instance has there been any significant change in their actual condition...During the past decade not much has changed particularly in the rural areas where 80 percent of the people live.[41]

Desai cogently states Even today, "there is a big hiatus between her position in theory and in actual practice. In the social sphere, women's position in real life is still extremely horrible...authoritarian progale values still shape the life of the large majority of women.[42]

C.A.Hate depicts their condition in the following words, "Age-long traditions and worn-out customs still block their (women's) way, which prevents women from rising to the full stature of 'being fully human'.[43]

---

41. G.Myrdal (1968) "Asian Drama: Inquiry into the Poverty of Nations, Twentieth Century Fund, New York, pp.764-65.

42. Neera Desai, (1957) Women in Modern India, Vora & Co. publishers, Pvt. Ltd. Bombay, p.290.

43. C.A.Hate (1969) Changing Status of women in Post-Independence India, Allied Pub.Pvt.Bombay p.6.

Mazumdar observes "Rural women constitute the largest group who have not only been by passed in the distribution of the fruits of development, but whose traditional roles and status in their own society are also being altered adversely by the nature of development process.[44]

In a study,[45] Mehra and Saradamani raised the key problems of rural women. Also sharma in the study[46] gives a detailed analyses of inquality and sex roles among women specifically in rural India.

The report of the CSWI sums up the position of women in the following words:

"Our review indicates that society has failed to frame new norms and institutions to enable women to fulfil the multiple roles expected of them in India today. The majority do not enjoy the rights and the opportunity guaranteed by the constitution. Increasing dowry and other phenomena, which lower woman's status further, indicate a regression from the norms developed

---

44. V.Mazumdar, (1978) (ed) Role of Rural Women in Development Allied Publishers, Bombay, Preface.

45. Rekha Mehra, Rekha & K.Saradamuni, (1983): Women and Rural Transformation: Two case studies, concept publ. New Delhi.

46. Kumar Sharma, and others (1984): Women in Focus: A Community in search of equal roles, Sangam Books, Hydrabad.

during the freedom movement. The content analysis of periodicals in regional languages revealed that concern for women and their problem has suffered a deline in the past two decades. The new social laws have remained unknown to the large mass of women.[47]

So considering the dismal picture of the position of women in rural India one can derive that a scientific analysis from social science angle about their position is quite necessary. Let us analyse their position with particular reference to 'health'. Some of the social factors which affect women's health directly or indirectly may be analysed as follows.

STRUCTURAL FACTORS

The causes of women's ill-health are found often in social structure. Class, caste, family agriculture and landstructure, poverty, unemployment, education, occupation and migration are some of the structural factors which need examination. These are discussed below.

---

47. Status of Women in India (1974), ICSSR, Delhi, p.37-38.

CLASS ISSUES AND WOMEN

In terms of health status as well as in terms of access to health services too there is a sharp polarisation between a small privileged class-which control the entire economic and political life, on one hand and the masses of people, on the other. In the world of the privilaged class, the health problems are neither so massive, nor so acute. In rural India, people belonging to this class are well nourished, they have much better sanitation, water-supply, housing, clothing education etc.

But the mass suffer from all sorts of diseases due to lack of basic facilities and prevalence of poverty, unemployment etc. Women belong to these two classes, ~~but~~ by virtue of their sex, ~~they~~ are exposed to double exploitation - class and sex. In most parts of rural India, women belonging to the unprivilaged class like landless labourers, marginal farmers etc. suffer a lot due to the existing class nature of society. Therefore, health problems of the underpriveleged are essentially problems which embrace social, economic and political fields. Women's health problems in rural India are rather exploitation, oppression, denial

of socio-economic justice and rights. Thus class is the key factor for women's ill health in rural India.

CASTE:

According to Srinivas "Caste is a hereditary, endagamous usually localised group having traditional association with an occupation and a particular position in the local hierarchy of castes. Relation between castes are governed among other things by the concepts of pollution and purity and generally maximum commensality occurs within the caste".[48]

Desai and Patel have demonstrated the adverse effects of caste system on women in a balanced way. They state, "Caste endogamy, as a mechanism of recruiting and retaining control over the labour and fertility of women, concepts of purity and pollution segregating groups and also regulating mobility have far-reaching impact on women's status.[49] They also analysis how caste affects

---

48. M.N.Srinivas (1978) : Caste in Modern India (Quoted in Neera Desai and Vibhuti Patel, op.cit, P.14)
& Vibhuti Patel

49. Neera Desai (1985): op.cit, p.14

women's status adversely by imposing restrictions on mobility, norms and practices in gender sub-ordination and by idealizing womanhood etc. If one analyses history, one finds the women belong to lower castes throughout the ages have always laboured for commodity production. They have placed a key role in agricultural development. But their health has not been considered in any way. The committee on the status of women concludes that the largest proportion of low-caste Hindus, tribals and Muslims are among the poorest of the poor. Occupationally also scheduled castes and tribes constitute the bulk of poor peasants, landless labourers, sweepers, scavengers, causal labourers etc. By virtue of being born in lower castes, women's status becomes lower and in this way their health status deteriorates. In rural areas, they are the worst suffers. No significant amount of health services has reached them. They don't have time, resources and manpower even to approach the PHC located in villages.

FAMILY

Sociologist and Social anthropologists have done a lot of studies on India's family system. These studies have shown that Indian family is oppressive to women. According to Desai and Patel family being the most intimate and private environment for women, it has serious

implications for women.[50]

AGRICULTURE LAND LAND STRUCTURE

Women are the majority of the world's food producers. They make up 60 to 80 percent of agricultural workers in Africa and Asia and more than 40 percent in Latin America.[51] In India, of the 27 million women in agriculture, the largest number are agricultural workers. These women suffer from tetanus, bovine TB, anthrax. Their exposure to grain dust, coconut fibre and hay results in their being affected by a wide range of respiratory diseases. Extremes of climatic conditions under which they work, and the nature of their heavy manual work can result in retarded foetal development and miscarriages.[52]

Inspite of these conditions, women plant, weed, supply water for irrigation, harvest, thresh, winnow, tend poultry and animals, store foods, grind flour and meal preserve foods in many other ways. They produce the world's food, cook it and serve it, yet they are malnourished. Women have very little control and very

---

50. Ibid, p.15

51. K.Marilee, (1983) "Women, Land and Food production" in Women in Development: A resource guide, Geneva, ISIS p.73.

52. "Slow death is their Lot" The Statesman, 4th June, 1984.

little say in decisions about food production. They are, in fact, the largest group of landless labourers, with little real security in case of break-up of the family through death or divorce inheritance laws and customs against them.[53]

Land is the essential resource for agriculture. The ownership, use and control of land determins who benefits from agricultural production. Land reform or charges in the land tendure system have not benefitted rural poor women. P.C.Joshi in his book[64] have shown it vividly. On the whole equitable access to land has not been ensured to women.

Mechanisation or in otherwords the so-called "green revolution" in India which started in early, 1960's has rather ~~alleviated~~ aggravated the burden of rural women. According to a Kelkar, "The bulk of the rural poor not having access to credit and the agricultural inputs for intense agricultural production, the new agrarian technology, went on to benefit the section that had enough

---

53. M.S.Swaminathan (1982) "The rôle of education and Research in enhancing rural women's income and household happiness", First J.P.Naik memorial lecture CWDS, Pub. p.7.

54. P.C.Joshi (1975) Land Reforms in India, Allied Publ. Bombay

resources to invest in it. For example, the programmes for the involvement of women in the development process which were taken up through Mahila Mandals was a scheme with a middle class bias using American text books and equipment with emphasis on training the rural women to sew knit, make jams and jellies and in kitchen gardening[55] The studies on agriculture by pattanayak, Ashok Rudra, Pranab Bandhan, Daniel Thorner and a host of economists have also hinted at the more ineuqality in rural areas in difference parts of India.

Chakravarty and Tiwari in their study[56] based on 1971 census finds that women's participation in the labour force in the state of Punjab and Haryana is 1.18 and 2.41 percent respectively. In Andhra Pradesh and Tamil Nadu, the new agrarian technology rather brought out a fall in female participation rate.

Thus, the deteriaration in land-tendre system, agricultural sphere has reduced rural women as a mere commodity. This has affected their health adversely.

---

55. G.Kelkar (1981): The Impact of the Green Revolution on women work participation and sex roles, ILO, Geneva, p.39.

56. K.Chakravarty, & G.C.Tiwari (1979) "Regional variation in women's employment - A case study of five villages in three Indian states, ICSSR, N.Delhi.

The impact of technology on rural women in India has created more inquality in rural society.

POVERTY, UNEMPLOYMENT AND UNDER-EMPLOYMENT

Poverty, that too rural poverty is a basic challenge before us. In the sixth five year plan, it was estimated that about 48.8% of Indian population is below the poverty line[57] i.e. those who spend 80% of their income on basic food items, but are still unable to get the minimum calories. In a work[58] Gulati says, there is no doubt that poor urban and rural women contribute much to the nation's progress through their heavy responsibilities for house-keeping child bearing and assisting in agriculture and industry. But it is their handicap.poverty is the source of all their sufferings including health. Dandekar and Rath, in their book have suggested that the population living below poverty line is increasing. R.N.Azad also defines rural poor as who are born in debt, live in debt and die in debt. But Banerji has

---

57. Sixth Five Year Plan, ~~& G.C.Tiwari (1979) "Regional~~ 1980-85 (1981) Govt. of India The Planning Commission, New Delhi, p.18.

58. L.Gulati (1981) - Profiles in Female Poverty Hindustan Publishers, New Delhi.

explicitly talked of poverty in relation to health. His rural study[59] showed that over 36% of families (in the 19 villages studied) did not get two square meals a day to satisfy their hunger for at least three to six months a year. According to his calculation, in his study population, 59 percent were without drinking water and only six percent had access to sanitation. In this way, Dr. Banerji relates poverty with health in much more clearer terms.

However, day by day there is disparties in income between the rich and poor. In a recent study by Food and Agriculture Organisation (FAO)[60] it is found that around 200 million Indians are malnutrished forming almost half of the world's total and about one third of the Indian population.

Hence, it can be gain said that poverty in India is the most important problem of ill health of Indian population.

---

59. D.Banerji (1981) Poverty, class and Health Culture in India, Vol.1, Parchi Prakashan, N.Delhi

60. As quoted in An analysis of situation of Children in India, 1984, UNICEF, New Delhi.

Unemployment is another important factor. Rural unemployment has affected rural women adversely. The Committee on the status of women in India (1974) has already given the alarming picture of this situation. It is unfortunate, even today we have not considered women as a dynamic factor for development. Their work both at home and industry has not be considered in labour stastics. This system has delineated women and girls as sex objects with little or nothing of their own in life.

The employment structure in rural India in respect of women provides a very grim picture "Inspite of decades of planned development the structure of employment opportunities for women in the rural areas remain relatively unchanged.[61]

In India, there exists regional variations in agricultural wages, employment and poverty. Employment opportunities in rural areas for rural women are very scarce. Chakravarty in an article,[62] argues how

---

61. Alfred De,Souza, (1976) "Women in India": Fertility in Occupational patterns in a sex-seggregated less developed society" in 'Social Action', Vol.26, 1976.

62. K.Chakravarty, (1975) "Employment, Incomes and Equality" in Social Scientist, Nov. Dec. 1975, p.104-14.

agricultural workers, peasant women in rural area have been neglected in case of employment in rural India. P.M.Mathew also argues how commercialisation of agriculture has created moreunemployment. Having analysed the census data on occupation pattern Mathew concluded "Women's employment in all sectors, except agriculture shows a lower compound rate of growth. The pressure of enemployment among women has been mounting in rural than in urban areas"[63]. In a CWDS publication[64] there has been an analysis of a policy attempt in case of employment.

Thus, employment opportunities are very low in rural areas and directly it affects women's conditions. All sorts of social problems are created because of lack of employment opportunity.

Wage discrimination in rural India among women is a common phenomenon. The CSWI has already analysed about it. Leela Gulati in her article[65] depicts the nature of discrimination. In her book Profiles in Female Poverty she says, "Sex discrimination in child

63. P.M.Mathew (1985)"Exploitation of Women labour: An Analysis of women's employment in Kerala", Social Scientist, Oct.Nov.p.34.

64. "Women's work and Employment: Struggle for a Policy Selections from Indian documents"(1983)WDS,N.Delhi

65. L.Gulati, (1975) "Sex-Discrimination in wages" in Social Scientst, Nov-Dec.

rearing in terms of education, household work, and the type of food exists in the lowest rung of the caste hierarchy. Even women discriminate against their own sex, and boys had greater freedom to spend wages than girls when the latter were also working.[66] In agricultural activities women although perform the same jobs are given unequal wages only on the ground of sex. Segregation of tasks in the work place ensures that men and women can be differently paid without discrimination being blantantly obvious. According to the 1981 census, India's working population constituted only about 32 percent of the total population. The bulk of working women, around 83 percent, is in the primary sector (agriculture, livestock, forestry, fishing mining quarrying) which is mostly unorganised. The largest single group of working women are agricultural labourers-46 percent in 1981. Only 19 percent of men are agricultural labourers in 1981.[67]

---

66. R. Gulati, (1981) op.cit, pp.164-70

67. Quoted by Sujata Madhok, (1986) "At the Work Place' 'Seminar' 318, Feb. p.25.

Poverty, unemployment and wage-discrimination are so important for women in rural India that their health is bound to suffer because of these.

EDUCATION, OCCUPATION AND MIGRATION

The fair sex in the country does not seem to have fared better since 70 percent of them live in rural areas with inadequate access to opportunities. Though women are included in the Govt. policy regarding universalisation of education, only 25% women are literate. The New Education Policy (August 1985) has not even given adequate attention to it.

Education of women is a key to their all round development. By getting education, a women can decide how family planning is useful and how different preventive measures can be undertaken for different diseases. They can control their fertility etc. In this way, women education can hardly be under-estimated.

A critical look at the educational system reveals that it is the exact imprint of colonial legacy. It had promoted imperialist and colonial values during British period. After the independence, although we witness a phenomenal growth in facilities for education in terms of reservations opening up institutions, incentives

for women education, etc. we have not been able to give a clear qualitative thrust to it. For example, in the post-independence period, after 35 years of "planned development in the country, the literacy rate has just reached nearly 36 percent, a rate of increase of only 1 percent per year. of these nearly 13 percent have never received any formal education, 11 per cent have studied upto primary and 6 percent upto middle level.[68] Pande shows that plan allocations for education in relation to the total plan outlay has been reduced from 7.6 percent in Ist plan to 2.6 percent in the 6th plan. There has also been calculated cuts at the elementary level of education. A large number of studies particularly be Chitnis, have revealed disparties in education disparity of standards, lack of basic facilities for teachers. Thus education is reduced to a commodity and is sold to the higher bidder at a vast profit. Education is geared to the employment market and examinations are used to eliminate young people rather than test their knowledge.[69]

Education, particularly women's education should aim

---

68. Balaji Pande (1985) "Women's education in social scientist, Oct-Nov., pp.11-12.

69. Ibid, p.13

at creating a spirit of self-confidence, self-reliance enquiry and solidarity. Our formal education has made women a piece of "office decoration'. Even though some middle-class women in rural areas are educated and employed they face the problem of security. Because, money in the hands of women is rural areas is culturally despised and it affects the 'IZZAT' of the partriarchal family.

The following figures speak of the real picture of women's literacy.

Of the total number of adult illiterates in the country, women constitute the majority" in the sector literacy there has been only a 6 percent increase in female literacy during the decade, the figure being 18.70 percent in 1971 and 24.82 percent in 1981...According to the 1981 census, female literacy in the rural area was 17.96 percent and in urban area 47.82. Kerala has the highest female literacy (65-73 percent, rural 64.25 percent) and Rajasthan has the lowest (11.42 percent rural 5.46 percent). The number of illiterate females has been increasing steadily, the figures being 185.2 million in 1961, 215 million in 1971 and 241.6 million in 1981.[70]

---

70. Ibid, p.15-16.

As far as Scheduled caste and scheduled tribe women are concerned the position is very unsatisfactory "There are 46 districts in the country (mainly in Andhra Pradesh, Bihar, M.P., Rajasthan and U.P.) where the literacy rate among scheduled caste women is less than 1% going down even to 0.2% in some case. At every level it seems that girls and women are neglected.[71]

Mazumdar and Pande in a paper and Karuna Ahmed in her paper[73] have cogently analysed the socio-economic causes of female illiteracy. We need not analyse those in details.

Therefore, women's education in rural areas is very low and it affects health as education is the significant indicator of women's status. George rightly says "It is established that literacy and education play a decissive role in the improvement of women's status and these in turn are related to fertility.[74]

---

71. Swaminathan, M.S.(1982) op.cit.p.5.

72. V.Mazumdar, and B.Pande (1985) "Perspectives on Women's education-1901-81" A paper for women's NAO consultation, New Delhi on 3rd April.

73. Karuna Ahmed (1982) "Family and women's Education" A paper prepared for the workshop on Family Research in India organised by CWDS New Delhi from Nov.10 to 12, 1982, IIC, New Delhi.

74. George Aleyamma (1975) "Literacy: Doorway to Liberation Social Scientist, Nov-Dec, 1975, p.145.

As far as occupation is concerned, it is really disheartening to note that our society has not accepted in true spirit the income-earning potentialities of women. In rural areas they just do some ephemeral ardous and menial occupations biding their time until marriage, when a gallant man will take care of them. Women in rural areas in different spheres beginning from household to agricultural works work from dawn to dusk and their workload in family is not considered. In an Assam study[75] jointly done by Saikia, Gogai and Lekharu sponsored by ICSSR between January and July 1981, it was found that women in the study villages are not only over burdened with domestic work but with other economic activities. In the agricultural peak season, they work more than 14 hours a day. In the committee report, we have seen different occupation pattern of rural women.

What is striking for us is that, certain occupation are exposed to the kind of serious health hazards. For example, in tribal areas, women walk miles together to fetch water and their household works are mostly with water-cleaning etc. In this way they are exposed to

---

75. P.D.Saikia, and others (1981) Changing role of women in rural societies, ICSSR Project

back-aching and other waterborn diseases. (In case of Bidi workers of Nipari, the cashew nut processers and coir workers of Kerala, the tabaco workers of Gujarat the tea-pickers of Assam, the chicken workers of Lucknow women are exposed to different occupational diseases. Their exposure to dust, and environment, unsatisfactory working conditions, resperatory diseases accidents, during work, etc. Causes morbidity of women. For example, 97% of the 45,000 women workers in chiken industry of Lucknow hail from nearby rural areas. They are mostly widows and deserted, But, they also spoil their eye-sight by the time they are 30 years and become blind by the time they reach 50. The tea pickers suffer from accidents while they work on the hill slopes. They are affected by insects, and snakes bites, severe pesticide hazards and asthama due to the tea dust that covers the area.[76]

But no serious studies have been done by social scientists to analyse the occupational pattern and the resultant diseases among rural women.

Migration, is another factor degrading health status of women. In a study[77] by Kasturi we find that migra-

---

76. The Statesman, op.cit.

77. Leela Kasturi, (1977) - Poverty, Migration and Women's Status, An ICSSR Project, New Delhi.

tion rate had increased, stupendously, till it represented 80 percent of the total internal migration. It had been assumed that this female migration was for marriage and associational reasons, but the CSWI investigation concluded that a large part of female migration was being caused by economic distress and the declining employment situation of women, particularly in rural areas.[78]

POWER STRUCTURE, legal measures as affecting women's Health

Political forces play a dominant role for effective health services; decisions concerning resource allocation, manpower policy, choice of technology and the degree to which health services are made available and accessible to different segments of the society are examples of the manner in which the political system shape community health services.[79] In rural area, women's participation

---

78. V.Mazumdar, (1984) "Women and Development in India" in the IDRC Report Vol. 13, No.2, July, p.4.

79. D.Banerji, (1985) Health and Family Planning Servicces in India: An Epidemological, Socio-cultural and Political analysis and perspective (Lok Parkashan, New Delhi p.1)

in politics is far from satisfactory. In the CSWI report, it has been nicely dipicted. Rural women have been conditioned to think that certain facilities and better living conditions are meant for the powerful and rich. Due to lack of political consciousness, they hardly participate in village politics in order to get more benefits. Even village politics has neglected women as a part and parcel of development. The power structure in rural India has been shaped in such a manner that it favours those who have the means to exploit the situation. Banerji's study of 19 villages have clearly shown it.

However, research data collected by Kelkar in Western U.P. revealed that all the aids in terms of soya oil, powder milk and cereal for expectant and lactating mothers was usurped by the rural rich who had links with the local bureacracy.[80]

LEGAL MEASURES

Although legal measures are one of the true ingredients of women's status in our country, in rural area the colonial legal legacy has deep roots and as result it has absolutlely no effect. The different acts like

---

80. G.Kelkar, (1981) op.cit.

Hindu Marriage Act, 1955, The Hindu Succession Act, 1956 The Hindu Adoption and Maintenance Act, 1956, The Hindu Minority and Guardianship Act, 1956, Prohibition of Dowry Act, 1961, 1985, Supression of Prostitution and Immoral Traffic Act, 1958 and the recent most contriversial Muslim Women Protection of Maintenance Act, 1986 etc. have not touched the magnitude of the problems. Therefore, rural women because of lack of education, effective political participation and deteriation of economic status fail to exercise her rights given by law.

Thus, so far we have only analysed some of the important socio-structural factors which are involved in Women's health in rural India. Now, we may analyse how cultural norms and value systems have shaped health of women in rural India.

CULTURAL NORMS AND VALUE SYSTEMS

A panoramic view of Indian society presents a spectacle of many contradictions. On the one hand, we are proud of calling our country 'Mother India' and on the other hand, we never hestitate to burn our ladies in broad day-light. There are many sophisticated upper-class women in public life, yet it is in the upper classes that women are more confined to men. In fact, it is a matter of social status for women not to have to work.

But as far as the lowest castes and classes are concerned it is common forthe women to be engaged in performing even the manual labour".[81] In religious text books, there has been always double-standard. Many studies have clearly revealed that women in India are handicapped by cultural norms and value systems. In case of health, rural women behaviour is largely determined by culture and value system. Here are some of the factors which are indirectly responsible for ill health among Indian rural women. Some factors which have direct bearing on it will be discussed in the next chapter.

Before the birth of a daughter in Indian society, discrimination starts and never ends even after he death. Interestingly enough, Indian culture, tradition and normative standards are so rigid that these have't been changed inspite of technological advance, urbanisation increasing population and constitutional directives. What is possible in theory, is seldom within their reach in fact.

Cultural norms like different religious traditions, early marriage, polygamy, enforced female infanticide,

---

81. Kamla Bhasin, (ed)(1972) "The Position of Women in India" Proceedings of a Seminar held in Srinagar Sept, p.2

fertility pattern, idealization of womenhood and patriarchy etc. have indirect bearing on health. Because, all these factors have degraded the status of women in this country. And because of the low status of women in our country their health also remains low.

Different religious traditions like Hinduism, Islam Christianity, Zorastrianism and tribal religions etc. have propagated religious injuctions and kept the health of women very low. In case of descent systems, there are mainly two types of societies exist. They are matrilineal and patrilineal. The former exist in South Western and North Eastern regions of our country and the latter exists in the majority. In both these communities there are no right to the ~~rich to~~ property, widow remarriage etc. ~~have not~~ ~~been given~~. The cultural notion is that a women's role is only supportive.

In family organisation, in rural areas joint family is another burden on women, because it enforces cultural oppression. For example purdah culture - a culture of secluding women-which had prevailed in India for a very long time certainly long before the 10th century A.D. still exists. The culture of purdhah represents a spatial boundary between men and women, but more importantly it represents the confirnement of women, not

just within the house but within its deepest recesses.[82]

Just as ideologic of domesticisation operate in the home to keep women confined to the boundaries of the house (the grihini, the grihalaxmi ideal) so too notions of IZZAT, of honour, of chatity operate to respect the choice of occupations for women. Women's space being household) space, all public space is by definition male space. Even Indian women do not run shops or sell their products themselves at village haats. Our culture teaches them to be submissive to the patriarchial authority.

To-day in rural areas when a girl gets birth she is considered as a sin or unwelcome sign. She is discriminated not only in the process of socialisation, but also at the time of food distribution, clothing and schooling. They are supposed to work from the very childhood for the household, and by the way they are trained to do household activities. Even, early marriage is a common phenomenon. Because of commercialisation of marriage, poor and middle class families fail to get their daughter married in time. If by the way, their

---

82. Uma Chakravarit (1986) "Pativarata" in Seminar, Feb, p.17.

daughter married in time. ~~If by the way~~, their daughters are forced to be widows, then, the attitude of our people never change towards them. Custom like polygamy which ~~are~~ is offensive still exist$in this country. The problem of dowry is rampant, it has destroyed the whole peace of social life. The concept of 'Kanyadan' and other Hindu concepts and prevalence of black money have aggravated the problem of dowry. Marriages in most cases are performed by ritual ceremonies and these customary marriage by virtue of its expensive nature, have affected the national economy.

The problems like rape, devdasi and prostitution still bother each and every section of our population.

Our value system has been such that our attitude has been nurtured in the same tradtion and culture. We have looked upon our women as not more than a weak sex. In every aspect of social life, this attitude has played a dominant role in shaping the status of women. Attitude reflects the social and economic forces of a society. Beca use, it is not an individual question. Even among the enlightened families, the emphasis is given on feminine tasks and femine abilities. This short of emphasis on femine roles affect girl's personalities and work. Therefore, male attitude as

well as female attitude which are based on deep-rooted prejudices should change.

Inspite of decades of planned development, the plight of rural women had not changed in a desired way. Rather, women suffer from all sorts of disabilities the roots of which lie in social structure value system and cultural norms. It is also because of their experience of discrimination is more extensive due to the sex-segregated character of society, the conditions of poverty and traditional value system.[83]

Ramalingaswami in her continuing project[84] is trying to develop a perspective which may be helpful in the area of 'Women and Health'.

Thus, to sum up the cultural norms and value system that particularly affect women's health are attitudes to marriage, age of marriage, sex of the child, fertility rate, the pattern of family organisation, the expected roles of women as prescribed and proscribed by social conventions. Cultural insistence on early marriage, high fertility, idealization of the roles of

---

83. Alfred DeSouza (1976), op.cit. p.66

84. P.Ramalingaswami, Health, Education and Income generation activities for tribal women in Andhra Pradesh, CSMCH, SSS, JNU, N.Delhi.

women as mother and housewife affect her physical and mental health. In poor families, malnutrition is the major factor of women's health. Women are expected to subservient to men in each and every stage of their growth. The taboos, restrictions which start with menstruction and reluctance to consult a doctor particularly a male doctor, result in ill health.

Against this social factors detailed analysis will be made in next chapter where, the health problems of women will be analysed and disease pattern in rural India will be dealt with.

CHAPTER II

HEALTH PROBLEMS OF WOMEN : AN ANALYSIS

The main thrust of this chapter is to analyse the health problems faced by rural women in India and the different specific national programmes which are in operation to raise their health status. In the previous chapter, we had sociologically identified the factors which have direct or indirect bearing on women's health. Now the second objectives of our work is discussed below.

For the last fifteen years health has become a central issue in women's movement internationally.[1] We have examined that rural women in India have faced occupational problems and still they have put on hard work. In this way they have also helped in the process of rural development. Not only that their health determines the health of future generation.[2] Let us identify their health needs and special problems.

Women's health needs are not adequately assessed. It is true that women specific problems (especially maternal mortality) are difficult to measure due to their

---

1. Quoted from 'Women's World' - A newsletter by ISIS Sept. 1984, No.3.

2. "Women, Health and Development" in World Health, April, 1986, pp.15-18.

complex causes determined by many different factors. Still researchers have carried out epidemiological studies in order to determine the causes, nature and extent of particular health problems. But more needs to be known about the specific issues and factors which define women's status and how they affect patterns of health problems. Unfortunately very few sociologists have done any serious efforts to analyse the unmet health needs of women, while working in the health field. However, on the basis of studies done by epidemiologists, social scientists, and nutritionists, we can here analyse the women's health problem.

It is really thought-provoking to analyse that women's health problems, their very personality and nature has been linked to their reproductive organs only. "In the past century, society, science and particularly Western medicine, has viewed women primarily as reproductive vehicles and secondarily as human beings.[3] The question in this context is generally asked - Is there a need to define women's health needs as distinct

---

3. S.Batliwala "Women and Health Care" A mimeographed paper by the Foundation for research in community health, Bombay.

from the rest of the population? Batliwala gives an emphatic yes to this question. According to her, women are socially and economically deprived, they bear the triple burden of child-bearing and rearing, domestic work and the ratio of women to men has been steadily declining except in 1981 census which shows a slightly reverse trend. "These social and economic inequalities and the extra burden of ill-health borne by women, establish beyond doubt the heed for a special focus on women in any national programme, but especially in the health sector."[4] Hence women's special health needs and problems need re-examination.

Health problems of women have been broadly divided into two categories (a) Illness which arise because of and attendant upon their reproductive structure and function; and (b) Health problems aggravated due to social taboos, customs and the overall structure of society and its processes.[5].

---

4. Ibid, p.2

5. Quoted by M.Daswani and G.A.A.Britto (1984) in "Women and Health" A critical review of available information in India". The foundation for research in community health, March, p.1

It is of course, difficult to compartmentalise the problems. For example, repeated pregnancies are health hazards, relating to the reproductive structure of women. However, they occur primarily due to the socio-economic and cultural conditions prevalent in most parts of the country. It has been recognised that women face health problems through their life cycle, starting from sex preferences during infancy, discrimination in feeding practices, biological vulnerability of women during the reproductive period, the effect of a high level of fertility, to special problems such as nutritional anaemia and maternal mortality.[6]

On the basis of the analysis given by world Health Organisation and different scholars in the field of health in India, the following health needs as well as problems of women in rural India have been identified. They are as follows: Child-hood, menstruation, adolescence, pregaancy, child-bearing, anaemia, contraception, fertility regulation, abortion, infection, anaemia, menopause, aging, stress and fatigue, health problems due to violence against women, mental health and psychosomatic

---

6. Ibid, p.2

ailment. The common complaints of women about the symptoms of physical health of women are backache, giddiness, ghabarahat, constipation, burning urine, dyspnoea on exertion, darkness in front of eyes, headaches, bodyaches, poor appetite, insomnia and pain in the calves etc. Apart from these, the disease pattern in rural India also affects women more than men.

Some of the health problems faced by women from childhood to death are analysed below.

CHILDHOOD; INFANT MORTALITY

In infancy and early childhood boys and girls grow roughly at the same rate; the later growth spurt is about one to two years earlier in girls than boys. Sexual maturation is completed sooner in females than in males, the process having begun earlier. The nutritional and health requirements are the same in both sexes during childhood.

But, in Indian society, particularly in rural areas the birth of a girl child is considered as a burden and evil omen. Most of the important studies have revealed

---

7. WHO Technical Document (1988) No.20, para.

that cultural norms and attitudes to girls result in parents having a preference for boys.[7] This son preference attitude is further reinforced in feeding patterns, clothing and health care. In India, girl child is not often taken for treatment to hospital and therefore succumb more often to serious starvation and infection. Without adequate supplies of protien, calcium and vitamin D the bones do not grow so strong, the pelvic bone becomes smaller resulting in deformed shape and hence causing difficulties during child-birth. In certain areas, traditional practice requires the circumscision of girls, which causes very serious health problems.

As far as infant mortality is concerned, female infant mortality in rural India is more. According to available statistics (Central Bureau of Health Intelligence (1983), there is a higher rate of infant mortality[8] among females.[8] In rural India, the number of deaths of female children per 1000 live births is 142, whereas the number of deaths of male children is 130. The foundation for research in community Health in a detailed analysis of the mortality profile in their rural Mandwa

---

7. WHO Technical document (1980) FHE/80, P.6

8. Quoted by Mona Daswani, and G.A.A.Britto (1984), op.cit, p.4.

Project (15 km from Bombay city) in 1982) gives a good account.[9] It was observed that among the deaths occuring in the age group 0-5 years, 64 percent were female. The causes of infant female mortality are varied. Along with cultural norms and social practices, sex-bias in infant malnutrition is important. This neglect of female babies and children during an economic crisis such as the floods of 1978 in West Bengal was very clear. In a study[10] by Kynch and Sen and another study[11] by Sen and Sengupta based on empirical field data in two villages in West Bengal it was found that the incidence of female children malnutrition was substantially greater than that of their male counterparts.

The point here is that a female child in rural India suffers from the discrimination during childhood.

ADOLESCENCE AND MENSTRUATION

Adolescence is a difficult stage of female sex.

---

9. Ibid, pp.4-5

10. J.Kynch & Amartya Sen (1983) Indian Women: Well-being and Survival, A paper presented at the Workshop in "women and poverty" Centre for Studies social sciences, Calcutta, March, 17-18.

11. A Sen and S.Sengupta (1983) "Malnutrition of Rural Children and the Sex-bias", 'EPW', Vol. XVIII Annual Number, p.19-21.

It is a stage when they try to cope with their bodies and environment. Menarche brings with it the problems of painful menstruation, severe bleeding, exhaustion and a state of mental confusion. According to Shatrugna, "Doctors brush aside these symptoms as temporary and hence do not pay attention-instead marriage and child-birth are suggested remedies if the symptom persist. No work or research is done into these problems of young girls.[12]

Menstruation is a normal, usual health occurance for many years of a women's life.

The onset of menstruation being a key event in female maturation needs a sociological examination. On the one hand, in some parts of India, this is treated as a welcome ceremoney among the family members. But, on the other hand, different studies have shown that this normal physiological fact of women's life isolates women from the others in the house, not allowed to cook food, touch pickle and any productive work. The general notion is that menstrual blood is unclean and hence

---

12. Veena Shatrugna (1980) - "Health Status of Women and children and the role of Community Health Volunteer Scheme" - Seminar Paper, P.1

~~13. Rogen, and S.Sengupta (1983) "Malnutrition of Rural Childrena and the sex bias", 'EPW', Vol.XVIII, Annual Number, p.19-21.~~

woman during this stage is treated as impure. According to Roy Burban, tribal customs are interesting to observe "A menstruating tribal woman must not touch hunting nets and other implements.

Studies on perceptions of menstrual bleeding show that the majority of women in all culturs were aware of distinctive features of their menstruation.[13]

In India, the health hazards of rural women becomes aggrevated during this stage. Because, menstruation increases the need for more nutrition due to regular loosing of iron. But poverty and unequal food distribution make women vulnerable groups. Due to lack of sufficient nutrition, blood formation becomes deficient and anaemia results.

The point which is important here is that menstuation as the usual and natural biological condition of women is given a different social colour. Second, the health risks which is involved during this stage is not given adequate attention due to the poor socio-economic condition of rural women. Third, no systematic study is being done to analyse how this process affects

---

13. "Health and Status of Women" (1980) WHO Division of Family Health, FHE/80-1, p.7

the preception of health problems of women.

PREGNANCY

Pregnancy is fundamentally a healthy process, but it can be dangerous to the mother if the environment is poor, for example, if no care is available, if food is inadequate, or if she has no time to rest. Too many pregnancies or pregnancies too close together also result in bad health or even death for mother and child. In India, it is a fact that lack of adequate maternal care has resulted in pregnancy-related problems. But sociologically viewing, one should also view the preganancy and child bearing of women as a necessary social condition. In a large number of women, of the 30 years of their reproductive lives (15-45 years) at least 16 years are spent in pregnancy and lactation and 2/3rd of these before she reaches her 35th birthday.[14] A large number of risks and obsteric complications are high, particularly under 16 years of age. In rural India, marriage of girls is being done at early ages. It results in toxaemia of pregnancy and low weight of babies. During the prime reproductive age (15-45 years)

---

14. Veena Shatrugna (1980), op.cit, p.1

the average Indian women becomes preganant about 8 times.[15] Each liveborn infant is generally fed up to 2-3 years of age. Out of the 360 months (30 years) of reproductive life, 200 months or 50-60% of the time is spent in pregnancy and lactation. Of this, some 140 months are completed before the woman reaches 35 years of age.

A large number of problems of pregnancy are related to nutritional deficiencies due to food inadequacy and poverty. Nutritional deficiencies like iron, folic acid, vitamin A, calcium lead to morbidity and even mortality. Women need about 1,500 cals and 55 gms of protein. Indian women gain less than 6 kgs during pregnancy while the ideal is 12 kg, leading to the birth of smaller babies (average birthweight 2.7 kg compared to 3.2 kgs in the high income group). Veena shtrugna further says "this results in high newborn deaths."[16] 30-50% of women have anaemia and about 30% have B-complex deficiencies leading to sore tongues with further restrictions in food intake. Atleast 70 to 80% of the maternal mortality. (417.6/100,000 live births) are preventable, such as those associated with sepsis, eclampsia, tetanus

---

15. Kamala.S.Jayarao(1983) "Who is Malnourished: Mother or the women" in Health Care: Which way to go, Issues and Alternatives, MFC, Pune

16. Veena Shatrugna (1980), op.cit, p.1

haemorrhage, malpresentation, etc. 80% of all deliveries take place in villages with unhygienic condition by local dais or older women in the family.

The studies [17,18] by Batliwala, & and Daswani have depicted how food requirements go up during the pregnancy and lactation. Also they have shown that just increasing food intake during the last three months of pragnancy can lead to the birth of healthier babies. Also women need adequate rest during the period. But women can't afford the luxury of rest in rural area. An Orissa medical journal claims that the death rate was high among women during their first pregnancy and 92% of women had never attended the antenatal clinic.[19]

There are certain taboos exist in rural India with regard to food intake in pregnancy and restrictions about behaviour patterns of women. In a study[20] of Bijnor District of Uttar Pradesh, Jeffery finds different rituals practices are associated with Childbirth.

---

17. S.Batliwala (1983) 'Analysis of Mandwa Death information 1982 "A mimeo at the Foundation of Research in community health, Bombay, January.

18. Mona Daswani (1984)"Analysis of Mandwa Death Registration 1983, Mimeo at the Foundation for Research in Community Health, Bombay, February.

19. Quoted in The Telegraph, 17th Jan, 1983.

20. P.Jeffery et.al "Child birth and collaboration among women in Bijnor District".

Here, we see how health hazards are associated with the type of birth practices we have in our rural area. Social elements like food intake, adequate rest and reasonable attitude towards pregnant women also can help for the birth of a healthy baby including proper ante-natal and post natal care. Health education in this context is also important.

LACTATION

Breast feeding is an integral part of the reproductive process, it is the natural and ideal way of feeding the infant and forms a unique basis for the child's physical and emotional development. The mother's milk also provides life-saving immunities against infection for the infant. In addition, women who are breast feeding, experience a later return of menstruation and evaluation after the birth and are therefore less likely to concive again too soon.

The thing is that among rural women, it is a usual phenomenon preparation for lactation during pregnancy involves the accumulation of energy reserves, but a rural poor woman can't afford energy reserve (food etc.). In this way, she suffers from ill health. For example, it results in the depletion of the mother's own tissues.

However, the feeding of infants and young children after breast feeding, during the wearing period is closely connected with women's status. Due to 'modernisation' women have gone out of home to work. Therefore, how far it is possible on the part of working women to give breast milk has to be researched upon.

FERTILITY REGULATION: USE OF CONTRACEPTIVES

It is well known that how high fertility rates, too many and too closely spaced pregnancies, pregnancy at early age etc. affect the health status of women and children. The glaring sociological issues in the context of fertility regulation are the ability of a woman to control her own fertility, family planning information and service and contraceptives.

Studies have been carried out on the health hazard of modern methods of contraceptives. But the issue here is the status of women in a community which will speak of the fertility regulation. The health and social benefits of fertility regulation among rural Indian women is far from satisfactory. Unfortunately in most of the parts of India, infertility is highly devalued. A woman is blamed for this. Men refuse to have themselves examined and the whole blame is put on the woman. ~~She~~ They are ~~is~~ being looked down upon as barren women. Society puts so much restrictions on them.

ABORTION

Abortion, both induced and spontaneous, are widespread. It is generally estimated that about half of all pregnancies are not completed.[21] The causes include infections and genetic, physical and chemical factors as well as other less well defined causes related to immunological, emotional or nutritional factors. Induced abortion, on the otherhand, is deliberate measure to interrupt a pregnancy before the fetus is viable. Whether legal or not, abortion is probably the most widely used method of fertility regulation. It is estimated that, each year, 40-70 per 1000 women of reproductive age have an abortion.[22] In another report,[23] the problem of abortion has been well documented.

In India, the medical termination of pregnancy Act has allowed legal abortion. But for the majority of rural women wanting an abortion, health services are not accessible, both physically and financially. Instead of money and personnel being provided for abortions or MTP service to the poor women, effort and time is spent-

---

21. WHO division of Family Health, FHE/80-1, p.12

22. Ibid, p.12.

23. Demographic, Social and Medical Aspects of Abortion (1969) (Demographic, Training and Research Centre, Bombay).

on research on pills and IUD. Abortions are induced in rural areas using methods that the community has evolved over the years. But the unhygenic conditions lead to sepsis and death, in a large number of them.

As far as induced abortion is concerned, timing is very important. Abortions early in pregnancy (within the first three months) is much safer. Legal abortion is possible because of failure of contraceptives, pregnancy caused by rape, danger to life, grave injury to physical health and mental health etc. Batliwala and Daswani in their study[24] find that percentage of deaths due to abortion in rural areas for the age groups at 15 to 24 is 13.7 per cent, from 25-34 is 8.1 percent and 35 to 44 is 21.2%. They have also found seasonal variation of infant deaths (0-1 year) The highest proportion of infant deaths (0-1 year). The highest proportion of infant death occur in July and August. Obstetricians confirm that if women in the last trimester of pregnancy engage in such intense physical activity, particularly the squatting position which is employed for tasks like transplanting and weeding there is continuous pressure on the uterus, which caused them to spontaneously abort. During this

---

24. Daswani & Britto, op.cit, p.15

period, women should confine themselves to ligher tasks.

According to Ghosh, insertion of a stick inside the uterus is by far the commonest method practised by the illegal abortionists. Other methods include forcing a stick of an indigenous root, an unsterilised rubber tube, soap solution or irritant chemicals.[25]

ANAEMIA

Anaemia is one of the important causes for the rapid aging of women in early years. Nutritional anaemia is a condition in which the haemoglobin content of the blood is lower than normal as a result of a deficiency of one or more essential nutrients, regardless of the cause of such deficiency. Iron deficiency anaemia is common. It becomes serious when it is combined with infections such as parasitic diseases. It is estimated that at least half of the non-pregnant and pregnant women of the world are anaemic.[26] Also it has been estimated that 230 out of 464 million, or two thirds of the women in developing countries are anaemic. In Asia itself,

---

25. Barun Ghosh (1983) "Abortion: A problem that would not go away" in The telegraph, August, 7.

26. WHO Division of Family Health, (1980) Part-II, p.43.

65% of preganant women and 57% of non-preganant women suffer from nutritional anaemia.[27]

About 60 to 80 per cent of the preganant women in South India suffer from iron deficiency anaemia. India has probably one of the highest prevalance of nutritional anaemia in women.[28]

THE MENOPAUSE AND AGING

Menopause is a distinct period of women's lives. It is a period when women experience physiological withdrawal of sex hormones. The menstrual cycle stops, marking the end of the fertile period of a woman's life. It has been clinically observed that menopause usually occurs between the age of 45 and 50, and may even occur between gradually or suddenly.[29] When the ovaries stop functioning there is a decline in the body level of the female sex hormones, oestrogen and progesterone. The decline in oestrogen, in particular affects the health and appearence of woman. Some women pass through menopause with few mental and physical traumas, while others suffer problems such as sagging and reduced breasts, headache, insomnia or disturbed sleep, depression, anxiety

---

29. "Coping with menopause" in Indian Express, Express magazine, Feb, 26, 1985.

27. WHO (1982) - "The Prevalence of Nutritional Anaemia in Women in Developing Countries: A Critical review of available information." World Health Statistics Quarterly, No. 2

28. "Highest incidence of nutritional anaemia in Indian women", Quoted in The Hindu, July 21, 1983

worry and psycho-somatic symptoms. The onset of menopause is a very critical and testing time in the life a woman. usually the patient complains that she does not get period regularly, that she experiences intermittent or excessive bleeding.

OCCUPATIONAL HEALTH

Occupational health hazards exist for both men and women. Studies of how they specifically affect women have shown that women have certain biologically determined characteristics, such as lower capacity to sustain heavy manual and physically demanding work, and less tolerance to heat and vibration. In the last chapter, we had already discussed these in details. Many studies have concerned themselves with pregnancy and have focussed on the effects of occupational hazards on the fetus; for example, the adverse effects of toxic sustance which include abortion or abnormality in the infant.[30] More needs to be know about the effects on women in Indian context. In India, a women works for more than 16 hours a day. Jain, estimated that 14-16 hours or nearly two third of a woman's day is spent in working.[31] Batiwala states that

---

30. WHO Division of Family Health, p.16

31. Devaki Jain, (1979): Women's Quest for power. Five Indian cases, Vikas publi, New Delhi.

respective energy contribution of men, women and children are 31 percent, 53 percent and 16 percent respectively.[32] Hence, the women are working longer and harder than the men. In a perceptive article,[33] a series of studies on Indian rural women reveal the fact that women work more, get less and there exists a male bias. In this way they face double trouble.

Batliwala finds that because of excessive hard work women particularly rural women need more calorie intake. But in actually, men take 3270 calories intake, women only 2410 calories. Moreso, during the period of pregnancy and lactation when an additional 500-600 calories are required, are not given to them.

The important point is to be noted is that women spend more hours a day on survival related activities such as fetching water (0.78 hours) and cooking (2.28 hours). Apart from the sheer drudgery of the work it created a high demand on human energy. Hence, merely collecting a vital source of life (e.g. water, firewood etc.) leads

---

32. S.Batliwala (1984): "Rural energy situation: consequence for women's health" in socialist health Review Sept. p.72

33. "Double, trouble and toil" (1982) in "Health for the Millions - A special issue on women and health, Vol.VIII No.4 Aug. p.3-5.

to ailments such as backaches and worn out feet for women. Not only that, according to S.Batliwala, the present stoves used for cooking are not only primitive and inefficient, but also a potential health hazard for women. It has been estimated that women who spend around 3 hours a day for cooking, inhale benzo-pyrene which is equivalent to smoking 20 packets of cigarettes a day.[34] The answer to this would be to promote an appropriate model of the smokeless "chula" which is reported to have a fuel saving of nearly 50 percent.

As far as stress is concerned, it depends on changing family pattern and how women perceive stress and fatigue. More needs to be known about how status of women affect stress and fatugue, and vice versa, how stress and fatigue affect the states of women.

MENTAL HEALTH

It is an area which has not been given due attention becuase there are considerable problems related to diagnosis and assesment of causes of mental health

---

34. "Quoted by Mona Daswani and G.A.A.Britto (1984) in women and Health: A critical review of available information in India" from SNDT (1983) Bio gas fuel hazard for Indian women: Bulletin of the unit on Women's studies SNDT women's University, May.

because of attitudinal biases, which depend on cultural and social setting. There is, of course, ample evidence to show that pregnancy or child birth can trigger off episodes of major psychiatric pathology, such as manic-depression or acute psychosis.

In India, rape, wife-beating, forced prostitution etc. create not only physical problems, but also it affects mental health. It results in suicide, Divorce, dissertion, immature widowhood create unnecessary mental tension among rural women. The problem of physically handicapped women is really acute. Hence the violence against women poses a serious health hazard. Female circumscision which exists in some tribal communities also create fear psychosis. In this way, women suffer from pychosomatic ailment, there is lack of research in this investigative areas in India. Apart from the above health problems, women in rural areas also suffer from infections. Infection specific to women (e.g. gential tract infections) are acquired through sexual intercourse, ~~in appriate~~ inappropriate care, poor hygiene, during child-birth and abortion.

Accidents are also becoming a common health problems of women.

There are certain diseases which causes more maternal

morbidity and mortality in India. These are discussed below.

WOMEN AND DISEASE PATTERN IN RURAL AREAS

Communicable diseases account for a large number of deaths and considerable morbidity in rural India. The major communicable diseases which are prevalent in rural India are malaria, tuberculosis, leprosy, filariasis, trachoma and typhoid etc. Some of the diseases are discussed below.

LEPROSY:

Leprosy is a chronic disease caused by small germs. Though the disease is curable, there exists a fear complex because of the deformities it creates. This fear is much more in women then man because there is the added danger of being deserted. Shatrugna adds, detection of leprosy means the detailed examination of the whole body surface of the person for (i) altered skin colour (depigmented patches) on the arms, legs, body, (2) change in the sensation or reduced sensation in these areas (3) thickened nerves on the arm, neck, leg, (4) weakness of the muscle. One can not see an investigator pursuading an apparently normal woman to subject herself to this examination.[35] She has shown with data

---

35. Veena Shatrugna Women and Health, SNDT, Current Information series. p.70.

that the prevalence of leprosy is very highwith younger girls being more prone than boys.

There are really very scarce data to show that communicable diseases affect women adversely. But, one has to analyse how for different communicable diseases affect women's health. More studies in this are necessary.

Diabetes is a disease which has higher incidence among women than men at older ages. Having quoted data from the survey of diabetes Mellitus in rural population Shatrugna has shown this.[36]

Having considered the diseases in rural India which affect women more, let us very briefly analyse the major national programmes which are launched in India to tackle the problem of ill-health among women.

PROGRAMES FOR WOMEN

Some programmes have been launched to effectively tackle the health problems of women in India. Most important programmes which are directly linked with the improvement of health status of women are maternal and

---

36. Ibid, p.69.

child-health programme, National programme for the distribution of iron and folic acid, national nutrition programme, the medical termination of preganancy programme, ~~the medical termination of preganancy pregramme~~, dai training programme ICDS programme and above all family welfare programme. Now, a very brief attempt has been made below to analytically show the nature, importance and success of these programmes.

MATERNAL AND CHILD HEALTH PROGRAMME (MCH)

It is an established fact that mothers and children are integral part of the family, the social group and the society at large. And therefore, inspite of the limitation of specific programmes for specific groups, there exists a wide net work of particular health programmes to improve the health of mothers and children.

EVOLUTION

The idea of MCH is not new in India. Although its origin dates back to the planned parenthood movement of the West in general and welfare movement in particular, in India in 1855, it was started in a rudimentary form. In 1855 the Dufferin Fund Committee started midwifery courses but only in 1931, a maternity and child welfare Bureau was established under the aegies of the Indian Red cross Society to provide technical assistance to

government and non-government organisation. In 1933, a Department of MCH existed in All India Institute of Hygiene and Public Health in Calcutta.[37] The Sokhey Committee and the Bhore Committee urged a very high priority formaternal and child health services in the development of health services in India. Employment in PHCs of Auxilliary Nurse Midwives (ANMs) to provide MCH services to rural populations and employment of Lady Health visitors (LHVs) to provide supervisory support to the ANMS were among the earliest efforts to professionalise India's health services.[38] In the 1950's MCH was an independent programme in the hands of female doctors and nurse midwives. In the sixties, it was merged with family planning. In the Seventies, considerable attempt was made to develop a comprehensive approach towards health through the concept of primary health care. In the eighties it has been given enough importance.[39]

---

37. Ibid, p.39

38. D.Banerji (1985), Health and family planning services in India, Lok Paksh, New Delhi, pp-280-81.

39. Seventh Five Year Plan, p.395, Chapter 14.

DELIVERY OF SERVICES

In 1952, when primary Health Centres (PHC) were first established, MCH services were almost the only ones among their activities to reach out the rural population. The Nurses, ANMS, LHVs were entrusted to this work. Later on family planning work became a part of MCH work in theory. But in actual practice, according to Banerji it turned out that MCH work became a part of family planning work.[40] Over the years, the 'at-risk' and 'extensive-intensive area' strategies were suggested. The 'at risk' approach involves identifying pregnant women who face high risks in pregnancy and delivery by being poor general health. The health for all committee (1980) recommended the community approach. "In the use of MCH, it will mean the training of traditional birth attendants, dais, and female community health workers in modern procedures and utilizing them for MCH care.[41] The dais and female community health workers were given utmost responsibilities. The MCH services are largely domiciliary. The dais and CHWs generally indentify high risk cases through ante-natal

---

40. D.Banerji (1985) op.cit. p.286

41. Health for All. An alternative strategy (1986) ICSSR ICMR Report, p.94

care, regular home visits, check-ups, treat nutritional deficiencies etc. Immunization control of infection and nutrition care of mother and child are done in parental care services. School health need is also given through school teachers by CHW. The sub-centre has all the equipments and staff to handle MCH cases referred by dais and female CHWS. In case of complicacies like forceps deliveries, intravenous rehydration, IUCD insertions, terminal contraception, doctors and nurses do it in the community hospital. The primary health centre also do surgical works if referred by the sub-centre. The district hospital handle the more important cases particularly specialised cases. In this way, the present MCH services is delivered.

SUCCESSES ACHIEVED:

MCH programme has succeeded in terms of immunigation and nutrition work. In 1975-76, there were about 16.84 million MCH beneficiaries in terms of TT, DPT, DT, Vitamin A and other nutritional supplements. In 1982-83, it has been increased to 80.51 millions beneficiaries.[42] Also launching of multi-purpose worker scheme in 1974 is

---

42. D.Banerji (1985) op.cit, p.286-87

yet another milestone in the field of MCH. In the review of sixth plan, seventh plan states that in order to induct local women as auxiliary nurse, midwives (ANMS) the educational qualifications for their training were relaxed to the seventh standard if girls with requisite educational qualifications at the higher level were not available. The upper age limit of training for AWMS was also raised. Prophylaxis programmes against nutritional anaemia of pregnant and lactating mothers were implemented. Iron and folic acid tablets were distributed to more than 72.5 million pregnant women and nursing mothers. Tetanus Toxaid was administered to about 36 million pregnant women.[43]

NATIONAL NUTRITION PROGRAMME

Earlier we have examined the low profile of nutritional status of rural women in India. Central and state government have taken a number of programmes to tackle the problems of malnutrition. Before independence, the Bhore Committee had expressed grave concern on the size and extent of India's nutrition problem. The Govt. of India in its successive plans has started

---

43. The Seventh Five Year Plan, op.cit, p.323-324

short term nutritional intervention programmes like Applied Nutrition programme, supplementary nutrition programme, vitamin A prophylaxis programme, Special Nutrition programme and Integrated child Development schemes.[44] The Sixth Five Year Plan for the first time included a chapter on 'women and Development' and initiated a new approach to the problem of malnutrition among women. In previous plans, women had been viewed as targets for only health, education and welfare service. The Sixth Plan provides long strategy like generation of employment among women along with provision of nutrition supplements to the most vulnerable members of society. The seventh plan document also very clearly shows the coverage of pregnant women and nursing mothers.[45]

The International agencies like UNICEF, The Food & Agricultural Organisation (FAO), The World Food Programme (WFC), Cooperation for American Relief Everywhere (CARE) and Red Cross Society have also aided these programmes.

Let us very briefly analyse the major nutritional programmes and its achievements.

---

44. The Sixth Five Year Plan, 1981, pp.377-79
45. Seventh Five Year Plan, op.cit, p.325.

a) APPLIED NUTRITION PROGRAMME

It was launched in 1963 in order to help collective production of protective foods on the common government lands in a village such as eggs, milk, fish, fruits and vegetables for the mothers and children. Training of health workers and Health education was the major component of this programme. 1375 community development blocks have been covered by the programme.[46] The presumption of this programmes were the following (i) The existance of co-operation among all the different strata in village (2) Fair distribution of food to those who need it most, (3) the possibility of mobility, free labour for the protective food and sinking of the caste differences.[47]

b) SUPPLEMENTARY NUTRITION PROGRAMME

Under this programme, the coverage was to the specific slum areas of Bombay, Calcutta and Delhi. Its main aim was to provide education on the production and consumption of nutritious food and on the adoption of small horticultural remedies involving kitchen gardening for the major nutritional maladies of

---

46. D.Banerji (1985) op.cit. p.326.

47. Veena Shatrugna, Women and Health, op.cit.,p.40

women and children.

c) VITAMIN 'A' PROPHYLAXIS PROGRAMME

This was a programme mainly attributed to prevent the occurance of endemic blindness.

d) Special Nutrition Programme:

This programme was launched in 1970 to cover pre-school children and pregnant and lactating mothers through a 'take home' system. Based on the finding that the short fall claorie and protein intake of the order of 500 calr and 20 gms of protein for pregnant and lactating women, a concentrated food pocket consisting of pulses, jaggery, groundnut and oils were prepared with various combination and distributed to the remote corner. The aim was to distribute food supplements containing 200 calsand 10 gms of protein to children and 500 cals and 20 gms of protein to pregnant and lactating women.

INTEGRATED CHILD DEVELOPMENT SCHEME (ICDS)

It was introduced in 1972. It is a centrally sponsored programme under the department of Social Welfare. The main objective of this scheme is to provide for an integrated delivery of a package of services

to pre-school children (below 6 years of age) and pregnant women and nursing mothers. In October, 1975, 33 ICDS objects were taken up. According to the Seventh Plan, under the integrated child development service (ICDS), special nutrition will be provided to pregnant and nursing mothers. Medical colleges which are attached to ICDS, the training and orientation of personnel is carried out by the department of social welfare. At the end of the Sixth Plan more than 1.2 million such women were receiving benefits under the programme.[48]

The package of Services provided by the ICDS includes supplementary nutrition, immunisation, health check up, referal services, nutrition and health education and non-formal education. The number of villages covered by each rural project (non-tribal usually 100 with a population of about 100,000 of which 17 percent would be below 6 years old and 20 percent women in the 15-44 years age group.[49] A tribal project covers about 50 villages and a population of 35,000 with about same proportions of eligible women and children. The Anganwadi

---

48. Seventh Five Year Plan, op.cit, p.327

49. D.Banerji, (985) op.cit. p.327.

worker in each village is headed by a child Development project officer. PHC network is used with ICDS funds and personnel. The whole programme is monitered by the Central committee at the AIIMS through different medical colleges which are attached to ICDS. The training and orientation of personnel is carried out the department of social worker.

FAMILY PLANNING (WELFARE) PROGRAMME

The current system of family planning (now called family welfare) is a mixed programme for women. The Government sees, family welfare as a panacea for increased poverty, increasing crowding, high child mortality, decreased standard of living, inadequate food consumption and all social evils.

The family planning movement started in the early fiftees in India. India was the first country in the world to initiate an official programme of family planning with an Anglo saxon pattern. From the very beginning, emphasis was laid on the welfare aspects of family planning. The guidelines laid down stressed the voluntary nature of the programme, the need to provide family planning services at people's doorsteps, andthe need to integrate them with medical and public health services, especially with MCH programme, so as to afford them maximum relevance and effectiveness. The method used for family planning were changing continuously. In

the early fifties, stress was only on promotion of rhythm method. It was later shifted to foam tablets. Sterilization of males (vasectomy) and use of condoms were popularised as method, only towards the end of the fifties and in the early sixties. The advent of the intra-uterine device (IUD) in July, 1965 was a turning point. Tremendous enthusiasm was whipped up, both among the family planning workers as well as among the masses. Later on it was observed that half of the eligible couples had already more than three children and insertion of IUD also created problems. Then, sterilization camp, method was initiated. Later, oral pills were made easily available and to-day they are distributed free of cost. Laprascopic tubectomy and medical termination of pregnancy are the methods in current use. Abortion laws have been liberalised to provide easier access to medical termination of pregnancy.[50]

The CSWI finds, the neglect of maternity and child health service and over-concentration of efforts on family planning is responsible for faulty family planning programme. CSWI opines that improved status of women, rise in the age of marriage, better education, employment,

---

50. D.Banerji, (1985) op.cit., p.796-97

good living conditions and greater general awarence have rather good impact on the acdeptance of family planning. D.Maine says family planning improves the health of women by enabling them to have children when they are best prepared to have them.[51] Thus, if the above facts are considered, family welfare will definetely improve women's health.

THE MEDICAL TERMINATION OF PREGNANCY PROGRAMME

The magnitude of the problem of illegal abortion is really high. Every year in India, 6 million women resort to "illegal abortion" which result in very high death rate (100 to 1050/100,000 procedural and other complications like infection, bleeding, injury etc. which could have been avoided.[52] It is also estimated that 30% of all maternal deaths in hospitals are due to abortion complications. Abortions are carried out usually very late (after 12 weeks of pregnancy) due to late diagnosis, lack of adequate medical care and social stigma attached to it.

The medical termination of pregnancy Act was passed in 1971 and came into force from Ist April, 1972. It aims to reduce the incidence of criminal abortions.

---

51. D.Maine, (1981) "Family Planning: Its impact on the health of women and children", Centre for population and family Health.

52. Veena Shatrugna, Women & Health, op.cit, p.42

The Act allows termination of pregnancy on the therapeutic grounds, pugenic grounds, humanitarian and social grounds. While the MTP emphasises its importance as a health measure, the permission given under section 3(2)(b) for termination of pregnancy for married women in cases of contraceptive failure, emphasizes its importance as an instrument of population control. In 1975, the rules were changed. The new rules allow for a registered medical paractioner. The new rules allow for a to qualify by performing a mere 25 cases of MTP in a hospital established or maintained for the purpose by the government. To increase the number of trained personnel in this field, doctors belonging to various organisations are being trained in MTP techniques in 161 institutions belonging to the post-partum programme. 970 doctors were trained during 1982-83 and the number of doctors trained in the technique since the inception of the programme were 9,931 by 1983, 2,913,762 operations have been performed, 506,230 having performed in 1982-83.[53]

DAI TRAINING PROGRAMME

Importance of 'Dais' can hardly be underestimated.

---

53. Govt. of India, Annual Report (1983-84) - Ministry of Health and Family Welfare, New Delhi, p.142.

In 1943, J.N.Norman states in his book "...It is necessary and good policy to make use of local ~~class~~ Dais to encourage them to accept training and help them when trained to obtain practice and livelihood. If the local dais are antagonised, the development of useful work will be delayed and hindred.[54] Women in rural India have more faith in Dai than the fleeting medical doctor. But after independence in the name of international standards, we have neglected the importance of Dais.

However, the dais training programmes intensified in 1977-78 with UNICEF assistance. During the IVth Plan this was transferred to the Family Planning Programme. By 1978, 65,000 Dais were trained and by 1980-81, 3,44,994 having been trained. The training schedule are vast, such as (i) knowledge of the reproductive system, (ii) Care delivery, (iii) antenatal and post-natal care, (iv) aseptic practices, (v) contraception.

Unfortunately, the training does not respect and utilise the richness of the dais experience. of course, certain social problems like caste of dai exists. It seems that only one dai may not be quite acceptable to

---

54. Quoted by V.Shatrugna in Women and Health op.cit. p.57.

the whole village.

AVAILABILITY OF RURAL HEALTH SERVICES

Having analysed different national programmes specific to enhance women's health, a brief attempt may be made now to discuss the health service structure in rural areas from a historical perspective.

After independence, health planning in India was made an integral part of the overall planning for the socio-economic development of the masses. The successive Five Year Plans in order to raise the health status of population launched different vertical programmes to combat the communicable diseases. The Primary Health Centre (PHCs) were established for providing some degree of integrated, preventive and ~~creative~~ curative services to the rural population of India. In order to give a social-orientation of Medical Education the medical council of India suitably changed the contents of education. Family Planning Programme was launched to tackle the population problem. Special national programmes for water supply, sanitation, nutrition etc. were launched to supply protected water, minimum nutrition and improve environment. The minimum Needs programme, the multi-purpose workers scheme, the community health volunteers (guides) scheme were the other major

developments in health policy. On 4th April, 1979 a draft National Health Policy by Government of India provided achange in health policy. The two corner stones of this policy were (a) encouraging people to cope with their health problems in their own ways, and (b) ensuring that the tools of health technology are placed under the control of the people themselves.[55]

This National Health Policy starts with the recounting of the achievements: eradication of smallpox and reduction in morbidity due to cholera, and related diseases and malaria, reduction in the crude mortality rate from 17.4 to 14.8 and increase in the expectation of life at birth from 32.7 to 52; a fairly extensive network of services for providing curative care and a significant increase in manpower resources and considerable growth in the production of drugs and equipment.

For delivering health services in rural areas PHCs were the main institutions. According to the recent statistics, there were 7250 PHCs in India between 1984-85. Between the same year, there were also 83,008 sub-centres

---

55. D.Banerji (1985) op.cit, p.28

and 613 upgraded PHCs.[56] Originally each PHC had one medical officer, one sanitary inspector, one lady health visitor, one compounder and four auxilary nurse midwives. This skeleton staff was expected to cover a population of 60,000. But the Mudaliar Committee (1962), recommended for more staff and a coverage of 40,000 population. In the sixties, the ANM was appointed for every 10,000 population who were responsible for MCH work. Every four ANMs were supervised by a LHV. A family planning Health Assistant (one for 20,000 population) did family planning work and his work was supervised by a Block Extension Educator. A Basic Health Worker (BHW) for every 10,000 population did malaria surveillance work and every four BHWs were supervised by a Health Inspector (HI). And there were two Medical Officers, one of them being the officer-in-charge.

In 1963, the Chadha Committee recommended that rural populations may be provided integrated health and family planning services through male and female multi-purpose workers-each worker serving a population of 10,000 at the initial stage. It became problamatic because of the clash in the functionary of malaria and family planning

---

56. Health Statistics of India (1985): Ministry of Health and Family Welfare, DGHS, New Delhi, p.2

works. Again Mukerji Committee (1968) reversed the situation and recommended for unipurpose workers for family planning.

Again the Kartar Singh Committee (1973) criticised the separation of duties of various health workers and recommended that the smallest unit of population could be better served by co-ordinating these programmes.

However, today there is a large manpower support to the PHC. Through the multi-purpose workers scheme, a male and female multi-purpose worker is there for a population of 5,000. There has been a strengthening of the supervision of PHCs at the district level and referred services at taluk, district and higher levels. To avail health services, Homeopathic, unani dispenseries have been established. To treat more complicated cases facilities have been provided at the Taluk/tehsil hospital district hospitals, urban general hospitals, teaching hospitals and hospitals providing facilities for super-specialities in medical care in post-graduate medical institutions.

Thus, on the whole, in rural area, facilities have been provided through PHC, to serve rural population. Different national communicable diseases programmes, malaria, small-pox work, nutrition and family welfare

programmes and MCH and other community health activities have been served by the vast army of doctors, para-medical staff.

What has been done so far in India in the area of rural health is a very substantial achievement. The following table speaks of the physical targets and acheivements under rural health programme during Sixth Plan (1980-85).

Sl. No.	Programme	Norms	Unit	Position on 1.4.80	Target additional 1980-85)
1.	Health Guides	1 for every village of a population of 1,000	Lakh	1.40	All vilage will be covered.
2.	Sub-Centres	1:5,000 population in Plains and 1:3,000 in t-tribal and hilly areas.	Nos.	50,000	40,000
3.	PHCs	1:30,000	Nos	5,400(in-addition 1,000 subsidiary centres were also set up.	690 additional primary health centres plus upgradation of 1,000 dispensaries into subsidiary Health Centres.
4.	Upgraded health centres to be converted to community health centres	1:1,00000 or 1 percent C D block	No.5	340	

Source: Sixth Five Year Plan, 1980-85 (Planning Commission)

Now, having analysed the health problems of women, different specific programmes and available health services for rural areas, let us analyse the health status of women in the next chapter.

CHAPTER - III

HEALTH STATUS OF WOMEN : A CRITIQUE

So far we have analysed some important sociological factors associated with women's health, certain health problems faced by women andthe available health services in rural India with particular reference to National Health programmes for women. In this chapter, our primary concern is to measure the health status of women with major indicators like sex-ratio, life-expectancy, morbidity and mortality pattern, nutritional status and access of rural women to health services with critical touch. Also a crtical appraisal will be given for the different national health programmes for women.

It is stated earlier that measurement of health status is a complex task. Because data on rural women's health is not only scarce, but also poorly standarised. In most of the cases, birth and death rates are not reported. Moreso, data is not sufficient enough to measure the health status, because, sometimes experience of women about their health problems which have not been generally documented properly, counts much. However, our analysis on the measurement of health status of women in rural India will be based on certain empirical studies conducted in different parts of India and the following sources referred below:

These are census reports, SRS data, NSS data,

vital statistics, pocket book on health statistics, demographic year book, and health statistics of India.

MAJOR INDICATORS

The important indicators of the health status of women, as we have grouped earlier, may be drawn from two sources. They are 'demographic trends' and 'access to health services'[1]. As far as demographic trends is concern, the major indicators are sex-ratio, life-expectancy morbidity and mortality pattern, and nutritional status. It has been clearly stated in a WHO report[2] that at the national level, mortality data are the most reliable indicators of maternal and child health. The indicators are critically analysed as follows.

SEX RATIO

One of the most remarkable demographic features of India is the steady decline of what is called the 'Sex-ratio' i.e. the ratio of female to male population.[3]

---

1. Towards Equality: Report of the Committee on the Status of Women in India, (1974) Govt. of India, Ministry of Social Welfare, p.311.

2. "The Health Status of Mothers and Children: Present situation and recent trends" (1976) New Trends and Approaches in the Delivery of MCH in Health Services, Sixth report of the WHO export committee on MCH, Technical report series, 600, WHO, Geneva.

3. J.Kynch & A.Sen (——) Indian Women: Well-being and survival, ICSSR, p.7.

This ratio has fallen from 972 per 1000 males at the turn of the century to 935 in the last census in 1981. Details have been clearly demonstrated in Table 1. As far as sex-ratio is concerned the Indian sub-continent gets a very low ranking among the nations. In India, male infants do die, as naturally as anywhere else, but female despite the fact that they are biologically stronger, die at even higher rates.[4] Right from infancy, the sex-ratio is also quite low in India. In Table - 2, it has been shown that in rural areas, the age-specific death rates are higher among females. More women die during the period of their reproduction. It is true that the 1981 census shows a marginal rise of females. But there is no cause for complacency since the higher female infant mortality rate as compared to male infant mortality rates have not declined. Table 3 clearly shows it

---

4. Women in India (1981): Research Unit on Women's Studies SNDT Women's University, Bombay

TABLE - 1

Demographic Picture of India (In Millions)

(1901-1981)

Year	Total Population	Female population	Male population	Total No. of women per 1000 men i.e. Sex-Ratio
1901	238	117	121	972
1911	252	124	128	964
1921	251	123	128	955
1931	279	136	143	950
1941	319	155	164	945
1951	361	175	186	946
1961	439	213	226	941
1971	548	264	284	930
1981	684	331	353	935

Source: Census Report, 1981, series - I, Paper I, Provisional Population totals, New Delhi, p.35.

TABLE - 2

Ratio of Age specific Female to male birth rates (1976-78)

Age Group (Years)	Rural	Urban
0-4	1.17	1.04
5-9	1.31	1.59
10-14	1.04	1.40
15-19	1.42	1.57
20.24	1.65	1.45
25-29	1.47	1.27
30-34	1.09	1.07
35-39	0.93	0.89
40-44	0.74	0.82
45-49	0.68	0.64
50-54	0.69	0.69
55-59	0.63	0.75
60-64	0.75	0.76
65-69	0.83	0.77
70 Plus	0.82	0.92
All ages	1.06	1.03

Source: Padmanabha (1982) Table 5 the figures are derived from the results of the 'sample registration system'

Table:3

Infant Mortality (expressed as No. of deaths per 1000 live births:

Area	Males	Females	Persons
Rural	130	142	136
Urban	69	71	70
Total	120	131	125

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

No specific cause could be found for the female death rate. The main reasons of such lop-sided male-female ratio are strong social influences. For example female infanticide, etc. Mitra states, female infanticide, greater neglecte of females specifically at the earlier ages, pre-mature cohabitation and child-bearing coupled with unskilled midwifery, hard work done by females in lower income groups, general adverse conditions of climate, nutrition, ventilation, house accommodation, etc. are the reasons for adverse sex-ratio in our country.[5] According to the report of the Committee on the Status of Women in India, the apparently low sex-ratio of deaths is actually due to large under-reporting of female deaths as compared to male deaths. The Committee, on the basis of certain evidences has also questioned the accuracy of SRS Data.[6]

Moreso, the male-female ratio in different states of India provides an interesting picture (see Table 4). The State like Kerala which has the only favourable sex ratio for females has not changed much. But other states give a grim picture. The so-called

---

5. Asok Mitra, (1979), Implications of Declining Sex-ratio in India's Population, Allied Publishers, Bombay, p.9.

6. Towards Equality (1974), op.cit., p.312.

Table:4

The Ratio of Females to Males in Modern Indian States (1901-1981)

States	1901	1911	1921	1931	1941	1951	1961	1971	1981
Kerala	1004	1008	1011	1022	1027	1028	1022	1016	1034
Orissa	1037	1056	1086	1067	1053	1022	1001	988	982
T.N.	1044	1042	1029	1027	1012	1007	992	978	978
A.P.	985	992	993	987	980	986	981	977	975
Karnataka	983	981	969	965	960	966	959	957	963
J & K	882	876	870	865	869	873	878	878	953
Bihar	1054	1044	1016	974	996	990	994	954	947
Gujarat	954	946	944	945	941	952	940	934	942
M.P.	990	986	974	973	970	967	953	941	941
Maharashtra	978	966	950	947	949	941	936	930	939
Rajasthan	905	908	896	907	906	921	908	911	921
W.B.	945	925	905	890	852	865	878	891	911
Assam	919	915	896	874	875	868	869	896	900
U.P.	937	915	909	904	907	910	909	877	886
Punjab	832	780	799	815	836	844	854	865	886
Haryana	867	835	844	844	869	871	868	867	877

Source: P.Padmanabha (1981) Registrar-General and Census - Commissioner of India, Census of India, 1981, New Delhi p.61.

agriculturally prosperous states like Punjab and Haryana show higher decline of female sex.

From the above discussion on sex-ratio in India it is crystal clear that adverse sex-ratio of India speak of the poor health condition of rural Indian women. Rural women suffer during infancy, childhood and productive age. Kulkarni in a report on the basis of the analysis of different analytical studies find that in India mortality is a major determinant of adverse sex-ratio and inadequate health care is the cause of mortality.[7] He has identified factors like, migration, sex-ratio at birth, under enumeration and female mortality, which are associated with sex-ratio. It is not our purpose to go into the details of this. Let us very briefly analyse the life-expectancy of women in rural India.

LIFE-EXPECTANCY:

"Expectation of life is defined as the average

---

7. Suresh N, Kulkarni, "Demographic and Nutritional Background of the Health Status of Women in India", A mimeographed paper, I.E.G., Delhi University, Delhi, p.10.

number of years likely to be lived by a person who is subject to the mortality risk of the whole population at any given time.[8] Indian males have lived longer than Indian females. The gap between male and female life-expectancies had been increasing at least until 1972. The following Table (5) clearly shows the picture.

Table : 5

Average Expectation of Life at Birth in India

Year	Male (years)	Female (Years)
1901-1911	22.6	23.3
1911-1921	19.4	20.9
1921-1931	26.9	26.6
1931-1941	32.1	31.4
1941-1951	32.4	31.7
1951-1961	41.9	40.6
1961-1971	46.4	44.7
1971-1981	52.6	51.6

Source: Health for all, An Alternative Strategy, Report of the Study Group, ICSSR and ICMS, 1981.

8. Veena Shatrugna, Women & Health, published by SNDT Women's University, Research Unit on Women's studies, pp.5-6.

The above Table (5) clearly indicates that life-expectancies have increased over the years. But strangely enough, the increase in life-expectancy has favoured the male. But, in developed countries, females outlive males by nearly ten years.[9] To compensate for the life-expectancy of the males, normally more male infants are born.

MATERNAL MORBIDITY

Morbidity is not only a precursor to mortality but is a demographic consequential in its own right, symptomising the state of social-medical care. Sex-wise morbidity is not easy to come across. Because rare social science research has gone into this aspect. Morbidity among women can be assessed by taking into the incidence and prevalence rate of different communicable diseases. The data on morbidity is sporadic. The Bhore Committee has observed that even psychiatric morbidity among Indian women was the result of malnutrition, frequent pregnancies and anaemia.[10] According

---

9. Saroj.S.Jha (1983) "Health Status in the Context of Social Development", Journal of Family Welfare, 29(4), p.5.

10. Report of the Health Survey and Development Committee (1946), Government of India, Vol. III (Appendix), New Delhi, p.75.

to a WHO report, psychiatric morbidity is more prevalent among women than men.[11] An interesting study[12] by Jesudasan and Chatterji in Bhitarwar Block (Gwalior District and Banda Block (Sagar District) of M.P. during January - Feburary 1977 finds that morbidity can be measured by calculating the number of days of illness within a particular period of time. Illness may be defined as a chronic or acute condition which prevented the respondent from carrying out her normal physical activities.

MATERNAL MORTALITY

We cannot understand maternal mortality and its effect on health status without having a conceptual clarity about the concepts which are associated with it. Maternal mortality rate refers to the number of deaths from peurperal causes per 1,000 live births. Likewise, neo-natal mortality rate refers to deaths occurring within four weeks or 28 days of birth. Perinatal mortality rate is the mortality occurring

---

11. Quoted in Towards Equality (1974) op.cit., p.314 from WHO Vital Statistics of South East Asia Region (1966).

12. Victor Jesudason, and Meera Chatterjee, (1980), "Inter-relationship of Health indices of women in two rural communities," Social Change, Sept-Dec. pp.27-34.

during the period from 28 weeks of pregnancy to under seven days of the post-natal life, for 1,000 total births.[13]

Maternal mortality in India is one of the highest in the world though exact figures are not available, estimates ranging from 500 to 800 per 100,000 births.[14] Kohli in a state-wise survey on Mortality in India concludes, "All the states of India show that female mortality is higher than that of males but the magnitude of the differential between the state is not the same. The sex-differentiation mortality are maximum in the northern states followed by the southern states."[15]

The problem and magnitude of maternal mortality pattern in India was also realised in 1914, when Annie Besant drew attention to the statistics on illiteracy, widows and the heavy death toll of women between 15-30 years. Even now, the same disparity exists.[16]

The table in the following pages give a true

---

13. Veena Shatrugna, op.cit., p.5.

14. Health for all by 2000 A.D. (1981), Government of India, Ministry of Health & Family Welfare, New Delhi, p.61.

15. Kohli, K.L. (19), Mortality in India: A State-wise Survey. ICSSR

16. Saroj S. Jha (1983), op. cit, P.5

picture of mortality indicators in India, as has been enunciated by Sample Registration System. Also two tables, 7 and 8, give data about the cause groups for maternal mortality in rural India for the year 1980.

According to Shatrugna, "the main causes of maternal mortality are anaemia, septic abortions, severe bleeding, and eclampsia.[17] All these are preventable. She states that eighty per cent of deliveries still take place at home in the hands of traditional Dais. If communication could reach rural women, maternal mortality deaths could be reduced to ten-fold. The problem of pregnancy and other related problems can be solved by trained Dais. These are some of the reasons for maternal mortality. But there are certain sociological factors involved in it. It may be discussed below.

SOCIOLOGICAL EXPLANATIONS OF MATERNAL DEATHS

The evidences of high female mortality shows that medical research has concentrated more on maternal health status in the age-group of 15-44. In other

---

17. Veena Shatrugna, op.cit., p.11

Table : 6

Mortality Indicators in India
(1979 & 1980)

Indicators	Years 1979	1980
Rural		
Crude death rate	13.9	13.5
Infant mortality Rate	129.7	123.8
Neo-natal mortality rates	77.7	75.5
Post-natal mortality rate	52.0	48.3
Peri-natal mortality rate	63.1	59.8
Still birth rate	13.3	12.0
Urban		
Crude death rate	8.4	8.0
Infant mortality rate	72.2	65.2
Neo-natal mortality rate	42.4	39.1
Post-natal mortality rate	29.8	26.1
Peri-natal mortality rate	38.7	35.3
Still Birth rate	9.1	7.9
Combined		
Crude death rate	12.8	12.4
Infant mortaltity rate	120.0	113.9
Neo-natal mortality rate	71.7	69.4
Post-natal mortality rate	48.3	44.6
Peri-natal mortality rate	59.0	55.7
Still birth rate	12.6	11.3

contd...

Source: Survey of Causes of Deaths (Rural) 1981 A Report, RGI.

Table : 7

Distribution of the number and percentage of deaths by major cause groups - India (Rural) 1979-1981

Code No.	Major cause-groups (Prominent symptoms)	Total deaths 1979	1980	1981	Percentage 1979	1980	1981
1.	Accidents & injuries	780	887	878	4.6	5.0	5.1
2.	Child-birth and pregnancy	180	209	175	1.1	1.2	1.0
3.	Fevers	1501	1505	1461	8.9	8.5	8.4
4.	Digestive disorders	1637	1634	1395	9.7	9.3	8.0
5.	Coughs (Disorders of respiratory system)	3415	3540	3600	20.3	20.0	20.7
6.	Disorders of central nervous system	600	678	603	3.6	3.8	3.5
7.	Disorders of circulatory system	1561	1517	1538	9.3	8.6	8.8
8.	Other clear symptoms	1400	1325	1411	8.3	7.5	8.1
9.	Causes peculiar to infancy	2280	2409	2112	13.5	13.6	12.1
10.	Senility	3120	3650	3896	18.5	20.7	22.4
11.	Rest	374	318	325	2.2	1.8	1.9
All causes		16848	17672	17394	100.0	100.0	100.0

Table : 8

Percentage of deaths by causes related to child-birth and pregnancy (Maternal) - 1979 to 1981 (Rural)

Specific Causes	Year		
	1979	1980	1981
Abortion	11.7	12.5	13.7
Toxnemia	16.1	12.4	8.0
Anaemia	15.0	15.8	17.7
Bleeding of pregnancy and puerperium	20.0	15.8	23.4
Malposition of child leading to death of mother	10.5	13.4	9.1
Puerperal sepsis	11.1	12.4	13.2
Not classifiable	15.0	17.7	14.9
Total	100	100.0	100.00
Percent to total deaths sample No. of deaths	180	209	175
Percent to total deaths	1.1	1.2	1.0

Source: Survey of Causes of Deaths (Rural) 1981

A Report, RG

words, female mortality is examined in terms of state of pregnancy, abortion, etc. But the story does not end here. Social scientists have identified the causes of maternal mortality in a broad manner. As Davis puts rightly, the status of women including her health status is governed by whether her society, is familistic oriented or para-familistic oriented. In familistic society the male-female relationship is kinship based. The accent falls on procreation. Family organization in such a society accords a subordinate status to women. Joint familial values like denial of mate selection to women, arranged marriage, absence of property rights, absence of widow remarriage, the dowry institution, physical segregation through veil or confinement only help women to fertilise and produce.[18] A woman ony gets status after giving birth to children. It is true in case of rural India, where woman gets her status through mother-role and pregnancy role.

In case of para-familistic changes the dimensions of the indices are urbanization and modernization education, employment and family planning.

Therefore, the health status of women in terms of maternal mortality should consider the above values

(18) Quoted by Suresh N. Kulkarni, op. cit, P. 4-5

and attitude of society. The Registrar-General and Census Commissioner of India, Padmanabha in 1981 has also given this type of explanations. He states that preference for male children results in neglect of female babies.[19] High maternal morbidity and selective mortality indicators also aggregate the problem. However, Padmanabha agrees, there is little evidence to support the view that there is a deliberate neglect of female babies despite the fact that there may be a preference for male children. But Bardhan in a perceptive article,[20] provides some evidence of comparative neglect of female babies and children, especially in north-India. The extent of discrimination can be particularly sharp in hard times like floods, famines. Visaria goes a little further. She gives more emphasis on infant mortality of female babies. According to her, "Some of the important factors causing high neo-natal mortality in India and particularly in rural areas of the country are the place of delivery, the type of attendant and practices followed with the care of the new born. She also adds that the level of IMR can be brought down to a very small fraction of it, if births take

---

20. Pranab Bardhan, (1982): "Little girls and Deaths in India," EPW, Sept. 4.

19. Quoted by Kynch & Sen, op. cit; p. 12

place in hygienic conditions, and certain level of medical care is available to the mother.[21]

Mitra says, the hard and monotonous work girls and women in India, particularly in the lower income brackets, have to put in day after day throughout their lives in adverse conditions of purdah, insanitary housing and lack of ventilation, lack of open air exercise and nutrition, etc. create maternal mortality. Sociologically viewing, the roots of neglect are, not easy to ascertain. One line of reasoning suggests the relevance of social considerations such as the importance of male pregency for the 'continuation' of the female in a maledominated society. Another line points towards economic factors such as that the son will help in old age, income-earning help from son is possible and perhaps even a greater scope for male child labour over female child labour.

Son-preference attitude of Indian people has been demonstrated by various studies done by Visaria, Mitra, Khanna study by Wyon and Gordon views the mortality pattern during and after reproductive period. But, very few studies have

---

21. Leela Visarai, (1985) "Infant Mortality in India: Level, Trends and Determinants, Part II", EPW, Vol.XX, No.33, August 17, p.1399.

touched upon the effects of monetisation, wage discrimination, usurping of women's occupations, the crop-pattern and its effect on mortality, level of education, the widowhood and other social factors.

However, Sen gives a truely living picture of Indian women's condition in relation to mortality pattern. According to Sen, "The elitist character of Indian society is brought out also by the treatment of women. Although women in elite groups may still suffer from disadvantages, many doors are open to them. But the general position of women in Indian society is nothing short of scandalous. Their mortality rates are typically higher than men's (except for those above forty). The expectation of life at birth is lower for the Indian female than for the Indian male, and this pattern is quite contrary to that of the overwhelming majority of countries. All these help to explain the extraordinary fact that the so-called sex-ratio, the percentage of females to males in India has declined first around 97.2 per cent in 1901 to 93.5 per cent in the last census in 1981. This, of course, an ominous

and starting trend, since with modernisation one would have expected a relative reduction of female mortality vis-a-vis male mortality. On the contrary it appears that with the progress of modern medicine and health services in India, the opportunities have been much more effectively and unequally-seized by men than by women. The traditional differences have been heightened by new opportunities, and as the absolute positions of both men and women have slowly improved in health and longevity, the relative position of women has fallen behind.[22]

Thus, we can safely argue herethat the higher death rates of females which is striking in India reflect the role and status of females both within family and in society at large in as much as they represent the health consequences of social, economic, and cultural discrimination against females. Women's health situation in terms of sex-ratio, life-expectancy and mortality is not an exclusive area of demography. Other social science inputs like socio-cultural dimension, socio-economic factors are also

---

22. Amarty Sen, (1983), "How is India doing," in Mainstream, Republic issue, pp.59-60

important. The changing patterns of women's work and family structure also affects their health. For example, women's role in the formal and informal labour market effect their roles as mothers, and women's roles also affect family health care.

NUTRITIONAL STATUS

So much literature has been generated on the problem of nutrition in its different facets. Nutritionists in particular have given different theories, measured the food in take and offered a host of explanations. But our purpose here is very limited. We will analyse the nutritional status of women in rural India from social science angle. On the basis of some of the major studies done by social scientists in Indian context, we will critically examine how nutritional status is one of the most important determinants of health status of women.

MAGNITUDE OF THE PROBLEM

A large number of Indian women suffer from malnutrition. What is alarming is that the nutritional status of our women has shown no improvement and if anything, seems to have deteriorated over the last few years. According to the National Sample Survey

estimates of calories intake for the year 1971-72, the per capita calorie intake in the country as a whole declined from 2,445 in 1961-62 to 2,170 in 1971-72. The worst sufferers paradoxically are the agricultural labourers, as also people living in slums, in drought-affected regions and in remote tribal areas. And, among all these people, the axe has fallen mostly on women.[23] But the poor rural women's nutritional status is deplorable. The average calorie intake of rural women is estimated to be 1,400 while that of men is 1,700.[24] These figures are meaningless, unless in themselves are compared to the actual amount of work and have energy spent by them respectively. Application of Science and Technology to Rural Areas (ASTRA), a programme at the Indian Institute of Science, Bangalore, in an interesting study calculated the energy cost of doing each task. The study concludes, "if we disaggregate human energy, the contribution of men, women and children is 31 per cent, 53 per cent and 16 per cent respectively (as percentages of total human

---

23. Amarty Sen, (1983), "How is India doing," in Mainstream, Republic issue, pp.59-60. (1983),

24. Saroj, S.Jha (1983), op.cit., p.6.

hours per household per day). According to the study, the daily calorie expenditure for women was 2,505 and for men 2,473.[25]

Nutrition in women is further aggravated by repeated pregnancies and lactation. It is stated that between 15 and 45 years of age, that is, in the thirty years span of reproductive life, an average Indian woman becomes pregnant eight times and gives birth to six to seven children of which four to six children live. The infant is breast-fed for at least two years or until the arrival of the next child.[26]

A recent study of six fishing communities in Tamil Nadu, Andhra Pradesh and Orissa by the Food and Agricultural Organization in a Bay of Bengal programme showed that one-fifth of the women surveyed had lost more than fifty per cent of their children. Malnourishment was more conspicuous among girls than boys.[27] Studies conducted in different parts of India have clearly established the growing nutritional

---

25. Quoted by S.Bhattiwala, (1984), "Rural Energy situation Consequences for Women's health" in Socialist Health Review, Sept.

26. Kamala S.Jaya Rao (1983) "Who is Malnourished: Mother or the Woman?", in Health Care: Which way to go, MFC, pp.59-60.

27. "Malnutrition high among Fisherfolk" (1986) The Statesman, March 11, P.5

and educational gap between boys and girls. For instance, in a survey conducted in villages around Ludhiana it was found that while 50 per cent of girls below five years were severaly malnourished, only 20 per cent of the boys in the same age group suffered this fate. Also the National Nutrition Monitoring Bureau has found that while only 28.4 per cent of adult Indian males suffer from calorie inadequacy, 57.3 per cent of non-pregnant, non-lactating women and 46.5 per cent of lactating women suffer from calorie inadequacy. Frequency of pregnancies causes protien malnutrition of the mothers. Ten to twenty per cent of maternal deaths are known to be due to nutritional anaemias. This has been borne out by a series of studies of the National Institute of Nutrition.[28] Women do not receive additional nutritional requirements so essential during pregnancy and lactation. The following Table clearly shows this.

Table 9

Nutritional Intake Gap

Nutrient	During Pregnancy		During Lactation	
	Actual	Recommended	Actual	Recommended
Calories	1440	2500	1425	2900
Grams (Protiens)	37	55	39	65
Iron (mg)	18	40	18	30
Calcium(gm)	0.2	1.0	0.2	1.0

Source: Quoted from CSWI, p.315.

28. Quoted in Towards Equality (1974), op.cit., p.314

According to a recent estimate[29] by the Food and Agricultural Organisation (FAO), around 200 million Indian are malnourished, forming almost half of the world's total and about one-third of the Indian population. Shatrugna, in her book[30] has reproduced tables which show that girls between the ages of 13-16 years had a daily calorific intake not exceeding 1,800 kilocalories (Kcal) in Kerala, Tamil Nadu, Andhra Pradesh, Maharashtra, Gujarat, Madhya Pradesh, West Bengal and Uttar Pradesh. Whereas the recommended level was 2,500 Kcal. Shatrugna concludes, one consequence is that women have no energy reserves for emergencies such as illness and that their mortality rates are higher if there is an epidemic, for instance. In another study,[31] Jesudason and Chatterjee have examined the nutritional status of rural women in the community development blocks in Madhya Pradesh. According to them, pregnant, lactating and weaning mothers have deficiencies of protein-energy, vitamin A,

---

29. As quoted in UNICEF (1984), An Analysis of Situation of Children in India, New Delhi

30. Veena Shatrugna, op.cit.

31. Victor Jesudason, and Meera Chatterji, Meera, op.cit., pp.27-28.

the B-complex, vitamin C and iron. One half of women in the middle-age group, and almost two out of three older women were victims of these inadequacies.

SEX-BIAS IN INFANT MALNUTRITION

Malnutrition too is more common among children under five. In studying the effects of the 1978 floods in West Bengal, Sen found that even among children under five, severe malnutrition was about 60 per cent more frequent for girls than boys.[32] Sen and Sengupta with their empirical field data in two villages of West Bengal, find that under-nourishment index of the girls was identical in both villages. It seems that the economic benefits, land reforms have primarily benefited the boys.[33]

It is clear from this study that improvement of the economic situation doesn't only elevate the status of women. According to Shatrugna, 60-70% of the children have mild to moderate forms of malnutrition manifesting as growth retardation.[34] She adds that though malnutrition is

---

32. Amartya Sen (1983) op.cit., p.59.

33. Amartya Sen & Sunil Sengupta, (1983) "Malnutrition of rural children and the sex-bias", EPW, (Annual) Number), Vol. XVIII, pp.19-21.

34. Veena Shatragna (1980) - Seminar paper "Health Status of Women and children and the role of Community Health Volunteers Scheme,", p.3

found to be greater in girls, more boys are brought to the hospital for treatment.

From the review of the above studies, now it is clear that malnutrition is widespread and women receive lesser share in the food available to family. But the basic question is often asked. What are the main causes of Malnutrition, particularly among women in India? The causes are analysed below:

MAJOR CAUSES OF MALNUTRITION AMONG WOMEN

Nutritional problems have been analysed by different scholars in different ways. For our analysis, the views and opinions of different scholars may be grouped under two approaches. Culturological and Socio-structural. Culturologists argue that female undernutrition is because of certain cultural norms, taboos and values, customs associated with food habit etc. They also talk of intra-family distribution of nutrition, and favour the population growth, biological peculiarity of women etc. as the important causes of malnutrition.

On the other hand, socio-structural approach find the root of the problem at the social structure. According to them, poverty, unequal social structure and unequitable distribution of scarce resources are some

of the important causes of malnutrition among females in India. On the basis of some studies, let us illustrate the two view-points.

CULTUROLOGICAL APPRAOCH

According to this school of thought, cultural norms and attitudes to girls in societies like ours result in a preference for boys in infant nutrition and material nutrition. While analysing the reasons of malnutrition Naik and Bardhan plead for such an analysis. Although they admit that female undernutrition in general and maternal deaths from diseases and infections in particular are associated with poverty, they haven't explicity put their views. They contend that there are specific social and individual moves which lead nutritional deficiency in women. They say social customs and individual motivations are responsible, for this. According to them, sequential eating and fasting, diet restrictions in women result in women's malnutrition.[35] Sen argues that nutrition problems faced by a large country like India are linked with over population and communicable

---

35. J.P.Naik, & Kalpana Bardhan, "Nutritional Problem of Women in India: Some Socio-economic issues" (Ministry of Education, Govt. of India, New Delhi Report, p.4

disease.[36] Ghosh says that malnutrition is not all due to poverty but also due to widespread ignorance of mothers about nutritional requirements of children.[37] But unfortunately she neither explores the epidemiological reasons, nor she explores out the reasons for the absence of amenities.

Less intake of food by women in general and pregnant women in particular is attributed to cultural beliefs. In a study,[38] it is said that maternal mal-nutrition is not just due to lack of diet, but also due to beliefs about maternal diet. Food is referred as a cultural concept in which beliefs are rigid and difficult to change in the interest of better nutritional status. Foster and Anderson say, "What tribal and peasant people have not learned in the relationship between food and health and between diet and pregnancy and the special food/needs of children.[39] Even the National Institute

---

36. P.C.Sen, "Ensuring Adequate Nutrition for Women by 2000 A.D.," DGHS Report, New Delhi.

37. Shanti Ghosh, (1976) "The Feeding and Care of Infants and young children," UNICEF, New Delhi.

38. "Dietary Habits and Beliefs in Pregnancy - A Bengal Study" (1966) "Swasth Hind", pp.33-37.

39. G.M.Foster, & G.G.Anderson, (1978) - Medical Anthropoligy, New York, John Wiley & Sons, pp.264-72.

of Nutrition in one of its studies concluded that most rural mothers do not give supplementary foods to their children because of fear and wrong belief.[40]

All these scholars attempt to study 'nutrition' in isolation with heavy emphasis on culture. They have failed to explore certain sociological as well as economic dimensions. In this way, they have failed to provide a link between culture and Socio-economic processes and hence treat the former as constant, rigid and unchangeable.

SOCIO-STRUCTURAL APPROACH

Batliwala in her article[41] has identified poverty as the main cause of nutrition problems among women. Shatragna says, Malnutrition is not due to the myth of protein deficiencies but it is due to food inadequacy. "Malnutrition is not a medical problem. It is a consequence of poverty, poor living conditions and lack of primary health care. It is a disease of socio-economic inequality".[42] Banerji, Qadeer, Sukhatme, Natarajan,

---

40. "Govt. of India: NIN on Supplementary food (1977) in 'Centre Calling', Vol.XII, No.11, Nov. p.7.

41. S.Batliwala, (1984) - op.cit.

42. Veena Shatrugna, (1980) - op.cit., p.3

Zurbrigg, Jaya Rao and a host of others have given clear and analytical picture of nutritional problems of women. Banerji in his paper[43] has very cogently identified the gaps in nutritional research and pleads for epidemiological research in the fields of nutrition in India which will consider social, economic and biolgocial implications of conditions of various grades of malnutrition with interdisciplinary research. Quadeer in her perceptive article[44] examined in some details the nutrition distribution programme of Govt. of India and concludes that it is not traditionalism or cultural backwardness, but the intensive area development model and the resultant inquality which is primarity responsible for the nutrition problems of the majority of the population.

Sukhatme demonstrated that protein gap only occurs when there is a calorie gap-but when overall intake of calories is sufficient, the amount of protein is also adequate.[45] In his other writings, Sukhatme has also

---

43. D.Banerji, (1979): "Epidemiological issues in Nutrition" in 'The Indian Journal of Nutrition and Dietect", Vol, 16, pp.189-194.

44. I.Qudeer, (1978) - "India's Feeding Programmes and their relevance", in Social Science and Medicine, Vol.12, pp.23-27.

45. P.V.Sukhatme, (1972): "India and the Protein Problem", Ecol. POL. & Nutrition, p.267.

questioned the statistical basis of the definitions of undernutrition and that of poverty.

But a little bit of critical analysis of Sukhatme's theory shows that as if women are the stumbling block in his analysis. Can women adopt to calorie deficits of 500 to 600 calories during pregnancy and lactation? Even if they can, Sukhatme ignores the possibility that such adoption over a life time may have disastrous consequences on health, Sukhatme didn't consider the vicious circle of maternal undernutrition, low birth-weight babies, high infant mortality or high fertility.

In an early National seminar on "Social and Cultural Aspects of Malnutrition' under the auspices of Nutritional society of India in 1968 some of the vital issues were raised. It is not our concern here to review all these materials. However, our analysis of maternal nutrition will remain incomplete if we don't give a brief analysis of Jaya Rao, who has really contributed something new in the parlance of nutrition.

According to Jaya Rao, "The nutritional status of any population group is a good reflection of its socio-economic status. Viewed with this perspective, nutritional problems of Indian women assume an entirely

different connotation. The problems do not arise merely out of poverty and ignorance; it has to be viewed in its totality. Neither nutritionists who formulate and recommend the programmes nor the administrators who are responsible for their implementation, appear to view the female first as a woman and an individual, but seem to view her only in her role as a mother.[46]

She further argues that it is a serious misconception to think that women's nutritional status can be improved through welfare programmes such as food distribution and anaemia prophylaxis. Also it is misconceived notion that the programmes will succeed through nutrition education. As long as our programmes will view women only as mothers, no concrete welfare could be made.

The problem, therefore, must be seen in its entirity. It must be appreciated that motherhood, howsoever significant, is only one aspect of female life. If nation has to change, women have to be brought into developmental process. They are dynamic factors of development, not merely a weaker section to be given concessions. Therefore, deliberate efforts are to be

---

46. Kamala S, ~~Gopal~~ Jayarao Rao, ~~Kamal~~, S. - op.cit., p.72

made in order to bring women into the mainstream of developmental activity.

Women, in rural India have been axed in this way. No 'pills' can help them in a society which consists of a small group of well-fed and very large group of them are under nourished.

There is neither proper land-distribution, nor irrigation facilities in most parts of the country. When, this is the state of condition in rural India, how can we talk of improvement of women's nutritional status? We have been talking of multi-sectoral and integrated approach to the problems of nutrition. But integration for whom and which level? India is a signatory to the Alma Ata Declaration to achieve Health for All by 2000 A.D. To achieve this we have increased our manpower, taken enough steps for better health through primary health centres etc. In the following pages we will examine how far the health services are accessible to rural women.

ACCESS TO HEALTH SERVICES

Accessibility to health services is one of the most important indicators of health status of women. The type of health services available to women also speaks of the status of women in India. The basic questions here crop up. What is the relationship between heath Services System and women ? or in other words, how do the -

health situation in India help in improving women's health status? Why the utilisation of health services by women is poor? What are the main reasons? Do women avoid ~~is poor~~ health care? What are the main reasons? Do women avoid health services of this country? What are the specific health programmes the Govt. has taken from time to time to deal with the health problems of women? Why these programmes have not come upto the mark? Is there any way out of this malaise?

These above questions are the main discussion points here. It is really difficult to answer all the questions within a limited framework. Therefore a succinct attempt will be made here just to outline some of these issues with clarity.

IN-ACCESSIBILITY: A GLARING PICTURE

A large number of studies have revealed that our socalled health care system hasn't been able to provide the necessary accessibility to the poor rural women. Even certain particular programmes have miserably failed to bring out the necessary changes of health status of women, specifically in rural areas. Primary Health Centres were meant to serve the health status of rural society. But that has failed miserably. According to Govt. of India report (1974), not more

than 11 per cent of the home deliveries in rural areas ~~are attended by any kind of the home deliveries in rural areas~~ are attended by any kind of a trained person, even though 93 per cent of the deliveries are conducted at home. The committee on the status of women in India reported that during their tours they were repeatedly informed of the inadequacy in the number of and services rendered by ANM. In rural areas, are attended by any kind of a trained person, even though 93 per cent of the deliveries are conducted at home. The committee on the status of women in India reported that during their tours they were repeatedly informed of the inadequacy in the number of and services rendered by ANM. In rural areas, 93 per cent of the deliveries are conducted at home. But only 18 percent of them are attended by any kind of a trained person ranging from dai to a private physician. "The committee on the status of women reported that during their tours they were repeatedly informed of the inadequacy in the number of, and services rendered by ANMS.[47] Even in 1978, about 75 per cent of the deliveries in rural areas were conducted by untrained practioners.[48]

---

47. Towards Equality, (1979), op.cit., p.

48. Office of the Registrar General 'Survey on Infant and Child Mortality, 1979; New Delhi.

Studies by Banerji (1981) is a glaring example of the accessibility of health services to rural women. His study along with other things shows how privileged class in rural areas exploits the services. According to his findings, PHC network like other welfare services, is not accessible to the poor. According to his Harijan Women respondent, "the Nurse is a memsab. How can she visit us? We are poor. We can't pay her fees."[49] In this way, Banerji finds on the one hand is the unmet felt need for the services of AMM at the time of child birth, and on the other hand, the rich section of rural society just take the advantage. The personnel of the PHC are also closer to the village elite who for their own interest provide them good facilities, rewards and even put in a good word for them with higher ups.

According to National Sample Survey Organization's (NSSO) data (1973-74) in Maharashtra as many as 90 per cent of rural pregnant women didn't register with any health centre.[50]

Another study by Djurfeldt and Lindberg (1980) in a Tamil Nadu Village, where a non-governmental

---

49. D.Banerji, (1982) Poverty, Class and Health Future Prachi, N.Dehi pp.67-68

50. Mandakine Khandekar, (1980) "Maternal and Child care in Maharashtra' (Secondary Analysis of NSS 28th round data for Maharashtra on MCH," Tata Institute of Social Sciences, Bombay.

organisation was running a health clinic shows that the government PHC in Combination with other institutions was providing services to less than 15 per cent of the village population while the elite of the village were unhappy with the voluntary organisation for treating them as equals to Harijans and putting them in the same queue.[51]

According to Prakash, it is felt that women have less access to health services not because they are healthier or possess adequate health knowledge, but becuase the health is a low priority.[52]

Another study by the Planning Commission reveals that about 59 percent of the pregnant women had no routine check up - about 23 percent had two check ups and the remaining 18 per cent three or more. The percentage of pregnant women who had no check ups at all was highest among the scheduled tribes (77 percent) and lowest (52 percent) among others. It was also found that only about 22 percent of pregnant women received immunization against tetanus. The evaluation report made by the planning commission on ICDS programmes showed that though the percentage coverage of pregnant women and nursing mothers by supplementary

---

51. G.Djurfeldt, and S.Lindberg, (1980) - Pills against Poverty: A study of the Introduction of Western Medicine in a Tamil Village, MacMillan Company, Ind., N.Delhi.

52. padma Prakash,(1980,"Women & Health:Health issue in the Context of Women's movement"A Seminar paper op.cit.,p.5

Nutrition had gone up at the time of the repeat survey (1977-78) as compared to the Baseline Survey (1976).[53]

A study[54] in a tribal district of M.P. has shown that the introduction of the community Health Workers' (CHW) Scheme has created yet another divide in the health services system. The poorer sections, who were earlier using the local healers for lack of accessibility to the PHC, now using the CHW in the hope of better treatment. But due to lack of effective linkages between CHW's work and PHC network, the PHC services remain as a distant dream.

Women are also constrained to utilize health services in rural areas which are staffed primarily by men. This has also been reported by the CSWI. "India does have a higher percentage of female health workers than even many developed countries. However, it is difficult to get them to accept postings in rural areas where the need is the strongest.[55]

---

53. 'Women's Health Status' (1985) India, Country Paper, Chapter V.

54. I. Quadeer (1985) "Social Dynamics of Health Care: A case study of the CHW scheme in Shahdol District (M.P.), "Socialist Health Review 11, (No.2)

55. Mona Daswani & G.A.A. Britto (1984) - "Women and Health: A critical review of available information in India, The Foundation for research in Community Health, Bombay, p.25.

Zurbrigg has very beautifully depicted the truth of rural women's in accessibility in South India. Sahu in his study[56] also finds the tribals (Oraons) particularly women fol(don't have access even to subcentres for minor-ailments.

Apart from the above studies, there are a sizeable number of studies which have exposed the inaccessibility of rural women to the health service system. To be precise, most of these have shown that rural poor particularly rural women get the hardest hit, because they have very little access to information, doctors, drugs, health care, transport and preventive measures. What is important to note that even after 39 years of independence, with heavy medical support including manpower, haven't been able to provide our women the minimum health facilities. The study[57] by Dandekar in 1957 in six rural communities in the districts of Maharashtra had provided an alarming picture of neglect of women's health in terms of

---

56. S.K.Sahu, S.K.(1986) - Health Culture of Oraons of Rourkela and its Hinterland, Ph.d Thesis, CSMCH/SSS, JNU

57. Quoted in Towards Equality (1979) op.cit., p.310

access to health services. But in 1980's the main focus of our study is also in tone with that. For example, when a woman tody in a village, entrests here village elite or money lender to help her in saving her dying husband or her dying son. She becomes vulnerable to exploitation: they can exploit her by extracting cheap labour from her; they may even exploit her because of her sex. Banerji, in this connection argues, this differential access to health services thus becomes a weapon for exploitation and oppression in the hands of the privileged class.[58]

On the basis of the above studies we can safely analyse that MCH services are rudimentary. Their integration with family welfare services has not yielded fruits in any way. Women in India need more than just maternal and child health. The Capital-intensive health care system of India is exotic, top-down, elite-oriented, urgan-based, centralised, bureaucratized and exclusively curative in nature. Committee after committee has given recommendations which are of no avail. Rural health care is a neglected area of health system.

---

58. Banerji, D (1975): "Health as a Lever for another development" in Development Dialogue, Vol.1 pp.19-25.

We have passed resolutions, instituted committees, given social Welfare measures, introduced hundreds of scheme, expanded primary health care in principle. But the role of women in primary health care approach as consumers and providers of health services have not been realised.

Now, having analysed the indicators of health status of women, let us provide the critic of different programmes which we have discussed in earlier chapter.

HEALTH PROGRAMMES FOR WOMEN: TOWARDS A CRITIQUE

Maternal and Child Health Programme:-

Inspite of the successes achieved by MCH programme, the failures have been more pronounced. At operational level MCH services have not been properly integrated. The so-called integration of MCH with family planning has resulted in the dominance of family planning and uttar neglect of MCH. This has been demonstrated by the working group on 'Health for all: Because of inadequate coverage, even after three and half decades of the launching of MCH, no significant improvement has been found. It is to be noted that MCH doesn't measure the performance of preventive activities in terms of their epidemiological impact. Apart from the

operational level, there are also certain serious limitations. The MCH was not directly derived from the basic needs of Indian population, but from the prescriptions of the British Medical Council. The social dimensions have been neglected. The MCH has been technocratic.

NATIONAL NUTRITION PROGRAMMES

The approach we have taken for solving nutritional problems of women is faulty. No amount of pills, pockets or social welfare measures will tackle the problem, unless its roots, poverty and hunger are emphasized. A study[59] by Raye reveals inadequacies in all the three major categories of services envisaged under the scheme-nutrition, health and non-formal education. Also, in many of the projects, there is irregularity of the supply of necessary materials lack of co-ordinated approach between health and non-heath staff, poor performance of the functional literacy component. The Sixth Five Year Plan confesses,

---

59. Santa Raye, (1982): "A Study of interaction between ICDS Scheme and the Community in three Anganwadi's of the Tribal Development Block at Sabdega in district Sundargarh (Orissa)", - An M.Phil. Dissertation, JNU CSMCH/SSS, N.Delhi.

Nutrition programmes introduced in the past didn't succed, as their implementation was not closely linked with other programmes like provision of employment, health, safe-drinking water, and improvement of sanitation and hygiene.[60]

FAMILY PLANNING (WELFARE PROGRAMME)

The basic theoretical tone behind family planning in India is Neo-Malthusianism which argue that the teeming millions are responsible for the increasing poverty. But the real issue is socio-economic inequalities, which have been neglected. However, at the implementation level, there are also a lot of problems. Poor Women in rural areas are given monetary incentive and therefore, they are ill-treated. All forms of compulsory sterilizations create unnecessary health problems. Due to lack of safe birth-control measures, women's health is adversely affected. Shatrugna has categorically unalysed the adverse effects of different measures in her book[61] with data.

Moreso, different research projects use poor

---

60. Sixth Five Year Plan, Govt. of India (1981), p.379.

61. Veena Shatragna, V. op.cit. pp.45-56.

women as the purpose of drug-research in the name of providing free pills. There is also over-emphasis on family planning. Technology has been used as an instrument of women's oppression. For example, use of loops which were introduced in the 1960s without proper medical care and follow up created more problems. Thus, family planning created more problems.

MTP PROGRAMME

MTP services are considered as a part of the health services, not a part of the National Family Planning programme. No separate budget has been allotted for MTP.

There also exists problems of lack of information, limited publicity and the widely held belief that abortion is illegal. Due to lack of abortion facilities, rural women come to the urban clinics at a later stage. The problems still are doctor's attitude towards abortion, so called moral issues and the question of morality and dignity. A large number of so-called illegal abortions are performed by dais and local abortionists

causing more pain and problems. As far as MTP Act is concerned, Section 8 of the Act provides over riding precaution to the doctor for any damage caused by the operation. It is not the real issue. The method of persuasion is important. The procedure and paper work involved in these operations are so complex to deal with. In this way, MTP has not come upto the mark.

Dai Training Programme

The dais training programme has not been successful due to the faulty approach. There are certain problems such as caste question. Also, one dai is not acceptable to the whole village. Moreso, this programme has been neglected due to over-emphasis on family planning.

Now, after critically analysing the health status of women and different health programmes for women, we are in a position to argue that in a stratified and hierarchical society like India where limited resources are being expropriated by a few persons, women, particularly rural women will definitely have less access to health care and other services. It is interesting that glaring class differentials along with a hiatus between men and women are visible in the health services

structure. This has to be seen from a holistic perspective. Judging from that perspedtive and cultural patterns not only lead to extensive poverty and inequality of the majority but also excessive deprivation and hardships for women in particular. This socio-economic and cultural processes affects health.

Next Chapter, we will assess the major social science issues and chalk out some general considerations for improvement of health status of women.

CHAPTER - IV

WOMEN AND HEALTH : A PERSPECTIVE

The area 'Woman and Health' is vast and of bewildering complexity. Throughout this dissertation we have tried to raise critical and challenging issues of women's health in rural India. We have clearly shown that the health of women in any community is the best indicator of whether a health system is effective or not. Health is not mere absence of disease. Autonomy, self- reliance, the ability to live independently and interdependently, and the possibility to develop fullest potential are necessary for a healthy woman. Not only that, women's health is affected by their social status. Therefore we have discussed in greater details the fundamental issues of women's health such as poverty, class, caste, family, agriculture and land structure, education, occupation, political structure, value system along with nutrition, sanitation, infections, stress, overwork, workhazards, drugs, contraception, and sexuality. Our analysis has shown that in all these aspects, women, particularly rural women have been neglected. In the analysis of women's health problems, it is found that discrimination of women continues from birth to death. Also we have measured the low profile of their health status considering the major indicators like sex - ratio, life - expectancy, morbidity and mortality pattern, nutrition and access to health services.

Health services structure has miserably failed to raise the health status of women, particularly in rural India.

The problem of ill-health of women is not one that can be solved by more or better medical care, health insurance, health education, while these may be desirable in themselves, they can't address the fundamental santitation, water supply and housing, hunger, illiteracy, unemployment, gross social injustice and discrimination generate ill health.

The researdh questions which have cropped up in our work are as follows. The socio-economic and cultural processes involve women's status as well as their health. But why these processes have been lopsided? Can health status of women particularly in rural areas be handled by tinkering with the health service system alone? How relevant are the concepts of 'integrated approach', 'comprehensive planning', 'primary health care' in the present Indian set up? If class is the key factor, then which class will undertake the historic task of ensuring that the vast mass of toilers get their basic rights and how?

How to organise peasant women to raise their status? How to tackle the problem of attitude? How will we combat the patriarchal value-system? What measures are necessary to place women in decision making process? Do women avoid health care? Why there is no equitable participation of women at all levels of the health care system? Can women's emanicipation be possible only through economic progress?

In the context of women's health movement, again fundamental queries are - what type of leadership is necessary for women's health movement? What are the issues? Can an autonomous women's health movement will take care of ill-health of women in rural India?

The above research questions are thought - provoking. It is not our aim to analyse each and every question separately because of the enormous amount of complexity involved in it and the limitations we have in this exercise. However, extensive well-designed empirical studies can well-tackle the above questions.

Theoretically, a perspective can be developed

with regard to women's oppression in general and their ill-health in particular. In second chapter, we had extensively dealt with different theoretical standpoints on women's issues. Also we had hinted at a perspective. Now, our perspective is elaborated below.

Mainly there are three distinct approaches to the analysis of women's status in society, and thus of women's relation to the health care system. These are liberal feminism, radical faminism and marxist faminism. Liberal feminists never challenge the existing system, within the system, they want certain constitutional amendments. They see the social sub-ordination of women as reflected in the sexual structure of the organisation of medicine. They argue that equal number of female physicians with male physicians can be of great help to the health problem.

But these liberal feminists never challenge the fundamental issues. They have a cosmetic view, that too only at the surface level. Their approachs to the problem of medical care is limited to middle and upper-class consumers. Hence, their views, are not relevant.

Radical feminists want to transform existing social institutions entirely from the clutches of patriarchy. They attributes men as their sole enemy. For them, medical profession is a yet another system which conforms to the patriarchal pattern established in the family. They argue that women should understand their bodies and know what reasonably to expect from physicians. Only then can they judge for themselves with competence of the care they receive.

But, in ultimate analysis, their theory is at the level of abstraction. Because, the struggle is not between men and women. They may talk of medical women's health movement through self-help movement with the establishment of feminist health centres. The important limitation is that they are only concerned with specific reproductive system. But a women's health is more than the care of reproductive system. Therefore, this school of thoughht does not provide convincing theory.

Marxist-feminists argue that the essential taks of theoretical development within the women's movement is to bring together feminist consciousness with the historical and dialetical method of analysis. According to this school of thought the fundamental antagonism

in society is that of between classes, not of sexes. The class struggle between exploited and unexploited, whatever their sex, is the driving force of historical change. Women's oppression can only be understood in the context of the wider relations of class exploitation. The gulf between slave-owner and slave, or king and peasant, makes the concept 'men' meaningless - likewise, the gulf between the slave-owner's wife and the female slave makes the concept 'women' also meaningless.

According to Marxist feminists, women are part of the society in which they live, and hence their situation cannot be studied in a vacuum. The position of women in society and the structure of the family can be understood only in the context of the prevailing mode of production. In capitalist society, the role of bourgeois women is to produce legitimate heirs, who will be able to carry the accumulated wealth of the ruling class into next generation. The role of working-class women is to reproduce this and the next generation of workers. And no women of the ruling class do benefit from the oppression of working-class women, for they benefit from the employment of cheap female labour. On the whole, they argue that rejection of capitalism

and its replacement by a humane, democratic socialism will take care of women's problems.

In this way, they state that the health system mirrors the priorities and organization of the whole system. In medicine, as in the condition of women generally, marxists find crucial contradictions. On the one hand, the possibility of extending superb health care to the entire population exists, we have the knowledge, the reasource, and the need. But the social relations of health care, the way in which it is controlled and organized, act as fetters. They believe that the only way to liberate the potential for improved care and better preventive measures is to retire and replace the capitalist order with a democratic socialist one.

There are certain criticisms against marxist feminism. For example, some criticise that marxists have no answer to specific problems like wife-beating, alcholism and the nature of the family.

However, our perspective is very clear. We do believe that economic independence of women is a necessary pre-requisite for women's liberation. In

Indian context there is need for effective linkages between women's movements and other broad-based mass movements. It is true that in India, we have pre-capitalist relations along with capitalist economic development. Therefore along with economic issues our women's movement has to give due consideration to the obscurantist cultural values, rape, dowry-deaths, prostitution, wife-beating, pervassive sexism in media, female infanticide etc. as the main issues. In the field of health, also there needs protest against forced sterilisation and abortion, use of amniocentesis test as birth control measure, un-necessary testing of drugs etc. This can be possible through autonomous women's movement. By autonomy we means independence of political ideology not necessarily apolitical. In this way people from different ideologies may organise on common issues. What is more important is that any decision taken on women's issues should be primarily decided by women only. They have to define the course of movement. Contributions to the advancement of marxist theory must come from women, whether they define themselves as feminists or socialists. Men sensitive to women's issues can help a lot in this

direction.

In the field of medicine, what is necessary is to explore and create a more holistic approach. A holistic approach will follow the following consideration -

a) Consideration of different dimensions of different community health problems including the ecological, cultural, social and economic factors. It can be done through epidemiological analysis.

b) Identification of people-oriented technology with people's active participation.

c) Identification of socio-cultural variables which can be effectively related to the delivery system supportive variables such as supplies, transport, referral system and supervisory staff.

d) Consideration of education and proper training of health workers of different categories and research, planning and evaluation.

e) Involvement of women in all decision-making processes.

With this approach as a theoretical base, some

general considerations for an alternative health care system may be analysed.

WOMEN AND HEALTH SERVICES : SOME GENERAL CONSIDERATIONS

It is estimated that eighty per cent of the Indian population live in rural areas, whereas eighty percent of the health budget is spent on urban areas. Rural India presents a gloomy picture of wide-spread poverty hunger, social injustice, extremely poor environmental conditions, extensive illiteracy, unemployment and exploitation of cheap lavour etc. The planners and even the members of different committees have not understood the above reality. To many of them, village is still remains as a concept. Therefore, the lofty recommendations remain only in paper and the rural rich eats the fruits of development. And women are the worst to suffer.

As a first consideration, proper resource mobilisation is necessary which will consider rural health as the priority area. Second, the whole approach to the health system must be community based and there is a need for relaxation in the entire culture of the

health services system - changes in the value system, in the socialisation of health personnel, social orientation of administrative apparatus and research institutions.

Third, integration of health services is a key factor. Preventive, curative and promotive services have to be effectively integrated from top to bottom. Promotion of indigenous system of medicine like Ayurveda, Unani etc. are to be emphasised. There must be linkages be between different sectors of development.

Fourth, priorities and issues are important. Larger production and better distribution of food, universal education and abolition of poverty are main priorities. Moreso, women are to be brought into the mainstream of development in general and health services in particular.

Fifth, proper training of health agents, paramedical staff, nurses, CHVs, ANMs, Dais at the community level are vital needs.

The above five general considerations are not enough. Because, for the last some years, we have been talking of eye-catching concepts like 'people's health in people's hands,' community approach, holism,

integration, appropriate technology and primary health care etc. But it seems as if all these are increasingly irrelevant due to the apathetic social structure. Without conscious and systematic efforts to change the existing social matrix or at least controlling the key components of the system, perhaps it will be unrealistic to talk of alternatives. Therefore, within the existing structure the above basic considerations were given for analysis.

The above analysis clearly reflects that social scientists have a vital role to play in research for the dissemination of knowledge on health issues. But unfortunately in India, social scientists involved in health due to prejudices, subservience to political and market forces etc, have not developed adequate theory and concepts.

CHALLENGE TO SOCIAL SCIENTISTS

The challenge is directly to social scientists and the leaders involved in the women's liberation movement to develop comprehensive social science approach to the study of women and health services. We had already identified the gaps earlier. But some

specific researchable areas are identified below. Considering the cultural, social, economic, and political diversities of India, suitable alternative approaches to be developed for empirical studies in these areas. The areas are as follows.

i) Health implications of changing pattern of women's work and family structure. In particular, how women's roles in the formal and informal labour market effect their role as mothers, and influence child health, and how women's roles affect family health care and what actions are required to support in carrying out their many roles,

ii) Researches should be directed towards the diseases as well as the sex-differential impact of the diseases along with social factors. This will facilitate to document the others health problems faced by women except their specific health conditions.

iii) Studies on occupational health are really rare. There is a need to undertake empirical researches on which occupations and in which way it effect's women's health negatively.

iv) Urgent researches are needed in the field of man-power development in the context of rural health. Studies on ANMs, Dais, LHVs and other paramedical staff will highlight the real problems of the implementation of health services system.

v) Physical violence against women (wife-beating, burning to death, rape etc. is common in India It causes injuries and death. However, its medical implications on a women's body are still not documented. But researches can be carried on the mental effects of such ill-treatment.

vi) Women's health problems have so far been minimised because data are generally not available to highlight the issue. It is equally true that data are not available because the problem hasn't been acknowledged. Therefore, urgent researchs are necessary in this area. A study on different women's organisations and their efforts to raise health status of women may be of immense help.

To sum up, today, inspite of decades of development

conditions of rural women in India have not changed much. The authoritarian patriarchal values, obscurantist forces and double exploitation by virtue of class and sex still smother the lives of millions of rural women. A small section of elite women have secured the real benefits. Science in general and health in particular is impregnated with ideologies which do not take into account the real needs of women and which, on the contrary, reinforce women's secondary position. Indian feminists have been talking of women's health movement in India since late 1970s. Their demands for women's right to decide if and when to have children, the right to safe and effective contraception, the right to safe and legal abortion, the right to freedom from sterilisation abuse etc., are definitely issues of significance. Their argument that women be the mistress of her own body may have certain grains of truth. But what is lacking in them is a strong theoretical analysis and attacking the fundamental issues at hand.

Thus, women have played and can also effectively play a key role in bringing about a necessary transformation. They have to organise a grass-root level

movement to fight against all sorts of oppression and ideological legacy. For this, economic emancipation is quite necessary. Also, they have to ~~fought~~ fight relentlessly against social subjugation. Women, have started organising themselves in various parts of India on different issues. A proper link up of these organisations is a challange. A systematic and conscious blending of women's movement with that of the wider struggles needs to be evolved. We do hope that the women's struggle in India will definitely bring about social changes in a desired direction provided the intellectual commitment of researchers in the field of women's studies and the active role of activitists help, at least, in the generation of sensitivity among the masses to women's issues.

BIBLIOGRAPHY

Ahmed, Karuna (1982) : "Family and Women's Education", A Paper prepared for the workshop on Family Research in India organized by C.W.D.S., New Delhi, from Nov. 10 to 12, 1982, IIC, New Delhi.

Aleyamma, George (1975) : "Literacy : Doorway to Liberation", Social Scientist, Nov.-Dec., 1975.

Asuri, T.Padmasiri (1976) : "Rural Women in India today" Religion & Society, vol. 23.

Banerji, D (1975) : "Health as a Lever for another development", Development Dialogue, Vol. I, pp.19-25.

Banerji, D. (1979) : "Epidemiological issues in Nutrition" The Indian Journal of Nutrition and Dietect", Vol. 16, pp.189-194.

Banerji, D. (1981) : "Indian Women and the Health Services" A report presented at the National Conference on Women's Studies held in Bombay, Apr. 20-23.

Banerji, D. (1981) : Poverty, class and Health Culture in India, Prachi, New Delhi.

Banerji, D. (1985) : Health and Family Planning Services in India : An Epidemiological, Socio-Cultural & Political Analysis and a perspective, Lok Paksh, New Delhi.

Bardhan, Pranab (1982) : "Little girls and Deaths in India", EPW, Sept. 4.

Batliwala, S (1983) : "Analysis of Mandwa Death information 1982, "A Mimeo at The Foundation for Research in Community Health, Bombay, January.

Batliwala, S. (1984) : "Rural Energy Situation: Consequences for Women's Health", Socialist Health Review, September.

Batliwala S : "Women and Health Care" - A mimeo paper by the Foundation for research in Community Health, Bombay.

Beteille, Andrew (1975) : "Position of Women in Indian Society" in Jain, D. (ed.) : Indian Women Govt. of India, publication division, New Delhi.

Bhasin, Kamla (ed) (1972) : The Position of Women in India, Proceedings of a Seminar held in Srinagar, September.

Census of India (1981).

Chakravarty, K (1975) : "Employment, incomes and equality" Social Scientist, Nov.-Dec. 75, pp. 104-14.

Chakravarthy, K & Tiwari, G.C. (1979) : Regional Variation in Women's Employment - A Case Study of five villages in three Indian states, ICSSR, New Delhi.

Chakravarti, Uma (1986) : "Pativrata", Seminar, February.

Chattopadhyaya, Kamaladevi & others (1939) : The Awakening of Indian Women, Everyman's press, Madras.

Childe, Gordon (1964) : What happened in History, Penguin, Middlex.

Chitnis, Suma (1975) : "Re-definition of sex-roles" in the ed. Book of Jain, D.; Indian Women, Govt. of India Publication.

Cottingham, Jane (1983) : "Women and Health : An Overview," Women in Development : A resource guide for organization and Action, ISIS, Geneva.

CWDS (1983) : "Women's work and Employment Struggle for a policy selections from Indian documents", New Delhi.

Daswani, M. & Britto, G.A.A. (1984) : Women and Health -- A Critical review of available information in India" The Foundation for research in Community Health, March.

Daswani, Mona (1984) : Analysis of Mandwa Death Registration 1983, Mimeo at the Foundation for research in Community Health, Bombay, February.

Desai, Neera (1957) : Women in Modern India, Vora & Co. Publishers, Pvt. Ltd., Bombay.

Desai Neera & Patel Vibhuti (1985) : Indian Women : Change and Challange in the International Decade (1975-85), Popular Prakashan, Bombay.

De Souza, Alfred (1976) : "Women in India : Fertility in occupational patterns in a sex-seggregated Less developed society", Social Action, vol. 26.

Djurfeldt, G and Lindberg, S (1980) : Pills against Poverty : A study of the Introduction of western medicine in a Tamil Village, Macmillan Company of India, New Delhi.

Durkheim, E (1952) : Suicide : A Study in Sociology, The Free Press, New York.

Engels, F (1968) : The origin of Family, private property and the state, progress, Moscow.

Erickson, E.H. (1974) : Dimensions of New Identity, Light and Life Publishers, New Delhi.

Fee, Elezabeth (1975) : "Women and Health Care : A Comparison of Theories", International Journal of Health Services, Vol.5, No.3.

Foster, G.M. & Anderson, G.G. (1978) : Medical Anthropology, New John Wiley & Sons, New York.

Freud, S (1952) : The Major works of Sigmund Freud, William Benton, New York, INC.

Ghosh, Barun (1983) : "Abortion : A Problem that would not go away" The Telegraph, Aug, 7.

Ghosh, Shanti (1976) : The Feeding and Care of Infants and Young Children", UNICEF, New Delhi.

Gerth, M.A. & Mills, C.W. (1970) : From Max Weber - Essays in Sociology, Routledge and Kegan Paul, England.

Govt. of India (1946) : Report of the Health Survey and Development Committee, Vol. III (Appendix), New Delhi.

Govt. of India Publication (1974) : Report of the Committee on the Status of Women in India, Dept. of Social Welfare., New Delhi

Govt. of India (1977) : "NIN on Supplementary food" 'Centre Calling Vol. XII, No.11, Nov. p.7.

Govt. of India (1979) : Office of the Registrar General Survey on Infant and Child Mortality, New Delhi.

Govt. of India (1981) Sixth Five Year Plan (1980-85), The Planning Commission, New Delhi.

Govt. of India (1984) : "Women's Health Status", India Country Papers,

Govt. of India (1985) : "Health Statistics of India" Ministry of Health and Family Welfare, New Delhi.

Govt. of India (1985) : Seventh Five Year Plan (1985-90) Vol. II.

Gulati, L. (1975) : "Sex-discrimination in wages", Social Scientist, Nov. - Dec.

Gulati, L (1981) : Profiles in Female Poverty Hindustan Publication, Delhi.

Hate, C.A. (1969) : Changing Status of Women in Post-Independence India, Allied Publishers, Pvt. Bombay.

ICSSR (1974) : Status of Women in India, Delhi.

Indian Express (1985) : "Coping with Menopause", February 26.

Jain, Devaki (1979) : Women's Quest for Power : Five Indian Case, Vikas Publ., New Delhi.

Jayarao, Kamala, S. (1983) : "Who is Malnocrished: Mother or the Women" in Health Care : which way to go, Issues & Alternatives, M.F.C., Pune.

Jeffery, Patricia (et.al.) "Child birth and collaboration among women in Bijnor District."

Jesudason, Victor and Chhatterjee, Meera (1980) : "Inter-relationship of Health indices of Women in two rural communities, Social Change, September-December, pp.27-34.

Jha, Soroj S. (1983) : "Indian Women : Health Status in the Context of Social development", The Journal of Family Welfare, 29, 4.

Joshi, P.C. (1975-76) : Land Reforms in India. Allied Publishers, Bombay

Kasturi, Leela (1977) : Poverty Migration and Women's Status, An ICSSR Project.

Kelkar, G (1981) : The Impact of the Green Revolution on Women, Work Participation and Sex-roles, ILO, Geneva.

Khandekar, Mandakini (1980) : "Maternal and Child Care in Maharastra." Secondary analysis of NSS 28th round data for Maharastra on MCH", Tata Institute of Social Sciences, Bombay.

Kohli, K.L. (———) : Mortality in India : A State-wise Survey. ICSSR

Kynch, Jocelyn & Sen, Amortya (1983): Indian Women : Well-being and survival, A paper presented at the workshop on "woman and poverty" Centre for Studies in Social Sciences, Calcutta, March, 17-18.

Kulkarni, Suresh, N : Demographic and Nutritional Background of the Health Status of Women in India, IEG, Delhi University.

Levi-Strauss, C. (1969) : The Elementary Structures of Kinship, Bacon Press, Boston.

Madhok, Sujata (1986) : "At the work place" Seminar, 318, February.

Maine, D (1981) : "Family Planning : Its Impact on the health of Women and Children", Centre for Population and Family Health.

Marieskind, Helen (1975) : "The Women's Health Movement", International Journal of Health Services, Vol. No.5, No.2, PP.217-223.

Marilee, K (1983) : "Women, Land and Food Production" in Women in Development; A resource guide, ISIS, Geneva.

Marx, K & Engels, F (1977) : Menifesto of the Communist Party, Foreign Language Press, Peking.

Marx, K & Engels, F (1958) : "The part played by Labour in the transition from Ape to man", Selected works, vol. II., Foreign Language Publ., Moscow.

Marx, K (1977) : Capital : A Critique of Political Economy Moscow Publishers, Progress, Vol. I.

Mathew, P.M. (1985) : "Exploitation of Women Labour: An Analysis of Women's employment in Kerala", Social Scientist, Oct-Nov.

Mazumdar, Vina (1976) : "The Social Reform movement in India from Ranade to Nehru", in B.R.Nanda' (ed) : Indian Women from Purdah to Modernity, Vikash Publ., Delhi.

Mazumdar, Vina (1978) (ed.) : Role of Rural Women in Development, Allied Publishers, Bombay.

Mazumdar, V. and Sharma Kumud (1979) : "Women's Studies Perceptions and Challenges", EPW, Vol. 15, no.3.

Mazumdar, Vina (1984) : "Women and development in India", The IDRC Report, Vol. 13, No.2, July, [illegible].

Mazumdar Vina & Pande, Balaji (1985). "Perspectives on Women's Education, 1901-81" A Paper for Women's NGO Consultation, New Delhi, on 3rd April.

Mehra, Rekha & Saradamoni, K (1983) : Women and Rural Transformation: Two Case Studies, Concept. Publ., New Delhi.

Mies, M (1980) : Indian Women And Patriarchy, Concept Publ., New Delhi.

Millet, Kate (1971) : Sexual Politics, Hart-Davis, London.

Mitra, Asok (1979) : Implications of Declining Sex-ratio in India's Population, Allied Publishers, Bombay.

Mukherji, D.P. (1951) : "The Status of Indian women", International Social Science Bulletin, vol. 3, No.4, pp.790-801.

Myrdal, Gunnar (1968) : Asian Drama : Inquiry into Poverty of the Nations, Twentieth century, New York.

Naik, J.P. & Bardhan, Kalpana: "Nutritional Problem of Women in India : Some Socio-economic issues" (Ministry of Education, Govt. of India, New Delhi, A Report.

Nisbet (1970) : The Sociological Tradition, Heinemann, London, [illegible].

Omvedt, G (1980) : We will smash This Prison, Orient Longman, Indian edition, New Delhi.

Pande, Balaji (1985) : "Women's Education", Social Scientist, Oct. Nov.

Parsons, T (1956) : "The American Family : Its relations to personality and to the social structure," in T.Parsons and F.Bales : Family, Socialization and Interaction process, Routledge & Kegan Paul, London.

Prakash, Padma (1984) : "Roots of Women's health : Editorial Perspective", Socialist Health Review, Sept.

Publication (1966) : "Dietary Habits and Beliefs in Pregnancy - A Bengal Study", Swash Hind, pp. 33-37.

Publication (1982) : 'Shutting out or shying away", Health for the Millions, Vol. VIII, No.4, Aug., VHAI, New Delhi.

Publication (1982) : "Double, trouble and toil" Health for the millions of special issue as women & health, Vol. VIII, No.4, VHAI, New Delhi.

Publication (1984) : 'Women's World' - A news letter by ISIS, Sept., 1984, No.3.

Quadeer, Immrana (1978) : "India's Feeding Programmes and their relevance", Social Science and Medicine, Vol. 12, pp.23-27.

Quadeer, Imrana (1985) : "Health Services System in India: An expression of socio-economic inqualities", Social Action, Vol. 35, July-Sept.

Quadeer, Imrana (1985) : "Social Dynamics of Health Care : A case study of the CHW scheme in Shahadol district (M.P.)", Socialist Health Review, 11, No.2.

Rao, Nina (1985) : "The Woman Question: Perspectives for today" Social Scientist, Vol. 149-50.

Raye Santa (1982) : "A Study of interaction between ICDS Scheme and the Community in three Anganwadis of the Tribal Dovelopment Block at Sabdega in District of Sundargarh (Orissa)" - An M.Phil. Dissertation, J.N.U., CSM CH/SSS, New Delhi.

Report (1980) ; "Health for All An Alternative Strategy", ICSSR ICMR Report, P

Report (1985), Women, Health and Development, director-general, WHO's offset publication, no.90. WHO, Geneva.

Research (1968) : Demographic Social and Medical Aspects of Abortion 68, Demographic Training and Research Centre, Bombay.

Sahu, S.K. (1980) : Health Culture of Oraons of Rourkela and its Hinterland, Ph.D. Thesis, CSMCH, J.N.U., New Delhi.

Saikia, P.D. & others (1981) : Changing role of Women in rural societies, ICSSR Project.

Sen, Amartya (1983) : "How is India doing?" Mainstream, Republics Issue.

Sen, P.C. : "Ensuring Adequate Nutrition for women by 2000 A.D." DGHS Report, New Delhi.

Sen (A) & Sengupta (S) (1983) : Malnutrition of Rural Children and the sex-bias" 'EPW', Vol. XVIII, Annual number,

Sharma, Kumud & others (1984) : Women in Focus : A Community in search of equal roles, Sangam Works, Hyderabad.

Shatrugna, Veena : Women and Health, Research Unit on Women's Studies, Current information series - 2, S.N.D.T., Women's University, Bombay.

Shatrugna, Veena (1980) : "Health Status of Women and Children and the role of Community Health Volunteers scheme" A Paper presented at the national conference on the perspectives of the women's movement in India, at Bombay, Nov. 1-3.

Simone de Beavair (1953) : The Second Sex Penguins, London.

Singh, Y (1973) : Modernization of Indian Tradition, Thomson Press (India) Ltd., Faridabad.

Srivastava, J.C. (1982) : "Technology for Development of Rural Women", Khadi Gramodyog, Vol. XXVIII, No. 4, January.

Sukhatme, P. (1972) : "India and the Protein Problem", Ecol., Pol & Nutrition.

Swaminathan, M.S. (1982) : "The role of education and Research in Enhancing rural women's income and household happineos', First J.P. Naik Memorial Lecture, CWDS, Publication, P.7.

The Hindu (1983) : "Highest incidence of nutritional anaemia in Indian women", July 21, '83.

The Statesman (1986) : "Malnutrition high among fisher-folk", March 5, Column I.

The Statesman (1984) : "Slow death is their lot", 4th June, 84.

The Telegraph (1983):, 17th Jan.

Twaddli, Andrew, C. (1974) : "The concept of health status", Social Science and Medicine, Vol.8,

UNICEF (1984) : An Analysis of Situation of Children in India, New Delhi.

Visaria, Leela (1985) : "Infant mortality in India : Level, trends and determinants, Part-II" EPW, vol. XX, No.33, August, 17.

WHO : Preamble to the Constitution of World Health organization.

WHO (1966), "Who vital statistics of South east Africa Region" quoted in Govt. of India: Toward Equality (1974).

Who (1976): "The Health Status of Mothers and children : present situation and recent trends", New Trends and Approaches in the delivery of MCH in Health Services, sixth report of who expert committee on MCH, Technical report series 600, who, Geneva.

WHO (1980) : Health and the Status of Women", Division of family Health, FHE/80.

WHO Technical Document (1980) : FHE/80, p.6.

WHO (1980):Women, Health and Development, Kits,11,P~~22~~.

WHO (1982): "The prevelance of Nutritional Anaemia in women in Developing Countries: A critical review of Available information,World Health Statistics Quarterly, No.2.

Zurbrigg, Sheila (1984) : Rakku's Story-Structures of ill health and the source of change, Madras. Eidma abbisct Press